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★ ★ JUNE 1944 ★ ★

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An Invitation To You

The STEIN-CAHILL Uniform Company looks forward to greeting you at the Biennial Convention of the American Nurses' Association, June 5th to June 8th in Buffalo. We will occupy Booth Number 9 and invite you to stop and say hello.

EDITORIALS

A Proud Profession

Prouder dress no woman wears
Whatsoever be her station;
Simple though it is, it bears
Pride of glorious occupation.[1]

NURSING is a proud profession. Over 90,000 young women are now wearing the gray and scarlet uniform of the U. S. Cadet Nurse Corps which exceeds, in numbers, all other uniformed women's services. The recruitment theme, "Join a Proud Profession," has been so skilfully and extensively used that the people of this country are more aware than ever before of nursing and of its importance.

Preinvasion tension is mounting rapidly and the war clouds over China are growing more ominous as this is written. The Army Nurse Corps had reached the previously announced goal of 40,000 authorized for the year ending June 30 when, early in May, the War Department officially notified the Directing Board, Procurement and Assignment Service, War Manpower Commission, that the ceiling had been raised to 50,000. The majority of these additional nurses should be secured when possible from recent and new graduates. Actual appointment of nurses, however, will be determined by the needs of the Army in relation to casualties and by the rate civilian nurses are declared available by Procurement and Assignment Service. Surgeon General Kirk has said:

> Much of the Medical Department's success with new drugs, such as penicillin and the sulfa drugs, has been due to the constant care and watchfulness of the Army nurse. Her ability and resourcefulness and her willingness to serve in all theaters under trying conditions, has made a great difference in the recovery of sick and wounded soldiers.[2]

Nursing is a proud profession for it has abundant reason to be proud of the service of Army and Navy nurses. We are confident that the new goals will be reached, namely, an additional 5,000 plus the number necessary for replacement by the end of 1944 and an additional 5,000 early in 1945. The Navy, it should be noted, has not changed its previous request for 500 nurses each month.

"The theory on which any democracy must fight a war," says Elmer Davis, "is that when the people understand what is expected of them, and why, and are convinced that it makes sense, they will do whatever is necessary." The importance of careful distribution of nurses in order that nursing service may be made available in relation to human need, is not difficult to understand. It makes sense to nurses. What makes the process of classification and distribution difficult is the "human equation," the complexity of each nurse's relationships and obligations, as well as her adaptability, her character, her sources of information, and her judgment in applying general principles to specific situations. Nursing is a proud profession because its service is essential not only to the military but to the civilian population.

The classification of nurses, we were informed early in May, was proceeding rapidly in thirty-eight states. Undoubtedly the process is now gaining momentum in all states. This, beyond doubt, is the most difficult task ever attempted by the profession. Military service for nurses is not compulsory, nor can any nurse be compelled to accept a civilian position, no matter how well qualified she may be for more urgently needed service than that in which she is engaged. Nurses are in no sense being regimented, but each and every nurse of military age is given the opportunity "to see oursel's as others see us," and to check a dispassionate evaluation with her personal conception of how and where she can be most useful. "One Hundred Who Were Private Duty Nurses" (p. 559) admirably illustrates the point.

Nursing is a proud profession, because most nurses have always responded to the challenge of difficult situations. Pride means different things to different people. The word has too often been associated with haughtiness. That combination is both superficial and unpleasant. Nursing is a proud profession, but its pride is a deep and powerful emotion. This wholesome pride is a dynamic and creative force for it is rooted in the dependable characteristics of the individuals who are members of the profession and in the individual and collective achievements of nurses. It accounts for the persistent

[1] "Nurse's Uniform," by Edgar A. Guest, *Detroit Free Press*, April 11, 1944. Copyright by the author.
[2] War Department release, May 5, 1944.

effort of the profession to improve its service and, at the same time, the status of nurses.

We have not the slightest doubt that a sufficient number of students will enter schools of nursing in June to complete the quota of the Cadet Corps for the year ending June 30. They will indeed be entering a proud profession and we have faith to believe that they will wear the uniform proudly and "wear it right," and that the cadets will enhance the usefulness and the prestige of the profession.

Few Experts in *Nursing*

THE NURSES who have acquired a body of knowledge, appreciations, and skills in any field of clinical nursing which is well beyond that which can be acquired in a good basic course may justly be called experts in their chosen fields. The number known to be expert in the several fields—maternity, orthopedics, pediatrics, and the like—is very small. The reasons are three: Very few postgraduate courses are offered which do more than supplement inadequate basic courses. Nurses completing advanced study are pushed into supervisory positions before they are secure in their skills. Sometimes the nurse herself is unaware of her need. A search for individuals who have had the initiative to find ways and means of becoming expert is often akin to the proverbial search for a needle in a haystack because the profession, generally speaking, has not been aroused to the significance of the trend toward specialization.

Nursing has experienced the cycles of development common to the older professions of medicine, law, and theology, but within a shorter time span. Possibly because it has developed so rapidly, it has been markedly unlike the others in one respect. The names of eminent doctors, lawyers, and theologians are associated with concepts of expertness in practice; the doctor at the bedside, the lawyer before the bar, the clergyman in the pulpit. Osler, for example, was a great teacher, but he was first a great internist.

The names of eminent nurses, until quite recently, have not usually been associated with a clinical specialty. Their prestige has most frequently been based upon administrative capacity, teaching ability, or their characteristics as leaders in various aspects of professional development. The university schools of nursing, following accepted patterns of faculty organization, clearly indicate the particular clinical field of each professor or instructor, but the fact that a nurse has a position on such a faculty tends to carry far greater prestige than her reputation for expertness in the clinical field in which she teaches.

Some of the experts who blazed their own trails to distinction in clinical nursing were already in public health nursing, and the private agencies with which they were associated encouraged them to go forward. For example, out of Edna Foley's anguish over patients who, although otherwise restored to health, were crippled because nurses had not understood the importance of posture in bed, came true specialization in orthopedic nursing. Her search for knowledge led to the Harvard and Northwestern Medical Schools. There, through her influence, modest Jessie Stevenson went to study physiotherapy. She combined that knowledge with nursing so effectively that the orthopedic nursing service she developed in the Chicago Visiting Nurse Association brought distinction to that agency.

State and federal funds have long been available for the care of crippled children. It was, however, not until the Joint Orthopedic Nursing Advisory Service of the NLNE and the NOPHN was established that the profession generally became aware of the need for specialization in orthopedic nursing.

The Maternity Center Association of New York City was organized more than twenty-five years ago. "From the very beginning," it reports, "it has been necessary for the Association to develop a continuous staff educational program to prepare nurses to do its work." It has also given special courses to selected nurses; it has conducted institutes up and down the length and breadth of the land, and it is now responsible for the Lobenstine Midwifery School.

Private agencies have led the way in other important developments in the fields of nursing and health. Current trends in both indicate urgent need for postgraduate courses of the type described on page 579.

As specific health needs of the American people have been brought to the attention of Congress and new or expanded programs are authorized, a lack of a sufficient number of experts in the type of nursing called for is invariably revealed. The Emergency Maternity and Infant Care program of the Children's Bureau is a case in point. So, too, but in a numerically lesser degree, are the venereal disease and certain other programs of the U. S. Public Health Service. Whether new programs call for hospital nursing service or for more public health nursing, the fundamental need for specialists in clinical nursing can no longer be ignored.

The committee of the NLNE which has been studying postgraduate courses for almost a year presents an extremely important progress report on page 579. It offers specific suggestions for use in developing postgraduate clinical courses in universities. Will qualified nurses carry this vitally important message to appropriate universities? Will they present the case so urgently that ways and means will be found to develop the courses? The time is ripe. The universities are now fully aware of the opportunities in nursing and this is a crucial period in the development of the profession. We are rapidly developing more nurses. Our next step must be to develop more nurses with the outlook, skills, and knowledge of specialists *in nursing*.

Service Nurses Urged To Maintain ANA Membership

THE ENERGETIC CHAIRMAN of the membership committee of a state association planned to make contact with every member of the Army Nurse Corps stationed within her state. She was astonished to find, however, that many were uninterested in joining or in maintaining membership in their professional organization. This issue of the *Journal* bears unmistakable evidence (if evidence is needed!), inside and out, that the ANA and the *Journal* have pride in and devotion to our service nurses.

Space in every issue of the *Journal* since November 1900 has been devoted to the Army Nurse Corps; and for shorter periods to the Navy Nurse Corps and other younger federal services. The registered professional nurse remains a professional nurse while in military service. The ANA has made special provision for nurses in service so that they need not transfer membership as they are moved from place to place. The ANA has consistently and repeatedly used its influence first in support of the establishment of the Corps and, through the years, in support of progressive efforts to improve the status and emoluments of service nurses. It is preparing now to assist nurses, when demobilized, to readjust to civilian life.

> Army nurses (writes Colonel Florence A. Blanchfield, Superintendent of the Army Nurse Corps) should not feel that they are exempt from continuing their membership in the American Nurses' Association while they are serving with the military forces. . . . . We are trying to put special emphasis on the fact that nurses are officers, not enlisted men. Their salaries are comparable to those paid to civilian nurses. Their allowances are much better than those enjoyed by nurses engaged in civilian capacity. Upon the cessation of hostilities, it will be the nurses released from military service who will have first priority in all plans for re-employment. It seems only fair that they should assume a share in support of the organizations that are expending so much time, energy, and money during the war to ensure that their interests will be protected when the war is over.

Captain Sue S. Dauser, Superintendent of the Navy Nurse Corps, has stated the same principle as follows:

> Those nurses who do not keep in good standing are misinformed as to the attitude of the Navy Nurse Corps in this regard. Since for many of these nurses naval service is a wartime measure only, it is especially important that they continue to support, by their membership and dues, those nursing organizations in whose hands are the responsibilities incident to maintenance of sound professional standards. The continuation of these affiliations and interests will enable them more easily to return to their civilian status when they are released from active duty. . . . . We are all of us, service and civilian alike, nurses with professional standards which we share in common. Each of us contributes in her own way to the welfare of our fellow man, be he sailor or civilian. Since our standards and ultimate aims are the same we feel that it is only fitting that we assume equal responsibility.

Nurses of the USA, let us remember that whether in military or civilian uniform, as professional nurses we are fighting in a common cause. We know that the world will continue to have need of us and that we can best move forward into that new world on the basis of mutual respect and co-operative planning within the profession.

A Patient Comments on Wartime Nursing

THERE should be no luxury nursing! How many opinions we had heard on that subject because the term has so often been misused. What a relief to find, when we had occasion to make personal use of an ambulance entrance, that the hospital requires patients, in its private pavilion, to have specials for the first twenty-four hours after surgery. Beyond that, the actual need of individual patients and the doctor's orders were determining factors. What a blessed sense of security and freedom from all responsibility good specials can give! How faithfully and unobtrusively they alertly and

competently meet one's needs until, as pain and weariness begin to subside, the will to live and to plan reasserts itself! At that point, in wartime, one is told, "You will not need special nursing any longer." The first dressing was done before that happened, however, and our doctor (an eminent surgeon) had astonished us by arriving gowned and ready with the dressing tray in hand.

Quite frequently the "attendings" were unaccompanied by either interns or nurses, a very real time-saver for the nurses, provided the doctors did not hurry away before all the orders they had intended to leave had been written.

For a few days the essential care given by graduate staff nurses was supplemented by the service of full-time aides, then the graduates (rarely the same one twice) were supplanted by students. By this time the aides assigned to our section of the corridor were old friends, a dependable factor in the changing pattern of our days.

Nurses are naturally of unending interest to us and the wartime pattern provided an unusual opportunity to meet a considerable number. Specials had a cheerful way of answering lights or of helping with trays at mealtime when not busy with their own patients. In one way or another one learned that, among both staff and special nurses, there were a number who had but recently returned to practice after long absence. We inferred that some of these were volunteers. One, we knew, could give only one evening a week, but the busy young head nurse was grateful for her help. One observed that the relative slowness of such nurses was very apt to be nicely balanced by excellent judgment. There were young mothers, too, who had searched for suitable nursery schools for their children in order that they might get back into uniform. A designedly casual comment would inevitably uncover the ever present anxiety about their babies.

The younger folk, both students and graduates, generously shared their enthusiasms and aspirations with us. Clear-eyed and clear-thinking, they seemed to have acquired a maturity of outlook very early.

The pattern of wartime nursing, as we observed it, was woven upon the strong warp of a splendid esprit de corps and well-established standards of service from which nonessential details had been stripped. Upon this warp, the supervisors and head nurses have woven the woof of full or part-time service of graduates, students, and aides. They, like the staff responsible for the service described on page 537, have anxious moments over week ends and periods when a high percentage of patients are acutely ill at one time, but—the patients who go to them in pain and discomfort depart cheerfully and with gratitude for the teamwork of the doctors, nurses, aides, dietitians, technicians, and a host of other workers who continue to make the civilian hospital a place of healing in wartime.

Hospitals Must Salvage Paper

AMERICA'S hospitals have a bigger than average stake in the current waste paper salvage program. If civilian hospitals are to continue to receive their full quota of paper-packaged supplies, and at the same time lend a hand to the military hospital units abroad, it is essential they dig out now every ounce of available waste paper and dispose of it.

The War Production Board is asking the cooperation of every hospital and its personnel in the scrap paper program—to collect and dispose of books, magazines, newspapers, records, wrappings, cartons, advertising literature, and bulletins, and to ferret out every last scrap or shred of paper for the salvage paper drive.

In Chicago, tons of old hospital records are being thrown into the scrap pile. Medical records of a confidential nature are being gathered together, bound up, and delivered to the shredding machine. St. Luke's Hospital is micro-filming all hospital's records for the last forty years and tossing the original records into the scrap heap. Micro-films form a more permanent and safer record and, at the same time, conserve sufficient floor space to provide additional locker-rooms and bed space. Waste paper from St. Luke's averages 6,000 pounds each month.

Cook County and Evanston Hospitals, are also micro-filming their records; both Wesley and Children's Memorial Hospitals (all in Chicago area) are preparing to do the same within the next few weeks. Micro-film machines can be rented from local sources, the names of which are available from the local WPB office.

Administrators should check the following sources of waste paper: old files, ledgers, correspondence, receipts, canceled checks, time cards, invoices, pamphlets, calendars, bulletins, obsolete catalogs, books and periodicals, containers, flower boxes, and waste baskets. Paperboard containers, particularly in demand, should be carefully conserved and turned back for reuse. Corrugated and solid fiber containers, and setup boxes should be carefully collapsed, tied into bundles, and turned over to a scrap dealer. More than a billion containers will be required in 1944 for the armed forces and lend-lease.—Salvage Division, War Production Board, March 1944.

How We Met the Poliomyelitis Epidemic

By Inez L. Armstrong, R.N.

Late in June 1943, the Denver Children's Hospital communicable disease unit of forty bed-capacity admitted two patients with the diagnosis of poliomyelitis. By December 1943, 120 cases had been treated in our communicable and orthopedic divisions. (See graph.)

In the fall of 1942 a Sister Kenny hot fomentation unit had been established in our orthopedic department. From twenty-two to thirty cases received hot packs daily for six to eight months following the acute stage of the disease. A physiotherapist and the clinical instructor of orthopedics had been previously trained in the Sister Kenny technic.

When poliomyelitis admissions began, in August 1942, an isolation unit was organized on a large unoccupied ward on the fourth floor of the hospital since the communicable unit had not yet been completed. The nursing staff included three full-time graduate nurses supplemented by students and by other graduate nurses trained in the hot-pack method and rotated from the orthopedic department. After the isolation period, parents, nurse aides, and auxiliary workers came to the unit and assisted us with the application of the hot packs.

By January 1943 all patients who could not be dismissed because of continued muscle spasm, or because they would be unable to continue physical therapy if they were sent home, were transferred to the orthopedic service. These fifteen to twenty-two patients received hot packs and physical therapy daily for five to six months. It was possible during these months to teach the principles of hot-pack application to approximately 150 affiliating student nurses who were rotated in groups of nine or ten every three weeks to the orthopedic unit with our own junior and senior students.

Since we had a nucleus of nurses and physiotherapists trained in the application of hot fomentations, it was evident, when the epidemic of poliomyelitis struck in the summer of 1943, that Children's Hospital was to be the key to the solution. By the second week of August the admissions had increased at an alarming rate. It would be impossible to admit all the acute cases or to continue treatment for months after their dismissal from the communicable hospital in our forty-six to fifty bed orthopedic department.

A meeting was called at Children's Hospital. The superintendent of the Visiting Nurse Association of Denver, the orthopedic consultant of the Department of Public Health, the chief physiotherapist, the clinical instructor of orthopedics, the director of social service and the dean of the nursing school discussed the problem facing us. How could all cases of poliomyelitis be assured adequate treatment?

Children's Hospital was to be the center where the staff of the Denver Visiting Nurse Association, other Colorado public health nurses, and parents could come for instruction and experience in the application of hot packs. After the communicable period, patients with mild spasm could have further treatment at home, thus releasing much-needed space in the hospital for patients with more involvement. The trained visiting and other public health nurses would follow up patients at home, supervising general care and hot packing. Arrangements would be made for these patients to be brought into the outpatient department for their physical therapy treatments.

Approximately thirty public health nurses came for periods of instruction from July to September, spending one or two days in both the orthopedic department and the communicable disease hospital. At least one day was reserved for conferences and observation in physical therapy. The physiotherapist conducted classes in the Kenny technic for thirty-two physical therapy students from Fitzsimmons General Hospital and later went to Otero County, to outline home treatments for twenty-four patients to the director of the County Health Department and the public health nurses in the county.

During these trying weeks from July to September, our communicable disease hospital had approximately thirty poliomyelitis patients, the orthopedic unit twenty to twenty-two patients, the infant pediatric department ten to twelve patients, with ten to twelve patients on our first floor all receiving hot packs. We were therefore forced to utilize all our resources and work out a practical nursing technic for the Kenny method.

In the orthopedic unit we had one electric machine for wringing the packs, which was constantly in need of repairs, and a small hand wringer. The engineer, physiotherapist, and

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Inez L. Armstrong, R.N., B.A. (Children's Hospital, Denver and University of Denver), has been clinical instructor on the orthopedic service at the Children's Hospital since 1941.

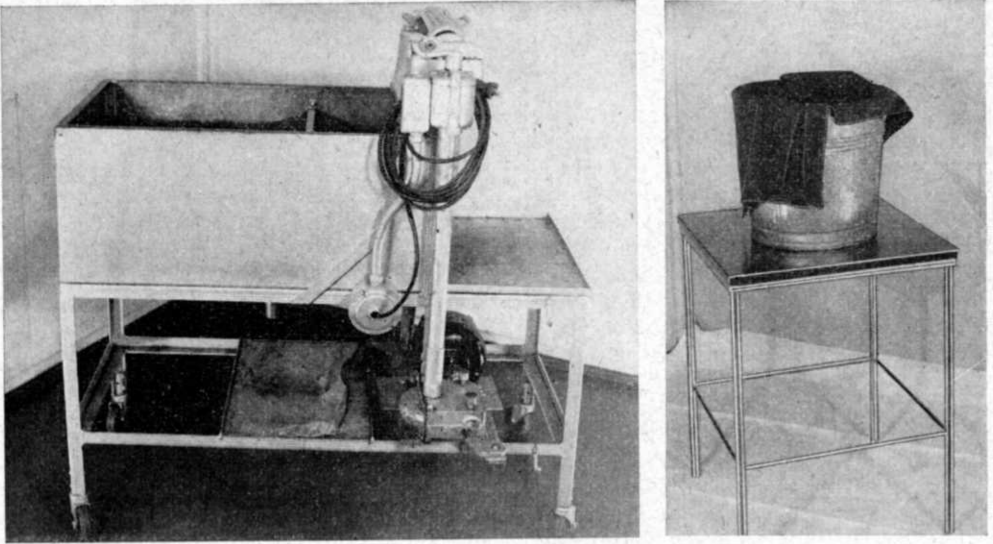
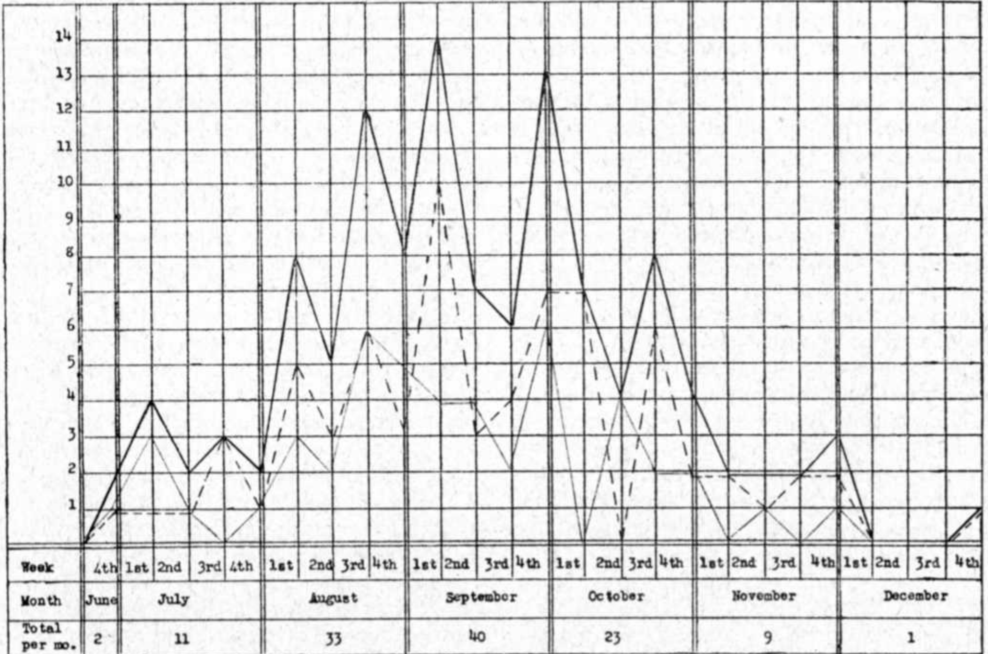


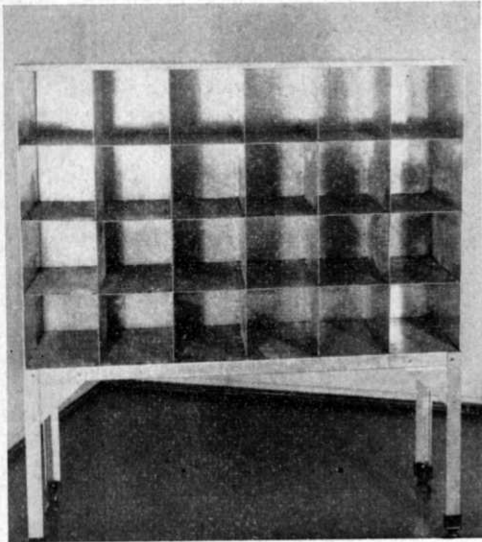
Figure 1 (left): The tub to which the electric wringer is attached has a built-in division so that water wrung from the packs will not run over the pail containing the boiled packs and cool them. Figure 2 (right): A small metal-topped table equipped with rollers carries a galvanized pail lined with rubber sheeting and simplifies transportation of packs to bedside.

the clinical nursing instructor of orthopedics met and decided that machines could be built which would be serviceable and practical.

The three machines built by the engineering department had the May-Tag wringer head with safety features provided by the control switch on the wringer head which made it more accessible for the operator (Figure 1). A division was provided in the tub so that the water wrung from the packs would not run over the



Solid line, total; dotted line, females; interrupted line, males.



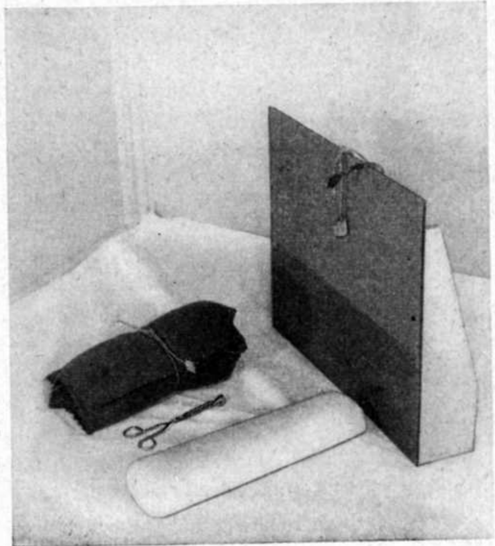


Figure 3 (left): A specially made metal storage rack has individual compartments for packs at night. Figure 4 (right): Roll for knees, made of rolled magazines or papers covered with washed stockinette; special forceps; footboard of tempered pressed wood supports feet with heels suspended; packs are placed in proper order, rolled, tied with rope, and labeled before boiling.

pail containing the boiled packs and cool them. As a safety measure for those operating the wringer, a special forceps was made which, if it became entangled in the pack while the latter was passing through the wringer, could easily be released from the operator's hand and pass through the wringer without damaging the rollers.

In the contagion unit, sterilizers and wash boilers were used for boiling the packs the required twenty minutes. The respiratory cases were treated in rooms where a hand wringer was utilized and the packs boiled in the room. Four respiratory cases were cared for in the respirator.

Strict isolation was carried out for at least twenty-one days for all of the acute cases. Everyone associated with patients—doctors, nurses, physiotherapists, laboratory technicians—wore gowns. The wearing of masks was optional. In cases where masks were worn they were discarded immediately after use. All excreta, including stools, urine, bath water, and emesis, were disinfected in 2 per cent lysol in five-gallon galvanized pails which were kept in each room. The time prescribed for disinfection was four hours. At first chlorinated lime was used because it was cheaper than lysol. However, because the odor of the lime was so offensive, lysol was used in its place. Nasal discharges were burned. All food, used dishes, et cetera, were autoclaved with live steam under pressure for twenty minutes. No visitors were permitted during the three-week isolation period.

At first the packs to be boiled were pinned together with large safety pins, but boiling caused them to tangle and to tear, so one of the nurses suggested that packs be placed in proper order and rolled into a compact bundle. They were tied with light-weight rope to which was attached a metal tag stamped with the proper identification—room or ward and bed number. After ten to fifteen minutes boiling the temperatures of these rolled packs ranged from 196 to 200 degrees F. When wrung two or three times and applied, their temperatures averaged from 146 to 150 degrees F.

Small metal-topped tables equipped with rollers, and carrying galvanized pails lined with rubberized sheeting, were placed by the sterilizers to receive the boiled packs before they were carried to the machines. (See Figure 2.) Transporting the wet packs to the wringers which are kept in the wards, by means of these tables, eliminates pushing the heavy machines back and forth to the utility rooms.

Cards listing the patient's packs were attached to each bed. Later, when the patients were transferred to the main hospital hot-pack units, a large chart was made listing the measurements of each patient's packs. When a pack was torn and needed replacement the chart was checked and the new pack cut according to the recorded measurements. As the mothers

came to learn the hot-pack application the measurements were given to them for their children's packs. At the time of dismissal the mother supplied the wool and waterproofing for the packs and was instructed in the technic of cutting them.

Many kinds of wool were used: old Army blankets, old woolen underwear, new blankets, wool received from the National Foundation for Infantile Paralysis, and mill ends. Material of 60 to 70 per cent wool proved to be most practical.

Several types of waterproof material were used, including pliofilm, oiled silk, rubber sheeting, rubberized rayon, oiled muslin, and shower curtain material. Proper care of the waterproofing—which consisted of drying it well and powdering it before it was rolled in the outside packs when not in use—proved that any of these materials could be used effectively.

Three patients developed fungus infections of the skin where packs were laid, but the lesions responded to treatment and made rapid recovery. It was evident the infections were due to the fact that packs were stacked one on top of another at night. A special metal storage rack was made with individual storage compartments, each labeled with numbers corresponding to the metal tag on the bundle of packs. (See Figure 3.) Since using the rack there have been no more fungus infections.

The carpenter had the principle of the Sister Kenny type footboard explained to him and designed a board constructed of tempered pressed wood which permitted the feet to rest against the boards with heels suspended. (See Figure 4). These footboards could be easily moved from bed to bed.

Later a special footboard of similar design, but smaller in size, was made for the respirator. This board was permanently attached to the carrier, its smaller size permitting the removal of the carrier from the respirator without disturbing the position of the footboard.

Rolls for the knees were made of magazines or rolls of papers covered with washed stockinette. (See Figure 4.) These were placed under the knees providing 5–10 degree flexion, or under the dorsa of the feet when the patient was turned prone.

While the patients were in the communicable unit eight to ten packs a day were given and those cases with persistent spasm and pain were packed at night. The ten to twelve packs plus physiotherapy every day was impossible except for the most acute cases because of the shortage of help. Physical therapy was given three or four times a week during the peak of the epidemic.

On the orthopedic unit, the patients were turned prone twice a day and packs laid on for 15–20-minute intervals, two or three times in one hour. This procedure was always followed in the morning before physical therapy was given and in the evening before packs were discontinued for the night. From 10:00 A.M. to 5:00 P.M., three to four sets of packs were pinned on the patients. All baths were given to the poliomyelitis patients in the evening. At the present time the majority of the patients receive tub baths.

The photography section of Lowry Field, Denver, Colorado, made two reels of film showing the technics of nursing and physical therapy used at Children's Hospital. These films are proving to be very useful for teaching purposes.

The untiring efforts of the doctors, nurses, physiotherapists, visiting nurses, public health nurses, nurse aides, parents, and every one called upon to aid in this poliomyelitis crisis helped us to meet the emergency.

[Acknowledgment is made to G. Valdemar, P.T. for the graph used in this article.]

Flight Nurses Creed

I WILL SUMMON every resource to prevent the triumph of death over life.

I will stand guard over the medicines and equipment entrusted to my care and ensure their proper use.

I will be untiring in the performance of my duties, and I will remember that upon my disposition and spirit will in large measure depend the morale of my patients.

I will be faithful to my training and to the wisdom handed down to me by those who have gone before me.

I have taken a nurses' oath[1] reverent in man's mind because of the spirit and work of its creator, Florence Nightingale. She, I remember, was called the "lady with the lamp."

It is now my privilege to lift this lamp of hope and faith and courage in my profession to heights not known by her in her time. Together with the help of flight surgeons and surgical technicians I can set the very skies ablaze with life and promise for the sick, injured, and wounded who are my sacred charges.

This I will do. I will not falter. In war or in peace.

[1] The familiar "Florence Nightingale Pledge" was written by Mrs. Lystra Gretter and a committee for the Farrand Training School for Nurses, Detroit, in 1893.

The Fight Against Infantile Paralysis Continues

By Ephraim Fischoff, D.S.S., and Don W. Gudakunst, M.D., Dr.P.H.

Despite the concentrated study devoted to infantile paralysis for a generation now, the most important questions have not yet been answered. Since 1909, when Landsteiner and Popper demonstrated that the causative agent of this dread infection was a virus, neither the exact mode of its transmission nor the usual portal of entry has been established. There are no specific diagnostic aids in the preparalytic stage or nonparalytic form of the disease(1). No method has yet been devised for determining susceptibility (e.g., as the Schick test does for diphtheria), or immunity, either temporary or acquired. There are no practical methods for detecting the many unrecognized carriers of the infection during epidemic periods. Nor can the laboratory measure the degree of protection known to exist. No means of prevention of the disease has been developed and no usable prophylactic measures have as yet been devised, both serums and vaccines having thus far proven ineffective(2). Isolation and quarantine are considered to be of very limited usefulness. There is no specific therapy for the disease. Nor is there any miracle cure for the paralysis caused by the disease in spite of the exaggerated claims made in some lay publications for the Kenny method, which has undoubtedly very great merits as a therapeutic adjunct.

Research has proceeded along varied lines to ascertain the answers to these various questions,—the properties of the virus, the portal of entry, mechanisms of immunity, clinical aspects of the disease, inapparent infections, nerve-muscle interrelations, and the treatment of after effects. Most of the laboratory research on infantile paralysis in the United States today is supported by the National Foundation for Infantile Paralysis. In the course of this organized scientific program much valuable information has been accumulated which has significant bearing on problems other than those connected with poliomyelitis(3).

The filtrable virus causing poliomyelitis is one of the smallest known,—its size has been estimated at ten millimicrons (ten millionths of a millimeter). It is extremely resistant to physical and chemical agents. It has recently been concentrated and purified to a great degree. By a special technic of "differential centrifugation" Loring, of Stanford, concentrated the virus to as much as 10,000 to 100,000 times that found in the spinal cord of a paralyzed monkey and showed that the virus probably consists very largely of protein. It is possible that further research along this line may reveal the possibility of using these highly concentrated virus sediments to prepare effective vaccines and antigens for poliomyelitis.

Efforts are also going forward to cultivate the virus artificially not only in order to supply larger amounts for study but possibly also to prepare better vaccines and antiserums. It is possible that one reason for the failure of poliomyelitis vaccines thus far has been their relatively low antigen concentration. Studies on the nature of the virus have included such problems as the epidemiology of all virus diseases including poliomyelitis, western equine encephalitis, St. Louis encephalitis, and other encephalitides; the means of the spread of the virus in nature—excreta, sewage, water, and the possibility of insect spreaders, particularly flies; the changes in the body of experimental animals caused by mild infection(4); the recovery of virus from persons and materials exposed to infection; the period of infectiousness; the nature of immunity; the influence of nutrition, dietary factors, and vitamin intake on the susceptibility to poliomyelitis.

Progress in research has been hampered by the lack of suitable experimental animals as the virus is generally pathogenic only for certain species of old world monkeys and chimpanzees (which are costly and difficult to obtain in large numbers), but not for the experimental animals usually employed—e.g., rabbits, mice, and guinea pigs. The monkeys most commonly employed for study are the Asiatic rhesus monkey and the cynomolgus. Not only were these animals enormously expensive but they did not show a constant symptomatology. Until 1939 all efforts to transmit the disease to animals other than monkeys and chimpanzees were unsuccessful. An important step in meeting this problem was taken by Armstrong in 1939, when he succeeded in transmitting one strain (the Lansing, so called from a fatal case of bulbar poliomyelitis in that city), to the cotton rat, and thence to the white mouse. However, similar transfer of other strains to easily available laboratory animals has not been successful.

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Intensive investigation has also been made of the portal of entry. It was believed until recently, on the basis of studies of the experimental disease in animals, that the upper respiratory tract, particularly the nasal mucosa was the pathway by which the virus got to the central nervous system. It was believed that the disease spread from the olfactory portion of the nose along the nerve to the olfactory bulb and thence to other parts of the central nervous system. But further evidence failed to support this theory as the virus or pathological change is only rarely demonstrable in human olfactory bulbs(5). There is also an "ingestion theory" which regards the intestinal mucosa as the portal of entry, with contaminated food and water considered as the agents of transmission. Recently evidence has accumulated that the portal may be pharyngeal mucosa, the intestinal mucosa or both(6); but epidemiologic evidence has never pointed to contaminated water and but rarely to milk as the major source of infection. The possibility of insect vectors has also been raised in view of the spotty distribution of the disease and its relatively higher incidence in rural communities; recently the isolation of poliomyelitis virus from flies has been reported. But whatever the precise fact about the point of invasion, the virus apparently travels only along the peripheral nerve channels to the central nervous system in which it then spreads, by neuronal pathways to cause its damage to motor nerve cells. The extent of the pathology produced in the central nervous system depends on factors that are but incompletely understood.

One of the interesting points of investigation in regard to immunity relationships is the fact that antibodies may be present and yet immunity absent. Actual invasion of the nervous system is not always followed by solid and lasting immunity and many instances of second attacks of paralytic poliomyelitis are on record. The investigations of Howe and Bodian(7) suggest that immunity to poliomyelitis is not the result of general immunization of the nervous system but rather of some process preventing infective quantities of active virus from reaching nervous tissue. In any case, until the portal of entry is definitely established and the pathogenesis of the disease better known, it seems hardly likely that practical measures for controlling the disease will be forthcoming.

Research in therapy has also yielded but scant results. Armstrong's adaptation of one strain of virus to growth in mice and cotton rats opened up new possibilities in the way of testing the curative action of various drugs. Hundreds of drugs have been tested on thousands of these animals. But as yet none has proven to be of the smallest value in controlling infection, neither sulfa drugs, urotropin, convalescent or immune serum, or potassium chlorate which European observers have praised highly.

After Effects

If treatment is to be improved, more complete knowledge is required of the pathological and physiological changes induced by infection of the nervous system by the virus of poliomyelitis. Accordingly the National Foundation is sponsoring extensive research programs in these fields. New electrical apparatus has been introduced to measure not only pathological involvement, the rôle of spasm, the degree of degeneration of nerves and muscles, but also the efficiency of therapeutic regimens, e.g., the effect of heat and exercise.

Analysis of the results of various newer experiences, especially the Kenny method, has demonstrated that in most cases prolonged and rigid immobilization as commonly practiced in the past is not conducive to rapid or full recovery. Research has also been conducted on two serious complications of poliomyelitis, i.e., unequal leg lengths and scoliosis(8), and in general on the kind of care that will prevent crippling complications. Studies are also under way on the intellectual and emotional factors involved in recovery from acute poliomyelitis and the educational implications of such findings.

Lessons from Recent Epidemics

The data from the epidemic of 1943 have not yet been fully compiled. But a few general conclusions can be drawn even now. In it the Kenny treatment received its largest application thus far and it is generally agreed that worth-while results were obtained; the patients were definitely more comfortable and in better general condition and the amount of deformity was apparently minimized.

Educational and Research Activities

The National Foundation sponsors far-reaching programs of research into the nature and transmission of the disease and into newer methods of treatment and cure; it seeks to prevent the disease; it trains personnel in newer methods of treatment and provides possibilities for adequate treatment to patients in every part of the country; and it conducts a far-flung educational campaign for the public and special trained groups.

In the over-all fight with poliomyelitis the

rôle of nursing is of the utmost importance. To prevent and repair the crippling after effects of the disease months and sometimes years of hospitalization, nursing care, and medical and surgical treatment may be required. For maximum service in this cause knowledge of the newer developments in the field is imperative.

But the National Foundation does more than support research; it disseminates new information widely and assists professional groups in keeping abreast of accumulating knowledge, thereby making it possible for the newer knowledge to be utilized in actual practice.

To this end grants have been given to a public health nursing organization, to a nursing education association, to a professional organization of physical therapy technicians, and to the National Research Council. These organizations select candidates for the specialized training, prepare literature in their particular field, and provide specialized counsel to numerous teaching institutions regarding problems of poliomyelitis. Nurses have also been trained in the public health and bedside nursing care aspects of orthopedic nursing.

Thus the National Foundation has extended a grant to the National League of Nursing Education to continue instruction of nurses in the care of orthopedic patients and to provide scholarships for teachers of orthopedic nursing; and to the National Organization for Public Health Nursing to continue the provision of scholarships in orthopedic public health nursing. Grants have been made for various advisory services to nurses and public health nursing agencies, to stimulate university postgraduate programs of study in orthopedic nursing problems, and to prepare orthopedic nursing educational materials. Grants have also been made to various hospitals and schools for the basic and advanced training of physical therapy technicians and nurses in the treatment of poliomyelitis, and especially in the training in the Kenny method of treatment(9). It should be observed that the provision of special graduate training for nurses and physical therapy technicians resulted in improved treatment not only of infantile paralysis but of other orthopedic disabilities as well.

The Kenny Method

Since 1940 the National Foundation has assisted Sister Kenny's work. Continuously since March 1942, with funds provided by the National Foundation, the University of Minnesota has conducted a training program in the Kenny technics of treatment for physicians, nurses, and physical therapy technicians. Since that time over 1,300 physicians, nurses, and technicians have been trained at this center. Schools of physical therapy in other parts of the country and certain schools of medicine and nursing as well have been given funds for special courses in the Kenny method for doctors, nurses, and physical therapy technicians already in practice. During the epidemic of 1942 in Arkansas and Tennessee, the Kenny method had its first field test under epidemic conditions. Trained nurses and physical therapy technicians were equipped with the required apparatus—especially wool for the application of hot packs.

By the middle of 1943 when the next large epidemic came many thousands were acquainted with the method, but even these were not always to be found where they were needed. The National Foundation thereupon recruited trained personnel from non-epidemic areas and sent them to areas where the case load was highest.

Recently the National Foundation has made a grant to the University of Minnesota to study the physiological problems connected with the mechanisms of the disease process and to further develop appropriate methods of treatment.

A distinction should be drawn between the Kenny treatment and Sister Kenny's interpre-

Polio Guides and Loan Folders

The following publications have been prepared by the Joint Orthopedic Nursing Advisory Service for the National Foundation for Infantile Paralysis:

A Guide for Nurses in the Nursing Care of Patients with Infantile Paralysis. Publication No. 45 (revised).

A Guide for Parents in the Nursing Care of Patients with Infantile Paralysis. Publication No. 46 (revised).

Nursing Care of the Patient in the Respirator. By Carmelita Calderwood. Publication No. 49.

These may be secured without charge from the National Foundation for Infantile Paralysis, 120 Broadway, New York 5, New York.

Loan folders on poliomyelitis with reprints of articles on the cause, treatment, and nursing care of infantile paralysis, together with bibliography, are available from the Joint Orthopedic Nursing Advisory Service, 1790 Broadway, New York 19, New York. The loan material may be kept for a period of two weeks, and the only charge is for transportation.

tation of the disease. The treatment is widely accepted; the interpretation is still under careful scrutiny. Briefly, Miss Kenny maintains that the dominant factor responsible for the crippling effects of poliomyelitis is not a flaccid paralysis due to destruction of lower motor neurons, but a spasm of the muscles leading to apparent loss of voluntary contraction in muscles opposing those in spasm. Contractural deformity results from the sustained pull of the muscles in spasm. The Kenny method is a sturdy and ingenious attempt to treat the threefold syndrome she sets forth of "spasm," "alienation," and "inco-ordination"(10).

Conclusion

Nurses should know the many sided activities of the National Foundation for Infantile Paralysis and should feel free to use its ample facilities. Above all they should be acquainted with the ample educational resources made available by this public service organization and the numerous publications it distributes.

Reprints of the numerous scientific articles on the subject of poliomyelitis are available from the Foundation on request and there are special publications of particular interest to nurses. Among these are *A Guide for Nurses in the Nursing Care of Patients with Infantile Paralysis*, 1944; Jessie L. Stevenson, *The Nursing Care of Patients with Infantile Paralysis*, 1940; Carmelita Calderwood, *The Nursing Care of the Patient in the Respirator*, 1944; Don W. Gudakunst, *The Importance of Research*, 1942; and *Doctor . . . What Can I Do?*, 1942.

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Central America Grows Drug Plants

Central American republics are in position to look to greater participation in hemisphere drug trade as a result of intensified cultivation of medicinal plants for United Nations' needs.

Ipecacuanha roots, source of ipecac, have become one of the leading export items of Nicaragua and Costa Rica. El Salvador is the chief source of balsam. Costa Rica and Honduras are supplying sarsaparilla. Guatemala and Costa Rica are developing a cinchona plantation industry. Guatemala also is planning cultivation of digitalis and belladonna.

One stimulus to this development is the big medicinal requirements of the fighting forces. Quinine, formerly obtained from the Far East, is a prime necessity on tropical battlefronts. . . . . Balsam is another indispensable battlefront drug for treatment of wounds. Ipecac, a purgative, is the source of emetine, an alkaloid for treatment of amoebic dysentery.

The Division of Economic Information, Pan-American Union, Washington, lists these wartime developments in Central America's drug trade: Six quinine plantations are in cultivation in Guatemala. One of these—"El Porvenir"—contains approximately 1,000 acres of cinchona trees and is the largest in the Western Hemisphere.

Cinchona tree nurseries are in operation in Costa Rica.

El Salvador substantially increased production of balsam. Approximately 50,000 trees are capable of an annual yield of from 300,000 to 500,000 pounds of crude balsam. Nicaragua also is increasing balsam production.

Intensive cultivation produces good results, so returns by the acre of these drug plants would be profitable in Central America, where farms are generally small, new cash crops are needed, and labor is plentiful.—News Release, No. 90, Office of the Coordinator of Inter-American Affairs, Washington, D. C., February 1944.

A Nursing Service Adjusts to Wartime Pressures

This is the story of the way in which one nursing service has adjusted to wartime shortages in personnel. Probably some or all of the expedients have been used in many places. It is presented here because it exemplifies many of the adjustments suggested by the NLNE and certain improved personnel practices as set forth by the ANA.—The Editors.

Two years ago, as the war got under way, we had a small student body and a large graduate staff. The hospital had a daily average of nearly 600 patients. The general staff nurses began to leave for military service and were increasingly difficult to replace. As the months went on, wards had to be closed as there were no nurses available. The census remained continuously high, with only seriously ill patients admitted, which meant that extra nursing care was needed on most wards.

Because of our relatively small school and a diminishing graduate staff, we were pinched harder than many hospitals. The census was curtailed in 1943 until the June class was ready for ward experience in November.

Now we have reopened wards. It has been a strain on every member of the staff to see the patients needing more care than we could give them. With the increasing numbers of students, we have improved nursing care.

Today we have 604 patients, 169 students assigned to the nursing services, 46 preclinical students (three classes admitted during the academic year 1943–1944), and 74 general staff nurses (seven more may leave for the Army at any moment); 44 nurses are serving on a part-time basis, giving from three or four to 40 hours weekly; 42 licenced practical nurses are employed.

Adjustments in Nursing Service

The following are some of the adjustments in nursing service which have been made during the past two years:

1. *Increase in salaries* for all nursing and auxiliary positions, with three pay brackets for each position and full cash salaries. Meals and laundry have been made optional. Nurses may secure rooms at the nurses residence when they are available.

General staff nurses receive $140–$150 without maintenance. There have been two increases in salary scales since 1942.

Licenced practical nurses receive $115–$125; $90–$105 a year ago.

Paid aides receive $75–$95; $68 a year ago.

Orderlies begin at $102; began at $95 a year ago.

General staff nurses receive a bonus of $10 additional for evening and night duty. Orderlies are paid for overtime as they are scheduled for overtime duty.

2. *Straight eight-hour day.*—In July 1942, in the face of increasing shortages, the entire nursing staff began to work a straight eight-hour day. Although it has meant that each nurse cared for more patients, morale has been definitely better. The hour schedules are 7:30–4:00; 3:00–11:30 p.m.; and 11:30–7:30.

3. *Efforts to improve morale.*—Salary increases and a straight eight-hour day have improved morale markedly. Head nurses conferences have helped to interpret the needs of specific services in relation to the needs of the hospital as a whole. Discussions of better use of volunteer service have reduced the requests for additional nursing help.

4. *Use of volunteer service.*—An extensive volunteer program began in the fall of 1942. Red Cross volunteer nurse's aides, Gray Ladies, and men and women volunteer aides have given greatly needed and useful service. In March 1944, 385 volunteers gave 7,660 hours of service; this was equivalent to 37 full-time employees working a 48-hour week.

Men volunteers supply all the male help between 6:00 and 10:00 p.m. From six to ten men serve each night.

A year ago a special room was set up under the direction of a nurse (now a lay volunteer as we could no longer spare the nurse) where volunteers go when they are not able to do the physical work on the wards or have not been prepared for it. Here they prepare surgical supplies and dressings. The work is planned on a day-to-day basis. The person in charge goes to the central supply-room and operating room each morning to ask the respective supervisors what supplies need to be prepared that day.

5. *Service by private duty nurses.*—Private duty nurses are employed on an hourly basis when available, at an hourly rate based on $140

Data for this article were provided by Katharine G. Amberson, Director of Russell Sage College School of Nursing, Troy, New York, and Elizabeth A. Bell, Director of Nursing Service, Albany Hospital, Albany, New York.

a month. They may work from one to eight hours, depending on their availability and the needs of the hospital. When they come in for a specified period, of one month or longer, they receive $140 a month. At the end of the year they are given a proportionate amount of vacation pay; this is part of the private duty nurses' agreement and applies only to those on the hospital registry.

Approximately 20 did one month of general staff nursing in 1943; save for age, many others would have served. We have postponed asking for this type of service this year until the present time when, because of student and other vacations, our need will be most acute.

6. *Substitutions in personnel.*—Practical nurses formerly worked with graduate nurses; now they are assigned a group of patients with a graduate nurse responsible for treatments and supervision. Their service is used to a great extent on the private floors.

When the operating room staff had been reduced from 20 to 11 nurses, paid aides were sometimes assigned to operating rooms to assist the circulating nurses. One circulating nurse serves two operating rooms; a paid aide stands outside the operating room door and obtains supplies for the circulating nurse. The aide takes a table of supplies with her to work on in free moments.

When operating room orderlies were reduced from five to one, the cleaning was turned over to the housekeeping department; a more thorough cleaning is done by maids from 4:00 to 12:00 P.M.

Drug boxes were previously taken to and from the wards by orderlies. Now personnel from the drugroom collect and return them.

Laboratory reports are pasted into the records by a messenger girl from the laboratory who comes to the wards to do this. When there are several dozen a day to attach, this means a considerable saving.

A *clerical worker* has been added in the health service to keep health and medical records of nurses and other personnel up to date. She orders trays for nurses who are ill in the residence, makes appointments for immunizations, and assists personnel in making appointments in clinics and x-ray.

7. *Streamlining nursing procedures.*—A year ago, when general staff nurses were few in number, every effort was made to cut procedures to the limit of safety and effectiveness. This has been the responsibility of the Nursing Procedure Committee which for more than five years has been improving, simplifying, and reducing the amount of material used in procedures. All changes have been approved by a Professional Advisory Committee of the medical staff.

The committee is considering at present the use of one glove for catheterization. They question whether it is an economy, when reclaimed rubber gloves are obtainable, to ask the central supply-room to put up single glove packages.

The nursing school faculty are now questioning whether certain procedures may have been streamlined too far. Routinizing procedures has resulted in less adequate observations by nurses; it is uncertain whether or not less exact observations prolong the period of care.

8. *Changes in charting and record keeping.*—A year ago, bedside notes and routine expressions such as "comfortable day and night" were reduced for convalescent patients; no nursing notes were recorded unless specific information needed to be charted. However in recent months extensive omissions on records

Professional Nursing and Auxiliary Nursing Personnel

	1941 December	1942 December	1944 April
General staff nurses	176	92*	74
Student nurses assigned to hospital wards, exclusive of preclinicals	79	92	169
Postgraduate students	0	10	8
Licenced practical nurses	45	53	42
Ward secretaries	10	14	16
Paid aides	53	35	32
Orderlies and male attendants	36	15	13
Red Cross nurse's aides	0	73	104
Men volunteers	0	10	78
Women volunteers	83†	251	320†

* 137 per cent turnover in 1942.
† Estimated.

indicate the need of further study. The use of "forced fluids," "routine back care," and "routine afternoon care" has caused concern.

The time the head nurse has to give to records, the variety of the personnel making notations, and other factors, are more significant than the form itself. A more satisfactory record should be worked out which would be somewhere between a detailed form and an extremely brief one.

9. *Assignment of diet and floor clerks.*—A lay person, often an intern's wife, is assigned to diets on the private floors. This requires someone who makes a good contact with patients. She removes trays from the conveyor, sees that food trays and nourishments are delivered to patients, carries trays, and contacts patients in regard to special requests or complaints. She is responsible for about fifty patients' trays. The salary is $85 per month with meals; the hours are 7:00–1:00 and 4:00–6:00—a nice job.

Floor clerks are now charting temperature, pulse, and respirations, writing in names of treatments and medications which the nurse initials and records the time as the treatment is given. The beginning salary is $75.

10. *Electroshock therapy patients grouped.*—Patients receiving electroshock therapy are placed in a central room until they have recovered from the therapy. Medical students assist with both therapy and observations, thus saving nursing time.

11. *Large ward divided.*—A 54-bed floor has been divided into two wards of 17 and 36 beds each. This helps both the nursing school and the nursing service. Remodeling[1] meant giving up one room—space that was badly needed for patients—for a service-room. However it was almost impossible for a head nurse with a small staff to administer a 54-bed floor. Remodeling made possible the grouping of patients for another medical ward to which students may be assigned.

12. *A loudspeaker system* has replaced a ticker system. This aids in locating doctors, thus reducing phone calls to wards. It is especially useful at night.

13. *Telephone calls reduced.*—No telephone calls from outside the hospital are connected with the floors unless the patient concerned is critically ill. All other calls are routed to a clerk at the Information Desk who writes any messages and sends them to the patient by messenger service.

14. *Vacations adjusted.*—All graduate nurses vacations are planned on a 12-month basis. A slip is sent to each ward (or department for tuberculosis and psychiatry) in February or March with all the possible vacation weeks indicated. The number of weeks which each nurse receives is listed. When two nurses may take the same weeks, that is noted. The weeks when students change wards, are crossed out as inappropriate vacation weeks.

15. *Policy books revised.*—The administrative policy books distributed to wards have been revised and brought up to date. This is saving hours of time.

16. *Nursery school facilities provided.*—In July 1943, a nursery school project[2] was initiated by the Junior League to provide facilities for the care of children of nurses, volunteers, and other employees. It was very active during the summer and fall. As the attendance was irregular during recent months, due to illness in the homes, the nursery school closed temporarily on April 1.

17. *Other economies of time.*—During our acutest period, complete baths were given every third day; unless acutely ill, patients were given bath water each morning and they bathed their own hands, face, and back.

In *incontinence* accompanying paralysis, retention catheters are used to save frequent changing of the bed and the possible distress of decubitus.

Postoperative beds are made without treatment blankets, as the hospital is warm. The bed is made with two hot water bottles and loose top covers, using only the blanket that comes back with the patient.

Douche equipment, prepared in the central supply-room, consists of sterile irrigating can, nozzle, finger cots, all wrapped in a towel which can be used under the patient.

Tincture of zephirin, a disinfectant, is used in one strength, 1–1000, for as many purposes as possible, i.e., cleansing skin areas for injection, for douches, forceps jars, hand soaks, and thermometer trays.

Requisitions to the central supply-room and stockroom are no longer made out in triplicate unless the supplies are to be ordered outside the hospital. No copy of the requisition is left on the floor.

The frequency with which *temperature, pulse, and respiration* are taken is the responsibility of the head nurse. After 48 hours, if the temperature is below 99.6°, the head nurse may place the patient on a twice daily temperature, i.e., at eight and four.

Admissions and *discharges* occur within speci-

[1] See JONES, EVERETT W.: Nursing Costs, *Mod. Hosp.*, Vol. 59, pp. 51–54 (Aug.) 1942.

[2] See a Junior League Nursery School, *Am. J. Nursing*, Vol. 43, pp. 979–981 (Nov.) 1943.

fied hours. Patients are admitted between two and five and discharged usually before noon, surely by four o'clock. If the patient remains after noon, he is charged half rate for the day of discharge, and full rate if he remains after six.

Visiting hours have been limited. Doctors have been asked to advise patients to have friends send flowers to their homes rather than to the hospitals. Doctors were given a list (to be given to patients) limiting the equipment which patients should bring to the hospital.

A basic *formula* has been prescribed by physicians for all newborn babies. All 2:00 A.M. feedings to newborns weighing more than seven pounds are omitted unless they are especially indicated. After the first 24 hours, mothers on the obstetric service who are not nursing their babies feed their own infants the formula.

Orders for medical patients are reviewed twice weekly to eliminate all unnecessary ones.

Adjustments in the Nursing School

The following adjustments related to the school of nursing may suggest further possibilities:

1. *Ward instructors for preclinical students.*—To provide for supervision during the preclinical period, six general staff nurses have been appointed as ward instructors. Most have had a course in ward teaching and have demonstrated good bedside skill. They are responsible to a ward co-ordinator who works closely with the nursing arts instructor.

They received initial instruction through conferences with the nursing arts instructor. They are responsible for supervising and reporting all preclinical ward practice. This plan saves the time of the nursing arts instructor and clinical supervisors, and helps the student in developing skills more rapidly. They supervise from three to six students at one time. When not engaged in supervision, they give general staff nursing service. There is no additional salary for this responsibility; the divided responsibility has caused no difficulty.

2. *Revision of courses.*—Courses have been revised to eliminate overlapping, and certain courses have been combined to better advantage. This has been an annual activity. In the sophomore year, the 12-week units (in medicine, surgery, and communicable disease) have been reduced to 10 weeks because of change in the course in nursing arts. This course is taught in three sections (small groups) with three-hour periods. This permits demonstrations and return initial practice at the same period. In operating room technic, classes of two to two-and-a-half hours also allow for demonstrations with return practice.

3. *A secretary in the nursing arts department* takes care of mimeographing, assembling, and numbering pages in the procedure books (150 per year), keeps ward manuals and those in administrative offices up to date, handles student records, assists with correction of examination questions and arithmetic pretests, summarizes Red Cross nurse's aide records, posts notices, obtains equipment for demonstrations on loan from the central supply-room, maintains contact with uniform company representatives and orders, sorts, stacks, and stores student uniforms. She is taking on work related to the Cadet Nurse Corps uniforms.

4. *Class photo-folders for instructors.*—Small photographs of students in uniform are arranged in a 5 by 7 inch folder. Twenty-five pictures, with the students' full names beneath, are arranged on each side of the folder. These are given to each instructor—for the duration of the course—so she can learn the names of the students more readily.

Conclusion

We are living from day to day doing what we can to facilitate and improve the nursing service. The administration has been most helpful, saying that *short of reducing the number of patients admitted, we might do anything that did not endanger the health or life of the patients.*

The co-operation of the medical staff has been ever so important in "our getting along." They have tried hard to reduce unnecessary or superfluous ordering. They have tried to get their patients to the hospital early and to discharge them early. They aim at admissions before four and discharges before noon. At times, they conduct ward rounds without a nurse. They are writing the greater number of orders in the daytime rather than at night when the staff is reduced.

A second important factor has been the extensive and wholehearted service of volunteer workers. In recent months, the names of volunteers who have given outstanding periods of service since Pearl Harbor have been inscribed on a board in the lobby of the hospital. Names of men and women who have given from 500 to 1,600 hours of service are listed.

The spirit of the nursing staff and their eagerness to work together to solve the large and the small problems related to nursing service have been vital factors in going forward through the past two years. The complexities of a nursing service demand the most which a well-qualified graduate staff is prepared to give.

A Central Supply-room in Wartime

By Katherine Zorn, R.N.

The picture that our Central Supply Unit presents in this, our third year of war, is different from that of six years ago. To-day, most materials are scarce, some are unobtainable, and equipment is difficult to replace. Our staff of experienced workers has left us for more attractive positions. Mature people, most of whom have never been employed before, and youngsters of high school age have filled the vacancies. More than ever we are conscious of the value of materials and efficient work. Ways and means have to be found to economize and to prolong the life of equipment and materials; at times, substitutes have to be used. Time and energy need to be saved whenever possible, and more than ever we are more keenly aware of the importance of assigning each task to the person best able to do it in order to maintain established standards in relation to the quality and quantity of the finished work.

Dressings and Linen

For greater economy in the use of gauze, wider mesh gauze, such as 14 by 10 mesh, serves the purpose of covering wadding or cotton quite well and is cheaper than the regular 20 by 12 mesh; 28 by 24 mesh gauze may well be substituted for the 44 by 40 mesh which is more expensive and more difficult to obtain. Combination cotton and gauze dressings are cheaper and more absorbent than all-gauze sponges; the first kind can easily replace the latter for secondary dressings. Cellu-pads that are especially well suited for heavy drainage cases have to be used sparingly at present due to a tremendous shortage of cellulose and rise in price. Drainage pads made of cheap grade absorbent and nonabsorbent cotton wrapped in 14 by 10 mesh gauze are a satisfactory substitute both from the standpoint of expense and serviceability. These pads may be bought ready made.

Due to the shortage of laundry personnel, a considerable scarcity of clean linen is noticeable, especially of "surgical towels" that are used for creating a sterile field near wounds. We have found that squares of 40-pound brown Kraft paper, size 12 by 12 inches, can take the place of surgical towels. To facilitate the use of these substitute towels, one corner of each paper needs to be folded over. When packing the papers (use about 15 papers to every 250 pieces of 4 by 8's) the corners should be kept separate and the papers placed in the center of the dressings in upright position. (See Figure 1.)

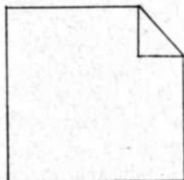

Figure 1.—Forty-pound kraft paper 12 by 12 inches, one corner folded as shown to facilitate handling, substitutes for sterile towels for changing dressings. Towels (upright) and dressings are shown as stacked for packing.

Another means of saving surgical towels, especially for intravenous work, lumbar punctures, et cetera, is the use of fenestrated sheets like those used for surgery, but on a smaller scale. This type of sheet is a square of muslin measuring about 36 by 36 inches with a square window, measuring about 1¾ inches, in the center of the sheet. The edge of the window is reinforced. Thus, only a small sheet is used instead of three or four towels.

Small and medium-size packages are most economically and conveniently wrapped in Kraft paper instead of twill. Kraft paper of 40-pound stock endures at least ten sterilizations. Large packages, however, are better wrapped in twill, as large paper wrappers are difficult to handle and endanger the sterile technic when the packages are used. Straight pins that are the usual means of closing cloth wrapped packages are scarce at present and those that are to be had are of poorest quality. Strong twine tied around the packages with a knot that can easily be opened, proved to be a good substitute for the missing polished pins. Time is saved, and there are fewer injured fingers due to pin pricks.

All clean, but unsterile, gauze and linen that is left in wrappers and drums after dressings have been completed is placed in paper bags or drums, marked with contents, number of floor, and date, and picked up by the Central Supply Service for resterilization. These supplies are returned to the floors after sterilization.

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An orderly system in handling and storing sterile dressings, linen, intravenous sets, et cetera, both on the pavilions and in the Central Supply-room aids in preventing waste and extra work. When storing sterile supplies, the rule to take from the left and add at the right side of the shelf saves time and prevents fresh supplies from being used first and old ones last. Little or no gauze needs to be discarded on account of its gray or yellow color and weakened condition caused by frequent sterilization. All sterile and unsterile items must be kept strictly separate; the dates on the packages need to be checked daily, and supplies older than eight days, with the exception of solutions, should be resterilized. Solutions if closed with cellophane—or paper—caps are considered sterile for two weeks; vacuum-sealed solutions are considered sterile indefinitely.

The following method of treating new and used rubber tubing, metal parts, and glass connections has proved to be effective as well as time and labor saving.

New Latex Rubber Tubing

Cut the tubing into desired lengths; adults' sets are usually a yard and a half long, children's sets measure one yard. Put on a pair of rubber gloves. Fill an enamel tub or pail (an arm bath without cover seems to be the ideal container) three-quarters full with fresh 2 or 3 per cent sodium hydroxide solution.

Immerse the tubing, making certain that it is completely filled with the solution. Soak only eight or ten pieces at a time. Grasp the ends of the tubing on both sides, immerse, and allow the solution to run in. Keep hands in the solution, hold one hand near the bottom of the basin, while bringing the other directly beneath the surface of the solution. Wait until all air has escaped, then allow the tubing to float.

After all pieces have been soaked, weight the tubing with a heavy glass rod or a similar object, and autoclave for fifteen minutes at 250 degrees Fahrenheit. To prevent bubbling over, do not use the "exhaust" after the sterilizing period has elapsed. Turn off the steam in the sterilizer chamber and jacket, and allow the temperature to fall gradually to 212 degrees; then remove the tubing from the sterilizer. Experience has taught that a mere boiling of the tubing in sodium hydroxide solution in a basin placed on top of a stove is insufficient.

Rinse well with tap water using a manifold spigot. (See Figure 2, f.)

Soak for fifteen minutes in 1 per cent hydrochloric acid solution, making certain that the tubing is completely filled with the solution.

Rinse for five minutes with a forceful stream of tap water.

Rinse well with freshly distilled water. (See "Siphon Arrangements," page 547.) The distilled water should not be older than twenty-four hours from the time of manufacture. This final rinsing may be given after the sets have been assembled, just before the packing and sterilization.

Allow the tubing to dry thoroughly before making up the sets. Do not dry the tubing in the sun or expose to great heat; both are injurious to rubber. Unless new tubing is dry and has returned to its normal condition after the curing, glass parts and tubing often disconnect when sterilized as complete sets for the first time.

Donor and Recipient Sets

Used sets that have been in direct contact with blood, e.g. donor and recipient sets, are cared for as follows:

Tubing and glass connections.—On the pavilion, where the set was used, the apparatus should be rinsed within five minutes after use with at least 1,000 cubic centimeters of cold tap water. Cold water easily removes fresh blood. The set should not be allowed to dry before its return to the Central Supply-room. There, further cleaning is carried out as follows:

The set is completely disassembled to facilitate the thorough cleansing of all parts. The tubing is placed in tubs containing 3 per cent sodium bicarbonate solution, care being taken to fill the tubing completely. The three quarters-full tubs are then sterilized for fifteen minutes without the use of the "exhaust." The glass parts are autoclaved in soda bicarbonate solution at the same time.

Rinse the tubing for five minutes with a forceful stream of tap water. Rinse all glass connections with hot tap water.

Rinse with freshly distilled water after the sets have been assembled.

Metal parts.—After soaking in fresh hydrogen dioxide for 15 minutes, scrub all *metal valves and adaptors* with a brush, bon ami, and water. Thorough rinsings with soap solution and hot water follow. Metal screens (filters) are soaked in fresh hydrogen dioxide for 15 minutes and then boiled in 2 or 3 per cent sodium hydroxide for 10 minutes. The latter dissolves the protein that frequently clings to the sides of used wire filters. For a thorough rinsing of the wire mesh, attach a short piece of rubber tubing to the spigot, turn the water on, and move the open end of the tubing slowly and firmly over the screen, while applying light pressure on the

tubing. Then rinse filters with freshly distilled water.

Place *needles* in fresh hydrogen dioxide for 15 minutes. Rinse with tap water, using a full syringe for each needle, and test the inside of the needle stems with a piece of needle wire. Sharpen needles on an oil stone. For the speedy and efficient sharpening of needles, a good light and a mounted adjustable magnifying lens (reading glass) are of great help. To save time, badly damaged bevels are best sharpened with a motor driven grinding wheel. Rinse with reclaimed alcohol and ether.

Clysis and Infusion Sets

Sets that have not been in direct contact with blood e.g. clysis and infusion sets are treated thus:

The sets should be thoroughly rinsed with cold tap water immediately after use, on the pavilions. They should not be allowed to dry before their return to the Central Supply-room where the treatment is continued as follows:

All sets are disassembled; tubing, glass connections, and metal parts are placed in separate basins.

The tubing then is soaked in Solventol for at least 30 minutes (see page 542), care being taken that the solution completely fills the tubing. (Use one tablespoonful Solventol No. 2 to one gallon of fairly hot tap water; stir and wait until all powder has dissolved.)

All glass parts are soaked in Solventol solution of the same strength.

On removal from the solution, the tubing should be kneaded and manipulated to simulate a scrubbing of the inner surface. It is then forcefully rinsed with tap water for 5 minutes.

The glass connections are also rinsed with tap water.

The metal parts, such as stopcocks and metal adaptors, are best cleaned with Solventol and a brush. Bon ami is used whenever necessary. A thorough rinsing with hot tap water follows.

Assembly, Packing, and Use of Sets

The sets are then assembled and thoroughly rinsed with freshly distilled water. At the same time, they are tested for leaks, proper assembly, working condition of stopcocks and valves, et cetera. Any dilated or broken ends of rubber tubing that need to be cut off, are collected and sold for remelting.

The sets are packed while the interior is still wet from the last rinsing. The presence of moisture inside the sets is important for proper sterilization. Packing should be done in such a way that during sterilization the steam can circulate as freely as possible through the apparatus. No needles may be attached to the tubing, all stopcocks and valves must be open. One towel and brown Kraft paper measuring about 22 by 24 inches have proved to be the proper wrapping materials for sets both from the standpoint of protection and effective sterilization.

On the pavilions, immediately before use, the sets are rinsed with sterile physiological saline solution to prevent hemolysis which might be caused by blood coming in contact with the residue of distilled water.

Surgical Rubber Gloves

Surgical rubber gloves come in contact with the most infectious substances and must therefore receive a thorough, but least injurious, treatment to make them clean and sterile. When caring for gloves, it must be remembered that disinfectants such as cresol or bichloride of mercury as well as heat and sunlight are injurious to rubber. Therefore, thorough washing with soap and water, followed by a short boiling period, should take the place of disinfectants, and the exposure to heat during sterilization be watched carefully. Rubber should be allowed to rest at least 48 hours between uses.

If possible, the gloves should be tested with water rather than air as the latter method is too costly. Experience with testing approximately 500 pairs of gloves per day showed that when the gloves are tested by inflating them with air, approximately one dozen pairs are lost daily due to the excessive dilation and the bursting of weak spots on used gloves. When using water, no gloves are lost during the testing process as water readily shows the damages.

All torn gloves should be repaired and used for nurses in the operating rooms and for all dressings carried out on the pavilions. Cuffs and fingers of gloves that are beyond repair, if cut wide enough, make excellent elastics for closing large and small solution flasks. The remaining rubber remnants may be sold for remelting. Another aid in conserving rubber gloves is the issue of sterile gloves on an exchange basis. Thereby no gloves are discarded on the pavilions, and only a few trained workers in the Central Supply-room judge on the condition and further usability of the gloves.

The following method of caring for rubber gloves has proved economical and efficient:

Treatment of gloves on the pavilions.—Rinse with cold tap water immediately after use, while the gloves are still on the wearer's hands.

If fatty substances were handled, wash the gloves while on the hands with fairly hot water and soap before removing gloves. On removal, deposit gloves in a container filled with soap solution, until there is time to wash them. When washing the soiled gloves, wear gloves for one's own protection. Wash the gloves well with fairly hot water and soap. Wash on both sides and rinse.

Boil for from three to five minutes in a water sterilizer. When placing the gloves in the sterilizer, wrap them in a heavy cloth or weight them with a heavy instrument to prevent them from floating on top of the water.

Remove gloves from the sterilizer, dry on both sides, and return to the Central Supplyroom regardless of their torn or undamaged condition.

Treatment of gloves in the Central Supplyroom.—The gloves are tested with water on a perforated tray that may be placed over a sink. (See Figure 2, a, page 546.) They are sorted at the same time and deposited in buckets marked with the different glove sizes. Leaks are marked with small wooden markers. (Figure 2, b.)

The tested and sorted gloves are hung on movable racks. (Figure 2, c.) There is a tilted tray under each rack; the lower end of this tray is provided with an outlet that drains into a pitcher. All dripping water collects in the pitcher. The gloves are dried on both sides at room temperature. The "marked" gloves are dried on one side only.

The "marked" gloves are mended with rubber cement and patches cut from torn gloves. (See page 546, "Glove Patches.") All patches must be on same side of glove. Mended gloves are allowed to dry from eight to ten days; then the patches are checked and the gloves put back into service.

The gloves are powdered, turned inside out, repowdered, and packed inside the glove powdering cabinet. (See page 546.) The gloves, together with a small envelope of powder that has been sterilized prior to the packing, are wrapped in brown Kraft paper size 18 by 20 inches.

Synthetic rubber gloves are promising. Of the two kinds, one variety gray and thick, the other brown and light weight, the latter was received favorably by the surgical and medical staff. The durability of the synthetic gloves seems to be excellent. Tests showed that the life of the synthetic rubber gloves is about five times as long as that of those made of latex rubber.

Sterilization

The proper sterilization of surgical supplies is necessary for successful surgery and it is of special importance in difficult times when equipment is hard to replace and materials need to be conserved. The results of faulty sterilization and improper care of equipment are readily seen. There may be untimely deterioration of linen; rubber tubing and surgical gloves may wear out more quickly than they can be replaced; overexposure to heat may turn procaine yellow or may decompose eye solutions; suture silk may break; the metal lining of a sterilizer chamber that should have been painted may develop leaks that cannot be repaired quickly on account of war shortages.

The sterilizers should be checked and serviced at regular intervals. The discharge lines need to be cleaned, the vacuum attachment must be kept in good working condition, the chambers have to be painted as soon as there are signs of corrosion, the gauges, the recording clocks, and the thermometers must correspond, and the pressure maintained both in sterilizer chambers and jackets should not exceed 17 pounds.

The preparation of the supplies for sterilization, the operation of the autoclaves, such as the turning of the valves, the timing of the various periods included in sterilization, and the loading and unloading should be under the supervision of a nurse, day and night.

Preparation of supplies.—When packing supplies in preparation for sterilization, we must remember that speedy and effective sterilization does not depend so much on the size of the load as it does on the size of the individual packages making up the load. We may not forget that wrappers that are too heavy (canvas) and bulky will delay the sterilizing process. The size and density of the packs should be kept at a minimum; the drums may not be packed too tightly. The contents of packs and drums should be arranged in such manner that the steam on its downward movement will circulate between linens and dressings. When preparing solutions, the flasks should be filled only to two-thirds capacity. Brushes and orange-wood sticks should be placed in containers with loose covers only. It is necessary to mark all packages plainly with contents, name of unit, and date in order to prevent loss and mix-ups.

Method of loading.—The correctness of the temperature at which we sterilize and the complete and speedy steam penetration of the chamber contents are of equal importance. The latter can be obtained only by the correct packing of the loads. The following simple rule has proved to be quite helpful:

1. Always place drums and packages in sterilizer basket in such manner that the downward circulating steam meets with as little resistance as possible.

2. Have all drums standing on their sides with holes open.

3. All packages and trays should rest on edge.

4. Have jars and tubs rest on their sides with covers leaning against them.

5. Do not pack the load too tightly.

Duration of sterilization.—The average sterilizing time for medium-size packages is 30 minutes at 250 degrees Fahrenheit (15 pounds pressure). The length of steam exposure varies with the size and density of the packages and the heat sensitiveness of certain materials. Following is a list of sterilizing periods for different kinds of surgical supplies. Tests have shown that, providing the loads have been packed properly, these periods assure sterility without causing unnecessary injury to materials.

	Minutes
Surgical rubber gloves	20
Suture silk	15–20
Brushes, orange-wood sticks	20
Medium-size packages, e.g. two surgical towels or two gowns	30
Mesh or muslin bags containing small and medium-size dressing packages	30
Large packages, e.g. incision and drainage packs, tonsil packs	40
Infusion, clysis, and recipient and donor sets	30
Dressing drums	30
Towel and gown drums	45
Laparotomy drums	50–60
Saline, distilled water	20
Procaine	15

Bone wax, vaseline, glassware, talcum, and needles are best sterilized in a dry-heat sterilizer at 320 degrees Fahrenheit for one hour or longer. The high oven temperature does not injure these materials and leaves them completely dry which is especially desirable for needles, syringes, and petri dishes.

Drying the loads.—Although at present the number of daytime loads has to be increased because of the labor shortage, the drying periods may not be neglected. Wet packages may not be considered "sterile." On completion of sterilization and after the use of the "exhaust" and "vacuum," it is good practice to open the sterilizer doors slightly while the jacket steam is still turned on. The chamber contents will dry thoroughly in comparatively short time depending on the size of the packages. Gloves wrapped in paper need not be dried longer than 10 minutes. This drying, of course, does not apply to solutions for which the "exhaust" is opened only about 1/16 turn of the valve and "vacuum" is not used at all.

Unloading the sterilizer.—On removal of the sterile supplies from the autoclave, the perforated rings of all drums must be closed and packages marked to indicate their sterile condition and date. Paper-wrapped packages are easily marked with a rubber stamp. Time is saved by marking the packages with the date of expiration of sterility rather than with the date of sterilization. Cloth-wrapped items that have been marked with the date at the time of packing may be marked with colored chalk. Sterilizer controls (Coleman or Diack) packed into the center of drums may be used to show that the temperature in the chamber was sufficiently high at the time of sterilization. The caps of solution flasks that have been marked with the date at the time of preparation are easily marked with a grease pencil to denote their sterile condition.

How To Save Time

One of our present problems is the lack of night workers for the loading and unloading of the large sterilizers after midnight. It was necessary to find a way to complete all sterilization before that time. The following steps were taken, and not without success:

The operating and supply-room services increased their sterile stock to avoid any "waiting" for sterile supplies which are always needed urgently. Thereby all partly full special loads were eliminated.

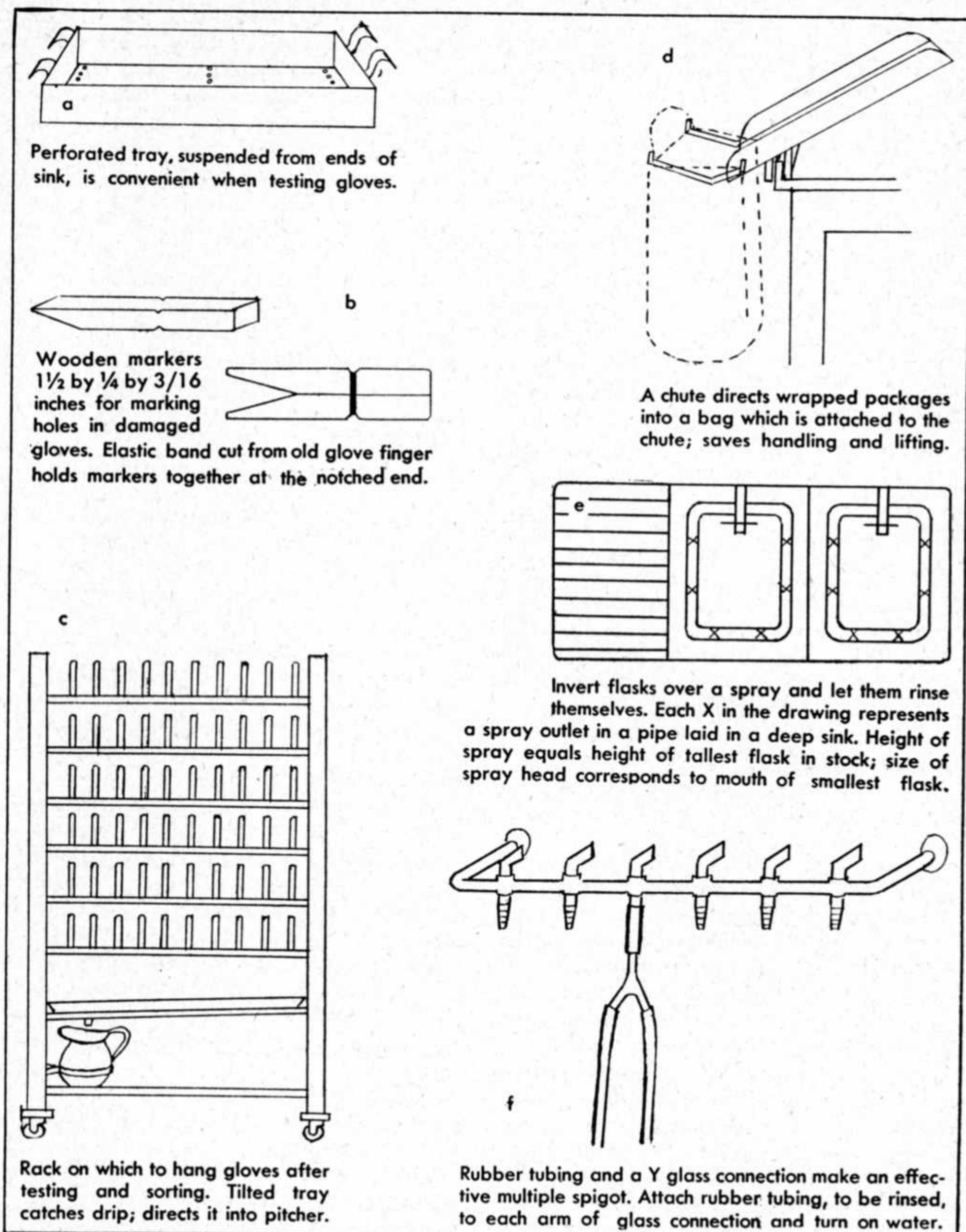
The pavilions were asked to co-operate by ordering sterile supplies carefully, as the day orderlies' increased tasks of loading and unloading the sterilizers allowed only one delivery of sterile supplies and one pick-up of used equipment per day. The gynecological and private operating rooms, the delivery room and the clinics co-operated by sending their supply trucks as early in the day as possible which aided greatly in the planning of the various loads.

Considerable time is saved by running full loads only, and by sterilizing at the same time all items requiring the same length of steam exposure. Loads are packed carefully to hasten steam penetration and special attention is given to the timing of the various periods of the sterilizing procedure.

Other Time Savers

Wooden markers for damaged gloves.—Cut scrap wood into pieces 1½ inches long and 3/16 inch thick and about ½ inch wide. Cut a notch into each side and taper the end (Figure 2, b). Hold two pieces together with the tapering ends pointing outwards, and wind an elastic around the notches. About ½ inch wide elastics

FIGURE 2.—SIX TIME-SAVERS



Perforated tray, suspended from ends of sink, is convenient when testing gloves.

Wooden markers 1½ by ¼ by 3/16 inches for marking holes in damaged gloves. Elastic band cut from old glove finger holds markers together at the notched end.

A chute directs wrapped packages into a bag which is attached to the chute; saves handling and lifting.

Invert flasks over a spray and let them rinse themselves. Each X in the drawing represents a spray outlet in a pipe laid in a deep sink. Height of spray equals height of tallest flask in stock; size of spray head corresponds to mouth of smallest flask.

Rack on which to hang gloves after testing and sorting. Tilted tray catches drip; directs it into pitcher.

Rubber tubing and a Y glass connection make an effective multiple spigot. Attach rubber tubing, to be rinsed, to each arm of glass connection and turn on water.

may be cut from fingers of torn gloves. When placing the elastic, hold pieces separate to distribute the elasticity evenly.

Glove patches.—Place two rubber strips of about the same size together and punch as many patches as possible by means of a ¼ or ½ inch paper punch. Pull the two layers apart thereby loosening the patches, then pull the patches off entirely.

Chute.—When a large number of packages need to be wrapped, the working table must be kept clear and the packages deposited in bags. A small wooden chute to which the bag may be attached (Figure 2, d) is of good service. It rests on the back of the table, in front of the worker. The chute is easily made from wood, two metal braces, and four hooks.

Powdering and packing gloves.—The use of the

glove powdering cabinet will save time and will eliminate the inconvenience of a dust-laden atmosphere when preparing surgical gloves for sterilization.

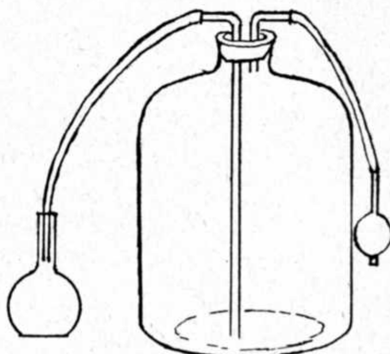
Convertible sink.—The washing of solution flasks is time consuming. It requires a person of average speed at least four hours to wash and rinse 180 flasks if the usual method of cleaning the flasks with soap and water and rinsing them individually is used.

The use of a sink with a multiple fountain arrangement will reduce this time by at least two hours. (See Figure 2, e.) Any fairly deep sink may be used: one with two compartments is to be preferred. The piping with from six to twelve sprays is laid and fastened in the bottom of the sink and connected with the main water supply line. The height of the sprays corresponds to that of the tallest flask in use; the size of the head, to the mouth of the smallest one. At the base of each spray is a perforated disc which can be made adjustable to the height of the various types of flasks. The head of the spray is provided with four cut-in slots from which the water sprays. The fountain stem, the head, and the base are detachable (screw connections) to facilitate cleaning.

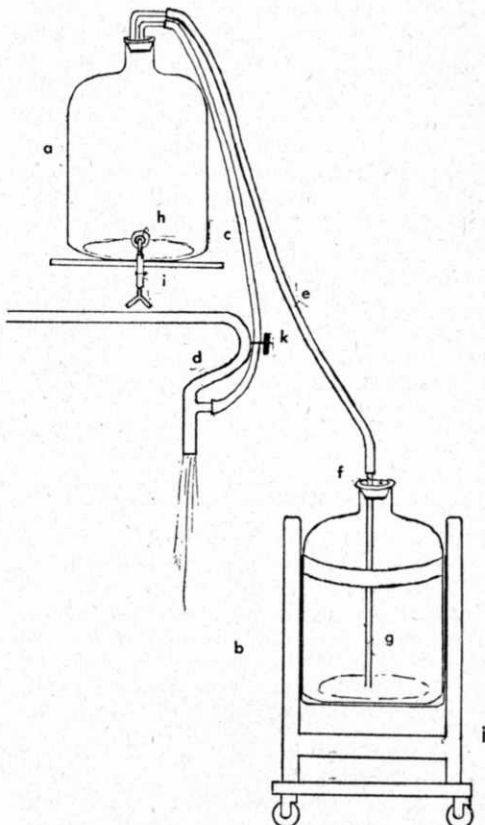
Solventol, a sudsless cleansing agent in powder form, is better suited than soap for the cleaning of flasks. Time is saved, as there is no suds and the hydrochloric rinse, that usually follows the use of soap solution, may be omitted. Following is a time-saving procedure for the washing and rinsing of solution flasks:

1. Prepare a concentrated solution by adding four tablespoonfuls of Solventol to 1,000 cubic centimeters of fairly hot water; stir until the powder has dissolved.
2. Pour some of the concentrate into a small bowl, have sponge, bon ami, and brush handy.
3. Place 6 or 12 used flasks on the drainboard and pour about 125 cubic centimeters of the concentrate into each 2,000-cubic centimeter flask.
4. Pick up one flask, dip the sponge into the solution, and wash the outside well.
5. Fill the flask with fairly hot tap water and shake well. (If the flask was used for the mixing of some drug, clean inside with brush; if there are stove marks on the outside of the flask, use bon ami to remove the stain.)
6. Place flask upside down on one of the sprays.
7. As soon as all the fountains have been covered, turn the hot water on and allow flasks to be rinsed for five minutes. If there are two compartments, one batch of flasks may be cleaned, while the other is being rinsed; no waiting is necessary.
8. Turn the water off, remove the flasks from the fountains, and rinse them thoroughly with freshly distilled water.
9. Use the flasks on the day of rinsing.

FIGURE 3.—SIPHON ARRANGEMENTS



A.—A siphon used to transfer stock solution from a large bottle to smaller container saves time and energy, consists of one short and two long pieces of cured rubber tubing, an atomizer bulb with adaptor, a two-holed stopper, one straight and two "L" glass-connections.



B.—A siphon transfers distilled water from bottle on floor to elevated one that is hard to handle. On connecting aspirator bottle with packer bottle and sink, the water is turned on by means of a valve (k). As soon as vacuum in the upper bottle is complete, distilled water is drawn up from five-gallon bottle into aspirator bottle. Tubing connected with sink should be detached as soon as this bottle is full.

Manifold spigot for curing tubing.—Such an attachment (Figure 2, f) that can be connected with any sink is most time saving for the thorough rinsing of rubber tubing. Attach a small piece of rubber tubing to each spigot, and a glass "Y" connection to the end of each piece. The tubing that is to be rinsed is then attached to the ends of the glass connections.

Siphon arrangements.—If the distilled water is not piped to the sink where the tubing is treated, the main water line of the sink may well be utilized for operating a siphon for the transfer of distilled water from one bottle on the floor to an elevated one that is hard to handle (Figure 3, B). The mouths of the aspirator bottle (*a*) and the five gallon packer bottle (*b*) are closed with two-hole stoppers. One glass connection with rubber tubing (*c*) leads from the aspirator bottle to the pipe connection in the sink (*d*); the other (*e*) to the bottle on the floor. Use cured tubing for latter connection. A straight glass connection (*f*) leads through the stopper of the packer bottle; a long piece of cured tubing (*g*) reaches to the bottom of this bottle. The bottom outlet of the aspirator bottle (*h*) is closed with a one-hole-stopper. An "L" glass-connection, a short piece of rubber tubing with a "Y" glass-connection at the end and a stopcock (*i*) complete the rinsing arrangement. For easy handling, the five gallon bottle rests in a wooden carrier (*j*).

On connecting the aspirator bottle with the packer bottle and the sink, the water is turned on by means of a valve (*k*). As soon as the vacuum in the elevated bottle is complete, the distilled water is transferred from the five gallon bottle into the aspirator bottle. The tubing connected with the sink should be detached as soon as this bottle is full.

Due to the present shortage of glassware and labor, five-gallon bottles that are difficult to handle are frequently used in place of small ones of convenient size. A siphon arrangement consisting of one short and two long pieces of cured rubber tubing, an atomizer bulb with adaptor, a two-hole-stopper, one straight and two "L" glass-connections (Figure 3, A) saves time and energy when transferring stock solutions from large bottles to handy flasks of smaller size.

The atomizer bulb needs to be operated only until the flow of the solution has been started.

Volunteer Workers

Volunteers, old and young, have been a great aid to us ever since the war began. To obtain desired results in relation to quality and quantity of work accomplished, proper assignments are important. Older people usually do well with tasks requiring time and care, e.g. mending rubber gloves, cutting elastics, assembling and packing special dressings, et cetera, while youngsters prefer work that requires less care, but speed, e.g. folding towels, wrapping large numbers of packages, salvaging used paper wrappers, et cetera.

Our efforts towards conservation of materials, time, and labor are essential to the war effort; the experience gained will undoubtedly be beneficial in coming times of peace.

Gonorrhea and Syphilis—Wartime Health Problems!

Gonorrhea and syphilis remain this country's most serious wartime health problems. Although the rate "is the lowest in our military history," venereal disease is still "a leading cause of lost man days among the armed forces," Dr. Walter Clarke, American Social Hygiene Association, states in the Annual Report. "Indications of increased venereal disease prevalence in civilian communities are causing anxiety among civil and military health leaders.

"The past year's experience again substantiated the basic fact that active, united support by the public of all measures against venereal diseases is the key to victory against these infections. If these activities are strengthened," Dr. Clarke declares, "the new discoveries—especially the modern intensive therapy of syphilis and the penicillin treatment of gonorrhea—may make it possible, in the not too distant future, to bring venereal diseases completely under control."

The report indicates stepped up participation by individuals and community groups in every phase of the Association's activities in 1943. ASHA medical staff members served as consultants to several federal agencies, and participated in the training of Army, Navy, and Public Health Service venereal disease control officers at the Army Medical School, Johns Hopkins University, Harvard University, and the USPHS headquarters at Bethesda.

The American Social Hygiene Association officially represents voluntary health agencies in carrying out the federal government's venereal disease control program. It is teamed up with the Army, Navy, U. S. Public Health Service, and the Social Protection Division of the Federal Security Agency, and co-operates with state and local health and law enforcement authorities, social hygiene societies, and other citizen groups in preventing the infection of soldiers, sailors, and war industry workers.—American Social Hygiene Association Release, April 26, 1944.

Toxemia Mortality Can Be Lowered

By Gordon W. Jones, M.D.

It is an alarming fact that at least ten thousand women a year die for reasons of motherhood in this country alone. That is a high rate indeed for a process that is fundamentally physiological. Of these thousands it is variously estimated that 25 to 35 per cent are the victims of the toxemia of late pregnancy.

It is puzzling that these three thousand women are by no means equally distributed geographically. The southern states actually have so much more toxemia that they have been grouped together as the "toxemia belt." The progressive rise in the death rate from state to state down the Atlantic seaboard is dramatic. Pennsylvania presents three times the rate of New York, Virginia more still, while South Carolina has eight times the New York rate, eleven times that of Connecticut. And South Carolina, with more toxemia deaths proportionately than most of her sister states, has one of the lowest doctor-patient ratios in the nation!

Such a large number of deaths presents a vital challenge to those of us who are interested in maternal welfare in the South. Because of the limited understanding of toxemia generally, the only effective way of combating it is through early recognition. Thus, it should be the duty of every nurse, in public health or in hospital service, to cultivate an *awareness*. Whenever she is confronted by a pregnant woman her first and almost instinctive thought should be, "I wonder if she is toxemic." With such a cultivated attitude functioning, few patients plagued by this malady would be missed.

What is toxemia?

Of all the vagaries in medicine that term, literally "toxins in the blood," tells least. Because of this fact and the ready confusion with other diseases lumped under the same name, modern students prefer to designate the hypertensive-albuminuric diseases peculiar to and arising from pregnancy as pre-eclampsia and eclampsia. The significant difference between these two subdivisions lies in the presence of convulsions—and often coma—in the latter. As the term implies, the former is really the forerunner of eclampsia, that dramatic end-result of prenatal neglect.

By definition and from experience, any pregnant woman, typically in her last trimester, with a blood pressure of 140/90 or more, who has albuminuria, be it a mere trace or 4-plus, must be considered toxemic. As regards the blood pressure, the diastolic reading is by far the more important since systolic pressure varies a great deal with excitement and exertion. Furthermore, the systolic pressure may actually be below 140 without precluding the possibility of toxemia.

The next point to be emphasized is that even in the presence of hypertension, toxemia may not be diagnosed unless there is also albuminuria. But such a hypertensive patient must be watched carefully since a toxemia is relatively easily superimposed upon a previously existing hypertension.

The largest proportion of toxemia is mild—that is, there is only moderate elevation of the blood pressure and slight albuminuria. With these people, symptoms are usually absent. It is at the mild stage that we hope to diagnose and treat our cases.

In the more fulminating form the blood pressure is usually higher and there are considerable amounts of albumin in the urine. Here, another objective sign becomes more evident. It is the common observation of obstetricians that too great and too rapid weight gain often precedes and accompanies the development of toxemia. Prevention of more than twenty-five pounds of weight gain in the whole course of pregnancy is one of the cornerstones of prenatal care.

This weight gain is due to the storage of water in the maternal tissues which eventually becomes manifest in the form of edema. This latter is a very confusing sign since many pregnant but nontoxemic women develop a certain degree of it. However, edema is universal and often very marked in toxemia; eclamptics are literally water-logged.

The great edema in severe cases involves even the face and, when coupled with the expression of distress that the very ill ones demonstrate so often, we have the picture which an experienced person may diagnose at a glance.

As mentioned before, it is usually only when the disease is well advanced that patients develop symptoms. Headache of the typical dull hypertensive type is the commonest of these subjective manifestations. Occasionally patients complain of dizziness and drowsiness. Most significant, perhaps, are the eye symptoms:

Dr. Jones writes from the Department of Obstetrics and Gynecology at the University of Virginia where he is resident.

blurring of vision, "spots before the eyes," rarely diplopia, and occasionally blindness. The most alarming symptoms of all originate in the epigastrium. Severe pain there, a sense of tightness, plus, sometimes, nausea and vomiting are indeed the aura of impending eclampsia. Such a patient is a grave emergency.

The whole gamut of these signs and symptoms from the very mildest to those of eclampsia proper may be run in the course of a few hours. Happily, this is not often the case for such an event thwarts the best of prenatal care. It is because the average toxemia takes several days to develop that we generally consider it safe if prenatal patients return to the physician only once a week during their last two months.

In the earlier months it is best to ask the patients to return every three weeks. However the nurse should urge the women of the community to seek attention early in pregnancy so that any abnormalities may be discovered.

At this first visit, and in any subsequent home visits, the patients should be taught how to care for themselves properly and warned as to the dangerous possibilities and important signs. This educational work is essential. Only if they realize the importance of prenatal attention will the poorer people request it.

It has been demonstrated to our satisfaction that if care and instruction are adequate the malignant process of toxemia can be bested. There has been sufficient improvement in the statistics during the past forty years to justify this opinion.

One of the first admonitions will be against excessive weight gain. This can be controlled by asking the patient to curb her appetite and restrict consumption of fats—butter, fried food, cream, and the fat of meat. Fats produce twice as many calories as other food does. Further, excessive use of carbohydrates should be forbidden.

Lean meats, the fundamental body-building and supporting food, must not be limited. It has been demonstrated that there is no relationship between abundant protein and the development of toxemia, as was once claimed. Likewise, milk, preferably skimmed, is essential for the pregnant woman not only because of the protein but also the minerals and vitamins.

To satisfy her appetite the patient should be urged to "fill up" on vegetables. She will incidentally be getting the needed vitamins in their most easily assimilable form. Studies before the war by the Germans proved that troops do better by far on naturally obtained vitamins than on the synthetic products.

If, despite diet, too great weight gain is found, such simple and harmless procedures as restriction of table salt and oral administration of epsom salts daily may cause the disappearance of stored tissue-water.

Since excessive weight gain may precede the onset of a toxemia, possibly the most important part of the prenatal check-up is examination of the urine for albumin and the taking of the blood pressure. Any nurse can do this. She can likewise inquire for the symptoms of toxemia.

Whenever the technical definition of toxemia has been fulfilled, the nurse should inform the physician in charge. He may admit the patient to a hospital for sedation and observation. This, however, in view of the mildness of slight pre-eclampsia, may not be practicable or necessary. But such a woman must be followed carefully in the home by the public health nurse (or nurse-midwife) in daily visits. Skipping a single day may be dangerous.

At each such visit the blood pressure will be taken and checked once or twice since the first reading may not be accurate. The urine must also be examined for albumin. A very simple, quick, and accurate test for this is the addition of a few cubic centimeters of Esbach's solution to urine in a test tube. In the presence of albumin there is immediate clouding; if much is present, the urine in the tube will become densely flaked by the sudden throwing down of protein. It is easy to carry a small bottle of the solution in the bag.

Not only should the nurse make and record these observations, she must also explain to the patients the nature of the disease, warn them to remain in bed and take a mild sedative. The diet should be checked. Inquiries concerning the symptoms of headache and visual disturbances are necessary.

If, under proper management in the home, signs increase and symptoms appear, admission to a hospital will be the next step. Once there, of course, supervision of the patient's course by the physician will be more close and direct. The blood pressure readings made by the nurse will be checked, the urines will be run by the intern.

But the nurse's main function of watching, caring for, and reporting on toxemic patients is an essential element in their treatment. If any patients need special nursing, sick toxemics do.

As a part of her duty to watch the patient, the nurse will collect the required urine specimens, will keep an accurate fluid and urine chart. She will be quick to notice and report evidence of renal shutdown. She will watch

carefully for, and notify the doctor of, the danger signal symptoms of increasing headache and epigastric pain.

Just as important as observation is conscientious care. In no other case is it more important to guard the fluid intake and check the diet to be sure it is fat poor and has no free salt. (The most severely ill will, most likely, be fed by venoclysis.) Medications must be given accurately, promptly, skilfully, and with all gentleness. It must be remembered that seemingly trivial painful stimuli occasionally initiate convulsions in patients on the brink of eclampsia. Even a rough venepuncture may do it.

More than any other noninfectious patients these women deserve isolation. They must be protected from the rending noises so typical of a hospital. There should be little more than twilight in the room. Doctors and nurses should tread lightly and talk in whispers.

The special nurse of a severe pre-eclamptic or eclamptic should not leave her even for a few minutes. Under the necessarily heavy sedation the patient may become unruly and be in danger of some such accident as falling out of bed. Or, a convulsion may appear "out of the blue" and if aid is not immediately at hand the woman may injure herself. The attending nurse must be ready with the mouth gag to prevent the frequent severe tongue biting incident to an eclamptic episode. Only by earnest hour-by-hour attention with a minimum of unnecessary handling and "fussing" can these severely ill people be managed to their benefit.

Of all the fields of preventive medicine, prenatal care offers the greatest challenge to nurses since our best present-day means of reducing toxemia mortality is careful guidance through pregnancy. Furthermore, reduction in the mortality should not be the sole goal, for the permanent hypertension and kidney damage which so often follow pre-eclampsia constitute a real problem. Surely, especially in view of the declining birth rate, those women who are willing to bear children should be protected from the ills they risk.

As was noted earlier, the regions of the country least well supplied with physicians are the very ones where toxemia is commonest and eclamptic deaths are the most frequent. The people of the Carolina and Florida swamps and of the barren Appalachians are so poor that expensively educated physicians cannot afford to go there. But they are our people and their children become our citizens; there is no better stock. They are just as deserving as the denizens of city slums to whom the doors of our great teaching hospitals open widely.

How are we to reduce the toxemia morbidity and mortality among this folk? At a time when prenatal care is improving slowly over the country as a whole, in these regions the patients are often left to the mercy of old "granny" midwives who know little more than that "the womb opens up." Toxemia is beyond their scope.

Any plan to solve this problem will require a considerable outlay of public funds. To hire the proper number of physicians would be extremely costly as well as impractical because of the probable postwar demands of the armed forces. There is no reason why nurses cannot be used extensively to lower not only the toxemia mortality and morbidity but to improve rural obstetrics generally.

Nurses employed to care for pregnant women should be thoroughly grounded in obstetrics, should, in fact, be nurse-midwives. Institution of many schools of midwifery about the nation like that of the Maternity Center Association in New York would be necessary to supply the demand.

For the benefit of the great Negro populations of the Deep South where white nurses may be reluctant to go and might even be received with distrust, schools for the training of Negro nurse-midwives should be established. Colored women make excellent nurses.

These properly trained nurses could be located in little centers convenient to the patients they propose to serve. There they could examine the prenatal patients at stated intervals, be checked when necessary by a physician in general charge of several counties. The records and any problem patients could be sent to his centrally located office for review and advice. It would be best that he see each prenatal patient once to relieve the nurse of too great responsibility.

It has been proven that such a plan is practicable, that nurse-midwives can give adequate prenatal and even delivery care under proper supervision. The nurses of the Kentucky Frontier Nursing Service have done it. So have those of the Maternity Center Association. Why cannot their programs become widespread?

Already many states have made rather groping beginnings in the field of public health obstetrics. Virginia spends a few thousands a year on prenatal clinics. Other southern states have employed itinerant obstetricians. The federal Children's Bureau extends maternal and child-health financial aid for obstetrical emergencies. But nowhere, as yet, have public agencies used nurse-midwives in their greatest potentialities.

The "Solace" Plies the Tasman and Coral Seas

By Ruth Young White

Jimmie was a gunner on a ship that had been dodging in and out of the fighting zones in the South Pacific for months, always on the alert for enemy submarines, never knowing when he would be called upon to train his guns against the ships of the Rising Sun, living in cramped quarters, seeing the same men day in and day out, never relaxing, always under strain.

He was a normal sort of boy, a clerk in a manufacturing plant back home. He had been an even-tempered worker, getting along with his family and friends. But putting him behind a gun had changed him gradually. He began to get irritable and to snap at his buddies when they kidded him. He was moody at times and homesick, resentful because he had to be separated from his wife and children.

Came a Japanese attack against the shipping being sent into New Guinea. Jimmie was engaged in firing his guns, hour upon hour. He looked haggard and his eyes were dulled. That night he slept badly; the sound of firing rang in his ears. He dozed and wakened babbling about torpedoes and bombs and explosions. He was nearing the end of his endurance. Realizing Jimmie's condition, the medical officer transferred him to sick bay and on to shore as quickly as possible. He was slated for a berth on the U.S.S. "Solace," Navy Hospital Ship, plying Pacific waters, to care for the men who were sick or wounded while fighting under the Navy's command.

Scores of those Jimmies were patients of Lieutenant (jg) Catherine Shaw during the year she was a Navy nurse in the mental ward aboard the hospital ship. She told me about her service, as we walked through the wards at St. Albans Naval Hospital, St. Albans, New York, where she is a chief nurse. Greeting her from their hospital beds were men who recognized her bright service ribbons, representing the South Pacific and the American theater.

"My ribbons remind them that they met me at Samoa or New Zealand or Fiji and it makes a tie between us. They feel that I understand what they have undergone and I do, of course!" she told me.

As she talked of her experiences, I could understand what a welcome sight the "Solace" was to the soldiers, sailors, and marines who were the casualties of the fighting in the mysterious and hitherto romantic isles in the Coral and Tasman Seas. I could visualize the floating hospital steaming into a distant harbor, gleaming white, bearing the Red Cross of mercy, like a messenger from the folks at home, offering such luxuries as clean beds, delicious food, American nurses to care for them, and efficient doctors to treat them.

Only a small percentage of the patients were mentally sick like Jimmie. Many were veterans of the fighting around Guadalcanal and Bougainville and had deep wounds or fractured bones. Many were suffering from terrible burns after torpedoing or shipwreck. Many were sick from malaria, filariasis, or "cat" fever. Whatever the sickness or injury, the "Solace" was prepared to take care of it.

The ship's first days in harbor were busy ones. As soon as the anchor was dropped, a boat came out from the shore, bearing the shore's commanding medical officer to find out how many patients the ship could take. Seriously ill and wounded men were lined up and, when the word was given, they were lifted onto motor whale boats and launches, which had the benches knocked out to accommodate stretcher patients. A flat top barge took the patients who could walk.

When they reached the hospital ship, trained stretcher men were ready to pass them from boat to ship and up the gangway to the quarterdeck. Chiefs of medicine and surgery and their assistants tagged the men that needed instantaneous treatment and sent them to the proper wards: surgical, medical, orthopedic, mental, or ear, nose, and throat. If they were in pain they were given hypodermics. If emergency operations were indicated, they were placed on the elevator on the forward part of the ship which connected with the operating room, the nurses were summoned, and the anesthetic was administered immediately.

Even when the seas were rough and the engines of the ship were turning over hard as they battled the force of the waves, the doctors operated calmly, seeming to be able to calculate the heaving as they did their delicate repair-work. Everything in the operating room was tied down and the procedure was uniform: the corpsmen assisting the surgeons with the instruments and the nurses bracing their feet, as they stood at the patients' heads, watching the

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Ruth Young White, Publicity Department, American Red Cross, Washington, D. C., interviewed Lieutenant Catherine Shaw at St. Albans (New York) Naval Hospital to obtain this interesting story of the "Solace" in action.

pulse and ready to give blood plasma or saline solution in case of shock. Lieutenant Shaw told me that she had seen doctors take foreign bodies from men's eyes, while the ship was all but turning upside down during hurricanes in the Tasman Sea.

Where no emergency developed, the men were put to bed by corpsmen, while the two nurses in each ward supervised the nursing care and handled the charts. With burned cases, the clothing or dressing was cut away, the fuel oil washed off, and the dead tissue removed. Fracture cases were put to bed and made comfortable; if their fractures had not been set, x-ray pictures were taken and test casts were made. Those suffering from gunshot wounds and amputations were put in clean beds, bathed, and given clean clothing. Mental cases were assigned to bright, comfortable wards, where they could lie in the open air and get a good view of the sea. The main idea was to make them happy.

In the ear, nose, and throat clinic, the doctors looked over special cases to learn where shrapnel had lodged in the throat, to remove an injured eye, or to treat ears affected by explosions.

In the midst of the bustle of the first day, promptly at ten-thirty, sirens, klaxons, and whistles sounded and the announcement came over the broadcasting system: "This is a drill." Senior corpsmen, who had been making out assignments of stations for patients, were responsible for notifying each one. Life jackets were given to patients who could walk and they were shown where their life boat was located. Bed patients were told that since this was a drill they would not be moved, but that if the real thing happened they would be carried out by corpsmen.

With everyone in his proper station, names were checked and it was announced that if the order were given to abandon ship, the horn would blow thirty-three times, while the words came over the address system, "Provide and equip to abandon ship." After such a drill the patients realized that the ship was ready for all contingencies.

The second day was as busy as the first with operations booked one after another. Surgeons planned care for all cases as quickly as possible, so that the men would have a long period of rest before being moved again. Trips lasted from four to twelve days, according to how many stops had to be made. The route was set along nontraveled lanes and was changed frequently. Everybody was ready to give twenty-four-hour service when it was necessary.

Ordinarily breakfast was at seven and the day nurses reported in the wards at seven-thirty. They wore their hospital whites and the sight of them in their fresh dresses and daintily arranged hair seemed to please the weary men, now relaxed and comfortable. They read the temperature lists, visited the sickest men, checked those going to surgery, and prepared hypodermics.

When the doctors arrived at eight, they were given informal reports and began their rounds, accompanied by the senior corpsmen and the nurses. Orders for special baths, medicine, and dressings were written by the nurses for the corpsmen. The nurses were responsible for writing the log, a permanent record of each patient. Chow was at eleven and five. Food was good because the supply officers were ingenious about procuring it. At New Zealand, they could buy fresh fruits, vegetables, and meats, as well as frozen ones. When they contacted supply ships, they stocked up on frozen food. The "Solace" had immense space for storage and refrigeration and when she was at sea for a long period, cooks dipped into canned goods and powdered milk for cooking.

Two of the most pleasant hours were at ten in the morning and at two-thirty when "nourishments" were given out: ice cream, milk shakes, and soft drinks were savored because they had been lacking in the tropical islands. Magazines and Red Cross toilet kits were distributed. Men were sent on deck for sun baths and special exercises, and everybody became acquainted. The boys liked to sign up in a mock hotel register to find home-town friends. Seamen whom the nurses had known in boot camps and corpsmen whom they had trained in Navy hospitals appeared to say hello.

In the afternoons, patients and crew members put on informal shows, including singing to the accompaniment of guitars or banjos, recordings, and comedy acts. The nurses often had time to carry on helpful conversations with the patients who appeared unhappy. They enjoyed writing letters for the men since this was one way to learn to know their problems, especially those of the mental patients.

One trip brought eleven psychiatric patients to Lieutenant Shaw's ward and gave her an exceptional opportunity to study and to help them. None was injured or had a definite malady, yet all were so weak that they had to be made secure on their stretchers. At first they did not want to talk or eat.

The ship's psychiatrist prescribed rest, quiet, fresh air, good food, and pleasant companionship. Sometimes medication was ordered for the purpose of soothing them. After several days

they usually wanted to talk things over with the nurse and when they did, they often talked themselves out. They were allowed to bring up the subject of the war naturally and, when they fretted about having to explain their nervous symptoms to the folks at home, they were reminded of the strain they had endured and were assured that theirs was a natural emotional reaction that would not last.

Evenings were quiet, restful periods. At seven o'clock sick call, patients were checked as to comfort and were given sedatives, if needed. When the captain considered that the ship was in a safe area, there were movies. If not, they gathered in wards to sing and talk. Eggnogs were passed and lights went out early. After dark the ship carried an illuminated Red Cross, outlined by red neon lights.

Lieutenant Shaw reported that submarines never were sighted during her period of service, although several alerts were sounded when life belts were ordered. Seasickness had to be contended with when the hurricanes roared. Although she was a good sailor and never was seasick, some of the nurses were susceptible. Never did they let it interfere with their work. During busy times she has seen them turn green, go to the sink, be violently ill, wash their faces and hands, and return to duty.

The staff of the "Solace" was a close-knit group with perfect co-operation between doctors, nurses, and corpsmen, all of them appreciating the part that the others played in the healing of sick minds and bodies. Men assigned to the hospital ship for the first time sometimes resented finding nurses on board, declaring that the presence of women made it a "sissy" war for them. The nurses understood such an attitude and teased back, kept their equilibrium, and eventually won the complete respect of their colleagues. It worked out, Lieutenant Shaw said, that the medical officers were the big brothers, the corpsmen were the little brothers, and the nurses were sisters to all of them, resulting in a unique relationship that produced expert care and treatment of the patients.

The nurses on the "Solace," who ranged in age from twenty-three to thirty-five and averaged about thirty years, did a lot of teaching. They received many new replacements, as trained corpsmen were assigned to remote islands near the fighting, and it was necessary to train the new men while the ship was standing by for a new load. Corpsmen proved to be apt pupils, especially with mental patients, Lieutenant Shaw pointed out, because they expressed such admiration of the fortitude of the fighting men that their attitude tended to buck up the depressed ones.

It was wonderful to go on shore at New Zealand, Lieutenant Shaw related, and see your former patients walking about, well and happy, ready to go back on duty, their scars skilfully concealed by skin grafts, their wounds and fractures healed, and their war neuroses erased.

As Lieutenant Shaw put it: "Hospital ship duty is viewed as the crack assignment of the Navy Nurse Corps, and no wonder!"

The Navy Nurse Corps continues to need five hundred nurses each month! According to Lieutenant Shaw, every eligible nurse would try to get into the Navy if she understood how interesting and satisfying it is.

Evacuating the Wounded from Tarawa

ON THE NAVY HOSPITAL SHIP there are periods of intense activity when the ship takes on a load of patients. There are days at sea when all hands are busy with operations, transfusions, plasma administration, dressings, and the multitude of labors of the special departments in caring for the wounded; but there are often long cruises when, with no patients aboard, we are only standing by.

The ship on which I served had the unusual opportunity to be present not far from Tarawa on the final days of that bloodiest of Marine Corps battles. At a secret rendezvous in the Gilbert Islands we met the fleet of transports protected by the task force of battleships, cruisers, and destroyers. We took our place in formation and stopped our engines. The transports slowly drew up near us and loaded the wounded into landing craft which transferred them to our hospital ship. The sea fortunately was quite calm, but the wind and tide blew us out of position so that we had to suspend loading for a short time in order to get back in formation. With my assistant I examined rapidly each man as he came over the quarter deck and assigned him to a bunk in the appropriate ward. Doctors and nurses worked at high speed in their wards; the operating rooms opened at once and thirty-five operations were performed in the first twenty-four hours under the surgical leadership of the chief of surgery. It is encouraging to know that of this shipload of the most seriously wounded from Tarawa whom we tended for several days at sea, less than 1 per cent died and most of the patients were out of danger when we finally transferred them to a shore-based hospital. In this result the nurses deserve the highest credit.—From an address by CAPTAIN HOWARD B. SPRAGUE (MC), U. S. Navy, February 9, 1944.

The Nurse and the Blood Donor Service

By Vivian Olson Bradshaw, R.N., and Earl S. Taylor, M.D.

In the three years since its inception (February 3, 1941), the American Red Cross Blood Donor Service has grown from a single center producing 200 bleedings a week to thirty-five centers delivering up to 120,000 in the same period—the nursing staff from four to over 900. The nurse group in the service has become one of the larger nursing units in the country; it is the largest group of nurses employed by the American Red Cross on any single project.

The background and evolution of the Blood Donor Service has been dealt with in full elsewhere.(1) These reports have outlined the rules and regulations under which the service operates and have discussed the technics employed. With each step in the development of the program the nurse has played an increasingly important rôle.

The Donor Service, in performing its primary function of procuring adequate amounts of blood for the production of plasma and serum albumin for the armed forces, has had three main objectives: (*a*) protection of the donor; (*b*) prevention of spoilage of the blood; (*c*) performance of (*a*) and (*b*) with minimum personnel.

In the accomplishment of these aims, a new type of nurse group employing new nursing technics has been evolved. The blood donor nurse should be a valuable nucleus in the establishment of the many hospital blood and plasma banks.

Personnel

Each center has for its professional head as technical supervisor a volunteer physician appointed by the Subcommittee on Blood Substitutes of the National Research Council. He is responsible for the employment and direction of the nursing personnel. All nurses are required to become members of the American Red Cross Nursing Service except for some overage nurses, citizens of allied nations, and a few nurses known to be qualified, but who do not quite meet the formal scholastic requirements. All nurses are full-time paid employees, except for substitutes for illness, vacations, et cetera.

Mrs. Vivian Olson Bradshaw is a graduate of the Columbia University-Presbyterian Hospital School of Nursing, class of 1940. She has been associated with the New York City Blood Donor Center since February 1941 and its head nurse since December 1941. Earl S. Taylor, Major, MC, AUS, is national technical director, Blood Donor Service, American Red Cross.

In view of the present nursing shortage, the recruitment of nurses for the service has presented a number of problems. Regardless of the importance of the work of the service and despite the complete devotion of its efforts for the Army and Navy, it was felt that the service should in no way hinder the procurement of nurses for military service. Since January 1, 1943, no "military eligible" nurses have been employed by the Blood Donor Service. The term "military eligible" has had a somewhat different connotation to the service than to the nurse recruitment and classification agencies, in that married nurses with or without dependents who indicate their unwillingness to join the military are not considered eligible and available. It will be noted (Table 1) that this group represents the largest number of nurses in the service. These young women are maintaining homes for their husbands or have husbands overseas, and many of them have been requested by their husbands not to enter military service. Since many of these nurses have been drawn back into nursing from private life, the varying hours of work at the centers or on mobile units have enabled them to make arrangements for the care of their homes and children that would not be possible in full-time hospital nursing positions. Only twenty-six nurses who could be considered eligible for the military have been listed as essential, and deferment for them requested. These nurses were all employed before January 1, 1943 and, for the most part, represent head nurses who were employed when the centers first opened. They have remained as key personnel, essential to the operation of the service.

It will also be noted (Table 1) that a number of the nurses are Army and Navy rejects or have received medical discharges from these services. In addition, each center employs a certain percentage of older nurses who are unable to fill routine hospital nursing positions. However, only a limited number of positions are open to these women, because of the nature of the work at the centers and on mobile units. Employment of these nurses must be on a 2:1 basis as compared with the younger group. The policy of the service is not to recruit nurses from responsible hospital positions.

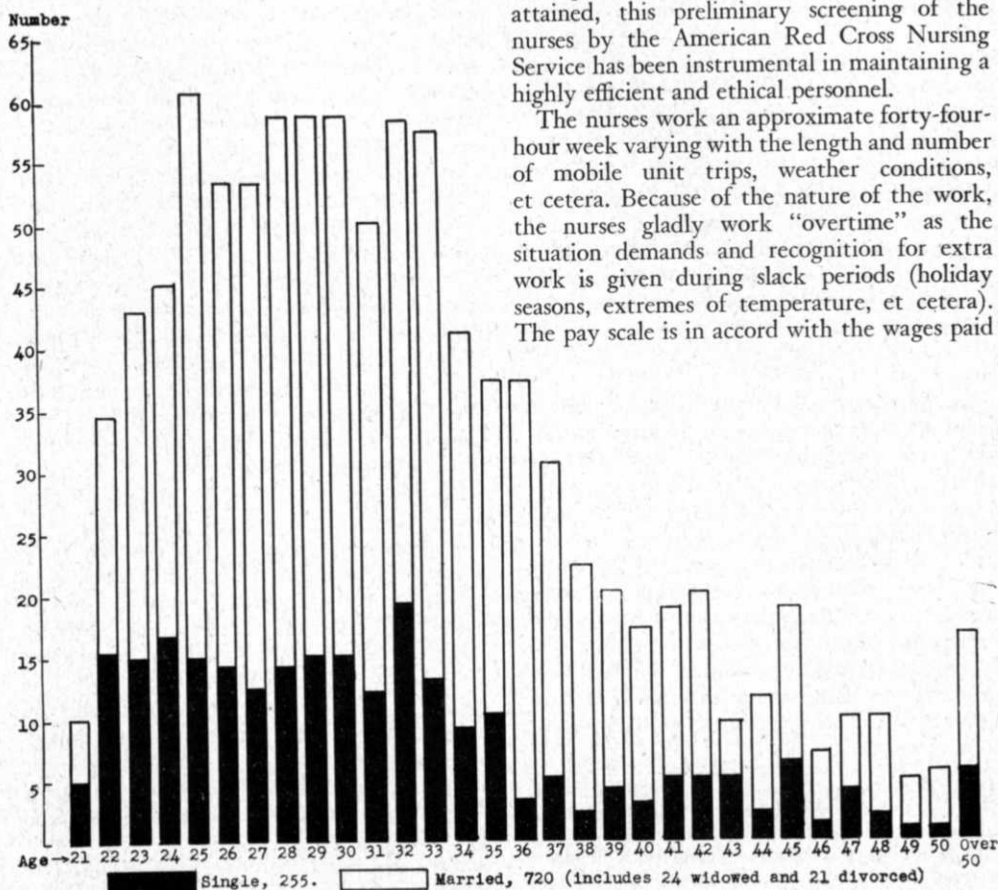
Absenteeism and turnover in personnel are inevitable with a group recruited from the sources noted above. Difficulty in procuring

help at home for care of children, et cetera, is a real problem. Change of station of service husbands also means sudden shifts. However, because of the scope of the service, employment is often secured at a donor center in another city. With so high a percentage of young married women, pregnancy, except for resignation to join Army or Navy Nurse Corps, has occasioned the largest number of withdrawals.

The nature of the work of the Blood Donor Service also imposes limitations on the type of nurse that can be usefully employed. Older nurses are not usually familiar with intravenous technic and not all can be taught. Although the actual number of hours of work is not excessive, the nurse must be on her feet constantly and work at a rapid pace. Approximately 50 per cent of the blood is procured on mobile units, often requiring the personnel to be away from home from two to five days at a time. The personnel of such teams must thus have few home obligations. In those mobile units that do not make overnight stands, the workday, including travel to and from the base of operations, amounts to ten to twelve hours.

Although the American Red Cross Nursing Service has no administrative jurisdiction in the Blood Donor Service, it has been of inestimable value in helping to answer some of the above-mentioned personnel problems and in procuring nurses for the service. Miss Banfield, Assistant to the National Director of the Nursing Service, has advised and offered guidance in establishing overall policies for the nurses in the service, particularly as regards their relation to the military. By clearing the credentials of nurses applying to the Blood Donor Service, and in referring to the service nurses rejected by the military, the local heads of the Red Cross Nursing Service have aided greatly in the recruitment of personnel. As the public relations aspect of the work is almost as important as the professional proficiency attained, this preliminary screening of the nurses by the American Red Cross Nursing Service has been instrumental in maintaining a highly efficient and ethical personnel.

The nurses work an approximate forty-four-hour week varying with the length and number of mobile unit trips, weather conditions, et cetera. Because of the nature of the work, the nurses gladly work "overtime" as the situation demands and recognition for extra work is given during slack periods (holiday seasons, extremes of temperature, et cetera). The pay scale is in accord with the wages paid



Age distribution and marital status of nurses employed by the American Red Cross Blood Donor Service.

locally in hospitals in the community in which the center is located. Head nurses and those performing a technician's duties aside from their regular nursing duties, are paid accordingly. Vacations are granted on the basis of one and one half days per month of service (after three months employment) and are cumulative up to fifty-four days.

It is impossible to determine either a wage scale or the necessary number of nurses on the basis of the number of hours of nursing per "patient." The service differs from hospital nursing practice in that the "patient" is not always on hand and consequently work cannot be charted on a time-table basis. The blood donor nurse cannot perform her duties according to prearranged schedule, but must adjust the tempo of work to the scheduling and appearance of the donors.

Technic

The Blood Donor Service operates under regulations approved by the National Research Council and in accordance with the stipulations of the National Institute of Health. The general details of procedure and technics both in the appraisal of the donor and in the actual venesection are prescribed in the *Manual;*(2) their local interpretation is carried out by the physicians and nurses at the center.

There are four general groups of functions carried out by the nursing staff.

1. Evaluation of the donor.—Determination of pulse, temperature, and hemoglobin. This is usually done by a nurse's aide or other qualified volunteer who has been trained by the blood donor nurses and works with and under the full-time registered nurse personnel. The taking of the donor's medical history as outlined and the blood pressure determinations must be done by a blood donor registered nurse.

2. *Venesection.*—Over 90 per cent of the actual bleeding is performed by nurses. In some centers all nurses do venesections; in others a small group of venesectionists has been selected after a training period, and these nurses, with the doctor, do all the bleeding. The latter plan is the most desirable, particularly with a shifting personnel. The degree of skill these nurses obtain is remarkable, as has been previously recognized in venereal disease clinics. There are few doctors who have comparable proficiency in venesection.

3. Supplies.—In dealing with so large a number of people per day in each center (200–1,200, depending on size of the center), the preparation and treatment of sterile supplies requires care and planning. The time of one or more nurses is completely taken up with this phase of the work. All centers sterilize their own supplies—needles, syringes, cotton balls, compresses, et cetera (the bleeding sets are received from the processing laboratory already prepared). All material is autoclaved. Washing, packing, and assembling of the equipment is done by volunteers or paid lay help under the supervision of a supply nurse.

4. Reactions.—Approximately 6 to 8 per cent of donors have some reaction, ranging from transitory weakness to profound syncope. The majority of these incidents can be fully cared for by nurse's aides, et cetera, who have been trained by registered nurses. Since there are occasional severe reactions, it is important that the work of these volunteers be directly supervised by a qualified registered nurse. It is in this capacity, and for the duties noted (in *3*) above, that older or physically limited registered nurses can be employed to good advantage.

The duties and functions of the nurses are planned and carried out by a head nurse under the direction of a physician-in-charge. An

TABLE 1

Centers		34
Nurses needed (estimated)		916
Nurses employed		975*
ARCNS members		823
Student reserve		0
Applied		116
Ineligible		36
Citizenship	9	
Age	13	
Education	14	
Married		675
Single		255
Widowed		24
Divorced		21
Dependents		216
Children	155	
Other	61	
Service reject		107
Army	86	
Navy	21	
Health otherwise known to preclude military service		119
Awaiting orders		24
Army	17	
Navy	7	
Eligible and available		35
Not available		916†
Calculated weekly production (maximum)		110,000
Actual weekly production (maximum)		123,000

* Being reduced to slightly over 900.
† Includes twenty part-time nurses and thirteen substitute nurses.

assistant head nurse or charge nurse assumes the same functions on the mobile unit teams. In many centers, particularly in the larger ones employing forty to eighty nurses, a nursing manual has been prepared by the head nurse in conjunction with the physicians, outlining the duties and functions of the nurses and detailing the technics employed. These manuals are prepared locally to conform with the physical variations in the individual center and with the particular problems in shipping and bookkeeping.

Complete treatment facilities are on hand at each center and with each mobile unit for treatment of syncope and the other manifestations of collapse that are recognized as possible sequelae to blood donations. The maintenance of this equipment and handling of the drugs are also the responsibility of the nurses.

In a project of this size, opportunity is offered not only for the evaluation of factors that are of importance to the Blood Donor Service itself but to general medical knowledge as well. Aside from the regular duties performed by the nurses, a number of research problems and statistical analyses have been and are being carried out as an extra function.(3)

Production

Every week 971[1] nurses are engaged in producing 110,000 bleedings. In order to deliver this number of bleedings, these nurses handle about 125,000 prospective donors per week. The nursing personnel of each center is apportioned on the basis of 120 bleedings per nurse per week. As can be seen from the various functions noted above, no more than 75 per cent of the nurses are actually concerned with venesection. It is of interest to note that the production per team is 50 per cent greater than that of comparable groups in the British Transfusion Service.(4)

A statistical analysis of the present nursing personnel is presented in Table 1. The age distribution and marital status of the nurses employed in the Donor Service is plotted on page 556. It is felt that both of these charts show a total employment figure and age spread that is comparable to that obtaining in the average civilian hospital.

Summary

The operation of the American Red Cross Blood Donor Service is built around its nursing personnel. By utilizing a full-time, carefully selected nurse group operating under a uniform technic, a high degree of efficiency has been attained. This has resulted in a high production rate per nurse, and at the same time has afforded maximum safety to the donor public.

"Military eligible" nurses are not employed except in the case of twenty-six in the essential group employed before January 1, 1943. In view of the nursing shortage, attempts have been made to recruit nurses who were not in active nursing and to employ a proportion of nurses in the upper age brackets.

Personnel needs of each center are computed on a basis of 120 bleedings weekly per registered nurse employed, no matter what her duties. Of those nurses who are directly concerned with actual venesection, this means a production of 200–250 bleedings per capita per week. At present, 971 nurses are procuring 110,000 bleedings per week.

The technical procedures, outlined on a national basis, are transmitted to the nursing personnel by the head nurse under direction of the technical supervisor and physician-in-charge of each center. By training nurse's aides and other volunteer groups to perform certain functions, it has been possible to reduce drastically the number of nurses in the service without impairment in efficiency.

In the development of the Blood Donor Service, there has evolved a new nurse group intimately familiar with a new technic—mass bleeding. It is hoped these blood donor nurses will form a valuable nucleus in the staffing of hospital blood and plasma projects in the post-war period.

[1] Until recently, the weekly production averaged 118,000 to 123,000 bleedings. On the basis of the present figure of 110,000 bleedings weekly, a reduction in the total number of nurses is now being carried out, which will lower this figure to slightly over 900 nurses.

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One Hundred Who Were Private Duty Nurses

By Elizabeth Maury Dean

But why can't you get me a private nurse?"

The patient in a Detroit hospital was a pretty woman in her early thirties, her dark hair tied with a pink bow exactly matching her ruffled bed jacket and her fingernails. She had asked the question of the floor supervisor as the latter paused on her rounds in the flower-filled private room, not petulantly, but rather as one interested in knowing the answer.

"I'm awfully sorry, Mrs. Linden," the supervisor replied. "I've had your order in for three days, ever since you came in, in fact, but the Nursing Bureau has been unable to fill it. I'll keep trying though," she added cheerfully as she replaced the chart.

She stopped suddenly in the doorway.

"Would you really like to know about the nursing situation in Detroit, Mrs. Linden?"

"Well, you had no trouble getting me private nurses when my other two children arrived," the patient answered, "and it seems a little strange that I can't have one now."

"I just read an article last night in the May *American Journal of Nursing*, by Mrs. Lulu St. Clair Blaine," the nurse remarked thoughtfully. "She's the chairman of the Michigan Committee, Procurement and Assignment Service, and I'll bring you my copy of it if you would like."

The next day Mrs. Linden found out why the hospital authorities had been unable to get her a private duty nurse.

> Approximately one hundred private duty nurses in Detroit alone (Mrs. Blaine had written) have left the private duty field since last October . . . . and taken essential nursing positions or gone into military service.

Behind that statement are approximately one hundred personal stories fascinating not only to nurses and those interested in the profession but of interest also to the public which is feeling the shortage of nurses.

Of these former private duty nurses, 35 have entered military service; 31, general staff duty in hospitals; 22, industrial nursing; 6 are in doctors' offices; 2 are in the Red Cross Blood Bank; 3, in nursing education; and one is in other essential nursing work at the Juvenile Detention Home.

Every one of the interviewed nurses in these groups agrees that in many instances private duty nurses are essential and that there will always be a place for the private duty nurse. On the other hand, each one felt that she, personally, was more satisfied in her present position than she had been in private duty.

Second Lieutenant Violet Raiche, ANC, enrolled in the Army Nurse Corps in March 1944, and is at present stationed at Percy Jones General Hospital in Battle Creek, Michigan. Her orders for overseas duty may come through at any time. Young and single, Lieutenant Raiche said before leaving Detroit, "I just don't see how I could do anything but enlist. I wouldn't feel right if I didn't."

"I felt that I was too old for Army duty," one hospital floor supervisor explained, "but I could fill in for a younger woman who could go. I think private duty is far more trying than my present work because of the greater personal interest one takes in the patients. I used to get terribly upset over my patients, but since I have come into hospital work I've even gained weight."

"My job as night supervisor seems harder than private duty work in some ways," Joanna Shimek, of St. Joseph's Mercy Hospital admits, "but at least I'm doing something essential. I wasn't able to pass the physical examination for overseas service, but the girl I replaced here at the hospital went with the Wayne Unit, so I feel that I'm doing more in the war effort now than I was in private duty."

Miss Shimek first became interested in the questions of essentiality and classification *versus* military service when she attended the American Nurses' Association convention in Chicago as delegate for the Private Duty Section of the Detroit District in the spring of 1942.

"I only planned to do this for the duration," she says now, "but I really don't know whether I ever want to go back to private duty again."

When the "Criteria of Essentiality for Nurses" [1] was published, Mrs. Anna M. Rasmussen was tied up on a long case. The minute it ended in January 1944, she turned her attention to essential fields and found herself, almost immediately, in the Red Cross Blood Bank which currently has about forty nurses on its staff in Detroit.

"I love it," she declares. "When I went into this I fully intended to go back to private duty after the war, but I'm not quite so sure now."

Mrs. Dean, formerly a reporter on the Detroit Free Press, and a member of the Detroit Council on Community Nursing for many years, wrote this account for the *Journal* to follow up Mrs. Blaine's article of last month.

[1] *Am. J. Nursing*, Vol. 43, pp. 977-979 (Nov.) 1943.

Courtesy Sav-Way Industries, Detroit

Left to right: Mrs. Julia Johnson, R.N., is now a physician's office nurse; Mrs. Selma Hahn, R.N., is an industrial nurse with the Sav-Way Industries, Detroit; Mrs. Anna Rasmussen, R.N., is on the staff of the Detroit Red Cross Blood Bank.

The blood bank nurses perform the venipunctures on donors and, as in every form of nursing, the job demands a sympathetic understanding of people and its attendant attribute, tact, plus skill in a highly technical procedure. Among the donors Mrs. Rasmussen admires most are the servicemen who realize what the plasma accomplishes, many of them because they have been given injections of it, and who head for the blood bank the minute they get a furlough.

Then there's the case of Mrs. Marion E. Neis, who wanted to do something directly in line with helping to win the war.

"Many of the patients don't really need you when you're on private duty," she chuckled. "You're a luxury and you know it."

Mrs. Neis finished up a seven months case during which she had not had a single free day, took a deep breath, and started to look for her niche in the war effort. She too found it at the blood bank. The greatest adjustment she had to make was to realize that she was dealing with well people instead of sick ones.

"I thought I had to practically carry them out," she laughs. "But I've gotten over that now. And the people you meet make you almost ashamed sometimes, they're so wonderful.

"Why, you should see the workers in the factories! We go around to the plants and usually spend a week at a time at the big ones. I've got to hand it to those men and women. Some of them look as if they need to have a transfusion a lot more than they need to give blood. They're working long hours and hard and some of them are really pale, but they pass the test. Some of the men are frightened. The women surpass them in taking it as a matter of course, but they're all determined to give what they can as often as they can. I'm certainly glad I went into this work. I feel I'm doing something worth while."

And in Detroit's roaring factories themselves, the nurses form an essential link in the vast machinery of production for victory.

Industrial nursing was in the pioneering stages even in Detroit only a few years back. Today the Procurement and Assignment Service office receives dozens of letters from industrial concerns pointing out the need for classifying their nurses as essential.

One nurse in a large war plant describes her job as first aid on "everything from small lacerations to traumatic amputations, not to mention epilepsy, insulin shock, and burns including arc welding flash burns of the eyes."

"I like it better than any nursing work I've ever done and, furthermore, I don't have to entertain the patient and help trim last year's hat!"

The hours in the industrial nursing field ap-

What You Can Do

Restrict graduate nursing abilities to essential nursing duties.

Encourage patient acceptance of group nursing.

Make good use of auxiliaries.

Streamline nursing procedures.

Rearrange facilities to conserve nursing energies.

Reorganize schedules to level off daily peaks.

Establish fair salary schedules.

Let your nurses live their own lives, as far as possible.

Remember that appreciation pays big dividends in co-operation.

Official U. S. Army Photo

Left to right: Mrs. Lulu St. Clair Blaine, R.N., Chairman of the State P&AS Committee, advises a private duty nurse to take advanced work in preparation for teaching. Lieutenant Violet Marie Raiche is now in the Army Nurse Corps.

peal to Mrs. Selma Hahn, nurse at the Sav-Way Industries plant, which is engaged 100 per cent in war work.

"I work from eight-thirty in the morning till five in the afternoon and I have Sundays off," Mrs. Hahn will tell you. "It seems like bankers' hours to me after being on duty from 7:00 A.M. for eight hours a day till the case ended. You need a day a week off when you work at nursing."

Before she took her present position, Mrs. Hahn was with the Detroit Visiting Nurse Association for three years, and had had ten years experience in private duty nursing. Mrs. Hahn had two other reasons for getting into an essential field. Both her nephews, Pilot Officer Edmund Corbett and Leading Aircraftsman Gerhard Hanson, are serving with the RCAF somewhere in England.

The industrial nurses are agreed that their job is no sinecure.

"I've never worked so steadily nor been on my feet more than I am now," declared one enthusiastic convert, "but it's so interesting I'd never go back to private duty work. I often felt some of my private duty patients didn't really need me, and only wanted me for company and to run little errands."

The salary offered in the industrial nursing field in Detroit appeals to many, as well as the regular hours. Sunday work, in many plants, is limited to four hours for which the nurse receives eight hours pay, and in all plants the maximum work week is forty-eight hours. In those plants where the nurses are employed on a salary basis, the general practice is to grant paid annual vacations. Where they are on the hourly wage rate, they can usually request time off without pay.

A further advantage of the industrial field is the steadiness of the work, according to one of the nurses who transferred from private duty to one of the large plants. She confessed that after one three-months case, she was so worn out she had to take six weeks to rest before she could accept another assignment, but that she had not been off a single day from her job at the factory.

Because the ratio of patients to private physicians has increased so tremendously, many nurses employed in doctors' offices have been declared essential by the Detroit Committee on Procurement and Assignment.

One of these, Mrs. Julia Johnson, finds that she is under much less tension in the office than she was on the hospital ward. Mrs. Johnson served as supervisor at one of the larger hospitals in the city for twelve and one-half years, but went into private duty work after a rest when her health suffered.

"I do like private duty nursing and I was very fortunate in having interesting cases," Mrs. Johnson relates. "I do not think private duty nursing is nonessential but, after having been in the hospital and knowing everything that was happening, I felt out of things when I was on private duty. In the office I do not have so much responsibility as I did on the hospital floor but I find the work, which includes electrocardiographs, x-rays, and assisting the doctor, extremely interesting."

Mrs. Ann Fisher, like all young people today, is looking beyond the war. The Cadet Nurse Corps program brought home to her on two counts the importance of further education for those already in the field. One was the necessity for better-educated women in the entire nursing profession for, as she says, "Medicine has im-

proved by leaps and bounds and new technics are being devised almost daily under the stress of war."

She believes also that the trend toward more education after the war, which is already being considered in Congress for returning servicemen and women, may leave those behind who are not well qualified. Mrs. Fisher, who graduated in September 1942, is wholeheartedly in favor of the P&AS classification of nurses.

"I'll grant you that in some cases it is essential to have private duty nurses," she says, "but many well-to-do patients who want private duty nurses don't really need them. You think of them as taking just one nurse from an essential post but in reality they take three because they want a nurse all around the clock."

Mrs. Fisher is intent on getting the war won as fast as possible, perhaps because her husband, Technical Sergeant Robert E. Fisher, is now serving in the U. S. Army Infantry. And she has lots of company in her own profession. One nurse (who wouldn't permit use of her name because she says, "I'm not important") received her nurses' diploma in 1909 in a small hospital out West. She followed her profession as a private duty nurse in the West and later in Michigan until the depression of the thirties, when she decided there was not much doing and she was getting old and would just retire.

Came the war, and nurses all over the country were told they were needed. She took a refresher course at Harper Hospital and learned first hand that she and thousands of others *were* needed desperately.

Today she is on staff relief duty nine days out of every fourteen and though she "is not important," she is a constant inspiration to the younger nurses, though she would be the last person on earth to realize it. She is a living answer to patients who wonder, "But why can't I have a private nurse?"

More About the Wagner-Murray-Dingell Bill

According to the March 11, 1944, issue of the *Journal of The American Medical Association*, at the meeting of the American Bar Association held in Chicago August 23–26, 1943, the House of Delegates of that organization on August 26 adopted the following resolution:

Resolved, That the House of Delegates is opposed to any legislation, decree or mandate that subjects the practice of medicine to federal control and regulation beyond that presently imposed under the American system of free enterprise.[1]

An analysis of the Wagner-Murray-Dingell Bill made by a committee of the Association is given in detail in the March 11, 1944, *Journal of the American Medical Association*. The conclusion only is quoted here:

"The American Bar Association is limited to an expression of opinion and judgment with respect to those fields which relate to the administration of justice and which directly affect the safeguards and protection of the rights and liberties of the citizens of this country. Under normal circumstances, therefore, it is not the function of this association to attempt to influence substantive legislation by the Congress of the United States. But when under the pretext of the general welfare legislation is proposed in Congress which either inadvertently or with deliberate subtlety constitutes a direct attack on the rights and liberties of the citizens of this country, it becomes the duty of this association actively to voice its objections, a summary of which is as follows:

"1. Local self government must be preserved in our federal system. State governments directly responsible to the will of the people are best adapted to exercise such supervisory control as may be instituted over the health and medical care of our citizens.

"2. S. 1161 seeks to invest in the Surgeon General, who is not an elected servant of the people and who is not amenable to their will, the power arbitrarily to make rules and regulations having the force and effect of law which directly affect every home.

"3. The measure furnishes the instrumentality by which physicians for their practice, hospitals for their continued existence, and citizens for their health and that of their families can be made to serve the purposes of a federal agency.

"4. The bill fails to safeguard the rights of patients, citizens, hospitals, or doctors with respect to disputes arising or rights denied through the arbitrary or capricious action of one man.

"5. The bill fails to provide for any appeal to any court from the action of the Surgeon General.

"6. The vicious system whereby administrative officials judge without court review the actions of their subordinates in carrying out orders issued to them is extended in this bill to a point foreign to our system of government and incompatible with the adequate protection of the liberties of the people.

"The Constitution of the United States is designed to protect the citizens of this republic in the exercise of the rights of free men. The provisions of that instrument can be rendered impotent when our citizens, for the sake of an apparent immediate benefit, surrender to their government such direct control over their lives that government, by imposing a constant fear on them of having those benefits withheld or withdrawn, can compel from them obedience and subservience to its dictates."

[1] *American Bar Association Journal*, Oct. 1943, p. 602.

Co-operating in the Employment Stabilization Program

THE FUNCTION of the Subcommittee To Study the Relationship of the United States Employment Service to Nursing,[1] which was appointed in 1939, is to keep informed about any relationship or activity which involves the nursing profession and the United States Employment Service, and to interpret such relationship or activity to the state nurses associations.

The action of the War Manpower Commission in placing physicians, dentists, veterinarians, sanitary engineers, and nurses under the employment stabilization program creates a functional relationship between nursing and the USES. But it does more than this. It places an opportunity and a responsibility before the nursing profession.

The function of co-operating in the administration of the employment stabilization program is the immediate responsibility of the state and local Committees on Procurement and Assignment of the state and local Nursing Councils for War Service. As you know, these committees receive their information and instructions from the Nursing Division of the Procurement and Assignment Service of the War Manpower Commission. But inasmuch as the program for employment stabilization constitutes a part of the machinery for the distribution of nursing service under wartime conditions, it is a matter which concerns the entire nursing profession. The state nurses association, as the most inclusive nursing organization in a state, is in a position to stimulate the understanding and co-operation which will be required by the state and local Committees on Procurement and Assignment.

Doubtless the Committees on Procurement and Assignment in many states already have established the machinery for handling their new responsibility and are functioning with splendid zeal and ability, also, many state nurses associations no doubt have given strong support.

Considerable information has been published and distributed about the stabilization program. To some extent, therefore, the succeeding statements may be a repetition of facts with which you already are familiar. But the purpose here is to present a simplified statement of facts, including some of the less well known features of the stabilization program and emphasizing certain important points. It is hoped this may be helpful.

The following explanation of the employment stabilization program has been approved by the Nursing Division, Procurement and Assignment Service, and the Bureau of Placement of the War Manpower Commission. It will be seen that the nursing profession may assume an important part in the administration of the program.

1. *Application of the employment stabilization program.*—Nurses "who are employed in essential or locally needed activities are subject to the provisions of the employment stabilization program."

Nurses who are "self-employed," such as private duty nurses, and those "who are employed in other than essential or locally needed activities" normally are not subject to the program unless they are to be employed in an occupation or activity which, because of local shortages, is subject to controlled referral. (There are some localities in which all workers, or workers in certain activities or occupations, are subject to "controlled referral." A worker who is subject to controlled referral may not transfer from one job to another without the approval of the United States Employment Service, or the Procurement and Assignment Service, in accordance with arrangements made with the United States Employment Service.)

Nurses who are employed by state, county, or municipal institutions and agencies are not subject to the provisions of the program unless the employing institutions and agencies have requested inclusion. Nurses employed by the federal government are included in the stabilization program.

2. *Procedure for transferring from one job to another.*—A nurse who is subject to the provisions of the employment stabilization program must obtain a statement of availability, or under certain circumstances she must be referred by the U. S. Employment Service (or the Procurement and Assignment Service) in order to change her job.

a) A statement of availability should be requested from the employer by a nurse who wishes to transfer to a new position. If the employer does not grant the statement of availability, the nurse may request a statement from the local office of the USES (or the P & AS). The USES (or the

This is identical with the letter sent out to presidents of state nurses associations on April 29 by the ANA Subcommittee To Study the Relationship of the United States Employment Service to Nursing, of which Anna L. Tittman is chairman.

[1] Subcommittee of the ANA Special Committee on Professional Counseling and Employment of Nurses (formerly called Committee on *Vocational* Counseling and Employment of Nurses).

P & AS) will determine whether or not the nurse is eligible for the statement.

b) As indicated above, there are certain situations in which a nurse may not transfer from one job to another on the basis of a statement of availability, but must be referred by the local USES office (or the P & AS). This requirement applies to (1) the nurse who wants to take a position in an area other than that in which she has been employed, (2) the nurse who wants to transfer to a new job because of under-utilization of skill, and (3) the nurse who is subject to controlled referral. *The USES must obtain the advice of the P & AS in every case before referring a nurse.*

3. *Eligibility for statement of availability or referral.*—Specific conditions are set up by the stabilization program under which workers who are covered by the program are eligible for statements of availability or referral. The nurse is eligible for such statement, or for referral, (1) if she has been discharged, or (2) if she has been laid off for an indefinite period, or for a period of seven or more days, or (3) if continuance in her position would involve undue hardship, or (4) if the salary and working conditions are substandard, or (5) if the work she is doing does not utilize her highest skill.

4. *Delegation of responsibility.*—Responsibility for handling requests for statements of availability and/or referral may be delegated to the state and local Committees on Procurement and Assignment for Nurses by the War Manpower Commission, *if* these committees are prepared to handle such requests promptly and adequately. If the Procurement and Assignment Service has reached an agreement with the USES and has definitely been designated to assume these functions, it acts as and in place of the USES.

5. *Appeals.*—If denied a statement of availability or referral, the nurse may appeal to the Area Management-Labor Committee of the WMC. Appeal from the decision of the Area Committee may be made to the Regional Management-Labor Committee of the WMC and finally to the National Management-Labor Policy Committee of the WMC. An employer may appeal in like manner. *The Area and Regional Management-Labor Committees must obtain the advice of the P & AS in every case of appeal.*

There are three methods by which the procedures in connection with requests for statements of availability and referral may be handled. It is the responsibility of the State Committee on Procurement and Assignment to decide how much responsibility it can assume and to make the approach to the State and Regional Directors of the War Manpower Commission for the purpose of agreeing upon and establishing the plan to be used.

The three possibilities are as follows:

1. The Committee on Procurement and Assignment may have full responsibility for handling requests for statements of availability and referral.

2. The Committee on Procurement and Assignment and the USES may co-operate in handling requests for statements of availability and referral, that is, the details and routine would be carried by the USES with the advice of the Procurement and Assignment Committees.

3. The USES may handle requests for statements of availability and referral independently of the Procurement and Assignment Service, consulting the Committee on Procurement and Assignment only as required in connection with referrals.

Possibly the Committees on Procurement and Assignment for Nurses will not want to assume full responsibility for handling requests for statements of availability and referral until they have assured themselves and the War Manpower Commission that they are adequately prepared to do so. (It is understood that it should be possible to take care of requests within twenty-four hours.) But it is obvious that every Committee on Procurement and Assignment will want to meet the professional challenge and responsibility by having some part in this program. In order that the committees may assume full responsibility as soon as possible, it is important that they have the co-operation of the profession as a whole.

There are many details involved. Both the local and the state Committees on Procurement and Assignment will need to know the location and the personnel of the USES offices and the area that each serves. The USES offices should know the areas covered by the local Procurement and Assignment Committees and they should have the names and addresses of the nurses who are to be consulted as the representatives of the Procurement and Assignment Service. No doubt two nurses will be designated by each local committee in order that one may be available at all times.

There are implications for the nurses professional registries also. If the district nurses associations recommend that registrars be appointed to the local Committees on Procurement and Assignment, as suggested by the National Nursing Council for War Service, each registrar will have an opportunity to become familiar with the details of the program and the way it is to function or is functioning in her locality. She then will be in a position to advise individual nurses correctly.

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Some Aspects of Wartime Nursing

On the West Coast

By Dorothy Deming, R.N.

War is having its effect upon every individual in the United States and the members of the nursing profession are no exception. Ever since England's declaration of war broke the peace of that September Sunday in 1939, our profession has grown in prominence and importance in the eyes of the public. Recognition of our essential place in winning the war has come from the armed forces, the federal government, and the man in the street.

Never in the history of the world has nursing had so much favorable publicity, so many opportunities to serve, so much public support devoted to its interests. History alone will show whether we have used these unprecedented situations wisely. Meanwhile, in this third year of our participation in the war, we ask ourselves what is actually happening on the home front. The 40,000 nurses of military age who have left civilian life are giving a good account of themselves. What is happening among the 200,000 of us who are left on active home duty? What new adjustments are we making to war conditions in our cities, towns, and villages? What changes are affecting us and our future as a profession?

It seemed particularly important to find out how the nurses on the West Coast were meeting the impact of war. This was desirable for several reasons—these states are closest to the enemy; our forces in the theater of war in the Pacific naturally turn to the West Coast for supplies, equipment, embarkation, and evacuation facilities; the geography of our country is such that these states which seem far enough from Washington, D. C., Chicago, Illinois, and Atlanta, Georgia, in peacetime appear even more distant when war slows trains, mails, planes, and all forms of communication.

Days and nights crowded with nursing duties, recruitment meetings, and committee work leave little time to nurses for telling about their work, and it is easy to see that much could be happening to one region of the country unknown to distant states.

Before describing some of the developments in nursing as viewed during a three weeks trip to the Coast in December, one must get the picture of what has happened there. The rise in population in two years is phenomenal. It is as if the continent had tipped and much of the working population had slid down to these coastal states from all directions. Ship and plane building on a mammoth scale, with subcontracts involving literally hundreds of small manufacturing firms, have brought men and women and their families from every state in the Union, attracted by the best wage scales in the country.

The area is officially listed by the War Manpower Commission as having an acute labor shortage. There are shipyards which have created large cities—90,000 workers with their families, for example, where 10,000 were before. There are housing projects barely two years old where 7,000, 10,000, and even 40,000 people are living. Trailer camps abound, with all their related problems. Bremerton, in Washington, and its surrounding county had about 45,000 people in 1939—there are 130,000 there now. Vallejo, California, near one of our older Navy yards on Mare Island, has jumped from 15,000 to 115,000 with another 20,000 in its county (Solano). Vancouver, Washington (outside Portland, Oregon), is in the throes of a similar boom with the Kaiser shipyards employing more hundreds every day. Approximately 10,000 Negroes from the South are coming into California each month.

The armed forces—all their branches—are naturally a beehive of activity with the gateway to Alaska and the Aleutians on the north, training stations, flying fields, evacuation hospitals along the coast, and the headquarters of the Ninth Service Command looking out across the ocean toward a Japan which until recently seemed a very real menace.

Housing shortages are acute, transportation in every direction is difficult beyond description, restaurants are jammed and usually run short of food before a meal is over. The cost of living is rising (as this is written, in December 1943) in spite of OPA efforts.

Under these conditions hospitals are running to capacity with overflow beds in solaria, children's wards, and corridors. People who never had money to pay for hospital care before have it now. Patients who would normally be admitted for free care in county hospitals have earned enough to make them ineligible. All sorts of insurance, prepayment, and group medical care plans are providing hospitalization, to say nothing of the vastly increased numbers

Miss Deming is well known to *Journal* readers through her earlier articles.

of industrial workers who, injured on the job, are entitled to care under workmen's compensation. Many of the processes in shipbuilding, as well as in making planes, are hazardous, and thousands of applicants for jobs have never handled a tool more complicated than a hammer. Job training, supervision, and a complete network of first aid stations minimize accidents, but there is an inevitable flow of injured workers into the hospitals.

In dozens of these small towns near the newly expanded industries the only hospital before the war was privately owned, and seldom of more than sixty beds. Occasionally a small county health department was functioning. In a very few instances a visiting nurse service covered the area, but usually the nearest large city served the population in illness. Essential medical care and first aid required by law were maintained in all large industries before the war, but the industrial nurses were actually very few—probably not more than 300 in all three coast states.

A Boom in Industrial Nursing

That was two years ago. Today the state of Washington has more industrial nurses (about 395) than it has public health nurses and Oregon has 174 industrial nurses. The Washington and Oregon State Nurses Associations have both formed active industrial nursing sections, with regular meetings, a planned educational program, and live discussions of personnel practices and policies. California has experienced the greatest expansion of all; some 800 industrial nurses are now on the job. They have come from all over the Union, trained and untrained, retired or newly graduated, and they, too, have a growing section in the state nurses association.

Salaries of industrial nurses in these three western states, without overtime, now range from $115 a month (lowest base pay for a 40-hour week) to $250 a month, the latter for supervisors. Nurses are on an eight-hour day, six-day week, with overtime (over forty hours) frequently paid for. Cafeteria meals are usually available at cost. Nurses "live out," of course; and there's the rub, for transportation and rooms are at a premium. Many nurses have to live an hour or more from work and even then are not comfortably housed. Many live in the housing projects to save travel. In some areas transportation for nurses for the "graveyard shift" (midnight to morning) must be provided by the company as it is unsafe for women to walk through the district alone at night. The California law requires that a company provide transportation for women workers on night shifts where public facilities are inadequate.

Many committees where the nursing shortage is acute are questioning whether so many young registered nurses are needed in industry. While the job is a busy one, it is not heavy. The visitor, watching the countless dry dressings, band-aids, or simple soaks for minor cuts, abrasions, and bruises, realizes that probably a third of the workers visiting the medical first aid department could be cared for by well-trained practical nurses. The records have been simplified, no special history is taken, and no effort made to get the patient to talk about himself. In many stations the patients stand for their dressings, so brief is their stay.

This impression is borne out by the fact that in the Navy Yard, with exactly similar industrial hazards and the same type of worker, there are only three registered nurses and a staff of corpsmen who handle several hundred cases a day. Similarly, the "safety men" in other shipyards relieve the graduate nurses. WAVES could certainly become adequate nurse's aides. One serious drawback to this plan in general industry is the fact that practical nurses are getting better salaries in plant jobs and are not available for nursing. Neither Washington nor Oregon has a state law controlling all those who nurse for hire. California does licence trained attendants (the California law is permissive—it does not control all who nurse for hire), but it was exceptional to find them working as nurse's aides in the plants.

In these states, as everywhere, about a third of the doctors have gone to war.

Washington had met and Oregon had nearly met their 1943 quota of nurses for military service, but California was far behind. Cadet nurses have come in large numbers to the schools and are "saving the day," although their housing is still a problem. Lanham Act funds are being tapped for new buildings and the schools are buying houses, turning over unused sections of the hospitals, doubling up in dormitories, or boarding students with private families.

Everywhere the cadet nurse plan seems to be acceptable and working well, if one may judge this early. Here in the West, as elsewhere, the problem of affiliations looms large and the whole future effect of government subsidy on nursing education in the poorer schools is beginning to trouble farsighted nursing leaders, just as it is a matter of serious concern to the directors of our medical schools.

These three states have been varyingly successful in persuading married and retired nurses to return to nursing. Wages for non-nursing jobs in industry running from $50 to $90 a week

have attracted some nurses, but probably fewer than rumor would have us think. Refresher courses given before Pearl Harbor in Washington and Oregon brought back a goodly number to their hospitals. Imagination in placing these nurses, adjustments to their time, and the breakdown of jobs to suit their capacities have retained many who otherwise would not have felt wanted. Everywhere there is the unanimous agreement that hospitals could not function without Red Cross volunteer nurse's aides. The university hospitals have been especially fortunate in being able to draw on the regular student body for aide service.

While there was no attempt to study salary levels and problems during this trip, the magnitude of the problem which faces the West Coast nurses was borne in upon the visitor at every stop. Discrepancies between the salaries of experienced professional nurses and inexperienced, untrained war workers cropped out continually. The rising wage scale for clerks, secretaries, maids, janitors, and domestic help of all kinds, made nurses salaries look picayune. Cleaning women in hospitals were receiving as much as eighty-five cents an hour working side by side with registered nurses at seventy-two cents. An elderly woman sorting scrap metal in a shipyard was receiving $45 a week, the registered nurse in the medical department $140 a month. Salary increases for nurses are being vigorously pushed in all three states—through committees of the state nurses associations and their various appropriate sections.

Meanwhile hospitals cannot get enough nurses. In many cities some of the hospitals have curtailed service because of lack of nurses. The reports of crucial situations sound worse than in the eastern part of our country, but no conclusions should be drawn without comparable data:

"I'll pay $9.00 a day for a temporary general staff nurse if I can get one—I can't," a director of nurses stated. Another had had a standing order for floor nurses on file at the professional registry for five weeks and had not received a single name.

"Where *do* you get your nurses?"

"Anywhere. They come in to see me, service men's wives write, my nurses tell their friends, I hear of someone coming to town and telephone. We advertise; we ask plant employees; we use the commercial registries. We have the money—we can't get the nurses."

Community Hospitals

The hospital as a community health center is exemplified in the new Franklin Delano Roosevelt Hospital, built with Lanham Act funds, in Bremerton, Washington. This modern 140-bed general hospital will have a staff of eighty registered nurses and, in a section of the building near the outpatient clinic, the city-county health department of Bremerton and Kitsap County will be housed with the usual staff under the health officer: public health nurses, sanitarians, and laboratory technicians. Many routine activities will be maintained jointly with the hospital, such as the laboratory service and record-room.

At the present writing the public health nursing staff consists of fifteen nurses carrying a generalized service—the USPHS pays for two nurses, the American Red Cross for five, the city-county funds, eight. There is a nutritionist in the department and a clinic nurse without public health training. The latter devotes full time to a very busy service which includes venereal disease clinics, tuberculosis, and immunization programs. Bremerton had no home bedside care service previous to the war, with the exception of a nurse giving care to policyholders of the Metropolitan Life Insurance Company. There were three school nurses in the vicinity carrying out a specialized service; two county public health nurses covering the entire area; the county and city each maintained a part-time health department.

Those responsible for the administration of this combined health service see in it several advantages:

1. Recognition of the hospital as a place where one may learn to prevent disease and keep well, as well as to get well in, if sick.

2. Continuity of service and, therefore, more efficient care for patients, thanks to a complete and continuous history of each patient.

3. Better understanding on the part of the thirty private physicians who will be using the hospital health center as to the value of preventive and follow-up services in a modern health department.

4. Closer tie-up between public health and institutional nurses working from the same center.

5. Future possibilities for nursing education as an affiliation for undergraduates and field experience for graduates studying at the University of Washington.

6. Saving on overhead costs.

Bremerton and the surrounding country (130,000 population) is a one-industry community, the Navy Yard. There is a large transient population and many nonresidents come in to work by the day. Tax collections are

low and the community chest has thus far not raised any money for public health. It is hoped that the help which Uncle Sam is giving now will be a spur to more community support of needed health services. It is recognized, however, that Bremerton will need government aid for as long as the war lasts.

Combining Services

The combining of public health nursing staffs as typified in Bremerton is happening elsewhere on the West Coast—San Jose, California, for example—and the most recent and significant merger is that of the Seattle Visiting Nurse Association (some twenty nurses) with the City Health Department, with a staff of like number. Eventually a generalized service with the exception of school nursing will be offered in Seattle. In San Francisco health centers of the city health department combine space with the visiting nurses and a generalized program is emerging. Berkeley, which has long had a generalized program, is facing an unprecedented opportunity for giving more home nursing care, with the influx of population in this area.

Since Vallejo was surveyed by a representative of the NOPHN as one of the sixteen communities studied to determine resources for the public health nursing care of the sick, the city and county health department has made excellent progress in the development of its program and now has a well-qualified supervising nurse, a staff of nine public health nurses, and two clinic nurses. The Red Cross Visiting Nurse Service has been established, is housed in the health department building, and has close working relationships with the health department. The health officer and supervising nurse of the health department are members of the Red Cross Nursing Committee. The Solano County Tuberculosis Association plans its program in co-operation with the health department and was housed in the health department building until the increase in the nursing staff of the health department made it necessary for the Association to find other quarters.

The nursing staff of the health department and visiting nursing service have joint meetings monthly. The city school department staff has meetings periodically with the health department staff at which joint policies are decided upon. Joint meetings are also held with representatives of the health department and California Physicians' Service to work out joint policies and to prevent duplication. The public health nurses from all agencies in the county hold monthly or bi-monthly meetings throughout the school year for the purpose of coordinating their activities.

Infirmaries

First aid for workers and hospital care for those injured at work or for those able to return to the plant medical centers for care was provided from the first, but what would happen to the man living in a housing project dormitory who was unable to get back to the plant dressing station, yet was not a hospital case? What about the man who was sick—a nonindustrial case? What about the families of workers who are sick?

The infirmaries in housing projects are a new development. They are only built where there are dormitory residents and are used primarily for bed care of illness which, under conditions of normal family life, would be cared for in the home.

The infirmary is usually a small eight- to thirty-two-bed building, operated for the Housing Authority by the United States Public Health Service.

One of these, in Marin City, of seventeen beds can be taken as an example.[1] The U. S. Public Health Service, reimbursed by the Federal Housing Authority, pays the salaries of three registered nurses and three nurse's aides, and the California Physicians' Service for two nurses. There are three of these infirmaries in California in which the USPHS, Housing Authorities, and California Physicians' Service are interested.

At the infirmary in Marin City the staff of five registered nurses and three practical nurses care for mildly ill persons not in need of hospital care. No maternity cases are taken. A doctor is on call at all times. A patient mildly ill may come over to the infirmary for two days without calling a doctor, but if a doctor is needed, in the opinion of the nurse, the patient must call one and he cannot stay longer than two days without medical attention. Meals are served from the adjoining cafeteria. Minor surgery is done and a small isolation unit can take care of communicable diseases temporarily. Patients in the California Physicians' Service plan are entitled to care from the CPS doctor. Patients injured on the job have to be seen by the Marinship doctor, as they fall under the care of the insurance company responsible for industrial injuries. Patients sick, without claim on either insurance doctor, pay directly for care from a physician of their choice. The CPS provides a home visit from a

[1] McGregor, Jean C.: Marin City Saga, *Am. J. Nursing*, Vol. 43, pp. 720–724 (Aug.) 1943.

nurse to anyone calling for aid to determine whether a home visit from a CPS doctor is required, transfer to the infirmary for care, to a hospital, or referral back to the "company doctors," in case of industrial injury. Any cases needing bedside nursing care in their homes may be referred to the Red Cross visiting nurse service for care, provided they are under the care of a physician. Marin County has one of the two county-wide visiting nurse services in California.

There are some four or five of these infirmaries in California in which the USPHS, Housing Authorities, and CPS are interested. By the time this article is printed, there will be more!

State Physicians' Services

The California Physicians' Service (already mentioned) and the Oregon Physicians' Service have similar objectives but differ in their set-up. Both employ full-time salaried physicians and nurses and, in the case of Oregon, administer a hospital.

The Oregon Physicians' Service has a membership of about 90 per cent of the members of the state medical society, and about 85,000 individuals are covered by insurance contracts. The contracts give employed individuals to whom unexpected hospital and doctor bills would be a drain a prepaid service for which approximately 60 cents a week is paid. Neither OPS nor CPS requires a pre-employment or premembership examination.

The Health of the Worker

Visits to nine war industries were both inspiring and disillusioning—inspiring that we are making miraculous production records in ship and plane building; inspiring that these beautiful creatures of steel are made by thousands of pairs of hands—a third of them the slender hands of women. The orderliness of the assembly line and the co-ordinating genius back of those ever-moving lanes of completed planes and ships make one proud of American industry. Watching the swing shift leave and the graveyard shift move in, you see every age of worker over eighteen, every nationality, every type of job lettered on the helmets. One line walks heavily, wearily, stumbling a bit as they get beyond the floodlighted yard. The new shift goes steadily into position. The tireless machinery whirs on. In the first aid stations nurses change places, safety men report on, workers start lining up for dressings, check-in after absence or to report new illness. The tempo of the graveyard shift is not quite so fast as the daylight, the shifts not quite so large, but the job is being done day and night.

Not the least thrilling moment is the launching itself. As the visitor comes out on the dock parallel to the basin where the great transport awaits its christening, the band is playing our national anthem. The crowd of guests and war workers are standing at attention—soldiers, sailors, Marines, SPARS, civilians—saluting the flag, their bodies erect, their eyes fixed proudly on the work of their hands. The ship, in battleship gray, towers upward, the crow's-nest easily 100 feet above the dock. On the platform the sponsors of the ship and their friends stand behind the master of ceremonies and the loudspeaker. Over all, the mild Western sun shines and a light breeze whips the flags decorating the new ship and the waiting water. A prayer by a Navy chaplain, asking God's blessing and protection on those who are to use this ship as an instrument toward lasting peace, a song by one of the yard workers—"Strong Hearted Men"—and then the sponsor, flower-bedecked, swings the champagne bottle on its rope, breaking it against the side of the ship. The whistles blare, the drums roll, and the little tug, so grubby and tiny compared to this mammoth new ruler of the deep, puffs and pulls the gray mass of the liner out of its water-filled basin into the sea. A new transport has been born. It is no wonder the eyes of the thousands of workers who have had a share in her building shine. It is no wonder the nurses smile at each other and say, "We helped build her."

The disillusionment? That men possessing the keen intellects and organizing ability to make these miracles of power, speed, and beauty have not had time to value the human life essential to their production. True, management takes pains to make the job itself as safe as possible, arranges to repair the injuries the machines inflict as well as possible. Yet in only two of the nine plants visited were pre-placement examinations made. In seven others the workers themselves, through union action, prohibit them. However, after employment, complete physical examination is available on request to any employee who is a member of the company health plan in one organization and corrective work for conditions such as hernias which exist when a person is employed is also available.

In one of the two which make pre-employment examinations, 5 per cent of the applicants are rejected only to go across the city to be employed in a shipyard where no examination is required. A man of sixty with high blood pressure, a hernia, and varicosities takes his

place beside an epileptic. A woman with diabetes works beside another with a chronic cough. It is entirely possible in these industries, where the union has ruled out pre-placement examinations, to have disease or a sudden failure of bodily function, due to a long-standing condition, result in a greater loss of man-hours than a dozen industrial accidents put together.

In many industries the workers eat on the job. The whistle blows, sandwiches and coffee come out. Hands are not washed. There are no tables, no seats. A half hour is allowed. No one oversees this most vital fuel for good human machinery—food. "No time."

It seems regrettable, too, that managers of industry do not always see the needs of the doctors and nurses in the way of space for work and comfortable restrooms. In a few plants these accommodations were adequate, in others woefully lacking. In one industry space for the large staff of thirty nurses to use in shifts for their coats, lunches, and restroom is 6 by 10 feet, with one lavatory. Patients crowd upon one another in the waiting rooms. There are not enough seats, although the nurses say this is a purposeful restriction to avoid giving patients a chance to linger and talk unnecessarily.

In one first aid station where three nurses plus part-time "floaters" work on each shift caring for sometimes 300 patients a day, there are six seats for patients (in addition to treatment chairs). Tired workers must stand for hand, arm, and head dressings. Sometimes there are ten patients at once and three nurses in a space 10 by 10 feet square. There is a toilet but no restroom for the women workers. The nurses at the medical department eat their lunches in the sterilizing room. A hundred feet away one of the most efficient war products rolls off the assembly line.

Yet, in spite of acute conditions of noise and overcrowding, the nursing staffs are doing a remarkable job. Again and again they appeared to be calm and collected in the midst of confusion. They have progressed far in the two years of war toward adopting nursing procedures that are medically approved, safe for the worker, and yet adaptable in emergencies, and their spirit is unconquerable—they make the inconveniences sound humorous, the shortages a part of war, the pressures all in the day's work, shared by every worker in the plant. "Some day we hope we will have time for . . . ." is the nearest thing to a complaint you hear from industrial nurses—time to do the many things they know need to be done.

"Do you get out into the plant? Do you have a chance to talk to the foremen?"

"I used to. No time now."

To an industrial doctor, "Are the foremen observant of conditions among their workers? Would they send a man to you with running nose, flushed face, and cough?"

"No, probably not. Too busy."

These nurses feel a part of the fighting front as they watch the weapons of war slide past their doors. They deserve praise—this new army of ours of 11,222 industrial nurses throughout the United States.

The appointment in each state health department of a nurse consultant on industrial nursing is just another evidence of the interest which the West Coast is taking in these plant services. The future co-ordination of plant and community resources holds great possibilities—when there is time!

Drape for Instrument Table

By Clara M. Ruehlow, R.N.

The need for economy of personnel and materials stimulated us to give thought, several years ago, to the designing of a drape for a sterile instrument table that would be simple, inexpensive, and easily made. The one herein described appears to be the most suitable for our purpose.

The drape is placed over a sterile sheet on the instrument table. It is made of unbleached muslin, double thickness, the proper size and shape to cover the table to be used. Three flaps are cut to conform with the shape of the table top. The flaps are made large enough to drape over the instruments for complete protection. These are then stitched on the cover in tiers under which the instruments are placed and kept covered for the entire operating period. One flap is stitched on the right half of the drape for larger instruments. The other two flaps are stitched to the left half in tiers, the

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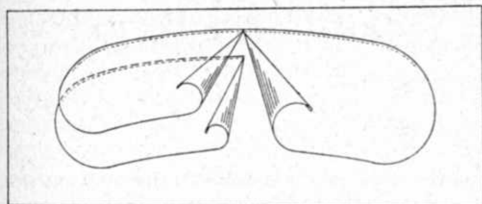
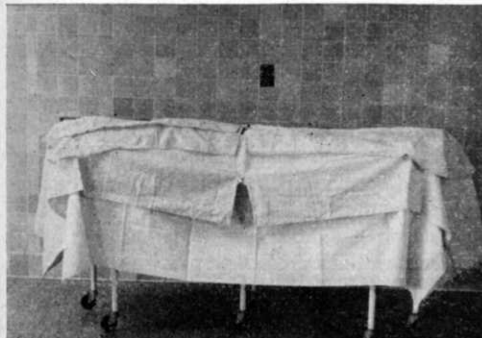


lower one about six inches below the stitching of the upper flap, under which the smaller instruments (hemostatic forceps, towel clamps, needle holders, and tissue forceps) are placed. Under the two left flaps two complete rows of forceps can be placed; the back row is accessible and the raising of the lower flap in no way interferes with the instruments in the back row since the table is wide and the instruments are small. It has been found to give complete protection to sterile instruments from dust or other sources of contamination.

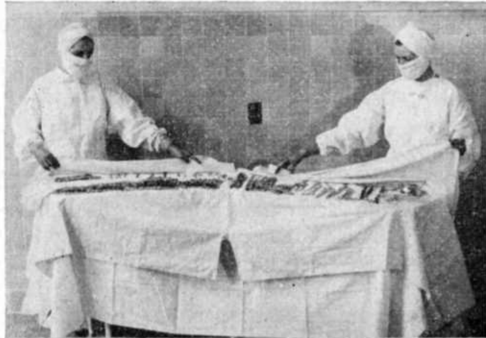
This drape is easily made—a matter of minutes from readily available material. It is so easily folded for sterilization that it can be draped on the instrument table by one person. The instruments are closely covered, but easily accessible without contamination of other instruments. Its simplicity results in economy in time and in number of employees.

Our surgical service is very active. The monthly average is approximately five hundred cases. This work is done in five operating rooms; one surgeon and his assistants occupy each room for the entire morning. To avoid delay, this system makes it necessary to keep a supply table of sterile instruments available for the cases to follow. We, too, are faced with the problem of having a limited number of nurses, and this drape has helped to solve the problem of keeping sterile instruments sterile for a comparatively long period of time.

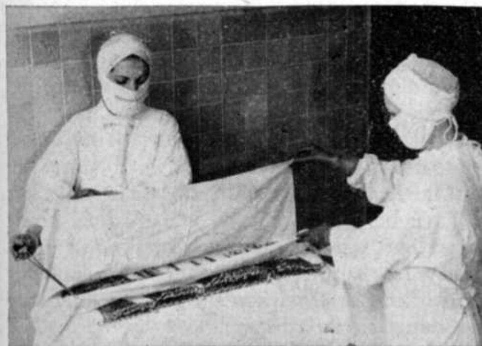
Cultures were made recently with the following results: Aerobic and anaerobic cultures were taken from the instruments and gauze under the drape at three periods (8:50 A.M.; 10:30 A.M.; and 12:45 P.M.) during a morning's operative schedule. One instrument used as a control was removed at 8:50 A.M. and allowed to remain outside the drape for the remainder of the period. All cultures from instruments and gauze under the drape were sterile. Cultures taken from the control instrument were sterile at 8:50 A.M. but showed many colonies of air contaminants at 12:45 P.M. These findings would indicate that the drape acts as a satisfactory protection against bacterial contamination from the air.



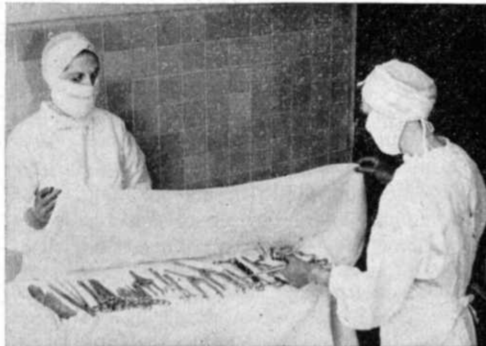
Closed drape kidney-shaped table



Open drape



Left side of drape showing tiers



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Making the Most of the Senior Cadet Period

In civilian hospitals

By Lucile Petry, R.N.

Maximum benefit from the U. S. Cadet Nurse Corps requires distribution of senior cadets. Approximately 12,000 students will have become senior cadets before July 1, 1944. Considerably less than the expected 2,400 will be assigned to federal nursing services before that date because of unavoidable delays in determining details of policy. Appointments to federal hospitals are beginning, however.

Approximately 24,000 cadet nurses will become senior cadets between July 1, 1944 and June 30, 1945. Approximately 4,800 (or 20 per cent) of these will find places in federal hospitals. The remaining 19,200 cadet nurses who will have completed all required instruction and types of experience, each of them almost the equivalent of a graduate nurse, will make a vital contribution to the country's wartime civilian needs for nursing service if they are effectively distributed in relation to needs.

The school of nursing is responsible for establishing sound programs for its senior cadets who do not receive appointments to the federal nursing services. The school which can assign many or all its senior cadets outside the home hospital will make a very large contribution to the war effort. The contribution is twofold: It makes possible greater expansion of the number of pre-cadets and junior cadets; it distributes nursing care to other institutions whose needs are even more acute than those of the home hospital. Obviously these assignments must be made with care to ensure effective distribution of nursing service and rounding out of the cadets' experience.

What constitutes a "good" assignment for senior cadets?

Senior cadet experiences should, in so far as possible, (1) round out previous experiences; (2) help students to develop in the line of their special interests in subsequent employment; and (3) make a substantial contribution to meeting acute needs for nursing service.

Let us consider these three points. The ingenious director should be able to make each senior cadet's assignment satisfy all three.

To plan senior cadet experience, you, that ingenious director, should calculate, for several months in advance, the number of senior cadets available after assignments to federal government hospitals have been made. You should survey the nursing requirements of your own institution for the same period of time and, allowing for the increased service from your augmented enrolment of junior cadets, determine the number of senior cadets which will be needed for your own institution. You should consider the relative acuteness of the needs of other institutions when making this determination. Your state board of nurse examiners or your local nursing council for war service, and particularly its committee on procurement and assignment, should be able to give you information on the needs of other institutions. With this information at hand, you then have two problems: (1) to make a plan for senior cadets, if you must retain some of them, in your own institution; (2) to make a plan for supervised experience in one or more other institutions or agencies.

For senior cadets in your own hospital, a "rotating" experience is preferable. From this point onward in your planning you will consider the other first and second characteristics of a "good" senior cadet assignment as listed above. What experiences are needed by this student to perfect her skills in certain fields; what experiences are needed to round out her total of skills? Examine what you know about each student from conferences, observation of her practice, and her record. Let us say this examination reveals that she needs more practice in the care of new-born infants (she was clumsy and still a bit afraid to handle them when she left the nursery as a junior cadet) and in the care of older children (whom she tended to invalidize when she was in pediatrics). Let us also assume that in your medical division you are now using new forms of chemical therapy with which she has had no experience.

What does this student plan to do upon graduation? Let us say that her major interest is in medical patients and that you would like to have her on your staff as a medical head nurse. She showed promise of administrative ability, but had little opportunity for planning the work of others when she had her medical experience six months ago.

A "good" senior cadet assignment for this student would be one month obstetrics and

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Miss Petry, who is director of the Division of Nurse Education, USPHS, develops further the discussion of planning for senior cadets, which was begun by Mrs. Spalding in the March issue of the *Journal*.

one month pediatrics and four months medicine including a week or two of diet kitchen experience. In obstetrics she should be placed with mothers to note how her handling of the infant teaches the mother, but her principal assignment should be in the nursery, perhaps including a week or two of night practice. Her month in pediatrics should be spent principally with older children so that her self-confidence can be built up in that area. The medical assignment should include care of most difficult patients and of patients receiving the new chemical therapy. In both these she could assume some responsibility for younger students who are also giving care to these patients. The diet kitchen experience should be focused on the interrelationship between that department and the medical division so that when she begins to serve as assistant head nurse there she is fully aware of the possibilities of smooth administrative relationships. As assistant head nurse she should have definite assignments of planning the work of the unit, of supervision of housekeeping and supplies, of learning the complete care of all types of patients and how to teach it to others, and of interrelationships with other departments. Near the close of her four months she should be able to relieve the head nurse on occasion; upon graduation she should be an extremely valuable member of your staff with her interest in administrative, educational, and personnel problems; and she should have also an intense loyalty to the institution and concern for the total welfare of its patients.

The record of another student nearing her senior cadet period might show that during her junior cadet assignment to orthopedics, the variety of cases was extremely limited, that she needs more practice in the operating room, and that her major interest is in surgical nursing. Orthopedics and operating room should be included in her assignment which might lead, with a major portion of her assignment to the surgical units, to her final preparation for a position as head nurse in a surgical unit.

Other students may show aptitude and even previous experience in teaching. Assistant to the nursing arts instructor or to one or more of the clinical instructors would be a profitable assignment both to those students and to the school. Many senior cadets will find continued and varied types of patient care a worth-while experience.

In planning the supervised practice period for senior cadets, you will, of course, see to it that this precious nursing service is not wasted in the performance of non-nursing tasks which others with less or no preparation for nursing could perform. The supervision given these students will be creative and stimulating and will demonstrate the returns in valuable service which proceed from an effective personnel program.

The director of a school who is planning the assignment of senior cadets to other institutions will make a diagnosis of each senior cadet's needs just as if she were assigning them in her own institution. The variety of experience available in the other institution is *one* of the criteria which led you to choose it as a place for your senior cadets and, with the person responsible for senior cadets in that institution, you will plan their assignments in relation to their needs and interest, just as you would have done had these students remained in the home hospital. The supervisor of senior cadets in that institution should understand the three characteristics of a "good" senior cadet period.

Since that institution may not operate a school of its own, it is quite likely that it will not have a large educational staff. It is essential that one person have primary responsibility for the senior cadets. Nurses in charge of units of that hospital should, in so far as their relation to senior cadets is concerned, be under the supervision of the person responsible for senior cadets in the institution as a whole. A "rotating" service is desirable, and personnel policies are all the more important since they must include orientation to a new situation and the building of new types of understanding of the institution's responsibility for its patients. You should, of course, note the qualifications of this supervisor and the persons in charge of the hospital units to which senior cadets are assigned. Obviously, in a nonteaching situation these qualifications will not be identical with those of a staff of a school of nursing. Expertness in handling the problems of patients and great interest in transmitting this knowledge to others may often substitute for other types of advanced preparation which at first thought might seem essential to you. The important point is that a good plan for the supervised experience of senior cadets in other institutions should be worked out jointly by yourself and those responsible for these students in that institution.

Obviously the plans for senior cadets in either your own institution or other institutions should be approved by your state board of nurse examiners. It is hoped that a method of expediting the approval of these plans can be devised by you and members of your state board. Thoroughness in planning on your part will ensure more prompt and certain approval.

Wide variety of opportunities for outside assignment of senior cadets should be available in your community. Consider the public health agencies giving care in homes [1]; consider nursery schools and psychiatric institutions, special hospitals, and general hospitals. Consider the adequacy of supervision in these agencies and institutions from the point of view of what is desirable in supervision for the institution itself rather than only the educational qualifications of this supervisory personnel. One good supervisor should be able to plan and coordinate the practice of ten or more senior cadets even though they are assigned to different units of the institution or agency.

State boards should assume leadership in exchange of information about those plans.

Conclusion.—From all over the country the Division of Nurse Education receives reports of the fine work being done by senior cadets and of their enthusiasm for their assignments, whether in federal hospitals, the home hospital, or other institutions or agencies. These reports indicate that even in the initial months of the plan when the number of cadets has been rather small, they are making an excellent contribution to our country's nursing needs. That contribution should be multiplied many times in the coming year. The kind of planning indicated above, combined with community and state planning which should be carried on by state boards of nurse examiners, state and local nursing councils, with the information obtainable from procurement and assignment committees, will guarantee that the promise shown in the fine beginning of this program will be fulfilled and that schools, students, and many types of institutions will benefit, as was intended by the Bolton Act.

1 See March 1944 *American Journal of Nursing*, page 259.

A Physiotherapy Clinic in the Jungle

A PHYSIOTHERAPY CLINIC was created recently out of makeshift materials by members of a hospital unit on the Ledo Road, the highway which Allied troops are building from Assam, India, through Burma to China against the vigorous opposition of the Japanese.

Lieutenant Colonel Willis M. Weeden, Medical Corps, of Woodbury, Connecticut, Chief of Surgery in the unit, saw the need for physiotherapy as a means of functional restoration for patients with fractures, contusions, and various injuries of muscles, bones, and joints. The hospital unit had no physiotherapy facilities.

Colonel Weeden selected Captain Hyman D. Stein, Elkins Park, Pennsylvania, and Second Lieutenant Pauline Moudy, ANC, Alhambra, California, to devise the clinic. Neither Captain Stein nor Lieutenant Moudy had had experience in physiotherapy, but Lieutenant Moudy had been a victim of infantile paralysis and she knew, from the patient's point of view, what was required.

The two officers took over a small space in a bamboo basha, decided upon the type of treatment for their patients, and set to work to make the equipment. The first thing needed was an apparatus to provide dry heat. This was made from a crate with a socket for an electric light in the center. A weight-lifting device for exercising arm and leg muscles, which had become atrophied through disuse, was devised from stirrups to which ropes and weights were attached. A grateful Chinese officer contributed a bicycle for the patients requiring leg exercises.

Old gasoline tanks were used for whirlpool foot and arm baths. A fifty-gallon gasoline drum, with a false bottom built a foot from the base, was prepared to heat water. Between the false bottom and the base an opening was made for the insertion of bamboo chips which could be set afire under the water. The hard rubber core of an overage softball, found in the game chest, was utilized for hand and finger exercises.

Some of the devices and gadgets looked rather formidable and Lieutenant Moudy wondered, she said, if the Chinese patients, unfamiliar with modern medical methods, might refuse to use them; but they went for them like children for new toys. Even when the treatments were painful, they never failed to express their thanks on leaving. When they came back for more treatments, they often brought gifts for Lieutenant Moudy, usually artificial flowers made from paper and cellophane. Some of the patients made the clinic gifts of devices to be used in treatment.

ACCIDENTS are the first cause of death among people between twenty and twenty-four; tuberculosis, second; heart disease, third; pneumonia, fourth; appendicitis, fifth.

Authorities say that if every unknown case of tuberculosis were found, prompt treatment instituted, and all contacts thoroughly investigated, the disease would soon become a rare medical curiosity.

Aero-Medical Nursing and Therapeutics

By Leora B. Stroup, R.N.

The administration and nursing care of patients in a fast moving airplane a mile or so above the earth's surface has become an entirely new phase of the old and great profession of nursing. It has opened a new field for study and for development of special technics in air nursing. Daily, from war fronts and on air routes all over the world, specially trained flight nurses are accompanying sick, injured, and wounded patients who are being evacuated from the battle fronts. This work is being done by nurses of the Army Nurse Corps who have graduated from the AAF School of Air Evacuation at Bowman Field, Kentucky, and are assigned to Army Air Force units. This school is the first of its kind in the world and these nurses are the first of any nation to be so trained.

Qualifications and Preparation

How does a nurse become a flight nurse? In the first place, she must apply for a commission in the Army Nurse Corps. After approximately six months work in an Army Service Forces or Army Air Forces unit hospital, she may apply for admission to the School of Air Evacuation. She must be in excellent physical condition, possess mental stability, and be of superior caliber in every way. She must be able to pass a special examination required of all flying personnel of the Army Air Forces. This has to a great extent limited the applicants to the young and physically fit who are extremely anxious to fly and to do this type of work which brings them closer to the battle front where they can practice their profession. All nurses who enter this field of work must volunteer and if at any time they lose interest or do not desire continuation of their duties, they are free to return to their former station. Thus, the esprit de corps of the air evacuation nurse is the highest of any in the world.

While at the school, she undergoes an intensive eight weeks course in aero-medical nursing, aviation medicine, aero-medical physiology and therapeutics, as well as the basic indoctrination of military discipline and Army familiarization. The graduates of the school have frequently been praised for their smart military appearance and excellent discipline. Upon completion of the course, each nurse has experienced a field bivouac, is physically fit, and has had a minimum of twelve hours of training flights, during which time she practices the care of patients in the field. She is trained to give blood plasma and intravenous medications with ease, and only is considered a graduate when she attains self-confidence in the performance of any and all types of duties expected of her.

Physical fitness of the nurse is particularly important in view of the fact that almost all her work is done while in the air at altitudes up to ten thousand feet. Work performed in the cabin of an airplane at this altitude is tiring and is certainly quite different from riding as a passenger in the comfortable reclining chairs of the modern air liner. Patients require almost continual nursing care and may at times be somewhat apprehensive.

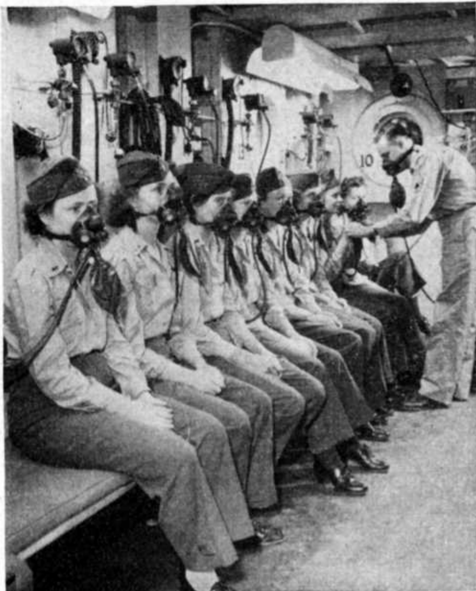
A Relatively New Field

The present types of aircraft being used to carry patients are, in the main, cargo airplanes, C-46, C-47 and C-54 types, but in emergencies almost any plane can be used. The aircraft acts in a dual capacity: it carries cargo and troops from its base to the battle front and, after unloading and rapid conversion into an ambulance plane, carries the sick and wounded on the return trip. By means of special litter fittings and brackets or web strappings, which are component parts of these cargo airplanes, eighteen to twenty-four litter patients can be carried in one plane. The cabin of the airplane, in which these patients are carried, is a hospital ward for the nurse. Instead of rows of hospital beds, the patients are arranged on litters in tiers of three to four patients on either side of the center passageway. When carrying ambulant patients, bucket seats, which are of a shelf type, can be unfolded from the lower part of the side of the airplane fuselage and quickly set into place. Frequently each plane carries both types of patients, ambulatory and litter.

Aero-medical nursing is a relatively new field of medicine, deriving its fundamentals from the science of aviation medicine, and applies the principles of aero-medical physiology and therapeutics.

The first large scale evacuation of patients by air was attempted by the German Luftwaffe during the Spanish Civil War. Because

Captain Leora B. Stroup, ANC, is director of nursing arts in the Plans and Training Department of the Army Air Forces School of Air Evacuation, Bowman Field, Kentucky. Captain Stroup (Lakeside, Cleveland; M.S., Western Reserve) is the first nurse to teach air evacuation. She has been flying for recreation since 1931, holding a private flier's licence; she is a member of the National Aeronautic Association.



U. S. Army Air Forces Photo

Flight nurses in low pressure chamber test their reaction to high altitudes to understand future effect on patients.

these flights were of necessity at high altitudes (over the Alps), and because little was known concerning the treatment of certain types of patients at these altitudes, Hippke, the German air surgeon, concluded that certain types of casualties were definitely contraindicated for air evacuation. He claimed that shock cases, for example, were absolutely contraindicated and serious head injuries, chest injuries, and abdominal cases should be considered "poor risks" and only attempted if no other means of evacuation were available. Since that time, however, research and experience gained in this and other countries have proven beyond question that *any* case, regardless of type, can be transported by air, provided the plane is equipped with adequate facilities and the medical personnel aboard is trained in the principles of aero-therapeutics.

Principles of Aero-therapeutics

Treating patients in the air involves the application of two fundamental physiological principles related to reduced atmospheric pressure: the decrease in oxygen pressure with consequent lowering of the oxygen saturation of the blood and the expansion of air or gas trapped in any of the cavities of the body.

The oxygen principle applies to all personnel, injured or not, at altitudes above 10,000 feet. The lowered oxygen pressure reduces the oxygen saturation from the normal 96 per cent to approximately 86 per cent at this altitude. Certain types of casualties, however, will require additional oxygen at altitudes below 10,000 feet because of the anoxic state caused by their particular injury.

Anoxia (oxygen want) may be caused by factors other than the lowered pressure. The lung membrane may be damaged, as in pneumonia, impeding the passage of oxygen from the alveoli to the blood. The transport system, or carrying capacity of the blood, may be inadequate to transport the oxygen from the lungs to the tissues as is seen in anemias and malaria. The whole column of blood may move too slowly to carry the oxygen in sufficient quantity to the tissues, as seen in circulatory collapse, due to shock or cardiac failure. Finally, the tissues themselves may be so damaged that they are unable to utilize the oxygen as seen in certain types of poisonings and alcoholism. Any of these factors, added to the decrease in oxygen pressure, necessitates the administration of adequate concentrations of oxygen at ground level and above.

The other principle the air evacuation nurse must be constantly on the alert for is the expansion of air or gas at high altitudes. Due to the fall in the atmospheric pressure, air or any gas trapped in the cavities of the body is subject to expansion in proportion to the pressure decrease (Boyle's Law[1]). This increase in volume becomes significant at 15,000 feet, at which altitude the volume of air or gas trapped in the body is about doubled. At 20,000 feet, the volume is increased two and one-half times the original and at 25,000 feet, three times the original. Thus, a person with 50 cubic centimeters of gas in his alimentary canal would have 150 cubic centimeters at 25,000 feet. For the normal person, this would be discomforting and annoying, but not dangerous. For the abdominal wound case, however, this increase might cause rupturing of recent intestinal sutures with a possible peritonitis as the result.

Application of Principles

Head injuries.—Severe concussions and skull fractures usually result in a decrease in oxygen saturation of from 4 to 44 per cent. Thus, even on the ground, administration of additional oxygen with consequent increase in oxygen pressure and oxygen saturation, is indicated. At any altitude, therefore, 100 per cent oxygen should be administered to these cases. Head in-

[1] The law that when a gas is subjected to compression, and kept at a constant temperature, the product of the pressure and volume is a constant quantity, that is, the volume is inversely proportioned to the pressure. It is approximately true for most gases throughout a considerable range of pressure.—Editor.

jury cases are further aggravated at high altitudes—above 20,000 feet—by an expansion of brain contents. Although no nursing procedure will alleviate this factor, these patients should be flown at as low an altitude as possible.

Chest injuries.—Anoxia, of course, should be the first consideration of any serious chest injury. In any damage to the lung, whether it be internal, as in pneumonia, or external, as in a crushing injury of the chest, there is interference with the gaseous exchange of oxygen and carbon dioxide. Thus, it is a good axiom that all serious chest cases require 100 per cent oxygen at any altitude. In many types of chest injuries, the nurse has also to consider the principle of gas expansion. Pneumothorax cases, open or closed, have a quantity of air in the pleural space. This air, at altitudes above 10,000 feet will expand as explained previously. This expansion will cause pressure against the lung and heart and result in circulatory and respiratory embarrassment. Thus, the nurse must be prepared to recognize this factor and to treat it. If the case is an open pneumothorax, the expanded air may be allowed to escape by removing the plug or dressing obstructing the opening. In the case of closed pneumothorax, it may be necessary to aspirate the air by means of thoracentesis.

Abdominal wounds.—In abdominal cases, the first consideration is, obviously, the expansion of gas in the gastro-intestinal tract. The gaseous expansion will cause distention and, in cases of recent intestinal suture, this expansion might produce rupture and result in peritonitis. If, as the gas expands it is allowed to escape either by mouth or rectum, this distention and possible rupture might be avoided. Thus, the air ambulance chest is equipped with stomach and rectal tubes, to facilitate the escape of the expanded gas. The anoxia factor should also be considered, if the distention is great, because of the possibility of the diaphragm being pushed up against the lungs and heart. If this does occur, oxygen will alleviate the resultant respiratory embarrassment.

Malaria and other anemias.—In malaria, with the destruction of many red cells and in other anemias, the oxygen carrying capacity of the blood is seriously impaired. Thus, the administration of additional oxygen will increase the oxygen being carried in solution in the blood and increase the amount of oxygen to tissues.

Shock.—The treatment of shock in the air has received much attention and it can be safely stated that practically all the standard methods of treatment that can be given on the ground can be given aboard a well-equipped air evacuation plane. Plasma and intravenous fluids are available and their administration is possible and practical. The standard shock position is made possible by special bracket equipment on each ship which allows the patient's head to be lowered. Oxygen is, of course, available and blankets and special heating pads are part of the air evacuation equipment. Morphine is also available, but the use is contraindicated at very high altitudes because of its supposed interference with oxygen utilization.

U. S. Army Air Forces Photo

Planes on air evacuation missions may fly so high above enemy territory that oxygen must be administered.

Summary

Thus, cardiacs, gas casualties, asthmatics, cases of tuberculosis, and many other types of cases involving either anoxia or gas expansion or both must be given specialized treatment aboard the air evacuation plane. The flight nurse, because of her thorough training in aerotherapeutics and because of the confidence in herself, imbued by months of training in all phases of air evacuation, has proven invaluable to the success of air evacuation. That it has been a success is evident in the glowing reports from all theaters of operation. The War Department has disclosed that American military aircraft, operating principally in battle areas, evacuated 173,527 sick, injured, and wounded patients in 1943 and that only eleven of the air-borne patients died during flight, a rate of one in 16,000. This excellent record is a tribute to the efficiency and courage of the flight nurse, in particular, and the nursing profession as a whole.

Civil Service Clearance for Senior Cadets

From the Division of Nurse Education, U. S. Public Health Service

The following clearance procedure for senior cadets requesting appointment to one of the five federal services has been established by the U. S. Civil Service Commission. This report was made recently to a representative of the Division of Nurse Education which administers the U. S. Cadet Nurse Corps under the United States Public Health Service.

The Commission acts only as a pool for the five federal hospital services—Army, Navy, U. S. Public Health Service, Veterans Administration, and Indian Service—to clear the applications of prospective senior cadets. A check is made by the Commission to see that schools of nursing are approved by state boards of nurse examiners.

Applications are then sorted according to the student's preference, and filed on cards. At present, representatives of each of the federal nursing services go to the Civil Service Commission headquarters in Washington to review applications for their service.

A cadet's eligibility is determined by the federal service to which she has applied. Each service makes its own selection. The scholastic standing of the cadet is a major deciding factor, with each service, in accepting the cadet's application. Certain physical requirements must must also be met. As this is written, applications returned to the Civil Service Commission indicate that a majority were rejected because the cadets did not meet the specified requirements of the service to which they had applied.

When a cadet nurse fails to meet the requirements of the service of her first choice, her application is returned to the Commission where it is referred to the service of her second choice. Should the cadet's application run the gamut of all the services she has listed and, as might occasionally happen, be rejected by all, the school of nursing is notified. All applications returned from these services to the Civil Service Commission state the reason for rejection.

Ruth A. Heintzelman, R.N., is nursing consultant, Medical Division, United States Civil Service Commission, and nursing consultant on the clearance of senior cadet nurses. She is endeavoring to speed the processing of applications as well as accelerate clearance.

"It is extremely important," says Miss Heintzelman, "to send in these applications as early as possible, preferably three to six months before the junior cadet training period terminates. It would greatly facilitate clearance if all applications were checked and rechecked before they are sent to the Civil Service Commission."

All forms received by the school must be returned together. When they are not, the application must be held in the office for processing until the missing form is written for and returned.

Miss Heintzelman urges also that the cadet nurse give serious consideration to her first choice when filling out her application. Last-minute letters and telegrams, asking that a change be made, from Army to Navy for instance, entail additional work and, what is more important, a general slowing down in the clearance procedure which may result in the cadet not getting into the branch of service desired.

Applications received during the cadet nurse's final week of the junior period do not allow sufficient time for clearance, for the federal services to make their selections, accept the student, and transport her into the group of nurses beginning their senior cadet experience. For this reason, it is of primary importance to have the application several months prior to the termination of the junior cadet training period.

Not more than 50 per cent of senior cadets in any one school of nursing are to be appointed to the federal services during their senior cadet period, unless a higher percentage is requested by the school of nursing. For accurate tabulation, Miss Heintzelman says: "It is most important to know whether 50 per cent of the senior cadets will be available for federal appointment. Thus the federal service may be informed ahead of time of the number of cadets from which they will be able to draw."

When a senior cadet requests appointment in a specified state, it is the federal service, not the Civil Service Commission, which decides whether she may complete her training within that state or elsewhere. The Civil Service Commission does not make appointments. It is a clearing house, bringing the applications from the nursing schools into the hands of one of the five federal services.

As of May 1, 1944, the Commission had received approximately 3,000 applications. Out of this number, approximately 2,000 had been processed and records of approximately 1,500 referred to the directors of the federal nursing services.

NURSING EDUCATION

Edited for the National League of Nursing Education by Adelaide A. Mayo, R.N.

Advanced Courses in Clinical Nursing

A discussion of basic assumptions and guiding principles

IT IS GENERALLY AGREED by leaders of the nursing profession that the development of advanced clinical nursing courses is one of the urgent needs of the profession. The purpose of such courses is the further preparation of private duty nurses, staff nurses, head nurses, supervisors, clinical instructors, and consultants in clinical nursing so that they may function more effectively as practitioners of clinical nursing or as teachers of practitioners. Since to provide good nursing care of persons who are ill, to prevent disease, and to teach positive health are the reasons for the existence of the nursing profession, it is logical to provide organized help for those who are most immediately concerned with such care and teaching.

Staff nurses especially are extremely important in our system of nursing care, but so far little has been done to provide for their further development so that those who excel as practitioners of nursing may find satisfaction in their service and the recognition their service deserves. It is hoped that the development and organization of advanced clinical nursing courses may lead to such satisfaction and recognition, and help to dispel the too prevalent idea that progress for the individual is synonymous with her leaving staff nursing for another field.

It has long been recognized, to be sure, that those who are to teach, guide, and direct student nurses should have professional preparation in addition to the basic nursing course. All too often, however, this has been an advanced superstructure, composed of courses in methods of teaching, supervision, and the like, and imposed upon inadequate preparation and experience in clinical nursing itself. As a result, head nurses and others in supervisory and teaching positions have often been placed in the difficult position of knowing something about *how* to teach without adequate knowledge of *what* to teach.

It was in recognition of this need that, in June 1943, a planning committee was appointed by the National League of Nursing Education to suggest a method of procedure for determining basic principles useful in the development of clinical postgraduate courses.[1] In accordance with their suggestions, the League appointed a Committee To Study Postgraduate Clinical Nursing Courses[2] in July 1943. The function of this committee was to determine basic principles which underlie advanced clinical nursing courses and to construct one course which would illustrate application of the principles. Psychiatric nursing was chosen for this application.

Since January, the committee has had several meetings in New York in which special consultants have participated. After preliminary reports had been drawn up, they were sent to a number of reviewing groups representing several fields of nursing and widely separated areas of the United States.[3] The material which follows is a revision of the early report and incorporates as far as possible the suggestions and criticisms which have been received to date.

It should be pointed out that the committee recognizes that there are many aspects to the problem of conducting advanced clinical nursing courses with which it has made no attempt to deal. Some of these are related to the present war situation and include the securing of properly qualified faculty members who in these times would be free to plan and direct such courses—there is a scarcity of clinical nursing specialists—and the necessity for spreading nursing service over a larger number of patients. Others include the question of meeting costs, the availability of adequate clinical facilities and the need for protecting basic professional courses, the possible limitation of mobility of highly prepared staff nurses within a nursing service, and the whole question of nonprofessional workers and how their influence will be felt in nursing. How these and many other problems are met will determine in

This material is presented by the NLNE Committee To Study Postgraduate Clinical Nursing Courses.

[1] See *Am. J. Nursing*, Vol. 43, pp. 1120–1123 (Dec.) 1943.
[2] See *Op. Cit.* for members of this committee; Mrs. Elizabeth K. Porter is chairman.
[3] Boston, New York, Philadelphia, Washington, D. C., Cleveland, Chicago, Minneapolis, Nashville. Denver, in addition to a number of individuals.

no small degree the success of any advanced clinical nursing course. Certainly much attention must be given in the near future to the solution of these problems. The committee's present function, however, is limited to the determination and application of basic principles useful in the development of advanced clinical courses, as stated above.

Description of Terms

For the purpose of this report and the discussion which follows, certain terms are herewith described.

Nursing situation.—In a clinical field, a nursing situation exists when an individual needs nursing of any kind. Every nursing situation involves the following elements—the patient's personality, his physical and mental condition, and his response to all the environmental factors which affect him. Nursing includes all that may be done by the nurse to teach positive health, to prevent disease, to assist in the cure of disease, to relieve symptoms, to support the patient by physical and psychological measures, and to help him make optimal use of his physical and mental potentialities and to take as much responsibility as possible for his own welfare. Such nursing may be performed by the nurse individually and through co-operation with the family and with community agencies.

Clinical nursing specialist.—A clinical nursing specialist is a graduate professional nurse who is an expert practitioner because she has broader knowledge, deeper insight and appreciations, and greater skills than those that can be acquired in a basic nursing course of generally accepted standards. She is therefore better able to analyze, explore, and cope with nursing situations in a specific clinical field and, in addition, to co-operate with other specialists in the improvement of service to the patient.

Advanced clinical nursing course.—An advanced clinical nursing course provides an opportunity for acquiring the additional understandings and abilities which are essential as a basis for becoming a clinical nursing specialist. Such a course is based on the understanding and skill acquired in a basic clinical nursing course, and requires *clinical practice* as well as formal instruction. The objectives set up for the advanced clinical nursing course will determine the nature and scope of the content, and this content may be organized in different ways in different schools. For example, an advanced course in medical nursing certainly requires advanced study of the medical and nursing aspects of medical diseases, pharmacology, and nutrition in disease. In one school it may seem desirable to integrate this content in the clinical nursing course itself; in another it may be set up as three distinct courses.

Advanced clinical nursing programs.—A program in advanced clinical nursing includes, in addition to the clinical nursing course itself as defined above, related courses which may serve to enrich the background of the student. These courses may vary according to the experience, capacity, and interests of the nurse pursuing the study, and might include physical and biological sciences, social sciences, public health nursing, and the like. These courses together would, of course, constitute a part of the total program leading toward a degree.

The present project deals only with the clinical nursing *course* as differentiated from the clinical nursing *program*.

Basic Assumptions

In presenting the guiding principles which follow, the committee has assumed the following statements to be true:

1. *There exists an advanced body of knowledge, appreciations, and skills in clinical nursing beyond that which is generally attained in the basic nursing course.*

Even in time of peace no student nurse can possibly acquire all the knowledge, appreciations, and skills involved in the various types of clinical nursing. Lack of time, necessity for rotation to a new service before the fundamentals of the last one have been fully mastered, variabilities in what a given service has to offer regardless of how careful the planning, and various other factors enter into this.

In addition to the factors already mentioned, new scientific discoveries are constantly bringing about changes in medical and nursing practice. Advanced clinical courses provide an excellent opportunity for the graduate nurse to acquire this newer knowledge and to apply it in her own field.

2. *This body of knowledge, appreciations, and skills can be acquired more effectively and more economically through an organized program of instruction designed to develop the specific abilities required.*

Many of the private duty nurses, staff nurses, head nurses, and others concerned with nursing service and nursing education have achieved a high degree of professional competence largely or entirely through "learning on the job." The committee recognizes the value of good experience in the preparation of any skilled nursing practitioner, but takes the position that a period devoted to intensive, organized study leads

more rapidly and more surely to the development of a high degree of effectiveness in nursing performance.

3. *The fundamental purpose of all advanced clinical nursing courses is the further preparation of qualified graduate nurses as clinical nursing specialists in order to ensure a constantly improving quality of nursing practice.*

If and when an appreciable number of qualified graduate nurses become clinical nursing specialists, it is reasonable to believe that the quality of nursing will be improved. Better performance of graduate staff nurses would, of course, contribute directly to this result because in all kinds of nursing the staff nurse is, or at least should be, the chief stabilizing factor.

There is, however, another reason why the quality of nursing would improve as a result of better performance of staff nurses. It is generally conceded that staff nurses play an exceedingly important rôle in the teaching of student nurses. Indirect though this may be in our present system, the influence of what the staff nurse does as she functions day by day is often at least as great as that of the teacher who has less frequent contact with the student.

4. *The advanced body of knowledge, appreciations, and skills in clinical nursing is basic in the preparation for the positions of head nurse, clinical instructor, supervisor, and consultant in any community agency concerned with nursing service and/or nursing education.*

Any nurse who is immediately responsible for the maintenance of high standards of nursing service and nursing education should be highly qualified in her specific clinical field. An expert knowledge of what constitutes good plans of nursing is at least as important as knowledge of supervisory and teaching technics.

Guiding Principles

The purpose here is, first, to state and to discuss briefly certain guiding principles for the organization and development of advanced clinical nursing courses, and then to list under the heading of *Criteria* statements of conditions and procedures which should characterize such courses and which represent corollaries of the principle. It is expected that this material will constitute the basis for an eventual check list for purposes of evaluation.

The principles and criteria have been determined on the basis of principles already established in the fields of general and professional education, and on the judgment of many experienced nurses in various clinical and other related fields of nursing who have been interested in the study.

The committee recognizes that many of the principles and criteria are true for nursing education at any level, but believes that in advanced study the goals which they imply should reach their most complete realization. The committee is also aware that the standard of achievement indicated is very high and believes that, although no one clinical course would be likely to measure up completely, continued progress along these lines is essential if advanced courses in clinical fields are to fulfil their purposes.

Principle I

The advanced clinical course should be an integral part of a major program in nursing education established in an accredited college or university which offers advanced professional curricula leading to a baccalaureate or higher degree.

Establishment of such courses in a college or university provides the type of educational control and facilities essential to the attainment of the purposes, and helps to protect them from some of the major weaknesses of many so-called postgraduate courses of the past.

Criteria

1. The college or university in which the course is established is accredited by a regional educational accrediting body. The nursing division or department [4] is accredited by a professional accrediting or policy-making body.[5]
2. The organization and administration of the program is in accord with the general plan in effect in the college or university.
3. There are contractual arrangements between the college or university and the other co-operating agencies.
4. The course is credited on the same general basis as other university courses.
5. The administrative control of the course is delegated to a nurse who is specially qualified for this responsibility.
6. The general educational and professional qualifications of the nurse reponsible for organizing and directing the course meet the general standards of the college or university and of the co-operating agencies.
7. The teaching personnel for the course have a teaching schedule comparable to that of the faculty in the college or university and in accord with best present practice.
8. Eligibility for matriculation in the college or university and in the department of nursing [4] are prerequisites for admission to the course.

[4] The term "department" as used throughout refers to the professional division, department, or school, responsible for the development of the course.

[5] These include the National League of Nursing Education, National Organization for Public Health Nursing, and Association of Collegiate Schools of Nursing—membership or eligibility for membership.

9. Financial arrangements which the college or university makes with field agencies for student experience ensure an educational program for students while in the agency.
10. The course is developed on a sound financial basis that assures its stability, continuity, and satisfactory provision for education.

Principle 2

An advanced clinical nursing course should begin at a level of achievement equivalent to that attained in a basic nursing course of generally accepted standards and lead directly to the development of additional information, skills, interests, and personal traits required by a clinical nursing specialist.

Any total scheme of education should represent a gradual and more or less regular progression from one point to another further advanced, each division articulating with the division immediately preceding or following. The place which the student can reach at the completion of the basic professional course has been generally agreed upon. According to the *Curriculum Guide*, the basic course must be considered as *general* rather than *specialized* training; it should supply the foundations on which all additional training and experience should be built; it should be broad and varied enough to serve as a preparation for the fundamental branches of nursing service.[6] The advanced clinical nursing course should then proceed onward from this point of a thoroughly substantial basic education to a new and higher point, making an essential contribution to the building up and enrichment of the student's professional skill in a specific clinical field.

Criteria

1. Clear statements concerning the purpose of the course, content, admission and credit requirements, are included in the catalog or announcements.
2. The department has evidence based on the best available procedures for appraisal that students accepted have already achieved the degree of competency in the special clinical field expected at the completion of a basic nursing course in accord with the recommendations of the *Curriculum Guide*.
3. The course leads to the development of those abilities which enable the nurse to function as a clinical nursing specialist. At the completion of the course, the student gives evidence of:
   a) Increased insight and sensitivity in recognizing and interpreting significant factors in any nursing situation in the specific clinical field.
   b) A clearer concept of what constitutes an appropriate and comprehensive program of nursing for any patient in the specific clinical field, and an increased ability to become self-directive in making and carrying out related plans.
   c) Skill in carrying out new and complex procedures essential to effective nursing practice.
   d) An increased ability to adapt any nursing procedure to the needs of individual patients.
   e) An increased ability to evaluate nursing in the specific clinical field.
   f) An ability to make a professional contribution to the improvement of nursing in accordance with her sphere of interest and degree of competence.

Principle 3

The learning experiences in the advanced clinical nursing course should be based on the special needs of students as individuals, and as professional nurses with a particular function to perform in a particular field of nursing practice.

The advanced clinical course should exist to serve both the individual nurse and society. It is assumed that even if the nurses enrolled represent a relatively homogeneous group, variations will exist in learning ability, purposes, personality, educational background, experience, interests, and the like just as among members of any other student group. That effective teaching takes into account such variations and makes adjustments as far as possible is an accepted principle of educational procedure. Along with this concern for the individual, however, there should be an equally paramount concern for the needs of society for this specific type of professional service. This social function of the course requires that all students attain the completeness, definiteness, and accuracy of knowledge and performance which society has the right to expect of a nurse who has received recognition for the completion of a graduate course in a clinical field.

Criteria

1. The department continually studies the needs of society for the specific type of nursing service, and the professional requirements of the nurse in meeting these needs.
2. The department has determined the type of student who will be able to profit from the advanced clinical course offered and only such students are admitted.
3. The faculty know the qualifications of students admitted in so far as these can be determined and utilize this knowledge in guidance.
4. There is evidence of interest and co-operation of the faculty in learning what students are like, what they want, and what they need.
5. The department makes students aware of the requirements of the field for which they are

[6] *A Curriculum Guide for Schools of Nursing*, ed. 2, New York, National League of Nursing Education, 1937, p. 43.

being prepared, together with its possibilities and limitations.

6. Students themselves are acquiring a fuller understanding of their own pattern of abilities in relation to the professional requirements of the specific clinical field.
7. Curriculum adjustments are made to the needs of individual students and differentiations are made both in theoretical work and in clinical experience as indicated.

PRINCIPLE 4

A satisfactory teaching-learning situation calls for teaching technics, study activities, and physical facilities appropriate to the level of advanced study in nursing.

Freedom of the faculty to experiment with methods of teaching on the advanced level is most essential, and the relative effectiveness of specific methods must be determined on the basis of such experimentation and evaluation of results. As in any graduate study, however, there should be a gradual transition to more mature, independent habits of work. The student should become familiar with authoritative sources for new learning, and should develop the ability to continue her study independently after completing the course.

Criteria

1. Experiences of students are related to nursing situations that are more difficult or more complex than in the basic nursing course, and involve the use of more extensive information, greater understanding, and a higher degree of skill.
2. Types of study activities employed include: critical interpretation of experiences in the clinical field, attendance and participation in case conferences, study of case histories, extensive reading, annotated bibliographies, critical reviews of current studies, and the like.
3. There is greater individualization of instruction than in the basic nursing courses.
4. For students who have the special interest and qualifications, opportunity is provided to evaluate and, if desirable, to modify or construct nursing methods under adequate supervision.
5. There is emphasis on developing the skills essential for independent study and for various forms of group discussion.
6. Students are required to maintain acceptable standards of achievement in relation to the specific purposes of the advanced clinical course, and a student who finds it impossible to do so is advised to withdraw or fails to receive credit.
7. The library provides satisfactory reading facilities, is adequately cataloged, is readily available, and there is evidence that it is being effectively used by students.
8. The library contains standard reference works in nursing and allied fields; also the special reference books, periodicals, and other publications essential for effective teaching of the specific course.
9. Adequate space for classes and conferences, equipment, and supplies are available to make good teaching possible.

PRINCIPLE 5

In the advanced clinical course a type of laboratory situation should be created in which a student can experience responsibilities under guidance comparable to those which she will be expected to assume as a clinical nursing specialist.

It is an accepted principle that students learn to meet nursing situations most effectively through actual practice in meeting them. Therefore, the first requirement for any advanced clinical nursing course is that adequate clinical facilities be available. Objectives can be achieved only if there are patients for the student to observe and nurse.

Criteria

1. The co-operating hospitals providing clinical experience are approved by the American Medical Association, the American College of Surgeons, the American Hospital Association, and/or special accrediting body for a specific clinical field.
2. Other agencies providing experience are approved by the appropriate accrediting body.
3. Superior clinical facilities, including outpatient and social service departments, and such facilities as may be essential to a specific clinical field are available within the hospital or allied agencies.
4. There is a segregation of services in the specific clinical field and a sufficient number and variety of patients are available to give the type of experience essential for specialization.
5. Other experiences needed to enrich the students' program are provided through close working relationship between the hospital and other community agencies.
6. Hours of nursing practice assigned to field work for credit are such as to permit, and are so arranged as to develop, desired nursing abilities.
7. If students are rendering additional hours of nursing service beyond those required for credit, such time has been prearranged, in order to safeguard the health and educational needs of students.
8. The nursing service in the field in which students secure experience is adequately provided for without dependence on these students.
9. Nursing situations selected for student experience are chosen in terms of the opportunity which they afford for developing the special abilities needed by a clinical nursing specialist, and are utilized in such a way that the desired learning is possible.
10. In the choice of experiences, consideration is given to the nursing situations which are most unusual or most difficult for the group con-

cerned as well as to those which are most important and most common.

11. The learning experiences of the students in the clinical field are adequately supervised by a person who herself is a nursing specialist in the specific field, who has had additional preparation for teaching and supervision, and who is reasonably well informed in closely related fields.
12. Classroom work and clinical experience are integrated or unified—formal instruction is viewed as a means of illuminating the experiences which students are having in nursing patients.
13. The relationship between selected clinical experiences and learning needs is apparent to the student.
14. Under guidance, students are becoming more self-directive and able to assume greater responsibility for the planning and carrying out of nursing care with a minimum of direction and supervision.
15. The conditions in the clinical field, including the rapport which exists between students and the medical and nursing staff, make possible a superior teaching-learning situation.

Principle 6

The advanced clinical nursing course should stimulate the development of interest in and methods for experimentation and critical evaluation in relation to practical problems in nursing.

Progress in nursing is dependent upon continued critical evaluation of existing practice and experimentation by members of the nursing profession. There is a great need for more nurses who are able to function creatively in nursing—who are able to analyze and to improve practice in a special field through the application of the related scientific knowledge which is available. Such study needs to be in relation to the total plan of patient care and not, as frequently has been true, to nursing procedures alone. It is reasonable to expect the nursing profession to look to the clinical nursing specialist for assistance in such creative work. For those students who are interested, and who have adequate professional and technical background, an opportunity should be provided in the advanced course to pursue some investigative study under competent direction.

Criteria

1. Members of the staff are interested and co-operative in efforts to foster a scientific attitude among students enrolled in the course.
2. The situation makes it possible for students to gain insight into the methods required for careful, objective study and revision of nursing methods.
3. Opportunity is given to students to compare different points of view and methods used in similar clinical services elsewhere.
4. For students who have the special interest and qualifications, opportunity is provided to evaluate and, if desirable, to modify and construct nursing methods under adequate supervision.
5. Students are encouraged to analyze and evaluate the clinical course itself as it progresses and to make specific suggestions for improvement

Principle 7

The advanced clinical course should be presented in a setting which favors the further development of those personal, social, and professional qualities that are essential for the nurse who is a leader in her own field.

It is obvious, of course, that for the clinical nursing specialist, as for the basic nursing student, personal qualifications are extremely important. It is well understood that effectiveness in meeting varying situations in nursing is conditioned by physical factors, motives, attitudes, ideas, habits, and the like, which go to make up personality. No advanced clinical nursing course must fail to take account of this. In addition, in advanced nursing education greater attention and more conscious, deliberate effort should be given to the development of qualities of intelligent leadership. Such qualities are not developed by chance nor through instruction in facts alone. They are built up through cumulative experience under appropriate conditions.

Criteria

1. The department selects students who give promise of success in terms of health, emotional stability, and social qualities.
2. Provision is made for adequate health service, and suitable living and working conditions are available.
3. Opportunities are provided for responsible participation of students in nursing situations which call for the functioning of the qualities and skills of leadership.
4. The environment is conducive to the functioning of right ideals.
5. The setting in which the course is presented promotes mutual respect and co-operation between the nursing staff and other professional workers.
6. Opportunity is provided for students to experience the realization of accomplishment, challenge, and constructive criticism.
7. The faculty consider the students as responsible, adult professional persons.
8. The faculty are alert to any physical, emotional, or social problems that interfere with the progress of the student.
9. Adequate guidance facilities are provided and students are encouraged to use them; at the

same time emphasis is given to development of necessary independence.

10. Students are encouraged to participate in social activities sponsored by the institution.

Principle 8

The advanced clinical course should be adapted so that it represents an acceptable balance of time and financial expenditure in relation to the total program.

Absence of experimentation and variations in the opportunities for acquiring knowledge, skills, and appreciations in different clinical fields make it difficult to set even maximum and minimum periods of time for advanced clinical courses in general. It is certain that they would vary in some degree because they are built upon background acquired in the basic nursing course. In general, psychiatric nursing experience is more limited in schools of nursing, if available at all, than is experience in other clinical fields as surgical and obstetric nursing. It would therefore be reasonable to assume that the time necessary for an advanced clinical nursing course in psychiatric nursing might profitably be longer than one in obstetric or surgical nursing. The committee believes that it is urgent to remember, however, that such courses must be of a reasonable length.

Criteria

1. The time allotted to the clinical course is consistent with the stated purposes, and follows the policy of the university or college with respect to credit hours.
2. The time required for completion of the course is such that it is educationally satisfactory and at the same time economically possible.
3. The time allotment for the essential theory and practice is determined by the educational needs of the majority of the students. Differentiations in time requirements are made on an individual basis—students with unusual previous preparation and experience may complete the course in less time, while other students are required to supplement the course by added internship.
4. The total program of the student, including experience, is so adjusted that the hours per week of class, study, and practice constitute a reasonable schedule so that both health and education are safeguarded.

Principle 9

Chief emphasis should be placed on measuring attainment of the objectives of the advanced clinical course in terms of student accomplishment, rather than in terms of months and credits.

Achievement tests, of course, have an important place in determining the attainment of the students in advanced clinical nursing courses. In addition, however, it is important to have a picture of the growth of the students in terms of all objectives and to know the degree of habitual effectiveness in their day-by-day performance in real nursing situations.

Criteria

1. Credit for the course is granted only on the basis of evidence that students have attained the required degree of competency.
2. The department secures and uses data which give evidence of the degree to which students have attained the required information, understandings, abilities, as indicated in the objectives.

Conclusion

The development of advanced clinical nursing courses is of great importance in the improvement of nursing and in the development of nurses themselves. The nursing profession is aware that, in the present organization of nursing service, those who serve as private duty or staff nurses do not receive the recognition and therefore the satisfaction which should result from one of the most important fields of nursing. It is likewise aware of the need for advanced preparation for those who teach and direct nursing in specific clinical fields. Advanced clinical courses will provide a means by which better preparation for these fields may be attained and will be particularly important for the young graduates of accelerated programs and for those who have been in the military services.

This is a progress report. It is presented for critical study by members of the profession. It is earnestly hoped that nurses, having studied it, will send comments and suggestions to the National League of Nursing Education.

The tremendous field of psychiatric nursing has many unexplored opportunities, and expert practitioners are urgently needed. Few advanced clinical courses are, to the knowledge of the committee, being offered. The committee is therefore continuing its work by using the principles and criteria herewith set forth to develop an advanced clinical course in psychiatric nursing which will be published in the *Journal* within the next few months. It is believed that this material will be welcomed by the educators in psychiatric medicine and psychiatric nursing and that they will stimulate appropriate universities to pioneer in this special field.

So far as is known very few advanced clinical courses which follow this plan exist at the present time. This plan aims to develop clinical nursing specialists, the need for whom is very great. Qualified universities are urged to undertake experimentation with this program.

Student Withdrawals

From the Department of Studies, National League of Nursing Education

For the past six years, the National League of Nursing Education has been collecting information on the number of students who withdraw from schools of nursing before completing their programs. Up to and including the class which graduated in 1943, there had been little variation in the withdrawal rate. Thirty per cent of the students who entered in 1940 had withdrawn before graduation in 1943. The two previous classes, graduating in 1942 and 1941, had each lost 28 per cent of the students admitted three years earlier.

Whether the war and the increased enrolment in schools of nursing necessitated as a war emergency measure will affect withdrawals of students cannot be determined with any finality until classes which were admitted after December, 1941, have been graduated. In order, however, to get some information on what is happening, data have been collected in the past two springs concerning the number of students withdrawing from those admitted the previous fall and summer.

During June, July, and August of 1943, 12,569 students were admitted to schools of nursing throughout the country. By March, 1944, 16.5 per cent, or 2,074 students, had withdrawn. Individual states varied considerably in the proportion of students dropping out. In six states, less than 10 per cent of the students admitted last summer have withdrawn. On the other hand, in nine states 25 per cent or more of the students admitted at that time have left.

TABLE 1

Students Admitted in the Summer and Fall of 1943 Who Had Withdrawn by March 1944 for Each Reason

Reason for Withdrawal	Per Cent Withdrawn	Number Withdrawn
Failure in classwork	38.6%	2,396
Personal reasons	12.8	794
Disappointment in nursing as a career	12.5	776
Health	11.0	683
Personality and temperament unsuited for nursing	6.6	410
Failure to meet school's standards concerning social conventions, regulations, et cetera	4.0	248
Immaturity	3.1	192
Preference for other war work	2.7	167
Failure in both classwork and practice	2.3	143
Failure in clinical nursing practice	2.2	137
Other reasons	4.2	236
Total	100.0%	6,207

There has been only a very slight increase in withdrawals this year compared with last. By last spring, 15.4 per cent of the 1942 summer class had dropped out, compared with 16.5 per cent this year.

Fall admissions in 1943 totaled 28,701. Of these, 14.4 per cent had dropped out by March of this year or, in other words, 4,133 students had withdrawn. There were only four states in which less than 10 per cent of the students admitted last fall had dropped out. In all of the other states, the per cent withdrawal ranged from 10 to 33 per cent. For the country as a whole, there was an increase of about 2 per cent in fall withdrawals this year compared with a year ago.

"Failure in classwork" is the reason for the largest proportion of withdrawals. Nearly two-fifths of all the students who had dropped out of school had left because they could not keep up to grade in their classwork. Approximately 2,400 students withdrew from school for this reason. In terms of the number of students admitted in the summer and fall of 1943, this represents a withdrawal of about 6 per cent.

"Personal reasons" were the next largest group, although only approximately 13 per cent of all who withdrew left for such a reason. Included in this category are marriage, transference of husband, financial reasons, and family complications, such as death of some member or removal of the family elsewhere.

Another 12.5 per cent withdrew because they were disappointed in nursing as a career.

Health was the cause of 11 per cent of the withdrawals. Nearly 700 students admitted last summer or fall dropped out for this reason.

Among the other causes were "personality and temperament unsuited for nursing," which accounted for 6.6 per cent of the withdrawals and "failure to meet school's standards concerning social conventions, regulations, et cetera," which was the reason for 4 per cent of the students dropping out. "Immaturity" was given as the reason for 3.1 per cent, and "preference for other war work" for 2.7 per cent.

Only 2.2 per cent left because they had failed in clinical nursing practice. Another 2.3 per cent dropped out because they could not keep up with either classwork or clinical nursing practice. However, since these withdrawals

are from groups of students who have been in the school not more than eight months and in many cases less than six months, there probably has not been time to eliminate those who may fail in clinical practice.

Among the miscellaneous reasons given which accounted for 4.2 per cent of the withdrawals were homesickness, preference for some other school of nursing, transference to a college, and decision to enter a religious order.

Apparently in the past year there has been only a slight increase in the withdrawals of students admitted the previous fall and summer. Whether there will be any change in the withdrawal rate of these students during their second and third years is a question. What effect the war may have on student withdrawals in general will not be known until reports are received for students graduating in 1945, 1946, and 1947, and possibly longer.

[Note.—This article is also being published in the June 1944 issue of *Hospitals.*]

Mary Adelaide Nutting Medal

On May 5, the first Mary Adelaide Nutting Medal was presented by the National League of Nursing Education to Miss Nutting by Stella Goostray, President of the League and Chairman of the National Nursing Council for War Service, in a simple ceremony held at Miss Nutting's home. The League plans to award this medal, from time to time, in recognition of outstanding leadership in nursing education.

The original plaque from which the medal, in reduced size, was cast, was designed by Malvina Hoffman and was presented to the National League of Nursing Education on its fiftieth anniversary in June 1943 by a group of Miss Nutting's colleagues and former students. On its obverse side is the profile of Miss Nutting as a young superintendent of nurses and inscription, "Mary Adelaide Nutting Award." The reverse side carries a laurel wreath and lamp, the name of the National League of Nursing Education, and the dates 1893–1943 with the citation, "For Leadership."

Miss Nutting was one of the founders of the National League of Nursing Education and of the original course for graduate nurses at Teachers College, Columbia University, which was initiated in 1899 by the college in co-operation with the League. In 1907, in recognition of Miss Nutting's outstanding ability as a leader and administrator in the field of nursing education, she was called from her position as director of the Johns Hopkins Hospital School of Nursing, in Baltimore, to the first professorial chair of nursing education in Teachers College or any other university. During the first World War, as chairman of the Nursing Committee appointed by President Woodrow Wilson, Miss Nutting left a brilliant record of swift and efficient organization to increase the supply of nurses and co-ordinate their services.

In the international field, she was active in the founding and work of the International Council of Nurses. She is honorary president of the Florence Nightingale International Foundation which, since 1934, has conducted a course in London for graduate nurses from all parts of the world. In 1921, in recognition of Miss Nutting's conspicuous service to nursing education and public health, she was awarded an honorary Master of Arts degree by Yale University. The four volume *History of Nursing* written jointly by Miss Nutting and Miss Lavinia Dock is still considered the authoritative work on this subject.

Miss Goostray said, in part:

"It is largely to your leadership that we are indebted for the progress that nursing education has made in this country. With your constant emphasis on sound educational, social, and economic principles for schools of nursing, we have gone forward towards a worthy preparation for the practice of nursing. We are confident that a medal bearing your name will be an inspiration in the years to come for others to continue the high quality of your leadership."

A Psychiatrist's Views on "Guidance" of the Student Nurse

By Charles P. Fitzpatrick, M.D.

From time to time in recent years and particularly in the past year articles have appeared in the *American Journal of Nursing* on various aspects of the problem of guidance for the student nurse. Helpful contributions have been made in these articles and specific technics in some instances have been outlined for dealing with specific problems.

Torrop(1) divides the problem into areas among which are social, personal and emotional, educational, physical and mental health. She also gives statistical data referring to the incidence of problems in the various areas and the periods in training at which they occur. Triggs and Bigelow(2) have reported on attitudes of the student nurse towards guidance counseling. Ingmire(3) has written on the function of a guidance program and among other things indicates that the purpose of nursing guidance should be to "help the student nurse to develop her whole personality." The writer in this article will endeavor to indicate what in his opinion the above quotation means in terms of specific aspects of personality development and the goals that are to be attained if possible.

Sometimes in writing about a subject useful help can be obtained from the dictionary by getting a definition of the subject. Webster defines guidance as, "The act of guiding; the superintendence or assistance of a guide; direction; a leading; also, something serving as a guide or model." For the purposes of this article the pertinent parts of the definition would seem to be "direction; a leading; serving as a guide or model."

First let us consider the persons being led and directed, next the goal we intend to lead them towards, and finally those who are to do the leading.

In most instances we are dealing with girls eighteen to twenty years of age who have completed high school and who probably for the first time are away from home and at least partially deprived of parental advice and counsel. They will be girls with varying degrees of intelligence and will come from a variety of social and cultural backgrounds. There will be many different personality types and varying degrees of maturity represented in the group. Some will rate high in scholastic achievement and others not so high. Some will have a high degree of motor skill and others a low degree with awkwardness and clumsiness. Certain groups will be slightly older and with more preliminary academic education than indicated above, but the same general differences will still apply and the guidance goals will not differ.

We should get as accurate data as possible about the points mentioned above. Otherwise we will not have a sound base line on which to build our guidance program. The problems of a girl with a favorable social and educational background will naturally differ from those of another student with a less favorable background. We should utilize our data intelligently in achieving our guidance goals which are, first, to develop a mature person and, second, to produce a technically skilled nurse.

To obtain the foundation knowledge we require to proceed intelligently, a battery of intelligence tests should be administered. Aptitude tests, personality inventories, and scholastic achievement tests should be given. Motor skill is important to an individual and a nurse, and can be measured by tests. The tests should be done by a psychologist if one is available. There are, however, satisfactory tests procurable which can be given and scored by one without professional training in psychology. In the case of students living within a reasonable distance, a social service visit is of great importance both for evaluating the probable influence of the home on the student and to establish rapport between the parents and the school. If the student's home is at a distance or a social worker is not available, some other method should be devised to get this information. It is also important, for various reasons, to know the student's financial resources. A physical examination should be done at the school, preferably by the psychiatrist if one is available and willing. This presents an excellent opportunity to make an initial psychiatric contact and to pave the way for a more formal interview later. Instructors, supervisors, and recreational directors should make a written report of their observations at the end of the first month or six weeks.

When all the available data are assembled, a psychiatric interview should be arranged. The purpose of this interview is to obtain a com-

Dr. Fitzpatrick is chairman of the Committee on Psychiatric Nursing of the American Psychiatric Association.

prehensive picture of the type of personality and the problems which may be anticipated in view of the background, intelligence, scholastic achievement, and other ascertainable data. It provides an opportunity to become acquainted and creates the feeling in the student that a psychiatric interview is not an alarming experience. It also provides an opportunity for the psychiatrist to find out what problems the student does *not* present and, if possible, why.

Written summaries should be made by the psychiatrist, instructors, supervisors, and psychologist of their impressions and a written prognosis made as to whether or not the student will make a good nurse. Reasons should be given for the prognosis made. A procedure of this sort is an essential step in developing tests, procedures, and estimates for future study and research. Any figures which might emanate from a school later would not be statistically reliable unless they included all students, not only those with difficult problems.

A great deal of time, energy, and money is lost because we have not yet developed good transferable technics for determining with any accuracy whether or not a given student is likely to make a good nurse. Guidance and research should both be kept in mind in setting up a program. Not the least benefit is often derived by the psychiatrist if he will put down his findings and his prognoses, then in five years time by review he will get a useful check on his batting average of correct prediction. Too frequently estimates and prognoses are made and then never checked to find out how often they are wrong.

Research should be directed towards developing tests and technics so that better yardsticks can be devised for gauging accurately the probability of the candidate becoming a good nurse. The writer believes that it would be definitely worth while to follow the girl's career as long as possible after graduation as part of the research program. The future may bring forth definite changes in the type of professional training given. Some students may be trained from the beginning for a career in bedside nursing and others with the definite objective of becoming an instructor or an administrator. In this event a complete longitudinal study of the career of the individual would be very valuable and of great assistance at the beginning of the training period.

After the psychiatrist has seen the student and formed his opinion, a conference should be called of all those who will be immediately responsible for the student's general program. A plan of approach should be worked out for each student emphasizing where special attention should be given to encourage and develop some personality attributes and to inhibit others.

The goal of any guidance program is or should be to aid the student in growing to physical and emotional maturity. We are all familiar with the two terms and I think we all understand reasonably well what is meant by the term physical maturity. The term "emotional maturity" may not be as clearly understood. Emotional maturity means to the writer that the individual has achieved reasonable emancipation from the original emotional dependency on the parents, the home, and whatever surrogates may have replaced the parents and the home. In the case of the student nurse these are the supervising personnel and the hospital. The term also implies that the individual can be economically and socially independent. This latter requires a healthy adjustment to the opposite sex and a capacity to be interested in and give respect and affection to others.

The period during which the student nurse is in training is critical in the above respects. The training school receives her as an adolescent who is just beginning to develop the independence necessary to carry on successfully as an adult. On graduation, if she has successfully grown up emotionally during her training period, she should be able to function adequately as a woman, be able to make her own living, set up her own home, and be emotionally free from dependence on parents, teachers, superiors, and other surrogates. Any general approach to the guidance problem should always be based on these fundamental and necessary goals. The professional education received can be regarded as giving the student a useful, practical tool to aid in accomplishing these goals and in being confident in herself as a person.

One has been impressed in the past in some schools with the inconsistency in philosophy with respect to the undergraduate period and the graduate. Restrictions have been placed on the student during her period of training, every part of her daily routine has been strictly supervised and watched but the day following graduation she is expected to step into adult shoes a free, responsible, competent individual and nurse. Under such a restrictive program she has not been prepared socially and professionally for such responsibility and, if she does assume it adequately, nature and the natural growing process must be congratulated rather than the training.

A patient admitted ill to a hospital is an extremely dependent individual and has regressed

temporarily to an emotionally and physically dependent status. The physicians and nurses on whom he is dependent become temporarily for him parental surrogates. The young student nurse, particularly in these times, often has to assume what are in many respects parental responsibilities for patients who are much older than she. She should be taught early in her career that this emotional situation exists between the patient and nurse, and be impressed with the necessity for handling it wisely in order that a minimum of friction and resentment develops. This aspect of the patient-nurse situation is often not adequately stressed and detriment to the student's development and the patient's comfort results. If the student is coached and guided in this emotional situation to the point where she can manage it adequately, then a good deal has been accomplished towards maturing her personality. If the student is allowed to develop, without correction, childish resentments and animosities or over-attachments, her usefulness as a nurse will be hampered and her development as a person hindered.

In a school of nursing there should be a person in a position of authority to correlate the various aspects of the student's guidance program. The person selected for this function should be an emotionally mature person who is well integrated in her occupational and social life and who is herself well adjusted emotionally. In the final analysis the success or failure of any guidance program will depend directly on all the people concerned in it, particularly on the person directing the program. In this connection I think we can with profit refer back to our definition of guidance, "something serving as a guide or model."

The writer is fully appreciative of the fact that many schools have not the specialized personnel required to carry out the program visualized in this article. Some schools are carrying on certain aspects of it and some are organized substantially on the above lines. Nevertheless, the goals mentioned should always be kept in mind and methods of achieving them devised within the limits practicable.

Nothing has been said about methods of dealing with the problems of individual students which may develop during training. They should be dealt with as they arise. The manner of dealing with them must depend on the individuals and circumstances involved. No matter what the problem, however, the aim in dealing with it should continue to be the maturation of the student emotionally and professionally.

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Management of the Senior Cadet Period

The New Jersey League of Nursing Education provides policies and recommendations

With a view to assisting participating schools in setting up the senior cadet program, the State Board Problems Committee of the New Jersey State League of Nursing Education has formulated certain policies as a guide in the general management of the senior cadet period. While this period is primarily one of supervised practice, it must also be borne in mind that it should provide opportunity for the student to give service in her chosen field, and that provision should be made for continuance of her progress in learning while she serves.

The policies and recommendations are:

1. That all service assignments for senior cadet nurses be made primarily to supplement and round out the learning and experience of the student beyond basic requirements.

2. That a variety of learning experience be planned, utilizing two or more services.

3. That, since one of the major purposes of the plan is to expand service to the community, it is important that no civilian hospital or agency have a cadet nurse for longer than twelve weeks. (Senior cadet nurses may spend the entire six-month period only in the home school, or in federal services,

This material was assembled and organized by the State Board Problems Committee of the New Jersey State League of Nursing Education. Edith Jane Holden was chairman of the Committee, with Eva Caddy, Zelma Fluharty, Jessie M. Murdoch, Irene Perry, Laura Robinson, Bernice E. Anderson, Harriet B. Cook, Lula P. Dilworth, Sister M. Herman Joseph, and Victoria Smith. This material has been published in mimeographed form as part of a series "Policies and Recommendations for the Senior Cadet Period," prepared by various groups within the New Jersey State League of Nursing Education.

where varied clinical assignments are available.)

4. That the possibility for an exchange of students between hospitals where special benefit could be derived be considered in planning senior cadet experience. Examples: Rural—urban; predominately ward—private; and special services that are very active and exceptional in clinical experience.

5. That night duty assignments during the senior cadet period be allowed in the home school only—the total in the entire three years not to exceed six months.

6. That instruction and practice not exceed forty-eight hours with one day off per week. (A reasonable division of time might be: practice forty-six hours, instruction two hours.)

7. That any orientation program or instruction be given through conferences, clinics, symposiums, seminars, and similar teaching methods, which tend to place greater responsibility on the student for her own learning.

8. That senior cadets be included in any staff education program or conferences planned for graduates.

9. That, if possible, the ten-week vacation requirement be met within the two and one half year period, and that an additional two-week vacation be granted each senior cadet, whether assigned to a federal or civilian hospital.

10. That any school not having some form of co-operative student-faculty government seriously consider the establishment of such an organization, in order that students be prepared for active, intelligent co-operation in "student co-operative government" in federal services.

11. That the record form prepared by the State Board Problems Committee be used for recording and reporting senior cadet experience and instruction in all civilian hospitals and agencies accepting senior cadets.

12. That written agreements be drawn up between the home school and any hospital or agency to which a senior cadet is assigned, as recommended in Government Circular, No. 1, page 2, under caption "Rôle of the Home School," and in the article "The Senior Cadet Nurse," by Mrs. Eugenia K. Spalding.[1]

13. That all plans for senior cadet experience be approved by the New Jersey State Board of Examiners of Nurses.

In planning service assignments for senior cadets several types of supervised experience are recommended for consideration. Public health, psychiatric, and communicable disease nursing as off-campus experience are desirable, while operating room, medical, nutrition, obstetric, pediatric, outpatient, and private floor services, in addition to the basic course, would in most instances be used either on or off campus. It is urged in choosing elective services that careful consideration of the faculty be given to the strengths, weaknesses, and preferences of each student in relation to her basic program of experience and instruction.

Students carefully selected because of special interest, aptitudes, experience, or educational background might be assigned to assist instructors, or to learn assistant head nurse work.

While it is hoped that all students may have at least one elective service assignment, it is important that each cadet be conscious of her opportunity to serve the needs of nursing service in any department for a limited period of time. Care should be taken, however, that student exploitation be assiduously avoided.

The committee suggests that payment of the government stipend be withheld during illness and/or absent days to save possible complications that might arise when the student is making up time lost. In case of schools allowing a specified number of days for illness, any ill or absent days *beyond* the specified days allowed would not include payment of stipend.

At the request of principals of schools of nursing in New Jersey, the State Board Problems Committee and three appointed principal representatives have formulated additional policies relating to the U. S. Cadet Nurse Corps uniform supplementary to the currently issued directive from the U. S. Public Health Service, Division of Nurse Education.

[1] *Am. J. Nursing*, Vol. 43, pp. 749–751 (Aug.) 1943.

Financial Support for Hospitals

Most of the funds for operating costs of hospitals are derived either from patients' fees or from government appropriations. Contrary to the assumption of many people that nonprofit hospitals are largely supported by the contributions of public spirited and generous benefactors, voluntary donations are a minor factor in defraying operating costs except in the small group of nonprofit tuberculosis hospitals. General and special hospitals received more than half of their funds from patients, about a third from tax funds, and about one-eighth from other sources. The responsbility of financing long-term care for tuberculosis and mental patients has been largely taken over by government agencies.—Pennell, E. H.; Mountin, J. W.; and Hankla, E.: *Hospitals* (April) 1938; as adapted by Bachmeyer, Arthur C., and Hartman, Gerhard in *The Hospital in Modern Society*, Commonwealth Fund, '43.

STUDENT NURSES PAGE

National Induction as Seen by a Cadet Nurse

TODAY I stood in the midst of the 750 cadet nurses at Constitution Hall in Washington, D. C. and repeated our induction pledge as administered by Dr. Thomas Parran, Surgeon General of the U. S. Public Health Service.

I have been enrolled in the Corps about six months but I have been too busy to stop and think about things. I chose to be a cadet nurse because I wanted to continue my education and still be of help in the crisis that faces my country.

When I entered Constitution Hall on May 13 in the opening processional for the national induction of cadet nurses, some feeling started deep inside me and, at the end of the ceremony as I sang the stirring new Corps march, I had a deep feeling of thankfulness and pride in my chosen profession.

On the stage forty-eight of our cadet nurses stood before the flags of the different states. A cadet nurse guarded the impressive flag of the Surgeon General of the U. S. Public Health Service—blue, with caduceus and anchor—and another stood watch over the brave new banner of our Corps, gray field with silver Maltese cross blazing in a center of red. After we were seated while Captain Burgess Meredith, USAAF, more familiar to us as a motion picture star, described the beautiful scene, the huge flag of the United States rippled down from the ceiling and came to rest far above our heads.

Mrs. Roosevelt painted an interesting picture of nursing as she has witnessed it on the actual battlefields of the world, and she commended us for our work on the home front. She told us that many a man will come out of this war owing his life not only to the doctor who may have operated on him but to the nurse who watched over him.

When the voice of Bing Crosby came through from Hollywood singing a song dedicated especially to us, a wave of approval swept over our gray-suited ranks; and when Helen Hayes stepped to the center of the stage and gave us a story "Remember Tomorrow," a warm and moving picture of the gift the cadet nurses are bringing to suffering people in our country, I glanced rapidly about me and all eyes were misty. I hope you heard her, too, because misty eyes are good for you when your feelings have been deeply stirred.

Congressman Frances P. Bolton, who sponsored the Act that made our Corps a reality on June 15, 1943, praised the work we are doing to relieve the critical shortage of nurses for both armed services and hospitals caused by wartime demands, and she explained to the vast audience the functions of the Corps to assure a continuous flow of graduate nurses pledged to essential nursing for the duration.

In St. Louis

Day Photographers

In Washington: Representative Frances P. Bolton; Dr. Thomas Parran, Surgeon General, USPHS; and Lucile Petry, Director, U. S. Cadet Nurse Corps.

In New York: Kathleen Kelly, Lenox Hill; Dorothy Rasan, Kings County; Mayor La Guardia; and Agnes Krudys, Metropolitan Hospital School of Nursing.

All these words of praise made you proud of the gray suit you were wearing, its red epaulets, and sparkling silver insignia. It made the long hours of work behind you seem like a mere nothing and the hours to come a privilege to be anticipated.

I realized for the first time the vast scope of the Cadet Nurse Corps membership of approximately 96,000 when our dynamic leader, Miss Lucile Petry, Director of the U. S. Cadet Nurse Corps, extended a cordial welcome to us and to the young women in a thousand schools of nursing over the nation. She expressed my feeling about the Corps when she said, "In taking unto yourselves the task of ministering to the wounded and the sick on the battle fronts or wherever you are called, you are carrying on a tradition which represents the finest in American womanhood."

Dr. Parran reminded us that this was a great moment in our lives, one we would treasure in years to come, and he said that it was also a great moment for him as Chief of the Service that administers our Corps to stand before us and hear our induction pledge.

> I am solemnly aware of the obligations I assume toward my country and toward my chosen profession;
>
> I will follow faithfully the teachings of my instructors and the guidance of the physicians with whom I work;
>
> I will hold in trust the finest traditions of nursing and the spirit of the Corps;
>
> I will keep my body strong, my mind alert, and my heart steadfast;
>
> I will be kind, tolerant, and understanding;
>
> Above all, I will dedicate myself now and forever to the triumph of life over death. As a Cadet Nurse, I pledge to my country my service in essential nursing for the duration of the war.

In unison we affirmed our awareness of our obligation toward our country and profession.

> The Maltese cross is marching again
> To answer the call, a new Crusade . . . .

I joined my fellow cadet nurses again in the rousing new Corps march. I thought of the thousands of cadet nurses who were listening in wards and in small hospitals, taking a little time to receive this commendation, but not much because there was work to be done, the job of guarding our country's strength and might from coast to coast.

It is hard to describe the thrills I received from the first national induction day program. I suppose I can sum it up by saying that I am determined to keep the lamp of personal interest in my profession ever burning to help preserve a world where free men live.

Virginia de Carvalho

In San Francisco

LETTERS FROM READERS

The ICN Latchstring Is Out

With the new offices of the International Council of Nurses located in New York City we hope that we can increase our activities and our usefulness. We are very anxious to get in touch with foreign nurses in this country. We want them to get acquainted with our aims and our work and to feel that they can use us for any help or advice we may be able to give. We want to know of the nurses coming to this country to study or having had their professional education in other countries and now working or seeking work in the U. S. A.

American nurses are, of course, most welcome to visit us at any time.

The office hours are from 9:00 A.M. to 5:00 P.M.—ANNA SCHWARZENBERG, Executive Secretary, International Council of Nurses, 1819 Broadway, New York 23, N. Y.

Courses for Nurse Anesthetists

The American Association of Nurse Anesthetists has set up a pattern curriculum which it recommends that schools of anesthesia follow. This specifies that a course should be of at least six, preferably nine months, or a year's duration. The minimum number of hours of theory is also specified.

Nurses who wish to specialize in this field would be wise to make enquiries concerning the qualifications and course offered by any school in which they contemplate studying. Membership in the AANA is often necessary in obtaining a position as a nurse anesthetist. The AANA does not admit to membership graduates of courses which do not give the minimum amount of theory and meet the minimum time requirements.

In the future, the Association plans to admit to membership by examination. It is doubtful if applicants who have taken courses which do not meet the minimum requirements will be eligible to attempt or be able to pass the examination.

The Association urges prospective anesthetists to make a thorough investigation before deciding on a school. Specific enquiries concerning the curriculum and length of course should be made. The executive secretary of the Association will be glad to answer enquiries addressed to her.—ANNE M. CAMPBELL, Executive Secretary, AANA, 18 East Division Street, Chicago, Ill.

Senior Cadet Experience

Senior cadets who read the statement on the plan of the Visiting Nurse Society of Philadelphia in the March *Journal*, page 261, or senior cadets who are interested in the plan of the Visiting Nurse Society may secure further information by writing to the director of the Visiting Nurse Society of Philadelphia, 1340 Lombard Street, Philadelphia, Pa.—RUTH W. HUBBARD, R.N., General Director.

Army Nurses' Rank Bill

In the March 27 issue of *Army and Navy Journal*, the Secretary of War opposed the Bill HR 3761, giving permanent rank to the Army Nurse Corps, with the opinion that the present would not be "an appropriate time to enact permanent legislation affecting the peacetime organization."

Major General Norman T. Kirk, Surgeon General, U. S. Army, who wrote "Girls in Foxholes" gives high praise to the Army nurses (May *American Magazine*). He says: "And if those three American soldiers at the front didn't know until that shocking moment what the Army Nurse Corps is up against in this war and how kindly and courageously they are doing their job, it is unlikely that all the people here at home realize the toil and danger those women are enduring so cheerfully to keep our soldiers comfortable and happy on the fronts of the world. . . . .

"But we've had some criticism, nevertheless, for sending women [Army nurses] so far forward. Not from the women. There isn't one at the front who would quit if she could. Not a nurse has been returned from the front who hasn't begged, sometimes with tears in her eyes, to go back. And every woman in the service at home or in critical areas abroad is eager to go to the battle zones."

Keeping in mind that all other women in the armed service are on the same status as the men in their branch, *will the American Nurses' Association allow the Army Nurse Corps to be underrated by legislation?* Surely, that organization, permanent and of long duration, can do for the Army Nurse Corps what Colonel Oveta Hobby was able to do for the WAC. To give nurses a permanent commission not only will lessen our present difficulties but will ensure a sound future for the nursing profession. —R.N., Nebraska.

[For information about what the American Nurses' Association is doing in regard to pending legislation affecting rank of Army nurses, see the May *Journal*, page 421.—EDITOR.]

Clubwork as a Hobby

As a school nurse and as a private duty nurse I neglected my off-duty hours. Later when I was a housewife and mother I became interested in club and community work. I began to see that newspaper people, lecturers, doctors, and other professional people have problems similar to ours, but they appear fresher because they keep up their interest in the work of other fields.

I realize now why nurses are so mentally tired. They need more contacts with other people.

Many colleges and schools offer courses in art, music, drama. Gardening is a good out-door activity and the garden encyclopedia has helped me to combat the disease which had infested my prize perennial phlox. As chairman of the publicity committee of my garden club, I have discovered an entirely new field, the newspaper world.—MRS. ERMEL SLOCUM TORREY, R.N., Maryland.

Housecleaning in a Station Hospital

We found our hospital to be in barracks, which had been occupied by the French and Germans before us, and inches thick with dirt and débris. Whole corners of buildings had been blown away. We knew the task before us would require hours of work, but with determination the Army nurses rolled up their sleeves, and started "housecleaning."

Handles were put on mops, brushes and brooms were improvised by tying handfuls of stiff weeds together, or covering a wooden block with heavy canvas and attaching a handle. Walls and floors were cleaned and scrubbed. Mosquito netting and cardboards nailed over windows substituted for the missing panes of glass. Heavy iron cabinets, left by our predecessors, were scrubbed and painted. Chart racks were made from packing cases, the nurses notching them with a jackknife. Cutlery boxes, chairs, tables, and desks were

made by the carpenters and corpsmen, but one of the most finished desks, complete with drawers, was made by a nurse. Equipment was unpacked and put in order. Beds made with new, glistening white sheets, soon stood in tidy, even rows, waiting for the patients.

All kinds of improvisations were made by the personnel, all working toward a common goal. The doctors were there with help, when needed. The supply department found a number of "little red schoolhouse" desks and benches that were placed in the ward offices. Paper napkins, which somehow we have never lacked, were used for everything, trays, covers, packaging supplies; old gasoline cans make excellent waste baskets, smaller cans, with two niches in the side, served well as ash trays. Red nail polish (which the nurses parted with sadly) was used for marking equipment. In an inconceivably short time—ten days—our station hospital was ready to receive patients.

The ambulances streamed steadily up the hill, week after week, bringing all types of diseased and injured. The nurses gave wet packs for those burning with fever. They administered sulfaguanadine, bismuth, and paregoric, until no more of the latter could be found. With a minimum of equipment and segregation of communicable diseases, there was never one cross-infection.

Then came the Sicilian invasion. The ambulances came day and night. The Army nurses worked twelve hours, fifteen, eighteen, but the wounded were bathed, fed, and given expert nursing care. There was a preponderance of shrapnel wounds and burns requiring skilled and sympathetic treatment.

Nurses did more than care for the physical needs of the patients on their wards, they brought cheer and comfort, and lifted the morale of the men who had spent endless days and nights in fox holes. "Nurse, I'm dead," one patient said, "and you're an angel from heaven. Just say something! Let me hear you talk." One patient said about one of the nurses who had cared for him when acutely ill, "You know, you can talk to her and she understands."

Arabic and French children, victims of war or automobile accidents, malnourished and diseased infants, brought to the hospital by frightened mothers, received care until hospitalization could be arranged for them elsewhere. The nurses brought hair ribbons for these children and their own clothing to replace the rags, bathed, fed, and lavished affection upon them, and when medical, surgical, and nursing skill could not save their lives, wept for them.

When there was a lull in the nursing activities in the hospital, additional off-duty time was given the nurses to make trips to the beaches, to visit historic ruins, and nearby cities. They came home with silver bracelets, gay-colored scarves, exotic perfume and rings, all kinds of souvenirs to send to family and friends at home. They came back with renewed vigor, refreshed from play on the shores of the blue Mediterranean, and ready to meet whatever the morrow might bring.

The Army Nurse Corps will come through wherever they may be.—First Lieutenant Mary Ann Harman, ANC.

Pioneering in Splendor

I am again in a new country and am very happy to be here. We had a lovely sea trip. The cabins were large and comfortable, the beds soft and clean, our meals excellent. We expected, on landing, to be billeted under canvas with our hospital set up in tents, but were amazed and delighted to find that we were to have a museum for our hospital building and that our quarters were to be in an apartment house. Our new home has seven large and beautifully furnished rooms, apparently abandoned in a hurry and left almost intact. We have a huge dining room with two china closets still completely filled with exquisite dishes and glassware. It is all so lovely and must have broken someone's heart to leave it all behind. Our living room has walls finished in gold brocade and is hung with paintings.

In my beautifully appointed chamber is a wardrobe, with full length mirror for a door, in which I have hung my one lone extra garment, my top coat. A bed was acquired only after some difficulty and many nights spent sleeping on the tiled floor sans bed, mattress, or much covering. At present, we have no light, heat, or warm water, but there is cold water and we can do nicely as we have become used to cold water bathing and life by candlelight. As the rainy season is here, it is both damp and cold in all this splendor. However, it is a real blessing to have a roof over our heads and we are, at present, on the lookout for either quilts or comforters to supplement our Army blankets.

This city has been subjected to repeated bombings, but the morale of the inhabitants is good. These people live in fear of what may come, it is in their faces.

We have been very busy in the hospital, cleaning, mopping, scrubbing down the walls and in general attempting to convert it into a place where patients can be cared for with dispatch and efficiency. The Navy gave us many lovely things to eat. For their generous gifts of food and candy we have been very grateful as for several days after our arrival we lived on K-rations which are nutritional marvels, but not very satisfying to our healthy appetites.—Lieutenant, ANC.

Correction

On page 387 of the April *Journal* the title of Miss Kraus' position was incompletely given. Miss Kraus is family health adviser at Syracuse (N. Y.) Memorial Hospital and instructor in public health nursing at Syracuse University School of Nursing, not at Syracuse University as the note indicates.—Editor.

Practical Nurses Preferred?

Why is it that doctors prefer male practical nurses rather than registered nurses to handle heart condition cases? I will tell you. Most of the women nurses refuse to work twelve hours a day while a male practical nurse will. —E. J. S., Practical Nurse, Wash.

The *Journal* at the Front

The March *Journal* with its article on the care of patients coming out of plaster casts was very timely. We have a great deal of work on cast cases and any article pertaining to our work is read by all. I am placing my copies in our medical library.—Second Lieutenant Agnes M. Plantier, ANC.

I have been overseas a year and have received every copy. Often it has been two months late, but it has always been more than welcome. The articles on amputations came just right for us as we seem to have many such patients now. Their morale has come up when they have been told what can be done. One young air corps captain had a big lift when he read the article "An Amputated Leg at Twenty-one."—Captain Dorothy Parsons, ANC.

Sign Your Letter!

Letters should not exceed 250 words and should be signed. Your signature to a letter indicates that you are willing to stand back of the statements you make. Your name will not be published if you so wish, and your name will be held in confidence.

The editors are not responsible for opinions expressed in this department.—Editors.

NEWS ABOUT NURSING

News from National and State Nursing Councils

Postwar Planning

The Board of Directors of the National Nursing Council for War Service at its April meeting recommended the appointment of a National Nursing Planning Committee. The function of this committee would be to formulate a five-year program co-ordinating the postwar activities of all member agencies of the Council. Membership would consist of the chairmen of the postwar planning committees of the member agencies, the presidents of their boards, and the chief executives of their staffs. Member agencies will be asked to vote on this recommendation at their next meetings.

Procurement and Assignment

Classification of nurses in thirty-eight states is progressing rapidly. In thirty-two states reporting, 60,000 nurses have been classified: about 13,000 in class 1-A; 400 in class 2-A; 12,500 in class 3; and 20,000 in class 4. Of those classified in twenty-three states 44 per cent are in hospital service, 9 per cent in public health nursing, 7 per cent in nursing education, 5 per cent in industry, and 35 per cent in other groups including private duty nursing.

The Council's *National Classification Committee* has cards of information on about 1,500 nurses, employed by national agencies or organizations, whom it plans to classify. The committee is responsible for classifying nurses employed by the following: federal nonmilitary hospitals and services, the national nursing organizations, the Metropolitan Life Insurance Company, and the John Hancock Insurance Company, and various commercial agencies such as railroads, air lines, publishers, and manufacturers.

One hundred and thirteen of the 173 national agencies or organizations have been heard from to date. Marian W. Sheahan (New York State Department of Health) is chairman of the committee, and Mrs. Hope Newell (formerly Henry Street Visiting Nurse Service) is its executive secretary.

New York.—The sixty-one county medical societies in the state were asked to permit a representative from the state P&AS committee to discuss the procurement and assignment program for nurses at their meetings. A similar effort is being made to reach the regional hospital associations in the state.

Recruitment

New members of the NNCWS Recruitment Committee present at the recent meeting (New York, April 26–27) were Katharine J. Densford (School of Nursing, University of Minnesota) and Dora Mathis (Protestant Episcopal Hospital School of Nursing, Philadelphia). Edith Smith (School of Nursing, Syracuse University) presided as chairman. Stanley Clague, President of the Chicago Rotary Club, attended the meeting as a representative of Rotary International on the committee.

Thirty-six state councils have completed their reorganization under the new recruitment plan. They now have on their recruitment committees a nurse recruitment officer and a deputy recruitment officer (the former a council representative who in many states is also the recruitment chairman, and

Number of Nurses To Be Assigned to the Army and Navy Nurse Corps from May 1 to June 30, 1944

Released by War Manpower Commission, Procurement and Assignment Service

State	Quota Jan.–June 1944	No. Yet To Be Assigned	State	Quota Jan.–June 1944	No. Yet To Be Assigned	State	Quota Jan.–June 1944	No. Yet To Be Assigned	State	Quota Jan.–June 1944	No. Yet To Be Assigned
*Ala.	34	0	*Iowa	92	0	*Nebr.	42	0	*R. I.	44	0
Ariz.	46	19	*Kan.	54	0	Nev.	5	2	*S. C.	37	0
*Ark.	6	0	*Ky.	30	0	N. H.	64	24	S. D.	31	0
Calif.	748	391	La.	53	7	N. J.	295	88	*Tenn.	42	0
Colo.	76	25	Me.	68	28	*N. M.	8	0	*Tex.	135	0
Conn.	357	214	Md.	146	16	N. Y.	1,957	1,328	*Utah	23	0
Del.	30	13	Mass.	434	97	*N. C.	76	0	Vt.	56	31
D. C.	163	48	*Mich.	230	0	N. D.	33	4	Va.	81	
Fla.	68	0	*Minn.	204	0	Ohio	377	51	Wash.	97	
*Ga.	43	0	*Miss.	11	0	*Okla.	24	0	*W. Va.	47	0
*Idaho	11	0	Mo.	138	4	Ore.	78	15	*Wisc.	136	0
Ill.	481	65	*Mont.	36	0	*Pa.	638	0	*Wyo.	8	0
*Ind.	107	0									

* The states starred had more than met their quotas by May 1, 1944.

the latter a representative of the state hospital association serving as vice-chairman of the recruitment committee). Both are appointed on a dollar-a-year basis by Surgeon General Thomas Parran, and receive from the U. S. Public Health Service travel expenses and franking privileges. The function of the recruitment officers is to stimulate and co-ordinate the work of local recruitment committees throughout the state, particularly the follow-up of prospective candidates for schools of nursing. The nurse recruitment officer has received permission to wear the uniform of the U. S. Cadet Nurse Corps, with special insignia.

Recruitment plans.—The college counseling program, undertaken this year under the joint auspices of the Council and the U. S. Cadet Nurse Corps, has aroused widespread interest among educators and undergraduates in the 612 colleges and junior colleges visited. The Clearing Bureau has an increasing number of inquiries about degree programs offered collegiate schools of nursing throughout the states.

Local councils are urged to offer their help to high school vocational counselors in screening prospective candidates for schools of nursing and to aid them in the application of the guidance principles laid down in the new pamphlet, *Professional Nurses Are Needed*, which has been prepared by the Occupational Information and Guidance Service, Vocational Division, U. S. Office of Education.

Many Rotary and other civic clubs, and state branches of the Women's Auxiliary of the American Medical Association are assisting with recruitment.

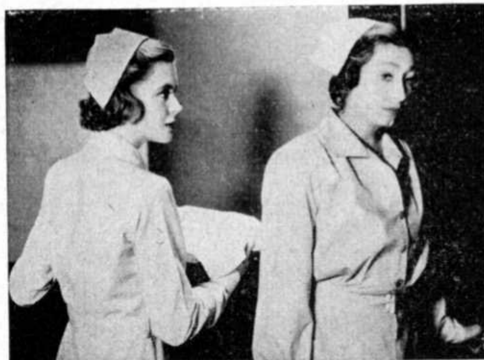
Mary L. Foster (Massachusetts General, Boston; B.S., Simmons College) has been appointed recruitment secretary to the Council. Miss Foster has served as head of the Clearing Bureau since June 1943, answering and following up thousands of enquiries about admission into schools of nursing and enrolment in the U. S. Cadet Nurse Corps.

U. S. Cadet Nurse Corps

Cadet Corps Plans for the Coming Year

Plans for the U. S. Cadet Nurse Corps for the coming year, and reports of the current year, will be discussed at the third meeting of the Advisory Committee to Dr. Thomas Parran, Surgeon General, U. S. Public Health Service, to be held in Washington, June 1–2. The Committee will consider problems of expanding schools, procurement of instructors, and many other questions.

Nurse consultants' field trips.—Since January 1 Mrs. Eugenia K. Spalding, Associate Director of the Division of Nurse Education, Minnie Pohe and Sallie Mernin, Assistant Directors, and Elsie Berdan, Marie Farrell, Jane Taylor, Mary Jenney, Wilma Stevens, and Agnes Ohlson, Nurse Education Consultants, have visited schools of nursing and consulted with school directors, state boards of nurse examiners, and state and local nursing councils in North and South Dakota, Minnesota, Wisconsin, Idaho, Colorado, Pennsylvania, New Hampshire, Kansas, Wyoming, Massachusetts, Montana, Mississippi, Rhode Island, Ohio, Texas, Alabama, Louisiana, New York, Illinois, Nebraska, and Vermont.



Dorothy McGuire, as Peggy Adams, who has just finished her course as a cadet nurse, and Aline MacMahon, the older graduate nurse, in "Reward Unlimited," Vanguard's short motion picture about the U. S. Cadet Nurse Corps

Supervised Experience for Senior Cadets Planned

New York.—Selected senior cadets will be accepted for a three or six months program of planned experience at Memorial Hospital, New York, which is one of the oldest and largest hospitals in the country devoted exclusively to the treatment of patients with cancer and allied conditions. It has a bed capacity of over 200, including a children's ward.

The program for senior cadets is planned to acquaint the student with the incidence, treatment, and prevention of cancer. Forty hours of instruction will be integrated with ward practice, placing special emphasis on specific procedures which must be carried on when the patient returns to his home.

Twenty students can be accepted for this program at one time—on the first of January, April, July, and October provided there are sufficient applicants to make up a workable group.

Georgia.—A program has been arranged for senior cadets to have supervised practice of three to six months in public health nursing on the staffs of local health departments. There will be no formal classes. A staff nurse, acting as counselor, will plan the experience of each cadet nurse and teach her the necessary technics.

Ohio.—The Toledo State Hospital (psychiatric) has arranged supervised training for two senior cadets from the Warren City Hospital School of Nursing.

Connecticut.—Another hospital offering cadets experience in psychiatric nursing is Norwich, Conn., State Hospital.

Michigan.—Several senior cadets of the Henry Ford Hospital School of Nursing, Detroit, are having experience at Tecumseh General, a rural community hospital, and others go to Maybury Sana-

torium, Northville, where tuberculosis patients receive convalescent care. Working with the W. K. Kellogg Foundation, five small hospitals in southwestern Michigan will receive cadet nurses by June 1 for experience in their medical, surgical, and obstetric departments and field work with the county health departments, welfare agencies, and other community resources associated with the participating hospitals.

Maryland.—Four senior cadets from Johns Hopkins will have experience in rural district nursing with the Frontier Nursing Service, in Hyden, Ky. The Service will provide for the maintenance of cadets and their horses, riding uniforms, et cetera.

Tennessee.—The students admitted to St. Thomas, Nashville, in March, are enrolled at Peabody College for Teachers for courses in social, physical, and biological science. They will have full college credit for these courses. Students of Protestant Hospital School also, entering in June, are enrolled at Peabody for their science courses.

The Methodist Hospital School of Nursing, Memphis, has arranged with the Memphis State Teachers College for the students entering June 1 to live on the college campus while taking courses in social, biological, and physical sciences there. They will go to the hospital for their professional courses.

Senior Cadets in Federal Government Hospitals

On May 4, President Roosevelt signed the executive order setting $60 as the monthly rate of pay for senior cadets having supervised experience in federal government hospitals and agencies. Members of these nursing services have been appointed to direct the program of experience (see the May *Journal* page 500 and this issue page 604).

On May first, 148 senior cadets had been accepted for experience in Navy hospitals, ninety-eight had started this program. Forty-two cadets had been accepted for experience in Veterans Administration hospitals and ten had started it. Nine had been accepted by the USPHS for experience in Marine hospitals, beginning early in May.

Developments in Nursing School Programs

College Affiliations and Co-operative Programs

Iowa.—The Division of Nursing Education of Loras College, Dubuque, offers a five-year degree program in co-operation with the schools of nursing of St. Joseph Mercy Hospital in Dubuque and Mercy Hospital in Cedar Rapids. Students have three years' work with the hospital schools, receiving college credit for courses taken in the school of nursing. At the completion of two or more years of college they receive the Bachelor of Science degree. There are now ten students enrolled in the five-year course.

Sister Marie Jeanne d'Arc (St. Joseph Mercy, Dubuque, Iowa; B.S., Our Lady of Cincinnati College, Cincinnati, Ohio) is chairman of the Division of Nursing Education at Loras College. Serving with other members on the Advisory Board for the Nursing Division are **Mother M. Carmelita,** Provincial Sisters of Mercy, Detroit, Mich.; **Mother M. Maura,** Superior Sister of Mercy, Cedar Rapids; and **Sister M. Barbara Ann** (Mercy, Cedar Rapids, Iowa), Director of Mercy School of Nursing in Cedar Rapids.

Students enrolled in the schools of nursing of Methodist and Lutheran Hospitals in Sioux City, have many of their preclinical classes at Morningside College. They live on the campus for five months attending college for four days weekly. The fifth day is spent in the home school where nursing arts and professional adjustments are taught. The faculty consists of members of the college and the nursing schools. Additional housing and classroom facilities have been made available by this means.

Students are selected by and enrolled in their respective schools before taking the courses at Morningside College. This program, organized for the preclinical period, has been approved by the Iowa Board of Nurse Examiners.

Thelma Biddler (Oklahoma State Hospital School of Nursing) is director of the Methodist Hospital School of Nursing, and **Jean Wessels** (Augustana, Chicago) of the Lutheran school.

South Dakota.—Eight of the ten schools of nursing approved by the State Board send their students to colleges or junior colleges for instruction in the science courses (anatomy and physiology, microbiology, chemistry, and in some instances for psychology, sociology, and mental hygiene). The colleges that are providing this instruction are: Augustana College, Sioux Falls; Dakota Wesleyan University, Mitchell; Northern State Teachers College, Aberdeen; Mount Marty Junior College, Yankton; and Huron College, Huron.

Washington.—The Deaconess School of Nursing, Spokane, offers a three-year basic program in nursing in co-operation with Whitworth College, Spokane. Classes will be admitted in June and September this year, and thereafter in March, June, and September. Students will spend their first two quarters (six months) in Whitworth College where full college credit will be given, and the remainder of the time at Deaconess Hospital, where they will have instruction from both school of nursing and college faculties.

R. Eline Kraabel (Emanuel, Portland, Ore.; B.A., St. Olaf College, Northfield, Minn.) is director of the Deaconess school.

Tennessee Schools Share Teaching Facilities

Students of three schools of nursing in Tennessee have an eight-week affiliation in psychiatric nursing at the Veteran's Administration Hospital in Murfreesboro. They are from the schools of Vanderbilt University, Nashville; Baroness Erlanger, Chattanooga; and Appalachian, Johnson City.

The schools of Protestant, St. Thomas, and Nash-

ville General Hospitals, all in Nashville, are conducting several lecture courses jointly.

Summer Preclinical Program at Goucher

Goucher College, Baltimore, Md., will again conduct a summer preclinical program from June 12 to September 2. The program is administered under the joint auspices of the schools of nursing of Johns Hopkins Hospital and the Church Home and Hospital in co-operation with Goucher College. Students must be accepted for admission by one of these participating schools of nursing.

Jessie B. Black, Associate Director of the School of Nursing and Nursing Service at Johns Hopkins, will be dean, with a faculty of fourteen others.

Cook County School Experiments with Phonographic Recordings

The Cook County School of Nursing began the first of a series of recordings of doctors' lectures in March in order (1) to preserve the information which has been assembled for the course in "Introduction to Medical Science," by Dr. Arthur Bernstein, who has taught this course from the time it was organized, and (2) to experiment in the use of the technic of phonographic recordings as related to the teaching program in the school of nursing. This series of recordings was approved by the Board of Directors of the school.

The recorded lectures are not intended to replace doctors' lectures in the curriculum. They are admittedly a makeshift to be utilized during the period of wartime conditions; considerable study and practice will be necessary in order to use the technic wisely.

Four faculty members who accompanied the physician to the studio for the recording are serving as a committee to determine ways to improve the technic and content of the lectures and to assure that the students receive the maximum benefit from the recorded lectures.

The records will be audited by the faculty and by groups of students who have already had the course.

The nurse proctor of the course is responsible for supplementing the recorded lectures with outlines and illustrative material.

Housing Enlarged Classes

Texas.—The Victory Hotel, adjacent to the campus of Baylor University, Dallas, has been purchased by the university to be renovated and remodeled as a residence for student nurses admitted in June. The average prewar enrolment of the school of nursing was 165; the present enrolment is 196. The purchase of the hotel will enable the school to increase the enrolment by approximately fifty.

New York.—The Adelphi College School of Nursing, Garden City, Long Island, dedicated two new residence halls on May 6. These dormitories, each housing 100 students, were constructed, furnished, and equipped under Lanham Act funds.

Each building has fifty double bedrooms, laundry, lounge, reception room, and study lounge with kitchenette. After the war, the college proposes to purchase the buildings from the government, making them available to all students in the college.

Three hundred thirty-five students are enrolled at Adelphi; 303 are in the Cadet Nurse Corps.

The college used the dedication ceremony to interpret collegiate nurse education and the vital war need for nurses to friends, college personnel, and the community. Eminent speakers were present.

With Army and Navy Nurses

Five More Nurses Receive The Purple Heart

The Purple Heart has been awarded to five more Army nurses for wounds received as result of enemy action in Italy. They are: **Second Lt. Irene V. Barton** (County Hospital School of Nursing, Anderson, S. C.), **Second Lt. Ruby L. Hoppe** (University of Missouri School of Nursing, Columbia, Mo.), **Second Lt. Helen A. McCullough** (Baylor University School of Nursing, Dallas, Tex.), **Second Lt. Frances V. Raymond** (St. Paul's, Dallas, Tex.), **Second Lt. Ruth C. Sobeck** (Shadyside, Pittsburgh, Pa.). (See also the May *Journal*, page 497.)

Army and Navy Need More Nurses

On May 5, it was announced that the authorized strength of the Army Nurse Corps has been raised to 50,000 to meet the needs of an increased number of hospital trains planned for service, added station and general hospitals, and nursing service aboard ships.

Present strength of the ANC is 38,500. The authorized strength of 50,000 is a ceiling. Actual appointment of nurses will be determined by the needs of the Army in relation to casualties, and by the rate civilian nurses are declared available by the Procurement and Assignment Service of the War Manpower Commission.

According to a release of April 17, an additional 1,800 Navy nurses must be procured to meet the Navy's June 30 quota; another 2,000 nurses will be needed by December 20.

New state quotas will be released soon. The number of nurses still to be assigned to meet the January–June quotas is shown on page 596.

Recent ANC Promotions

Eight more nurses now wear the silver oak leaf. They are **Lieutenant Colonels Edna L. Mahar** (Kennedy General Hospital, Memphis, Tenn.), **Ruth C. Anderson** (Cushing General Hospital, Mass.), **Lila A. Condon** (Camp Lee, Virginia), **Beatrice M. Quin** (Batty General Hospital, Rome, Ga.), **Edna M. Rockafellow** (Thayer General Hospital, Nashville, Tenn.), **Harriet M. Whitney** (AAA Regional Station Hospital, Coral Gables, Fla)., **Alice A. Becklen** (Fort Bragg, N. C.), and **Harriet P. Hankins** (AAA, Greensboro, N. C.).

The gold oak leaf now appears on the shoulders of

Majors Jessie E. Locke (Schick General Hospital, Clinton, Iowa), **Margaret M. Kennedy** (Winter General Hospital), **Bernice W. Chambers** (Sheppard Field, Texas), **Edna M. Aycock** (155th General Hospital), **Elizabeth Hansbrough** (Patterson Field, Fairfield, Ohio), **Alice C. Wickward** (Hq. 2d Air Force, Colorado Springs, Colo.), **Ruth Y. Ritenour** (Maxwell Field, Ala.), **Mabel Embery** (Randolph Field, Tex.), **Mary R. Leontine** (AAF School of Air Evacuation, Bowman Field, Ky.), **Maude Bowman** (Stark General Hospital, S. C.), **Pruella H. Droddy** (Tilton General Hospital), **Gertrude S. Evert** (Camp Myles Standish, Mass.), **Margaret M. Millington** (Moore General Hospital, Swannanoa, N. C.), **Mary Miller** (Camp Shanks, N. Y.), **Madolin E. Milheim** (Camp Stewart, Ga.), **Doris E. Medlin** (Camp Kilmer, N. J.), **Agnes A. Maley** (Camp Blanding, Fla.), **Marjorie Peto** (2d General Hospital), **Caroline C. Hageman** (Camp Rucker, Ala.), **Marie E. Reiners** (Kearns AAF, Utah), **Mabel G. Stott** (Lawson General Hospital, Ga.), **Alta Berninger** (Ft. Benning, Ga.). **Evangeline A. Poyet** (Finney General Hospital, Thomasville, Ga.), **Mary B. Schick** (Ft. Jackson, S. C.), **Willie P. Harris** (Camp Van Dorn, Miss.).

Recent Promotions in the Navy Nurse Corps

On the first of April 173 Navy nurses who were ensigns of the Regular Corps and 209 who were ensigns of the Reserve Corps were promoted to the rank of lieutenant junior grade.

Two Army Nurses Retire

Captain Anna Louise Barry (Kings County, New York), who entered the Army Nurse Corps in April 1918 and served overseas with Base Hospitals 37, 118, and 69, is retired after twenty-five years of active service in both the United States and the Philippines. She was serving as principal chief nurse at Deshon General Hospital at Butler, Pa., at the time of her retirement.

Captain Helena Clearwater (Army School of Nursing, Walter Reed General), who retired April 30, served in the United States and in the Philippine Department. She was at Pearl Harbor on December 7, 1941. She was awarded the Legion of Merit and was cited by Lt. General Delos C. Emmons. At the time of her retirement she was principal chief nurse at Rhoads General Hospital, Utica, N. Y.

All Army Nurses To Be in Olive Drab

Olive drab uniforms for Army nurses have been authorized for wear within the continental United States as well as in overseas theaters. Two complete olive drab uniforms will be issued by the Quartermaster Corps to every Army nurse not yet equipped.

Appointments to Air Evacuation Units

From ANC headquarters comes word that, at the present time, the Army Air Forces are not planning to establish new air evacuation units necessitating the assignment of nurses but replacements will be required from time to time for those units already in service.

It is planned to train one hundred nurses from Army Air Force installations every eight weeks, the nurses to be selected from those applying for the School of Air Evacuation. After their training is completed, they will be returned to their original station until a replacement is needed in one of the active units already established.

The transfer of nurses from the Ground and Service Forces to the Army Air Forces is completed in the same manner as the transfer of any officer, enlisted man, or WAC. It can be done only by the mutual concurrence of the two commanding generals concerned; that is, the commanding general of the Air Forces, General Arnold, and the commanding general of the other service involved.

At the present time the Army Air Forces are not assigning nurses directly to their service from civilian life.

Army Nurse Christens Destroyer

The destroyer U.S.S. "Hyman" was launched in April after being christened by **Second Lieutenant Edwige Brechon Hyman,** whose husband, Lieutenant Commander Willford Milton Hyman, USN, went down with the destroyer "Sims" in the battle of the Coral Sea and was posthumously awarded the Navy Cross for extraordinary heroism. Lieutenant Hyman is a graduate of the Auburn City Hospital School of Nursing, and is now stationed at England General Hospital, Atlantic City.

Pledge of the Army Nurse

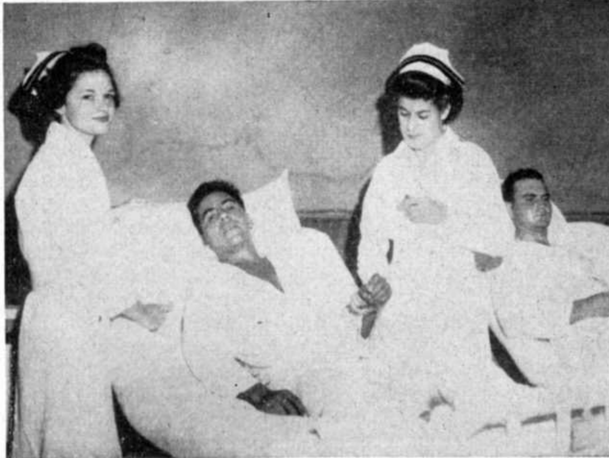
The recently released pledge of the ANC makes one feel that there is no need for worry about the type of women who care for our soldiers at home or abroad.

> As an Army nurse, I accept the responsibilities of an officer in the Army Nurse Corps. I will give faithful care to the men who fight for the freedom of this country and to the women who stand behind them. I shall bring to the American soldier, wherever he may be, the best of my knowledge and professional skill. I shall approach him cheerfully at all times under any conditions I may find. I shall endeavor to maintain the highest standards possible in the performance of my duties. I shall appear fearless in the presence of danger and quiet the fears of others to the best of my ability. My every criticism shall be constructive. The reputation and good name of the Army Nurse Corps and of the nursing profession shall be uppermost in my thoughts, second only to the care of my patients. I shall endeavor to be a credit to my country and to the uniform I wear.

Copies of this pledge, suitable for framing, will soon be available at the office of Colonel Florence A. Blanchfield, Army Nurse Corps, 1818 H Street, N. W., Washington 25, D. C.

Army Nurses on the "Tasman"

Sixteen Army nurses serving on the S.S. "Tasman" feel that, since they were the first complete American staffed unit to be assigned to any hospital ship in their theater of war, they should be duly



Associated Press Photo *Associated Press Photo*

Left: Ens. Elsie Lentwyler (Ft. Dodge, Iowa) and Ens. Kay Crane (Boston, Mass.) are among the Navy nurses who are caring for the wounded at Tulagi. Right: Lt. Gladys Pilger, ANC (Buffalo, N. Y.), helps give plasma to a wounded soldier in Italy.

recognized. The *Journal's* statement in December 1943, page 1144, was all wrong. **First Lt. Margaret L. Lomen,** from South Dakota, is chief nurse, and the other fifteen nurses come from Oregon, California, Canada, Ohio, Indiana, Idaho, Washington, and Massachusetts.

The "Tasman" is not, in a true sense, a U. S. Army hospital ship; it is a Dutch ship, operating inter-island as a hospital evacuation ship, assignment of personnel made from the theater involved.

For many months before going aboard, the Army nurses now serving on the "Tasman" had special training. They had to be able to swim, and with their clothes on. They trained corpsmen and taught them hospital procedures, learned to climb up and down rope ladders and row a lifeboat, learned routines for all emergencies, made their own surgical supplies, and finally cleaned the ship from top to bottom.

At present they have seven wards on various deck levels and care for all types of patients. They have learned to rub backs equally well in an upper or lower bunk, and know many "cures" for seasickness, although none of them has been so afflicted.

They are all proud of their assignment, their medical officers and detachment, and want *Journal* readers to know that there are sixteen nurses on the hospital ship "Tasman" which sails its course somewhere in the South Pacific.

Nurse-dietitians in the Southwest Pacific

From **Lieutenant Colonel Jane Clement,** Director of the ANC in the Southwest Pacific Area, comes word that nurses are being given courses in dietetics to aid that branch of the Medical Department. Says Lieut. Colonel Clement:

> The art of cooking dehydrated foods is in a class by itself. They can be made very palatable if the cooks have knowledge of the background of the food they are preparing. Never have I tasted better doughnuts made with powdered eggs and milk, shoe string potatoes, onions, carrots, in fact, every vegetable the girls cooked, and all were dehydrated. . . . . We trained fifty-two nurses as dietitians. This will be a great asset, especially in the advance areas where small hospitals have no dietitians assigned, to have a nurse trained to help in the preparation of patients' food.

Army Nurses Stationed in China

Nine Army nurses stepped off a transport in China several weeks ago, the first to be assigned to hospital units there. (Flight nurses have been evacuating wounded from China for some time.) Having served in hospitals in Assam while their units were being established in China, these Army nurses now are working side-by-side with Chinese nurses who have been caring for sick and wounded American troops there. **First Lieutenant Essie Chevalier** (Galveston, Tex.) is chief nurse of this unit.

Army and Navy Nurses Tell Us

On May 4 more than one hundred mothers of Army and Navy nurses now serving overseas attended a tea given in their honor by the Nurse Recruitment Committee of the Brooklyn Chapter, American Red Cross, and organized the "Mothers Club of Nurses in Service." **Lt. Myrtle E. Eville,** just returned from Sicily, and **Major Kathleen H. Atto,** Assistant Superintendent, ANC, represented the daughters in service.

Plans are being made to include nursing subjects in the courses offered through the Armed Forces Institute. When the plans materialize, nurses will be able to work toward a degree in nursing while still on active duty with the Army.

Band arrangements of the "Song of the Army Nurse Corps" for Army bands may be secured by writing to the ANC Headquarters Office. (See the March 1944 issue of the *Journal*, page 293.)

About People You Know

Mrs. Opal Aldrich (Bryan Memorial, Lincoln, Neb.) became director of nursing education at Christian Welfare Hospital on January 7. Mrs. Aldrich has been science instructor at Christian Welfare during the past year, and was a fellowship student at St. Louis University 1942–1943. She was a member of the Army Nurse Corps from January to June 1941 when she was honorably discharged to be married. She is secretary-treasurer of the East St. Louis Council on Nursing.

Florence M. Clarke (University of Michigan School of Nursing; A.B., Hiram College, Hiram, Ohio; M.S., Western Reserve) has been appointed director of the school of nursing and nursing service at Kansas City General Hospital, Kansas City, Mo., effective June 1. Miss Clarke was formerly assistant director of the St. Louis City Hospital School of Nursing, St. Louis, Mo., and was previously instructor in the schools of nursing of St. Luke's Hospital, Cleveland, Ohio; University of Nebraska, Omaha, Neb.; and Madison General Hospital, Madison, Wis.

Mildred S. Lunde (Presbyterian, Chicago; B.S., Teachers College, Columbia), formerly director of nursing service at Riverside Hospital, New York, is now director of nursing service at Goldwater Memorial Hospital, Welfare Island, New York.

Alberta M. Morgan (Ohio Valley, Steubenville, Ohio), formerly on the nursing staff of Brooke and Fayette County Health Departments, is now nursing consultant and instructor in midwifery in the Division of Maternal and Child Hygiene, West Virginia State Department of Health. Miss Morgan had postgraduate work at Children's Hospital, and the University of Cincinnati, Cincinnati, Ohio, and at George Peabody College in Nashville, Tenn. She is a graduate of the School of Midwifery of the Frontier Nursing Service.

Madeleine R. Murray (Bellevue, New York; B.S., Teachers College, Columbia), formerly assistant superintendent of nurses, New York City Department of Hospitals, became superintendent of nurses at Queens General, Jamaica, N. Y., in April.

Florence L. Phenix (Weld County Hospital Training School for Nurses, Greeley, Colo.; B.S., Teachers College, Columbia) has been appointed to the Nursing Unit, Division of Health Services of the Children's Bureau, U. S. Department of Labor as special consultant nurse in crippled children's services. Miss Phenix was formerly with the Crippled Children's Division of the Bureau for Handicapped Children, Wisconsin State Department of Public Instruction, and more recently with the New York City Department of Health where she was public health nursing consultant to the Division of Physically Handicapped Children of the Bureau of Child Hygiene and part-time instructor in orthopedic nursing at Teachers College, Columbia University. She is a member of the American Physiotherapy Association, the Registry for Physical Therapy Technicians, and the Joint Council on Orthopedic Nursing to the Joint Orthopedic Nursing Advisory Service of the NOPHN and NLNE. She will act as special consultant to state agencies in orthopedic nursing and physical therapy as arranged by the regional offices of the Division of Health Services of the Children's Bureau.

Agnes A. Plikunas (Bellevue, New York; B.S., Teachers College, Columbia), since 1941 superintendent of nurses at Queens General, Jamaica, N. Y., is now director of nursing service and the affiliating school of nursing at Morrisania Hospital, Bronx, N. Y.

Marian G. Randall (Samaritan Hospital School of Nursing, Troy, N. Y.; B.S., Teachers College, Columbia) has been appointed director of Henry Street Visiting Nurse Service of New York, effective June 1. **Elisabeth C. Phillips,** Acting Director, will resume her former position as assistant director.

From 1930 to 1937, Miss Randall was a member of the research staff of the Milbank Memorial Fund for which she conducted a series of administrative studies in public health nursing. She served as assistant director of the Henry Street Visiting Nurse Service, in charge of records and statistics, from 1938 to 1941, when she became nursing consultant in the Medical Division of the U. S. Office of Civilian Defense. Since completion of this assignment she has been making a study of prepayment plans for nursing service for the Associated Hospital Service of New York.

Mary A. Rinker (Christian Welfare, East St. Louis, Ill.), who has been nursing arts instructor and assistant director of nurses in her alma mater since 1938, was appointed director of nurses there as of January 3, 1944.

Sister Mary Silveria (Halstead Hospital School of Nursing, Halstead, Kan.) has returned to Mercy Hospital, Parsons, Kan., as director of nursing service and of the school of nursing.

Elsa E. Storm (Peter Bent Brigham, Boston, Mass.; B.S., Teachers College, Columbia), since 1940 director of nursing service and of the school of nursing at William Backus Hospital, Norwich, Conn., becomes superintendent of nurses at Peter Bent Brigham Hospital on July 1. Miss Storm was formerly on the staffs of Waterbury (Conn.) Hospital; Highland Hospital, Rochester, N. Y.; and Springfield (Mass.) Hospital.

Edith G. Willis (Wesley Memorial, Chicago), for the past thirty-seven years superintendent of the Good Samaritan Hospital and of its school of nursing, Vincennes, Ind., and **Winifred McCabe** (Epworth Hospital School of Nursing, South Bend, Ind.), surgical supervisor and assistant superintendent, resigned on May 1.

Miss Willis has been associated with Good Samaritan almost continuously since 1907 when she began preparations for the opening of the hospital, a county institution, in 1908. The development of the outstanding service which it has rendered to the community is largely due to the unusual business ability and high professional standards which she

Bachrach

Left: Katharine S. Read, R.N., Superintendent of Nurses, U. S. Public Health Service, Hospital Nursing Service, from 1935 to 1944. Center: Marian G. Randall, R.N., Director of Henry Street Visiting Nurse Service of New York. Right: Ruth G. MacDonald, R.N., General Secretary of the Tennessee State Nurses Association and Executive Secretary of the State Nursing Council for War Service.

brought to the task of co-ordinating the efforts of all the groups concerned with the organization and administration of a complex service to the community. The school of nursing was strengthened by affiliations for services not provided by the hospital.

Miss Willis was president of the Indiana State Nurses Association from 1916–1918, and she has also served on committees, as chairman of committees, and as chairman and president of her district association. She contributed generously to the collection of data for the history of Indiana hospitals and schools of nursing, a task that is not yet completed. From 1923–1926 she served on the Indiana State Board.

Miss McCabe has been associated with the Good Samaritan Hospital continuously since 1914. Before that she was assistant superintendent of Epworth Hospital, South Bend.

Changes at Baylor University School

The Baylor University School of Nursing, Dallas, Texas, announces the following faculty appointments.

Ruth Thompson (Montefiore, Bronx, N. Y.), formerly on the staff of Fordham University Hospital, Bronx, is now clinical supervisor in orthopedic nursing.

Ernestine McCain (Research Hospital School of Nursing, Little Rock, Arkansas; B.S., University of Texas), formerly instructor in nursing arts at John Sealy College of Nursing, Galveston, is nursing arts instructor.

Mary L. Lucas (King's Daughters Hospital School of Nursing, Temple, Tex.; B.S., Western Reserve) is instructor in health service in the family.

Theodora R. Lynch (Seattle General, Seattle, Wash.) is clinical supervisor in medical and surgical nursing.

Cora B. Radde (St. Mary's, Rochester, Minn.), formerly operating room supervisor at St. Mary's, has been appointed operating room supervisor and instructor in operating room technic.

Juanita Roe (Hillcrest Memorial, Waco, Tex.), formerly director of nurses at Hillcrest Memorial, **Alice Peppin** (Regina School of Nursing, Albuquerque, N. M.) and **Elizabeth Fulbright** (Grace Hospital School of Nursing, Morgantown, N. C.), are added to the staff as head nurses. Miss Fulbright, who has had postgraduate work in obstetrics, is head nurse in the Florence Nightingale Maternity Hospital.

Faculty Changes at Duquesne University School

Mary W. Tobin (Army School of Nursing, Washington, D. C.; B.S., M.A., Teachers College, Columbia), founder and the first dean of the School of Nursing at Duquesne University, Pittsburgh, Pa., will retire at the end of the academic year. Miss Tobin was instructor and assistant chief nurse of the U. S. Public Health School of Nursing before she became instructor, and later director, of the Army School of Nursing (1922–1932). She was on the faculty of Yale University School of Nursing before she went to the Duquesne University school in 1935, first as director and later as dean. She has now been appointed dean emeritus.

Ruth D. Johnson (Army School of Nursing, Washington, D. C.; Ph.B., Brown University, Providence, R. I.; M.A., Duquesne University), since 1936 a member of the faculty at the Duquesne University School of Nursing, acting as assistant to the dean, will succeed Miss Tobin as dean of the school. Miss Johnson was formerly a member of the faculty of the Army School of Nursing. She has also been on the faculty of the University of Minnesota School of Nursing.

Mildred I. Lorentz (University of Cincinnati College of Nursing and Health; B.S., University of Cincinnati; M.A., Columbia), who has served as sec-

retary of the NLNE Committee on Educational Problems in Wartime since January 1 (see the February *Journal*, page 184), has been appointed professor of nursing education and assistant to the dean.

Directors of Senior Cadets in Army Hospitals

Fifty-seven Army nurses have been appointed directors and assistant directors of senior cadets who will have supervised experience in Army hospitals.

Six of these nurses have the M.A. degree, forty-one have the A.B. or B.S. degree, and one has her LL.B. The remainder have had some special preparation in nursing education. Three of them were formerly directors of schools of nursing, nine were educational directors, and four were doing educational work in the public health nursing field; eighteen were science instructors, twelve, nursing arts instructors, and eight were teaching supervisors.

Limited space allows us to list only the directors of cadets, who are: **Capt. Gertrude Wilson,** Cp. Edwards Station Hospital, Falmouth, Mass.; **First Lt. Lillian V. Salsman,** Ft. Devens Station Hospital, Ayer, Mass.; **First Lt. E. Jacqueline Davis,** Cushing General Hospital, Framingham, Mass.; **First Lt. Alice L. Greene,** Lovell General Hospital, Ayer, Mass.; **First Lt. Mona R. LeGrand,** England General Hospital, Atlantic City, N. J.; **First Lt. Jean F. Richards,** Deshon General Hospital, Butler, Pa.; **Capt. Mary E. Grove,** Valley Forge General Hospital, Phoenixville, Pa.; **First Lt. Katherine C. Cox,** W. Wilson General Hospital, Staunton, Va.; **Second Lt. Annie L. Wyant,** McGuire General Hospital, Richmond, Va.; **First Lt. Edna C. Pruis,** Kennedy General Hospital, Memphis, Tenn.; **First Lt. Ruth N. Henley,** Lawson General Hospital, Atlanta, Ga.; **First Lt. Helen M. Hinckley,** Moore General Hospital, Swannanoa, N. C.; **First Lt. Frances Williams,** Darnall General Hospital, Danville, Ky.; **Captain Edna E. Sharritt,** Fletcher General Hospital, Cambridge, Ohio; **Second Lt. Louise Dingwerth,** Billings General Hospital, Indianapolis, Ind.; **First Lt. Marion W. Candon,** Nichols General Hospital, Louisville, Ky.; **Second Lt. Ruth M. Jubb,** Percy Jones General Hospital, Battle Creek, Mich.; **Major Agnes C. Jensen,** Camp McCoy Station Hospital, Sparta, Wis.; **First Lt. Dorothy H. Chapman,** Camp Grant Station Hospital, Rockford, Ill.; **Second Lt. Marjorie M. Sorenson,** O'Reilly General Hospital, Springfield, Mo.; **First Lt. Myra H. Heeren,** Fitzsimons General Hospital, Denver, Colo.; **First Lt. Myrtle A. Peterson,** Schick General Hospital, Clinton, Iowa; **First Lt. Mary E. Hendrixson,** Brooke General Hospital, San Antonio, Tex.; **Capt. Mildred V. Lucka,** McCloskey General Hospital, Temple, Tex.; **First Lt. Jessie A. Tvrs,** Bushnell General Hospital, Brigham City, Utah; **First Lt. Virgiline B. Mulvane,** Barnes General, Vancouver, Wash.; **First Lt. Shirley R. Timewell,** Letterman General, San Francisco, Calif.; **First Lt. Helen L. Van Gilder,** Hoff General, Santa Barbara, Calif.

Marion Seymour Joins National Red Cross Staff

Mrs. Marion Brown Seymour, Assistant Director of Nurses at Freedman's Hospital, Washington, D. C., has been granted a six-month leave of absence to serve on the staff of the Red Cross Nursing Service. Mrs. Seymour, who was in the Army Nurse Corps in World War I, will study the Red Cross Nursing Service programs with a view to bringing about the best possible use of Negro nursing services in Virginia, West Virginia, Ohio, and New York.

Mrs. Seymour is a former vice-president of the National Association of Colored Graduate Nurses.

Changes on the NOPHN Staff

Margaret S. Arey, who has been NOPHN assistant consultant in orthopedic nursing on the staff of the Joint Orthopedic Nursing Advisory Service since February 1943, left on May 15 to become consultant in orthopedic nursing with the Massachusetts State Department of Health, Crippled Children's Division. Miss Arey is known to *Journal* readers for her article on "The Care of Patients with Amputations," which appeared in the January and February issues.

On May 15 **Katherine A. Ott** joined the NOPHN staff, succeeding Miss Arey. Miss Ott had her basic nursing preparation, program of study in public health nursing, and orthopedic nursing at Western Reserve University where she received her B.S. degree. She received her certificate in physical therapy from Harvard Medical School and her certificate in the Kenny technic of treatment for infantile paralysis from the University of Minnesota. Her previous positions have been with the Visiting Nurse Association of Cleveland and the Division of Services for Crippled Children, Indiana State Department of Public Welfare, where she has been consultant in orthopedic nursing and physical therapy.

Superintendent of Nurses, USPHS Hospital Nursing Service, Appointed

Katharine S. Read, Superintendent of Nurses, U. S. Public Health Service, Federal Security Agency, since 1935, retires from active service on July 31. Miss Read entered the Army Nurse Corps in 1918, serving overseas with Base Hospital 37; American Red Cross Hospital, Lancaster Gate, London; and Base Hospital 204.

At the close of the last World War, she was one of a group of nurses who helped Lucy Minnigerode organize the nursing service in the Marine and Public Health Service Hospitals. She served as chief nurse at the U. S. Public Health Hospital, Washington, D. C., and the U. S. Marine Hospitals at Hudson and Jay, New York, Norfolk, Va., and San Francisco, Calif. In 1935 she was appointed superintendent of nurses. Since then she has also served as chairman of the ANA Federal Government Section; member of the National Committee, American Red Cross; and the Council of Federal Nursing Services.

Miss Read's sense of fair play for the nurses,

Petrelle

Left: Effie J. Taylor, R.N., Dean of Yale University School of Nursing from 1934 to 1944. Right: Elizabeth Seelye Bixler, R.N., who becomes dean of this school on July 1.

Black and Richards, New Haven

aides, and dietitians under her direction, combined with her loyalty and devotion to the Service, made her one whose leadership and guidance will be greatly missed. Says one of her co-workers, "Miss Read has been so self-effacing and has kept her own service running so smoothly and efficiently that many people did not appreciate the tremendous burden she carried. We frequently fail to pay tribute to those who function quietly and efficiently because we are so concerned with those who are having difficulties." Miss Read had great pride in the manner in which the whole group has met wartime needs and emergencies and enthusiastically assumed the duties of new Service activities.

Jessie MacFarlane (Hospital of St. Barnabas School of Nursing, Newark, N. J.) succeeds Miss Read as superintendent of nurses, Hospital Nursing Service. Miss MacFarlane had postgraduate work in anesthesia at Letterman General Hospital in San Francisco and studied at Wayne University, Detroit, and Johns Hopkins, Baltimore. She has served as staff nurse, head nurse, assistant chief nurse, and chief nurse in the Service, becoming superintendent of nurses on May 1.

Effie J. Taylor Retires

Effie J. Taylor, Dean of the Yale School of Nursing since 1934, will retire on June 30. She will be succeeded by **Elizabeth Seelye Bixler,** formerly director of nursing at the Norwich State Hospital. Miss Taylor was graduated from the Johns Hopkins School of Nursing, and served as head nurse, supervisor, instructor, and associate principal of the school and director of the nursing department of the Phipps Psychiatric Clinic. In 1918 and 1919 she was director of the Army School of Nursing at Camp Meade. She was superintendent of nurses at New Haven from 1923 to 1934, when she became dean of the Yale School of Nursing.

Miss Taylor received the B.S. degree from Columbia University and an honorary M.A. from Yale. She was appointed professor of psychiatric nursing, the first appointment of that kind to be made at Yale. She has served as executive secretary and also as president of the National League of Nursing Education, and has been president of the International Council of Nurses since 1937. She is an active member of many state and national nursing organizations and committees.

In announcing Miss Taylor's retirement, President Seymour said, "Dean Taylor's retirement at the end of the college year brings to all members of the university a sense of deep regret and a warm gratitude for her distinguished service to Yale. Under her administration the School of Nursing has worthily maintained the ideals which characterized its original purpose and has constantly enhanced the prestige of Yale in this vital field of education."

Miss Bixler, whose appointment as professor at Yale became effective March 1, received the B.A. degree from Smith College, M.A. from Radcliffe, and B.N. from the Yale School of Nursing. She is the first graduate of the school to serve as dean. Miss Bixler served on the staff of New Haven Hospital in 1927 and 1928, when she went to the Maternity Clinic of the New Haven Dispensary. Subsequently she was supervisor of nursing in the psychiatric clinic of the Yale Institute of Human Relations, assistant director of nursing service at the New Haven Hospital, educational director of the Worcester (Mass.) State Hospital, director of nursing at the Westchester Division of the New York Hospital at White Plains, and has been at the Norwich State Hospital since 1941.

Appointments to USPHS, Nurse Education Division

Helen G. Schwarz (Washington Boulevard, Chicago; B.S., M.A., Teachers College), formerly dean of the College of Nursing and Health and director of Nursing Service, Cincinnati General Hospital, has been appointed assistant director (in charge of the eastern area) of the Division of Nurse Education, U. S. Public Health Service.

Two consultants recently appointed to the staff are **Mrs. Marguerite Heimes** and **Mrs. Mary B. Lowery.** Mrs. Heimes was formerly supervisor and instructor in pediatric nursing at the Univer-

sity of Minnesota. Mrs. Lowery (Frances Payne Bolton School of Nursing, Western Reserve) was on the faculty of her own school and recently served as a member of the NNCWS college field staff.

Changes at Nurses' House, Babylon, New York

Lilian G. Staples (Nicholls Hospital Training School for Nurses, Peterborough, Ontario) recently resigned as assistant hostess at Nurses' House, Babylon, Long Island, and **Anna K. Wiant** (Johns Hopkins) came to the House on May 1 and **Elizabeth Letchford** on April 10 as assistant hostesses. Louise Deacon continues as hostess.

Miss Staples' association with Nurses' House began during the days when the Red Cross maintained a temporary Nurses' House at Bay Shore shortly after the last war; she was then assistant to the hostess. When the permanent House was established in October 1924, Miss Staples moved with the family of guests from Bay Shore, and became the hostess, continuing in charge through the early days at Babylon. Ill health led to her resignation in 1926, but in 1929 she returned to the staff as assistant to Della DeGraw. Since then, with Miss DeGraw and for the past two years with Louise Deacon, Miss Staples has contributed largely to the comfort of thousands of Nurses' House guests. The beautiful garden was her particular contribution. She has returned to Canada.

Appointments to UNRRA Staff

The United Nations Relief and Rehabilitation Administration has announced the appointment of three nurses to its staff as associate public health nursing consultants. They are:

L. Ann Conley (St. Elizabeth's, Brighton, Mass.; B.S., Teachers College, Columbia), formerly supervisor on the staff of Henry Street Visiting Nurse Service and later assistant public health nursing consultant with the USPHS. She was recently a Rockefeller fellow at Harvard School of Public Health.

A. Moneera Finley (A.B., Muskingum College; M.N., Frances P. Bolton School of Nursing, Western Reserve), formerly supervisor on the staff of Henry Street Visiting Nurse Service and recently a Rockefeller fellow at Harvard School of Public Health.

M. Frances Frazier (Church Home and Infirmary School of Nursing, Baltimore; B.S., Teachers College, Columbia), formerly supervisor on the staff of Henry Street Visiting Nurse Service and recently a Rockefeller fellow at Harvard School of Public Health.

Four nurses appointed as associate nursing consultants are:

Sylvia Geller (St. Mark's, New York; M.A., New York University), formerly teaching supervisor at Fordham Hospital School of Nursing, New York.

Isabel H. Needham (Mary McClellan Hospital School of Nursing, B.S., Skidmore College; B.S., Schauffler College of Religious Education and Social Work, Cleveland, Ohio), who has served two years in France with the American Friends Service Committee and recently returned from Ecuador where she was field nursing administrator with the El Oro Technical Mission.

Caroline A. Rosenwald (University of Minnesota School of Nursing; B.S., University of Minnesota), formerly instructor in nursing arts and in medical and surgical nursing at the University of Minnesota and at Skidmore College. Miss Rosenwald was recently on the staff of St. Paul, Minn., Family Nursing Service.

Mary Susich (Graham Hospital Training School for Nurses, Canton, Ill.; B.S., University of Minnesota), formerly instructor in nursing arts and pediatric nursing at Children's, Detroit.

News Here and There

Summer Courses and Workshops

Washington.—The University of Washington, Seattle, offers courses in teaching and supervision in schools of nursing, June 26 to August 25; courses in public health nursing, July 3 to August 25; and a two-weeks intensive course in psychiatry and psychiatric nursing, July 27 to August 5 (see the May *Journal*, page 502). For further information write to Mrs. Elizabeth S. Soule, Director, University of Washington School of Nursing Education, Seattle.

Iowa.—Loras College, Dubuque, through its Division of Nursing Education, offers the following summer courses for graduate nurses, June 26–August 7: Ward Teaching and Administration, Administration in Schools of Nursing.

California.—The summer workshop tentatively planned by the University of California School of Nursing, San Francisco, has been canceled.

Louisiana.—Louisiana State University, Department of Nursing Education in co-operation with Charity Hospital School of Nursing, New Orleans offers a workshop on administrative problems in nursing schools and nursing service, July 5–July 15. Write to Sister Henrietta, Director, Department of Nursing Education, Louisiana State University, School of Medicine, New Orleans 13.

Program for Nursing in the U. S. Civil Service Commission

The newly created position of senior nursing consultant in the Medical Division of the United States Civil Service Commission to which Ruth Heintzelman was recently appointed, carries with it responsibility for developing sources for the recruitment of nurses, and for determining the standards which must be met by appointees to the nursing services of the Veterans Administration, the U. S. Public Health Service, the Indian Service, the Children's Bureau, and other federal government agencies. (See the March *Journal*, page 297.)

Miss Heintzelman will confer with nursing personnel in federal agencies in connection with nurs-

ing standards and requirements, and will work with representatives of state and federal agencies (including national housing organizations) in developing the Commission's resources for recruitment of nurses. She will also be responsible for developing adequate examining programs for positions in nursing, drafting announcements, revising requirements, formulating questions for assembled examinations, supervising the rating of papers for both assembled and unassembled examinations for nursing positions. She will consult with appeals examiners on questions involving education and experience requirements for nurses and will suggest methods for interesting well-qualified nurses in positions in federal government agencies. The Commission is now recruiting nurses qualified for positions as graduate nurse (in hospitals), public health nurse, and public health nursing consultant (in public health nursing services), and nursing education consultant (in the USPHS Division of Nurse Education).

Another project of the Commission is the clearing of applications for senior cadet experience in federal government hospitals. (See page 578 in this issue.)

Standardized Fees for Private Duty Nurses

On April 21, the Greater New York Hospital Association and nurses representing Districts 13 and 14 of the New York State Nurses Association jointly approved standardized fees for registered professional private duty nurses in Manhattan, Bronx, Staten Island, Brooklyn, and Long Island.

Registered professional private duty nurses have asked for an increase in their fees to meet the advance in the cost of living, and the nursing and hospital associations agreed that the increase is justified at this time, although committees on personnel practices have not completed the study currently under way of salaries and working conditions for all nurses.

The rates put into full effect on May 1 are: $7.00 for eight hours, plus charge for nurse's meals; $10 for twelve hours, plus charge for nurse's meals; $12 a day for a resident nurse (formerly termed 24-hour duty).

The previous basic rates for private duty nursing were $6.00 for eight hours and $8.00 for twelve hours.

FNIF Office Reopened

On January 1, 1944, the Florence Nightingale International Foundation reopened its office in London at 8 Maresfield Gardens, Hampstead, with Olive Baggallay, Secretary, in charge. She has been instructed:

1. To communicate with the International Council of Nurses, the League of Red Cross Societies, and as many of the national FNIF committees as are accessible.
2. To make the work of the Foundation known to various relief committees here (in England) and abroad and to consult with representative nurses from other countries now in England.
3. To make a survey of present conditions in the sphere of education covered by the FNIF with a view to advising on future policy.

Since the Foundation was established in 1934 more than 300 nurses from forty-nine countries have taken courses offered by it. Of these, nine are Americans; two of whom had American Red Cross scholarships (one was returned following the early marriage of the recipient); two each had one-half of a Red Cross scholarship; two had scholarships from funds collected by the Committee; two had loans, one of which has been returned, the other is almost paid up.

With the approval of the Board of Directors, the activities of the Committee have been confined to occasional meetings during the war years. An informal meeting of the more readily available members was held in October 1943, in order to confer with Yvonne Hentsch, Chief of the Nursing Division of the League of Red Cross Societies. Miss Hentsch, an Old International, spent more than a year in the Americas before returning to Geneva by way of England. The Chairman was instructed to transmit to the Provisional Committee of Management an expression of the Committee's interest in reactivating the FNIF at the earliest possible date, but on the basis of careful study of the educational needs of candidates from many countries.

In 1938, the ANA House of Delegates voted to accept the quota which had been suggested at the preceeding meeting of the Grand Council of the FNIF, $88,575; this sum to be applied to the endowment fund. Each state nurses association's quota was worked out on the basis of membership. By December 31, 1943, twenty-two states had completed or exceeded their quotas. The financial report as of that date—May 1, 1935 to December 31, 1943—is as follows:

Receipts	
Contributions:	
Received prior to April 24, 1938—not applicable to quota	$18,808.74
Quota contributions	50,036.69
For administrative expense	85.00
For specified purposes other than administration	50.00
Sales: Florence Nightingale Oration	67.33
Interest on loans	18.62
Income from investments	1,312.50
Total receipts	$70,378.88
Disbursements	
Transferred to Endowment Fund	$24,000.00
Scholarships	2,000.00
Administrative expenses	1,228.05
Total disbursements	$27,228.05
Excess of receipts over disbursements from May 1, 1935, to December 31, 1943	$43,150.83
The excess of receipts over disbursements comprises the following:	
Quota contributions:	
Cash	$ 4,130.19
Bonds	35,906.50
Cash reserved for administration expenses	3,014.14
Loans outstanding	100.00
	$43,150.83

Fellowship in Health Education

Fellowships for graduate work in health education are offered by the U. S. Public Health Service for the fall term of 1944. Women who are citizens of the United States, between the ages of 19 and 40, and who possess a bachelor's degree from a recognized college or university may apply. The candidate should be skillful in the use of English, and have preparation in the physical and biological sciences, social sciences, and courses in education and educational psychology.

These fellowships provide 12 months training in public health education, three months of which will be in supervised field experience. Application forms may be obtained from the Surgeon General, U. S. Public Health Service, Washington 14, D. C. Forms accompanied by a transcript of college credits and a small photograph, must be in the Office of the Surgeon General by August 1.

Practical Nurses' Bulletin

Practical Nurse News is the title of the new bulletin published by the Practical Nurses of New York, Inc. This state organization has a membership of 2,000 practical nurses licenced to practice in the state of New York.

Minnesota Nurses Propose Amendment to Nurse Practice Act

The Minnesota Nurses Association has undertaken an active legislative program. The present nurse practice act controls only the use of the title, "R.N." and not the practice of nursing. The state nurses association is proposing an amendment to the law which will require licensure for all who nurse for hire in two groups: registered nurses and nursing attendants.

Other objectives of the bill are:

Defining the practice of nursing for both the registered nurse and the nursing attendant.

Providing a waiver for the nursing attendant.

Setting up standards for schools for registered nurses and nursing attendants.

Allowing credit in time for college work.

Raising the educational requirement for applicants for the R.N. from two to four years high school.

Changing the age of the R.N. applicant from twenty-one to twenty years because U. S. Cadet Nurse Corps students often enter schools at seventeen.

Increasing the number of members on the State Board of Examiners of Nurses from five to seven.

Defining the powers and duties of the Board.

Providing annual licencing of all who nurse for hire.

The proposed bill does not prohibit: (1) nursing of the sick by relatives or friends done without compensation, (2) incidental care of the sick by persons primarily otherwise employed, i.e., a housekeeper, (3) nursing service in the case of an emergency, or (4) employment of nurses registered in other states by U. S. government agencies.

Careful planning has gone into the program for promotion of this amendment. The Committee on Legislation, with legal counsel, is drawing up the new bill which will be sent to all members for study and discussion. Every nurse in Minnesota is asked to assist in a public information program.

Nursing in Other Countries

South and Central American Nurses Study in U. S.

Eighteen Catholic Sisters from eight American republics are having a one-year specialized training course in nursing sponsored by the Catholic Hospital Association, in co-operation with the Institute of Inter-American Affairs, an agency of the Office of Inter-American Affairs. There are two Sisters from each of the following: Costa Rica, Chile, Ecuador, El Salvador, Nicaragua, Peru, and Venezuela. Four are from Mexico.

The Sisters will have a preliminary orientation course of approximately two months at the headquarters of the Catholic Hospital Association in St. Louis, Missouri, before they go to a four-month in-service training course at various hospitals in the United States, depending on each student's specialized field.

At the conclusion of the first four-months in-service training period, the Sisters will be brought together for a joint résumé of the work which they have completed. After a month spent in comparing notes, the students will receive an additional four-months training at other hospitals. A final one-month consultation before returning to their respective countries will complete their experience.

A second course begins in September for Sisters from additional American republics.

Two South American nurses who are studying in the United States at their own expense are **Cecilia Laborde** who is on the staff of the Little Company of Mary Sanatorium in Buenos Aires and **Isabel Merubia** of La Paz, Bolivia. Miss Laborde is enrolled for study at the Little Company of Mary Hospital, Evergreen Park, Ill., and Miss Merubia is enrolled at the School of Nursing of Bethany Hospital in Kansas City, Kan.

Miss Smellie Returns to the VON

Elizabeth Smellie, C.B.E., R.R.C., Chief Superintendent of the Victorian Order of Nurses for Canada, who was released temporarily to become matron-in-chief of the Royal Canadian Army Nursing Service, was permitted to retire to the reserve list in March and to return to the Victorian Order of Nurses for Canada. On February 1, 1944, Miss Smellie was promoted to the rank of colonel, the first such appointment for a woman in Canada. Canadian nursing sisters in the Royal Canadian Army Nursing Service have for some time held full rank as officers.

Lt. Col. MacRae is Matron-in-Chief, RCANS

Lieutenant Colonel Dorothy MacRae, R.R.C., formerly principal matron in the office of the

matron-in-chief of the Royal Canadian Army Nursing Service, has now succeeded Miss Smellie as matron-in-chief.

Miss MacRae has served overseas for two years during the present war, returning to Canada in 1942 to become principal matron in the Directorate General of Medical Services, National Defence Headquarters.

London Hospital Damaged and Nurses Killed

A London hospital was badly damaged in April when three high explosives fell on one of the main buildings wrecking seven wards and starting a fire. A number of patients were trapped under the wreckage. Doctors, nurses, and attendants, police and rescue squads, worked through the night to rescue the patients, some of whom were badly injured. A sister (head nurse) and four nurses were killed. Firemen particularly praised the courage and splendid performance of the nursing staff.

From Bulgaria

Bulgaria has two recently inaugurated schools of nursing, established by the Department of Public Health. One is in Plovdiv, the other in Varna.

Recent Meetings

Public Health Nursing in the Reconstruction Period

What demands will the reconstruction period make on public health nurses and how can we plan ahead to meet them? Many aspects of this question from a national, state, and local viewpoint were explored at a conference of nurses from six states, meeting in Cleveland, Ohio, April 14 and 15. The meetings were held under the auspices of the public health nursing faculty of Western Reserve University School of Nursing, with the co-operation of the National Organization for Public Health Nursing.

About two hundred nurses registered for the conference, beside the public health nursing students at Western Reserve University, who were guests. Participating were representatives from Ohio and adjacent states: West Virginia, Michigan, Kentucky, Indiana, and western Pennsylvania. They included administrators and supervisors of public health nursing services in official and nonofficial agencies; state directors of public health nursing; state consultants; directors of public health nursing education in the states represented; board members; nurses, including regional consultants from the U. S. Public Health Service and the Children's Bureau; representatives from the American Red Cross and the NOPHN (the latter a sponsoring agency); health commissioners of Cleveland and adjacent counties; members of the Cleveland Health Council.

New problems that will follow demobilization, public health trends today and those envisioned for the future, and adjustments of nursing to these changes were presented by three speakers: Assistant Surgeon General R. C. Williams of the U. S. Public Health Service; Dr. Luther E. Woodward, Field Consultant, Division of Rehabilitation, National Committee for Mental Hygiene; and Marion Sheahan, Director, Division of Public Health Nursing, New York State Department of Health. Further implications for nursing were brought out in subsequent discussions.

Certain basic responsibilities of government for the health protection of its people—accepted before the war—were defined, and the growth of federal and state leadership with emphasis on local administration was described. Weaknesses in the fabric of all our health work shown by the impact of the war, particularly the inefficient use of personnel and the failure to work together among ourselves and with other community groups, were discussed. Nursing has had to make drastic readjustments, with the assumption of new responsibilities accompanied by the use of new personnel—nurses and lay people—untrained in public health. Careful job analyses and reassignment of tasks, with close supervision of new workers, have been necessary.

Postwar goals embrace an extension of essential public health programs to *all* communities, more equitable distribution of medical care to *all* the people, with a concomitant increase in hospitals, laboratories, and other necessary facilities. *Fundamental to such expansion is a greatly increased number of nurses for both clinical and public health work*. A potential source for both is the U. S. Cadet Nurse Corps. Strengthening of the integration of health in the basic curriculum and use of graduates from schools with high standards, without further training, for first-level public health nursing positions; assignment of teams, one nurse trained and one not trained in public health, in an area; better facilities for preparation of supervisors and special consultants to safeguard standards with the use of less trained and experienced personnel—these were suggestions for supplying adequate public health nurses to fill the gap now and after the war.

New problems which received emphasis were the appearance of diseases not heretofore endemic in this country, brought by returning soldiers from far battle fronts; necessity for retraining and readjustment in jobs of returning military personnel, including nurses, a program in which professional standards must be preserved; danger to standards from veterans' preference laws; and need for establishment of health services in occupied countries.

Increased emphasis on mental hygiene arising from our concern with wartime and rehabilitation problems was evident throughout the meetings, with frequent reference to the nurse's responsibilities in the total program for readjustment.

Indiana

Eighty-six nurses attended the sixth annual Conference for Elected Officers held in Indianapolis, April 18, by the State Nurses Association. Attending were officers of the State Nurses Association and its

sections, the district and alumnae associations, and the State League, as well as chairmen of all standing committees. The purpose of the conference was:

1. To give officers of the constituent units of the State Association an opportunity to become acquainted with each other.
2. To keynote the activities for the year.
3. To learn organization principles.
4. To discuss association policies.
5. And last, but not least, to give district and alumnae association officers an opportunity to express the views and needs of their respective associations.

Fifty-four of the nurses attending are *Journal* subscribers, and thirty-one use the *Journal* in preparing for meetings.

Texas

In spite of difficult traveling conditions, each of the twenty district associations of the Texas Graduate Nurses Association was represented at the annual convention of the State Nurses Association, State League, and SOPHN, held in Austin, April 18–19.

A service banner in honor of all nurses serving in the armed forces was dedicated and presented to the association. Reports showed a healthy growth of all activities and reflected much work done during the year.

A joint committee of the State Association, the Board of Nurse Examiners, and the State Hospital Association was authorized to study the subject of legislation for licencing auxiliary workers.

One hundred and six nurses attended the Private Duty Section meeting at which group nursing, which is being practiced in a number of the districts, was discussed. Districts 2 (Amarillo) and 7 (Temple) reported the plan favorably. Hospitals and nurses in all districts are urged to use this plan.

The Procurement and Assignment Committee reported that about 2,300 clearance forms had been checked.

Officers of the State Association for the coming year are: president, Daisy R. Moore; vice-president, Mrs. Sadie J. Brown; secretary, Olga M. Breihan.

Private Duty Section: chairman, Rose L. Adams; secretary, Ruth Burkland.

SOPHN: president, Grace Buzzell.

State League: president, Lucy Harris.

Connecticut

The spring meeting of the State Association was held in New Haven, April 27. Two films were shown at the morning session on psychiatric rehabilitation of the veteran: "Psychiatry in Action," and "Life Begins Again," showing interesting aspects of British wartime progress. The films were discussed by James M. Cunningham, M.D., Director of the Bureau of Mental Hygiene, Connecticut State Department of Health.

At the afternoon session, Mildred A. Richardson, President, reported on membership to date and the number of recent graduates who have joined the Association. The State Procurement and Assignment Committee reported on conferences with the state director of the War Manpower Commission and the State Personnel Department regarding nurse vacancies in state institutions. Classification of nurses was discussed using sample forms which included nurses in various age groups in all types of nursing positions.

Seventy-five nurses attended the Industrial Nursing Section meeting in the evening when "Nursing Aspects of Vision in Industry" was discussed.

The day's attendance of 543 included: public health nurses, 190; institutional nurses, 114; industrial nurses, 75; private duty nurses, 42; student nurses, 4; others, 28.

New Jersey

The joint annual convention of the State Nurses Association, the State League, and the SOPHN was held in Newark, April 28. After morning business sessions, they met together for a general session at which Lucy Germain, from the Nursing Division of the Procurement and Assignment Service, discussed the need for nurses and nursing service throughout the state as well as with the armed forces.

Florence L. Savage was elected secretary of the State Nurses Association.

Officers elected for the State League were: president, Katharine M. Horner; secretary, Adele Zweiman.

Caroline di Donato was elected president of the SOPHN.

Virginia

The joint annual convention of the State Nurses Association, the State League, and the State Nursing Council was held in Richmond, April 27–28. Registration was 354.

Officers for the State Association are: president, Mrs. Mildred Lawrence Glenn; first vice-president, Ruth Epperson; secretary, Virginia Drumheller; treasurer, Mrs. Jessie W. Faris.

Private Duty Section: chairman, Josephine Cunningham; secretary, Mrs. Marion B. Myers.

Public Health Nursing Section: chairman, Sarah Radcliffe.

The Public Health Nursing Section of District 2, Virginia State Nurses Association, conducted an all-day institute in Roanoke, March 20, on nursing problems related to the care of patients having rheumatic fever. Groups represented at the institute included social workers, school teachers and administrators, kindergarten workers, rehabilitation officers, and other lay groups as well as public health and hospital nurses. Registration for the morning session was ninety, for the afternoon, forty.

Convention Calendar

American Hospital Association, war conference and annual convention, October 2–6, Statler Hotel, Cleveland, Ohio.

American Nurses' Association (House of Delegates and Sections), **National League of Nursing Education, National Organization for Public Health Nursing** (business meetings), June 5–8, Buffalo, N. Y.

Association of Collegiate Schools of Nursing, annual convention, June 9, Statler Hotel, Buffalo, N. Y.

Canadian Nurses Association, twenty-second general meeting, June 26 to July 1, Fort Garry Hotel, Winnipeg.

Oregon State Nurses Association, annual convention, June 27–28, Columbia Gorge Hotel, Hood River.

Vermont State Nurses Association, annual meeting, June 28–29, Hotel Brooks, Brattleboro.

Federal Government Nursing Services

Navy Nurse Corps

Appointments to Navy Nurse Corps and Naval Reserve Nurse Corps.—Two hundred and seventy-three. Evelyn L. Aaberg, Agnes I. Acquistapace, Margaret F. Albright, Betty M. Alexander, Phoebe V. Anderson, Alice L. Andrews, Barbara C. Argianas, Dorothy H. Arntz, Ruth J. Atherton.

Margaret M. Ballingham, Angela P. Barbarino, Geneva Barr, Sarah J. Barringer, Muriel E. Bayley, Doris A. Beidler, Rita E. Belanger, Averill D. Beringer, Bertha Bernstein, Helen L. Betow, Janet B. Beyer, Helen A. Biemer, Mary M. Biemer, Virginia E. Bish, Doris I. Black, Gloria K. Blake, Verna M. Blomquist, Alma A. Blougher, Joanne Bodnar, Mary M. Boylan, Ethel M. Braithwaite, Doris M. Brazeau, Dorothy G. Brehl, Frances M. Brendle, Eltah M. Brinlee, Patricia A. Brown, Christine L. Bryan, Rhea V. Bullington, Nancy E. Bullock, Mary C. Burda, Grace M. Busch.

Clella P. Cain, Betty J. Cameron, Florence L. Campbell, Ruth L. Carter, Helen E. Casby, Florence C. Casella, Mary A. Cassidy, Kathleen Castleberry, Vivian R. Charno, Sarah E. Chipikitis, Anna F. Cianfrani, Victoria P. Cisek, Elizabeth A. Collins, Marjorie A. Conway, Sarah J. Cooper, Zona M. Cressey, Loretta P. Cyr.

Mavis M. Dahl, Dorothy A. Dalesio, Dolores I. Davis, Helen V. Deal, Amy L. DeShane, Thelma Desvousges, Mary M. Devine, Katherine M. Dillon, Magdalen M. Dingels, Berniece L. Donahue, Catherine P. Donohue, Claire F. Dooley, Norma R. Dugosh, Dorothy A. Duke, Helen M. Dukich, Corinne L. Duval.

Velma A. Edmonson, Margaret E. Edwards, Josephine F. Egbert, Frances H. Enright, Dorothy V. Erickson.

Mary M. Faucher, Jeanette F. Feeney, Velma L. Ferris, Hilda L. Freseman, Margaret M. Friedl, Ida G. Fuller.

Celeste C. Garrett, Ruth D. Gelber, Frances H. George, Alice F. Gibbons, Florence W. Gildersleeve, Martha J. Glasener, Harriet M. Goslin, Margaret E. Graham, Mary J. Grant, Audrey F. Graves, Mabel J. Grenat, Marie H. Griffin, Mary S. Grissinger, Grace M. Guerin.

Helen L. Haakenson, Bertha M. Hallows, Mary M. Hardy, Ruth E. Hartley, Irene C. Hayes, Helen A. Haynes, Geraldine R. Heffentrager, Louise T. Hennerty, Dorothy J. Herbst, Eileen L. Herman, Leah R. Heslop, Ruth A. Heyne, Mary S. Hickey, Marie E. Hocker, Leah M. Hoffman, Dorothy M. Holtberg, Ruth Horowitz, Beulah J. Howell, Claire J. Hubbs, Alice T. Hyer.

Leona M. Jones, Mary E. Jones, Myrtle E. Jones, Helen E. Jorgensen.

Irene M. Karsmarski, Mary J. Kavanagh, Marjorie Kellegrew, Verna P. Keihn, Mildred A. Klaproth, Eileen R. Koca, Marion C. Kohler, Mary C. Koontz, Mary T. Kovacevich, Vivian E. Krall, Albena M. Kuntar, Miriam F. Kyle.

Jacqueline A. LaLonde, Edna M. Lantzy, Anne M. LaSalle, Josephine E. Leininger, Regenia E. Leonard, Sarah K. Lieberman, Betty A. Lingensmith, Florence E. Lucey, Margaret E. Lynn.

Alice A. McArdle, Marion M. McCabe, Marion F. McCarthy, Marie McCauley, Helen E. McCormick, Eleanor G. McGee, Anna K. McGuigan, Catherine A. McGurrin, Helen J. McMahon, Patricia A. Maguire, Barbara M. Malone, Mary M. Malone, Rita M. Mangan, Emma A. Mansfield, Margaret M. Masciarelli, Cecile A. Massey, Grace E. Mastrodomenico, Lucy L. Matchett, Emma M. Mathews, Arveda Mazelin, Brooksie L. Meadows, Lena V. Mellen, Freda P. Melton, Mary L. Mendenhall, Catherine J. Mitton, Cecilia I. Mocker, Ella A. Moehlman, Malene K. Moklev, Hjerdis E. Molvig, Helen L. Mongan, Henrietta M. Mudd.

Alice L. Neenan, Barbara Nelson, Emeline C. Nelson, Lucille E. Nelson, Ellen M. Nielson, Elizabeth A. Nimits.

Marie G. O'Donnell, Wanda Oliver, Dagny I. Olsen, Eleanor D. Olson, Mary F. O'Neill, Theresa M. Orsatti, Jane L. Overman.

Pauline R. Palmateer, Mary E. Parsons, Alva B. Pelkington, Mary F. Perrin, Norma J. Perry, Rosemary Petre, Gertrude M. Piedmonte, Lorraine M. Pilotte, Agnes F. Pinkas, Mary E. Pinkerton, Hilda M. Plank, Margaret M. Poole, Barbara L. Potter, Grace B. Pratz, Mary J. Province.

Mary J. Ramsey, Betty D. Randolph, Dorothy E. Read, Phyllis A. Redman, Eunice E. Richardson, Pearl T. Riveland, Antonia J. G. Robinson, Lois C. Robinson, Nedra J. Rodenberger, Nana E. Rogers, Muriel Rose.

Faith A. Salden, Mary C. Schaeffer, Frances J. Schaser, Charlotte L. Scherzer, Roberta L. Schneider, Glenna M. Schofield, Augusta M. Schulte, Mona E. Scollard, Lova Scott, Bessie N. Seitz, Sara F. Sexton, Mary D. Shanks, Gertrude P. Shea, Lillian A. Shipman, Mary J. Shugarts, Ann E. Smith, Frederica J. Smith, Maryjane Smith, Mary L. Smith, Mary V. Smith, Margaret I. Sorensen, Leola I. Spear, Doris M. Stafford, Florine K.

Staiger, Bessie Steinberg, Mary E. I. Stevens, Nettie A. Storch, Gloria M. Strohecker, Patricia P. Sugnet, Kathleen C. Sullivan, Lucille M. Sutton, Virginia W. Szmachlo.

Betty J. Taylor, Mary M. Teefey, Augusta D. Thomas, Jane M. Thompson, Ethel N. Thrasher, Evelyn C. Timmerman, Margery E. Tingle, Mirla E. Tinkham, Grace E. Toohey, Hazel J. Toulson, Ruth M. Traver, Mary R. Trumble.

Ethelie M. Vachta, Roberta A. Wagner, Elizabeth B. Ward, Christine E. Warner, Ruby J. Warren, Dorothy M. Waterman, Dorothy D. Werner, Juanita A. White, Rose M. Williams, Mary C. Wise, Norma J. Wisegarver, Anita Wright.

Jane L. Yastrabek, Margaret V. Yurek, Loretta Zelis, Pauline P. Zoldak.

SUE S. DAUSER
Captain (NC) U. S. Navy
Superintendent

Army Nurse Corps

Appointments to Reserve Corps.—Nine hundred and sixty-six.

Promotions.—Eight hundred and eighty-nine. Promoted to assistant superintendent with the relative rank of lieutenant colonel, eight. Promoted to assistant superintendent with the relative rank of major, twenty-five. (See page 599.)

Promoted to assistant superintendent with the relative rank of captain: Margaret Harper, Claudia M. Draper, Ruth M. Schwing, Ruth M. Momberger, Margaret M. Bitzel, June B. Lemmon, Janie E. Belcher, Kathleen Harris, Marie S. Galloway, Florence M. Evert, Grace E. Keener, Frances I. Lay, Patricia F. Dolan, Nancy G. Gillahan, Claire E. Martin, Isa G. Pifer, Catherine M. Flatley, Blanche M. Sagner, Ruth F. Pacini, Lorena Hoffman, Mary S. Emery, Ina L. Copeland, Alice J. Johnson, Audrey Van Zandt, Claretta Evans, Irene G. Lewis, Grace H. Rickert, Eileen E. Donnelly, Dorothy M. Donahue, Natalie L. Rohland, Eunice C. Hatchitt, Mary T. Johnson, Georgia M. Hawkins, Mildred J. Tobiason, Ruby M. Duff, Luella M. Binns, Comfort A. Berry, Bernice R. Landig, Kathryn T. Whalen, Pauline Humiston, Ruth Barthel, Nanette Berkwits, Lorraine Setzler, Gladys M. Staub, Mary Scott, Bessie Walker, Ethel G. Westerman, Frances Crouch, Eunice H. Smith, Mildred L. Christansen, L. Leota Bradley, Paula J. Nolting, Mary E. McKinney, Mildred L. Langmack, Mildred E. Hoffman, Ruth B. Anderson, Gertrude A. Wilson, Henrietta K. West, Bernice Worley, Maida E. Hewitt, Harriett E. Grimes, Eula M. Walker, Louise R. Ringlein, Frances M. Evertt, Ilean Moore, Georgie K. Moss, Helen I. Schreiner, Lois S. Hines, Mabel Hammarlund, Elizabeth A. Breor, Grace J. Hayden, Leora E. Stich, Hazel B. Angle, Ruth H. Birthright, Blanche R. Grosscup, Nina Larkin, Marian B. Grimes, Catherine M. Acorn, Margaret E. Holbrook, Christine A. Snell, Ann P. Walatkus, Evelyn L. Libby, Margaret V. Alley, Jeanette Butler, Frances E. McClelland, Iva F. Lindstrom, Margaret L. Goodrum, Mary E. Gough, M. Marjorie Linehan, Dorothy L. Wilson, Jane Holden, Veronica C. Tighe, Margaret Kinney, Mary F. Morse, Julia M. Mally, Eliza A. Wray, Elinor C. Schultes, Ethelyn M. Peterson, Eunice R. Yoder, Virginia J. Cyples, Grace E. Alt, Maree DeWitt, Gladys R. Danielson, Nelly Newell, Esther A. Boyer, Eva M. Demchak, Clara A. Traver.

Promoted to chief nurse with the relative rank of first lieutenant: Frieda Kiesel, Florence R. Morgensen, Clara M. Simons, Cecilia W. Bladen, Margaret M. Quinn, Lillian M. Bozenhard, Margaret Neilson, Mary W. Zurowska, Sophie Adaskewicz, Flossie H. Aeschliman, Jane T. Becker, Mary A. Beougher, Ruth C. Bray, Dorothy J. Brown, Anita B. Cake, Eleanor M. Campbell, Ethel P. Chaney, E. Lynne Christy, Neva H. Coziahr, Elinor J. Cullom, Rita A. Davison, Mary G. Dickson, Vera W. Eberly, Gertrude M. Eckhardt, Opal L. Forrester, Delzena E. Garrard, Dorothy L. Goodale, Charlotte E. Greene, Frances E. Greenough, Dorothy K. Hagner, Florence C. Hale, Sarah G. Halterman, Claribel A. Halverson, Ethel Hammond, Ruth M. Harris, Beryl N. Hatch, Lena M. Hayden, Margaret J. Heath, Lillian K. Hestad, Dorothy M. Hoyt, Hazel Johnson, Ethel L. Johnston, Kathryn E. Jones, Roxie B. Kennedy, Margaret L. King, Mildred King, Rovertis Lee, Mildred K. Luscomb, Elma G. Lyndall, Juliana M. Mack, Mary J. Maegerlein, Virginia M. Maier, Ellen T. McBride, Helen R. McKnight, Millicent R. K. Mermell, Ella S. Miller, Hope E. Miller, Katharine M. Morse, Helen T. O'Connor, Olia D. Parker, Ruth E. Olson, Catherine Quinn, Mary F. Render, Dorothy E. M. Robinson, Clementine A. Rountree, Joan Riscigno, Elizabeth E. Sang, Grace M. Scanlan, Marguerite G. Schey, Adelaide E. Shade, Doris E. Shaffer, Esther J. Sipple, Laura D. Smith, Joy Springer, Inez N. Vogt.

Also promoted to chief nurse with the relative rank of first lieutenant: Edna Wohlfarth, Lillian A. Wright, Gertrude E. Wuerdinger, Irene L. Yeik, Catherine Ziegenbusch, Martha L. Nicholes, Helen F. Sprague, Evelyn O. Harbig, Louise M. England, Frances M. Cramer, Bernice H. Evans, Helen F. Wicko, Leona G. Lambing, Margaret L. Leonard, Loretta W. Bass, Alice C. Ringo, Ella A. Partons, Helen E. Dorsey, Grace I. McConnell, Joyce S. Mason, Margaret E. Gross, Ruth P. Hazelbaker, Lora J. Williams, Florence A. K. Walter, Marie I. O'Connor, Elizabeth G. Daily, Mary M. Dougherty, Helen L. Hall, Helen V. Hockman, Lena R. Robertson, Gertrude K. Hotinger, Evelyn L. French, Christine A. MacKinnon, Edythe H. Silbert, Esther E. Hesse, Josephine I. Morrison, Opal G. Davis, Evelyn B. Horstman, Lillian H. Held, Nellie J. Clark, Beulah B. Platt, Florence E. Feik, Colleen L. Poindexter, Alma L. Smith, Julia Jakubowski, Gladys L. Overstreet, Virginia E. Watts, Mary J. McCone, Dorothy R. McKee, Matilda J. Shamudosky, Mary G. Benfield, Rose E. Arcuri, Dorothy E. Beaty, Helen L. Kleinwechter, Frances E. Morris, Hazel L. Godfrey, Mary Blitstein, Letha

M. Fattic, Norma H. Haller, Julia R. Pollack, Ella M. Clark, Margaret T. Lampman, Dorothy F. Pudlak, Gertrude L. Joinville, Mary L. Jacobs, Mildred Hanson, Gladys S. Conradson, Rosemary Byrne, Frances V. Loughney, Nancy B. Kinsey, Kathryn E. Smith, Marguerite M. Lawlor, Marianne H. Walker, Louise P. Ludwig, Evelyn M. Hulse, Annie M. Donnell, Velma A. Dohm, Frances E. Gehman, Agnes A. McGraw, Josephine Steiner, Iolanda M. Cicerchia, Ottilia Brechtelbauer, Genevieve S. Minner, Helen S. Grace, Olga M. Drobek, Dorothy M. Hunter, Gertrude M. Schneider, Agnes A. O'Brien, Agnes A. Kosinski, Dorothy Cupery, Shirley R. Watson, Aleda E. Stolen, Marguerite E. Sill, Charlotte M. White, Marion S. Coffey, Evelyn L. Finkh, Marion A. Zibell, Rosemary J. Forsythe, Mildred M. Flory, Leone C. Duddleston, Lola A. Reddeman, Rellia M. Kjelstad, Harriett D. Sparks, Julia L. Tyler.

Also promoted to chief nurse with the relative rank of first lieutenant: Anne S. Zadylak, Filomena Valentino, Doris E. West, Julia R. Pollack, Natalie M. Woznick, Lena M. Tague, Betty A. Tomeny, Billie H. Dorton, Rose A. Donaghue, Emma V. Kaine, Carmel I. Maynard, Alice E. Adcock, Gladys Moore, Marian E. Martini, Louise Bainbridge, Joella Wallace, Rosalie Bacior, Lassye Greenberg, Ruth D. Lewis, Carol L. Behl, Martha Fulwood, Olie B. Martin, Ellen L. Busbee, Mary E. Nypaver, Ellie L. Stokes, Ruth E. Church, Mary M. Flowers, Louise M. Moon, Lucile Newton, Joan Dziecioloski, Margaret E. Tollefson, Hazel I. Lockhart, Iola R. McClellan, Ann B. Bakalar, Julie G. Bishop, Margaret N. Bishop, Margaret M. Coty, Lillian C. Girarde, Katherine Trask, Muriel Burchfield, Madeline Tietgens, Elvira A. Battista, Cornelia Kreager, Foy M. Scott, Ella R. Lockey, Marguerite P. Coffman, Josephine M. Diomede, Helen M. Felczak, Roberta M. Robinson, Ellen V. Marrello, Lucille M. Beal, Claudia C. Knight, Helen M. Shivers, LaVerne E. Anderson, Ruth E. Woodman, Sara H. Cooke, Harriet H. Cross, Marion D. Sweigart, Mildred Reed, Irene T. Barnhill, Lillian G. Blanchard, Maxine L. Cooper, Martha K. Hubley, Harriett E. Hammersmith, Mildred L. Van Dusen, Wilma M. Blosser, Hester O. Armstrong, Harriet C. Parks, Marie A. Rolla, Dorothy S. Stevel, Theresa C. Y. Cubbedge, Beulah L. Perry, Mary A. Heidenthal, Mildred L. Wilch, Kennyth M. B. Shank, Emma K. Scheib, Inez S. Pruitt, Marguerite E. Murphy, Muriel H. Klotz, Regina R. Trum, Margaret L. Robins, Edith H. Peiffer, Elma J. Mantila, Helen C. Humenansky, Rose R. Gregoratti, Georgeanna G. Farlow, Evangeline N. Dennard, Mattie C. Britton, Viola M. Anderson, Antoinette Dieg, Jessie W. Fallis, Rita M. Geis, Evelyn L. Andrews, Elizabeth H. Knell, Alma L. Robenolt, Gilettie C. Austin, Evelyn R. Spotts, Helen B. Clifton, Angeline C. Caprio, Lorraine T. Maciejewska, Mary F. Ferrero, Mary M. Swisher, Kathryn A. Smith, Joyce A. Barager, Edna P. Barry.

Also promoted to chief nurse with the relative rank of first lieutenant: Annabelle Longwater, Mary R. Peirce, Rowena L. Harrison, Elizabeth A. Schott, Velma G. Davis, Marguerite A. Collins, Eloise M. Lanford, Mary I. Streckfus, Martha L. Beatty, Helen J. Coyle, Almera L. Graham, Ethel L. Kufahl, Rita L. Quesnel, Elizabeth M. Wood, Carolyn A. Leyko, Mary R. Browning, Ruth M. Popernick, Edna R. Ballooh, Josephine R. Rak, Caroline L. Rabenold, Mary Jane Henderson, Lilly D. Hoekstra, Virginia G. Heath, Anna L. Hager, Helen T. Bayley, Violet T. Belnak, Veronica F. Blank, Wahneta T. Chapman, Margaret A. Cicerchia, Edna S. Cosgrove, Ruth E. Worthman, Freda G. Theil, Dorothy E. Terry, Mary J. Szarka, Retha M. Stoker, Evelyn E. Smith, Mildred Shiver, Phyllis M. Shaffer, Nellie L. Sewall, Rita M. Ryant, Madeline B. Rice, Minnie E. Hillen, Elizabeth I. Mitchell, Adelaide M. Mitchell, Ralphine A. Maynard, Elizabeth A. Marshall, Esther C. Lutz, Virginia H. Lloyd, Iva D. Lewis, Thelma R. Kellgren, Marion L. Jenkins, Frances M. Jackson, Margaret E. Huitt, Alene Davis, Mary A. O'Friel, Mildred J. Erhard, Dorothy E. Dibble, Evelyn T. Crary, Dorothy L. Gillette, Alma C. Frey, Mary S. Ferebee, Ruth M. Erickson, Rubye J. Duncan, Elizabeth A. Dill, Gladys E. Netterville, Narretta E. Myatt, Virginia F. Armbruster, Florence J. Bates, Blance C. Albright, Frieda M. Grimm, Letha M. Glunt, Ruth D. Goodwin, Rubye E. Putnam, Gwendolyn M. Peatling, Dorothy A. Vavra, Bernice G. Thompson, Zelda E. Smith, Jeannette M. Reeves, Eunice B. Kannette, Frances B. Booker, Wanda E. Biezunski, Lena La Badia, Elizabeth L. Sinatra, Anna M. Bliss, Margaret R. Jurek, Evelyn R. Perry, Frances P. B. Strate, Helen M. Gosney, E. Gloria Peters, Emerante M. Duhon, Fallie Y. Rowan, Donna M. Bratton, Elizabeth A. Wright, Clara M. Buck, Mary M. Smith, Phyllis Smallman, Mary R. Baril, Margaret M. Shaughnesy, Vera R. Dolf, Mary E. Hendrixson, Nina M. Basham, Gerda E. Cederstrom, Doris C. Johnson, Martha C. Burnette, Mary P. McCarthy, Urtha U. Skeels, Mary M. Crowe, Elizabeth H. McNair, Grace E. Hyatt.

Also promoted to chief nurse with the relative rank of first lieutenant: Margaret Schmidt, Agnes Komisar, Catherine M. Miller, Jane deS. Smith, Betty Sherwood, Adele M. Bandy, Diana E. Preston, Eleanore G. Jones, Thelma I. Nicholas, Mary M. Schulz, Margaret K. Wicke, Jane T. Tochman, June R. Walsworth, Suzanne M. Ottoy, Thelma G. Newland, Frances M. Madison, Bette J. Myers, Margaret M. Quigley, Dorothy S. Slavik, Agnes J. Coote, Belen D. Colon, Pauline Berryman, Josephine M. Buckley, Anita T. Romani, Emily M. Schmidt, Rosemary Ryan, Edna Holder, Ethel M. Baksa, Mabel M. Moore, E. Evelyn Westerberg, Teasie L. Mims, Lillian E. S. Pitts, Lucille M. Hug, Alice M. Georgeson, Elisa A. Venti, Rose R. Norman, Sabina A. Kozlowski, Anna E. Brunjes, Henrietta S. M. Jones, Lillian K. Bennett, Alice E. Moyer, Myrtle Jones, Rachel A. Rowland, Dorothy E. Kneipp, Doris Countryman, Esther L. McClafferty, Margaret E. McIntyre, Mary J. Wade, Lois R. Milbrandt, Gertrude G. Kilbane, Gertrude M.

Griffith, Mabel L. Sarin, Bernice E. Hedenschough, Leona O. Vetting, Grace E. Hearn, Virginia L. Shofner, Thelma I. Robbins, Lena W. Hogue, Jessica Orso, Daisy H. Spires, Helen M. Mosher, Isabel C. Scanlon, Ethel C. Cox, Marion Fairman, Virginia M. Morriss, Melva M. Snyder, Ruby E. Pritchard, Marie E. Lyman, Caroline E. Dangler, Gladys I. Hickman, Alma Day, Marion R. Jamison, Margaret M. Cote, R. Elizabeth Lewis, Helen E. Hughes, Iola M. Fiekers, Hattie M. Lewis, Alice F. Wever, Irma W. Flagg, Hazel F. Howard, Edna Schraeder, Rebecca E. Shriber, M. Etta O'Brien, Bernice M. MacDonald, Mildred O. Schmidt, Alma L. Moran, Evelyn D. Ellery, Mary E. Foley, Laura A. Murphy, Marcelline J. Connor, Ann E. Towey, Amy R. Webster, Susanna M. Strong, Matilda T. Saurick, Kathryn V. McCarthy, Anna R. Thurman, Ruth A. King, Marie A. Wasilewski, Julia Steedly, Thelma L. Howell, Margaret G. Bishop, Pauline Aikeley, Louise S. Holt, Ross Fischer, Minnie Escowitz, Alice M. LaPlant, Dorothy Lieb, Mabelle O. Conlin, Mary E. Langston, Miriam Citron, Florence E. Lake, Christine C. Mills, Jane C. Dry.

Also promoted to chief nurse with the relative rank of first lieutenant: Kathleen E. McMurrich, Elsa B. Dorloff, Geneva R. McLemore, Margaret Cutty, Doretta C. Lutman, Gladys R. Crawford, Hazel J. Lovett, Marjorie M. Wilcox, Sophie L. Sonnenberg, Lucy B. Small, Ruth E. Weise, Eleanor S. Slinger, Marcella M. Vediner, Ida M. Lacey, Marguerite A. Cerat, Agnes E. Knox, Retta E. Boyd, Barbara L. Jerome, Lola M. Bower, Beatrice M. Irwin, Mary L. BeDell, Grace E. Hodgson, Wilma L. Barnes, Frances Thomas, Gertrude M. Zellmer, Catherine Stevens, Marion Newson, Emma E. Garland, Adele J. Mueller, Hilda K. Fox, Louise E. Gilbert, H. Isabelle Pickett, Esther A. Gustafson, Ruth E. Peck, Sarah C. Heller, Harriet P. Putnam, Gladys L. Harm, Patsy A. Pritchard, Marie Guthrie, Elizabeth L. Gates, Virginia A. Ritten, Elizabeth L. Sandford, Ruth M. Conly, Lessie M. Bailey, Margaret L. Blackwood, Anna M. Moran, Isabelle K. Richards, Mary A. Salopek, Kathryn P. Mock, Helen M. Farrell, Mary E. Horner, Margaret L. Reed, Marion L. Massie, Lucille C. Kidwell, Marguerite E. McDonnell, Willie H. Lawson, Madeline E. Wanner, Victorine A. Obey, Thelma J. Harding, Iva A. Hughes, Ira T. Johnson, Townzella H. Kesling, Virginia M. Butler, Margaret L. Blackwood, Geraldine V. Beachem, Mary B. Baxter, Weir B. Barrett, Lucia O. Alewine, Vella Reeves, Marian L. Williamson, Grace L. McDonnell, Alice M. O'Hara, Jeannette F. Plutnicki, Ethel R. Smith, Mary C. Sullivan, Wanda E. Tworkowski, Vida M. Anderson, Marion L. Bridger, Agnes A. Chirmside, Anne R. Gibbons, Emily M. Gross, Evelyn V. Hopkins, Helen M. Lacy, Mary M. McNicol, Dora M. Nicholas, Mary V. Pembleton, Katherine M. Pollock, Helen E. Strong, Rita H. Walsh, Kathryn E. Weis, Pearl S. Adams, Anna E. Baker, Lucille G. Brooks, Kathryn W. Davis, Catherine W. Enders, Alice Greenhalgh, Catherine E. Holland, Elizabeth A. McEntire, Marion G. McIntyre, Ingeborg Ness, Marguerite F. Comella, Lois L. Turnbull, Wilma M. Gasser, Alene Dowda, Grace I. Freeman, Irene I. Spence, Anna M. Fiaschi.

Also promoted to chief nurse with the relative rank of first lieutenant: Helen M. Hinckley, Mollie S. Uttal, Edith G. Harer, Ruth J. Sirgany, Louise F. Galicie, Lucille M. Rosendale, Margaret E. Healey, Kate J. Stone, Derfla M. Richards, Mamie K. Starnes, Ruth E. Dvorschak, Evelyn L. Bessette, Catherine R. McGuinness, Margaret M. Loughlin, Yvonne F. C. Hudock, Rosalia A. Scheurich, Anna B. McCall, Mary S. Nicol, Ruth M. Griffiths, Mary E. Kutz, Martha L. Currence, Dorothy M. Drew, Virginia M. Elder, Lubov Wilcha, Mayme S. Rubinsky, Margaret Wells, Mary F. Wesneski, Irene I. Inglehart, Mary P. Long, Dorothy R. McWade, Margaret B. Kromer, Marjorie L. Bessette, June E. Rollins, Edith Swanson, Florence I. Bell, Frances R. Clifford, Caroline K. Paterson, Sue H. Robertson, Laura M. Eltringham, Helen B. Quinlan, Dorothy R. Shrier, Iva M. Rice, Anne L. Nodziak, Carol O. Turner, Ardella C. Broniszewski, Sadye E. Becker, Evelyn K. Olchowski, Nellie G. Galloway, Dorothea M. Travis, Mary H. Franklin, Genevieve H. Lyons, Bessie L. Brower, Marion A. Williams, Dorothy C. Farmer, Christine R. Fabian, Helene G. Mayo, Agnes H. Upchurch, Virginia M. Felker, Crettie H. Darden, Almyra M. Watson, Marie G. Parsons, Frances McNeill, Anna M. Ryan, Ruth J. Doellman, Mildred F. Hannah, Rose S. Nunes, Bessie L. Love, Thelma M. Johnsen, Claudine R. Steinmetz, Bernadette M. Primeau, Margaret F. Cameron, Elizabeth M. Wood, A. Sue Kerley, Mae L. Schmitz, Dorothy L. Stitzer, Genevieve E. Leonard, Alverta H. Montgomery, Alice E. Hall, Barbara M. Kynaston, Roberta A. Christy, Louise Bambauer, Margaret M. Budke, Dorothy L. Coulter, Edith S. Downs, Doris Hitchcock, Edna I. Kohenn, Anne E. McCarthy, Dorothy Sachs, Helen A. Shockites, Hilda M. Borcherding, Mary W. Holland, Sarah E. Harrington, Muriel A. Crane, Evelyn C. Krall, Mary E. Leahy, Marion E. Ross, Angela A. Scaletta, Vera H. Steele, Alberta L. Smith, Bessie P. Evans, Laila Spencer, Neva I. Armstrong, Frances E. Rubin, Helen V. Hyman, Sally L. Wright, Louise N. Madans, Maxine K. Kistler, Marigene Griffin, Angela C. Flanigan, Bettye P. Flippo, Mary E. Tyrrell, Leota Duke, Alice L. Damonte, Daisy O. Teeslink, Madeline McManus, Mabel Nygaard, Elizabeth E. Foster, Margaret J. Giles, Hazel F. Benner, Dorothy B. Conner, Myrtle M. Martin, Florian MacGregor, Alice M. Curto, Elnore L. Mendia, Annie T. O'Leary, Margaret B. Colbert, Mary E. Pierce, Mary E. Hartley, Alice M. Lane, Vernetta H. Seipp, Marie J. Sladeck, Helen E. Thuss, Margaret E. Senfleben, Hattie B. Lee, Hester M. Witherspoon, Dora E. Kirkwood, Loraine J. Braasch, Eleanor W. Miller.

Discharges.—One hundred and seventy-six.

Retirements.—Fifteen. Major Margaret M. Shook, Captain Anna L. Barry, Captain Helena Clearwater, First Lieutenants Caroline E. Bennett, Josie

Self, Second Lieutenants Margaret I. Brown, Mary L. Tullos, Julia M. Campbell, Susie B. Helm, Elaine O'Toole, Edith Faris, Adeline R. Engle, Amelia M. Gerhart, Maybelle A. Gay, and Phyllis W. Sedola.

Deaths.—Two. Second Lieutenant Nellie J. Moroni (retired), Veterans Facility, Hines, Ill., Dec. 24, 1943; Second Lieutenant Antoinette E. Vitarelli (retired), Dubois Hospital, Dubois, Pa., Feb. 16, 1944.

FLORENCE A. BLANCHFIELD
Colonel, AUS
Superintendent

U. S. Public Health Service Hospital Nursing Service

New Appointments.—Twenty. To Baltimore, Md., Elizabeth Stamm, Ruth Parker; to Boston, Mass., Marie Hale; to Cleveland, Ohio, Edna Rex; to Ellis Island, N. Y., Tillie BuDres; to Galveston, Tex., Margaret Wherland; to Memphis, Tenn., Ramelle Poindexter; to New Orleans, La., Robert Montgomery; to San Francisco, Calif., Mary Obermiller, Regina Wood, Margaret Baker, Dorothe Whittington; to Staten Island, N. Y., Harriet Blumenauer, Laura Walsh, Jeanne Edris; to Seattle, Wash., Carmella Johnson, Colleen Webb, Elizabeth Coe; to San Juan, P. R., Patria Valentin; to Lexington, Ky., Ina Byron.

Transfers.—Nine. To St. Augustine, Fla., Stasia Moskwa; to Curtis Bay Yard, Ruth Hart; to Evansville, Ind., Dorothy Komp; to New Orleans, La., Hazel Potter; to San Francisco, Calif., Anne Mason; to Los Angeles, Calif., Rose Bontsik; to Sheepshead Bay, N. Y., Marie Twomey; to Detroit, Mich., Martha Koesler, Monica Koesler.

Deaths.—One. Mrs. Irene Westerfield, Evansville, Ind., April 9, 1944.

JESSIE MACFARLANE, R.N.
Superintendent of Nurses

U. S. Veterans Administration

New Assignments.—Seventy-one.

Resignations.—Sixty-five.

Transfers.—Six. To Hines, Ill., Matilda S. Decker; to Cheyenne, Wyo., Corinne A. Fischer, Clara E. Leinen; to Oteen, N. C., Freda T. Caldwell; to Los Angeles, Calif., Helen F. Brown, Mary B. McDermott.

Retirements.—Ten. Jennie Honaker, Lincoln, Neb.; Harriet H. Connolly, Rutland, Mass.; Louise Ludwig, Pittsburgh, Pa.; Beatrice Stynes, Los Angeles, Calif.; Emma Voightsberger, Perry Point, Md.; Ruth Larson, Biloxi, Miss.; Ellen Hower, Walla Walla, Wash.; Ellen Robinson, Muskogee, Okla.; Myrtle V. Anderson, Los Angeles, Calif.; Margaret E. O'Connor, Castle Point, N. Y.

GWEN H. ANDREW, R.N.
Superintendent of Nurses

U. S. Indian Service

Appointments.—Two. To the Pipestone School, Pipestone, Minn., Edna S. Schroeder; to the Navajo Agency, Window Rock, Ariz., Ruth V. Cawthorne.

Separations.—One. Mrs. Frances P. Vardaman.

Transfers.—One. To the Indian Service at Large, unassigned, Mrs. Ida H. Bickers.

SALLIE JEFFRIES, R.N.
Director of Nursing

State Board Examinations

Delaware.—June 5–6, Nurses Residence, Delaware Hospital, Wilmington, Del. File applications with Mary A. Moran, Executive Secretary, 1313 Clayton St., Wilmington.

Florida.—June 21–22 for graduate nurses; June 22 P.M. for licenced attendants, Seminole Hotel, Jacksonville.

The Board will convene for a business meeting June 20 at 8:00 P.M.

Write to Florence V. Moore, Secretary-Treasurer, 227 S. Orlando Ave., Winter Park.

Louisiana.—June 16–17 and August 2–3, New Orleans and Shreveport. Applications for the August examination must be filed by July 10 with the secretary, Julie C. Tebo, Père Marquette Bldg., New Orleans 12.

Michigan.—June 1–2 for graduate nurses, the afternoon of June 1 for trained attendants, State Capitol, Lansing. File applications with fees with the executive secretary, Mabel E. Smith, 353 Hollister Building, Lansing 8.

Nebraska.—June 14–15, Lincoln and Omaha. File applications with Blanche Graves, Director, Bureau of Education and Registration for Nurses, Room 1112, State Capitol, Lincoln 9.

New Jersey.—June 13–14. File applications with the secretary-treasurer, Bernice E. Anderson, Room 1001, 17 Academy St., Newark 2.

Ohio.—June 23–24, Columbus, Cincinnati, Cleveland, and Toledo. Nurses who have completed the course in theory and practice and are twenty-one years of age by June 25 may sit for the examination. For further information write to the executive secretary, Clara F. Brouse, State Nurses Board, 21 W. Broad St., Columbus 15.

Oregon.—August 3–4, Portland. For further information write to Kathryn M. Parrish, Executive Secretary, 419 Pittock Block, Portland 5.

South Dakota.—June 6–7. Junior High School Building, Mitchell. Candidates within 180 days of completion of the thirty-six months course, including all senior cadet nurses, are eligible to write this examination. Applications with fees must be filed with Carrie A. Benham, Box 836, Mitchell.

Texas.—August 22–23, Dallas, Houston, San Antonio, Amarillo, and El Paso. For further information write to Mrs. Eloween Mesch, 1035 Milam Bldg., San Antonio.

Virginia.—June 13–14, Richmond. File applications with the secretary, Josephine McLeod, 812 Grace-American Bldg., Richmond.

Wisconsin.—June 21–23, Milwaukee. File applications with the secretary, Leila I. Given, State Board of Health, Madison, by May 15.

OBITUARIES

Blanche Easton (Brockville General, Brockville, Ontario, 1906) on March 13 in Rockford, Illinois. In various administrative positions prior to serving as superintendent of the Rockford Hospital, Rockford, Ill., from 1922 to 1935.

Emma A. Gibson (Bellevue, New York, 1914) on April 9 at the Veterans Facility, Dayton, Ohio. Staff nurse, Bellevue Hospital, 1914–1917; entered the Army Nurse Corps in January 1918 and served overseas with Base Hospitals 1 and 4, returning to the United States in April 1919; private duty, 1919–1923; ship's nurse, 1923–1925; night supervisor, Bellevue Hospital, 1925–1932; night supervisor, Grasslands Hospital, Valhalla, New York, 1932 until retirement in 1940.

Helen Mary Hickey (West Suburban Hospital, Oak Park, Illinois, 1917) on March 17 at Ishpeming, Michigan. Supervisor, pediatric, surgical, and group nursing divisions, as well as night superintendent, West Suburban Hospital, Oak Park, Ill.; assistant superintendent, Westlake Hospital, Melrose Park, Illinois, from time of its organization until May 1929.

Harriet Frances MacArthur (Presbyterian Hospital, New York, 1895) on November 24, 1943, in New York City. Miss MacArthur was one of the nurses who went with Miss Maxwell in 1898 to Chicamauga Park in the Spanish-American War. On her return she engaged in private duty nursing in New York City. Later she accepted the position of head nurse on the women's medical wards of her own hospital.

In 1912 she resigned to become director, school of nursing and nursing service, Lane Hospital, San Francisco, California. Returning to New York City in 1914 she taught Red Cross nursing classes at Mulberry Street Community Center and in 1919 became a teacher of home economics and practical nursing at the Washington Irving High School, New York City. She retired in 1937.

Aurelia B. Potts, R.N.

Mrs. Margaret Paxson Osborne (Woman's Hospital, Philadelphia, 1876) on March 28 in Los Gatos, California, at the age of 92. She was, at the time of her death, believed to be the oldest living graduate nurse in the United States.

Mrs. Osborne was the first directress of nurses of the Woman's Hospital of Philadelphia and received in 1876 the first "Pauline" medal, an honor given by that institution for outstanding nursing service. She had charge of the Emergency Pavilion at the Philadelphia General Hospital during the Centennial of 1876. Soon after her marriage to Dr. Osborne in 1880 she went to California where they established the first institution for the care of the feebleminded on the Pacific coast. In this work they spent many years, retiring only a few years before his death in 1935.

Aurelia B. Potts (University of Michigan Hospital School of Nursing; M.S., Columbia University) on April 19 at Vanderbilt Hospital, Nashville, Tennessee, after a brief illness. Miss Potts was a teacher in the field of home economics before she became a nurse and had been on the faculty of the Pennsylvania State College and the Michigan State College. She was associated with the Merrill-Palmer School, Detroit, between 1924 and 1928 and went to the George Peabody College, Nashville, Tennessee, in 1929, first as an instructor, subsequently as director of the Department of Nursing Education, continuing in this position until her death.

She had been a member of the Board of Directors of the Tennessee State Nurses Association and its president for two successive terms of office. This organization, in appreciation of her work, provided a life membership in the National Organization for Public Health Nursing. She was a member of the Board of Directors of the Southern Division of the ANA, past secretary of the Association of Collegiate Schools of Nursing, and a member of the board of that organization at the time of her death. She was active in all nursing affairs in the state, a member of the State Nursing Council for War Service, of the Procurement and Assignment Service for Nurses, and of the Board of Directors of the Nashville Public Health Nursing Council. She was a member of Delta Omega, the honorary fraternity in public health, and of Kappa Delta Pi, national educational fraternity.

Mrs. Rebecca Strong, on April 25 in Chester, England. Mrs. Strong studied under Florence Nightingale in 1867. She served as matron of the Royal Infirmary, Glasgow, Scotland, from 1879 to 1885 and again from 1891 to 1907. In 1893 she founded the school of nursing at the Infirmary, inaugurating *for the first time in history* a preliminary period for student nurses preceding their practical clinical experience on the wards. On entering this school, students took their preclinical theoretical work at St. Mungo's Medical College before going to the Glasgow Infirmary for their practical training.

In 1929 Mrs. Strong, then in her late eighties, attended the International Congress of Nurses held in Montreal. At the time of the Congress she was president of the Scottish Nurses' Association and still taking an active part in professional life. In her ninety-seventh year she received the Order of the British Empire as an award for her past services to the nursing profession. On her one-hundredth birthday she broadcast a message over the British Broadcasting Company network. (See the May *Journal*, page 490.) She was 101 years of age at the time of her death.

BOOK REVIEWS

EDUCATION AND HEALTH OF THE PARTIALLY SEEING CHILD. By Winifred Hathaway. Published for the National Society for the Prevention of Blindness, Inc. 216 pages. Illustrated. Columbia University Press, New York. 1943. Price, $2.50.

Reviewed by Lula P. Dilworth, R.N., M.A., Associate in Health and Safety Education, State of New Jersey Department of Public Instruction, Trenton.

GENERAL AND HEALTH educators alike owe a debt of gratitude to Mrs. Hathaway for having brought together in one volume significant facts which relate to seeing and education of the partially seeing child. Excellent illustrations, diagrams, and the general structure of the book increase its merits. Need for this sort of a brochure is of long standing. Those of us who have had the privilege of knowing Mrs. Hathaway feel that through the book a chat with the author is being enjoyed.

"Facts About the Eye and Eye Hygiene"; "Vision Testing, A Screening Process"; and "Outline for Checking Lighting Facilities and Equipment for Eye Work in the Classroom," appendixes one, two, and three provide basic information for the parent, nurse, teacher, and school administrator. Nurses in general—institutional, instructors, general duty, and public health—would profit by mastering this section of the book.

Through this treatise new inspiration comes, and the desire is created to rededicate our efforts in the advancement of eye health. As both a general and a health education reference *Education and Health of the Partially Seeing Child* takes its place alongside the "musts" in our functional library. The title may be misleading since the content which has to do with general health promotion, wholesome environmental factors at home and at school, and health instruction, is applicable to every gradation of sight from normal through partially seeing.

Establishment of a complete program for eye health as described comes as a challenge to every school administrator. Adoption of the recommendations would assure parents and pupils of a sincere attempt to bring the school experience more nearly into line with individual capacity and need.

FAMILY HEALTH SERVICE. By Margaret L. Shetland, R.N., M.A., 170 pages. Institute of Welfare Research, New York. 1943. Price, $1.00.

Reviewed by Helene Buker, R.N., M.A., Director, Bureau of Public Health Nursing, Michigan Department of Health, Lansing.

THIS IS a study planned to provide a descriptive analysis of the scope and quality of the family health service rendered by the Department of Educational Nursing of the Community Service Society, New York City. Sources of information used were operating statistics, summary cards of closed cases for one year, and a representative sample of the records of closed cases. The first two sources yielded largely quantitative and objective data while the study of case records served as a basis for qualitative evaluation.

The agency service is one largely of health promotion and the methods the author has developed to measure achievement in this field are unique and worthy of trial by other public health nursing agencies. Six criteria were set up for the qualitative evaluation and applied separately to each of a group of case histories. Results were measured by means of a scale which provided for separation of two major components, skill of the nurse and family progress.

As the author states, the nature of family health service makes it extremely difficult to isolate its essential characteristics and to measure its effectiveness. Though fully aware of the limitations in using case records as a basis for evaluation she has made some interesting and significant analyses. One is led to believe that the case records of the agency studied were unusually detailed and complete.

Experimentation in new methods of evaluating public health nursing services seems most timely and we can thank the Community Service Society for permitting others to share its study.

SMALL COMMUNITY HOSPITALS. By Henry J. Southmayd and Geddes Smith. 182 pages. Commonwealth Fund, New York. 1944. Price, $2.00.

THE FIRST of the thirteen rural hospitals which the Commonwealth Fund has helped to build was opened in 1927 and plans are ready for postwar construction of still another. This very important book is the crystal clear distillate of the experience, over the years, of the authors and other representatives of the Fund in its effort to promote the development of good standards of service in rural hospitals.

Good hospital service, say the authors, "involves careful thought and continuous attention to standards of service—medical, nursing, and administrative." Of these three areas, the administrative is stated to be that in which it is most difficult to promote good standards because so little has been done to prepare administrators for these exacting positions. Most such positions are held by nurses, but preparation for nursing does not include the elements of hospital administration; indeed some of it tends to inhibit development as administrators of a service in which the relationship to the medical service is quite unlike the traditional physician-nurse relationship.

The most significant statement in the section on

"The Nursing Staff" is "the fifty-bed hospital cannot run a satisfactory nurse training school and must therefore be staffed with graduate nurses." The statement is supported by cogent argument.

The seven chapters occupy only 135 pages, and a series of valuable appendixes another thirty-nine. Among the latter, one finds the list of hospitals built under the Commonwealth Fund program and "Suggested Rules and Regulations." (Those pertaining to nursing are basic and, in that sense, explicit.)

Rural nursing, in all its aspects, is a matter of increasing importance to the nursing profession. The book is recommended not only for the reference libraries of institutions offering courses for graduate nurses but also for those of all schools of nursing and those of the state boards of nurse examiners.

M. M. R.

Management of the Cocoanut Grove Burns at the Massachusetts General Hospital. By nine members of the staff and their staff associates. 171 pages. Illustrated. J. B. Lippincott Company, Philadelphia. 1943. Price, $4.00.

Reviewed by Ruth Evans, R.N., M.A., Associate Professor of Surgical Nursing, Frances Payne Bolton School of Nursing, Western Reserve University, Cleveland, Ohio.

The monograph has been arranged as a series of papers by the staff responsible in their particular fields. In the Foreword the author states that "had such a catastrophe taken place before Pearl Harbor, the hospital would have been swamped. As it was, the injured found the staff prepared, for the war had made us catastrophe minded." The hospital was well prepared, partly as a result of the foresight of Dr. N. W. Faxon, Director, and Dr. E. D. Churchill, Chief of the West Surgical Service. Besides, two research projects in burns were in progress under contract with the Office of Scientific Research and Development of the United States Government.

The first three papers deal with problems of administration and psychiatry peculiar to a civilian disaster. The next four describe the course and treatment of the lung injuries. The last five deal with the various aspects of surface burns.

The following papers are of particular interest to nurses. "Problems of the Hospital Administration" has special significance since it shows how a previous plan set up under Civilian Defense for the handling of war casualties was immediately put into operation. The great lesson learned was the value of anticipation and preparation. The fire started at 10:15 P.M., the first patients arrived at 10:30 and by 11:15 nearly the entire organization had been assembled—house staff and nurses on duty were called to the emergency ward, teams for burns and resuscitation, members of visiting staff, nurses off duty, social workers, volunteers, orderlies, and others. Many valuable lessons were learned, namely, having on hand large quantities of supplies, a well planned telephone service, organization of teams of nurses with previously assigned duties, and special medical teams for the administration of morphia and blood plasma, et cetera. The paper "The Treatment of the Surface Burns" is an exceedingly interesting and valuable description. The author states that surface treatment cannot be divorced from treatment of shock and that it was his purpose to outline a surface treatment which does not interfere with the lifesaving treatment of shock and yet which tends to prevent bacterial contamination. The treatment proved eminently satisfactory; its advantage was in its simplicity. The paper "Procedures in Rehabilitation of the Severely Burned" showed that failure to debride the wounds did not delay the healing of secondary burns; in fact, by the end of two weeks the secondary burns were epithelized and uninfected. "A Note on the Blood Bank" proves that a blood bank is a requirement for efficient handling of patients in disaster and that there should be no restraint in the use of frozen plasma.

The real value of this book lies in the fact that the authors recorded facts and not mere opinions and impressions. It shows the value of anticipation and preparation for an emergency and describes a simple but very successful treatment of surface burns. It does not, however, contain much information about the plan for nursing service in disaster.

The instructor of communicable disease nursing will find a significant article on current research in tropical diseases in the May 1, 1944, issue of *Life*. A world map of the major tropical diseases presents vividly the areas where malaria, yellow fever, dengue, typhus, plague, cholera, sleeping sickness, tularemia, Rocky Mountain fever, Japanese river fever, relapsing fever, helminthic diseases, yaws, leprosy, and leishmaniasis are prevalent.

Pharmacology, Materia Medica, and Therapeutics. By Charles Solomon, M.D., with the collaboration of Hazel Houston, R.N., M.A. Fifth edition. 823 pages. Illustrated. J. B. Lippincott Company, Philadelphia. 1943. Price $3.00.

Reviewed by Beatrice E. Fisk, R.N., Instructor in Nursing, University of Michigan School of Nursing, Ann Arbor, Michigan.

From the standpoint of format, presentation, and organization, this edition is no radical departure from the fourth, or even the third. It rather presents an expansion of content and minor adjustments of details to bring the book abreast of newer developments in medical science and to make it current with the twelfth revision of the *United States Pharmacopoeia* and the seventh edition of the *National Formulary*.

As was true of the last two editions of this book, this one holds quite strictly to the unit organization and content suggested in the 1937 revision of the *Curriculum Guide for Schools of Nursing*. Over and above this are adjuncts of more or less question-

able value. Among the attributes of Dr. Solomon's book have been its lucid presentation and generally succinct statement of the most essential pharmacological content with proper subordination of the less consequential. This has been due considerably to the mechanics of a generously used outline form.

The book purports to be inclusive in its content, and one again wonders if "therapeutics" may not have been too broadly interpreted. For example, it would seem that details of nursing procedures such as enemata, packs, and intravenous infusion could well be omitted. One would also question the value of the section on nonmedicinal therapeutics where dietotherapy and psychotherapy are given a hasty going over and where the entire gamut of physical therapy is crowded into about thirty pages. The section on pharmacology in the specialties and the one on treatment of emergencies would seem to fall in the same category. Evidently, the motive here is correlation with the various clinical courses rather than duplication of clinical content. However, as is often true when briefly covering a great quantity of material that is open to various interpretations, the author's synopses are frequently somewhat arbitrary.

The elaboration of content has been most comprehensive with the sulfonamides, for all the forms in clinical use are dealt with in considerable detail. The section on vitamins has been expanded generally with particular reference to the forms within the vitamin B complex. Among other additions one notes plasmochin, atabrine, and mapharsen.

The illustrations are essentially the same as in the previous edition. In an effort to make the diagrammatic and anatomical illustrations more pertinent, the parts have been colored in various ways. This has made interpretation easier in some cases. However, a better explanatory legend in many cases would have made things more graphic.

Relative to pharmacological content and presentation, the author has produced a most acceptable revision of what has always been an essentially good textbook in pharmacology for nurses.

TEXTBOOK OF PHYSIOLOGY. By William D. Zoethout, Ph.D., and W. W. Tuttle, Ph.D. Eighth edition. 728 pages. Illustrated. C. V. Mosby Company, St. Louis. 1943. Price, $4.75. *Reviewed by Meta E. Lemke, R.N., M.A., Educational Director and Science Instructor, Pennsylvania Hospital School of Nursing, Philadelphia, Pennsylvania.*

AS STATED in the Preface: "In this edition the first chapter, dealing with protoplasm and its environment, has been almost entirely rewritten." The material is arranged in a more systematic manner and is therefore more easily understood. In the chapters on the circulation, more headings and subheadings have been used which give a clearer organization of this subject. Material has been added on blood banks, traumatic and gravitational shock, the hormonal control of the reproductive functions, and several other topics. These last add very important and up-to-date material.

New illustrations have been added in several chapters, and many of the older ones have been redrawn. The material on "The Cranial Nerves" has been put into larger type instead of the very fine type formerly used; this gives it greater importance. "The Autonomic Nervous System" has been placed in a separate chapter and a clearer diagram used.

Comparison in this next paragraph is chiefly with the sixth edition of 1938. Some new material has been added on tissues, also new illustrations. In another chapter, the illustration to demonstrate the knee jerk has been redrawn. More material has been added on Vitamin B and some of the illustrations have been changed.

As in the last three editions, much of the advanced chemistry and the more detailed anatomy has been set in smaller type and may be omitted by beginning students without losing the value of the book.

This new edition is printed on good quality paper, light green in color said to make reading easier. Instructors will find this a valuable book for source material because of the up-to-date list of references at end of the book. Students will find it an excellent reference book because of the many headings, clear organization, and excellent illustrations which do much to help in the understanding of new material.

ARE YOU ALLERGIC? By Jessamine Hilliard and Charles C. Coghlan, M.D. 248 pages. M. Barrows and Company, Inc., New York. 1943. Price, $2.50. *Reviewed by Louise D. Larimore, M.D., Pathologist, Greenwich Hospital, Greenwich, Connecticut.*

IT IS TIME for the victims of allergy to have a book of their own, though the authors of *Are You Allergic?* make the word "victim" almost a misnomer, for they are flattered by being told that they are among the world's sensitive individuals, sensitive to ideas as well as to specific proteins. This is a very readable book, both to the patient and to the physician, and should serve well, through its many actually dramatic case stories of relief, to break down doubt, to spread good information, and to carry hope of such relief in hay fever, asthma, eczema, migraine, and certain gastro-intestinal disturbances. It runs to the optimistic side, but then optimism is needed for the allergic, through the possible long search for the causative agent in food or household or plant or drug contacts. And it may well arouse a more wide-spread realization that a specific sensitization is the cause of a feeding problem in infants, or a persistent skin eruption, or a recurring headache, in which much time may be lost in other methods of treatment.

The book is well documented by interestingly written chapters on the historical development of knowledge in the field, impressively augmented by

a real medical bibliography for the physician or nurse who desires further details.

Expansion of Pediatric Facilities To Increase Admissions and To Enrich Experience is the title of Bulletin No. 9, *Nursing Education in Wartime*, published May 4, 1944, and prepared under the auspices of the Committee on Educational Problems in Wartime of the National League of Nursing Education. This issue discusses ways in which schools have gauged student admissions, ways of expanding available pediatric facilities and computing admissions when facilities are expanded. *Nursing Education in Wartime* is sent to every director of a nursing school and to a selected list of other interested individuals and agencies. A limited number of copies of the bulletin are available at ten cents per copy. Orders, which must be accompanied by a remittance to be filled, should be sent to the National League of Nursing Education, 1790 Broadway, New York 19, New York.

THE HEALTH OF CHILDREN IN OCCUPIED EUROPE. 37 pages. International Labor Office, Montreal, Canada. 1943. Price, 25 cents. Distributed by the International Labor Office, 734 Jackson Place, Washington 6, D. C.

THIS PAMPHLET quotes figures from several sources to show the dire needs for food in the occupied countries. In 1943 the food rations and supplies available were often lower than the legal rations. Two quotations will suffice to illustrate:

> In Belgium, flour and dried vegetables are unobtainable, and according to recent reports oil and margarine have also disappeared from the market, and cheese is very scarce. . . . .
>
> In one department [in France] with a population of 138,000 children . . . . there was no meat, and fruit and fats were also unobtainable.

The pamphlet is well documented though admittedly assembled under present difficult conditions. Conditions within individual countries concerning food rationing levels and food shortages, dietary standards and deficiencies, et cetera, are presented as are the consequences in general undernourishment, spread of disease, rise in death rate, and increase in juvenile delinquency. Among the conclusions arrived at are these:

> Depopulation in these countries is proceeding on a scale which threatens their powers of recovery. . . . .
>
> The incidence of serious diseases is increasing, epidemics are already making their appearance, and there is a general decline in health due to malnutrition and undernourishment, the effects of which are not yet visible in the statistics but will appear in due course. . . . .
>
> One of the primary tasks of the United Nations when victory has been won will therefore be to bring immediate relief to the underfed and devitalized peoples of Europe, to provide them with the means of checking as quickly as possible the epidemics which are already beginning to break out, to restore normal conditions of public health, and to make it possible for these countries, by various measures of social security, to build up a healthy population as a foundation for their future welfare.

H. W. M.

FOREIGN RELIEF AND REHABILITATION—a bibliography. No. I of a series of occasional papers, "Administration of Relief Abroad." 23 pages. The Russell Sage Foundation, New York. 1943. Price, 20 cents.

ADMINISTRATION OF RELIEF ABROAD, Occasional Papers—First Series: No. 5. The American Friends in France, 1917-1919. By Rufus M. Jones. Together with Problems Involved in Administering Relief Abroad, by Clarence E. Pickett; No. 6. The American Relief Administration in Russia, 1921–1923. By H. H. Fisher; No. 7. Recent Relief Programs of the American Friends in Spain and France. By John Van Gelder Forbes and the American Friends Service Committee; No. 8. American Red Cross Famine Relief in China, 1920–1921. From the Report of the China Famine Relief, ARC. Four pamphlets. 20 cents each, from the Russell Sage Foundation, 130 East 22nd St., New York 10, New York. 1943.

THE EXPERIENCE of agencies in administering relief programs during and after World War I, and in more recent foreign relief operations, is of interest as plans for postwar relief programs are developed. This series presents material which was out of print, or had not been published, or was otherwise difficult to obtain. The need for serious consideration of our approach to relief problems is expressed by Mr. Pickett, in pamphlet No. 5. "One of the best ways to breed the next war would be to have a high-hat relationship between donor and recipient. One of the best ways to build toward the co-operative world which we seek is to begin that co-operative practice when the relief stage comes."

Public Health Nursing *for June*

Official publication of the National Organization for Public Health Nursing

Public Health Nursing Services in Clinics, II, Hortense Hilbert
Alcohol Research—Theoretical and Practical, II, E. M. Jellinek, M.D.
Public Health Nurse and Medical Social Worker in a Venereal Disease Program, Alice M. Kresge and Dorothy H. Brubaker
Students Study the Curriculum, Audrey Holt and Caroline Rosenwald
Recommended Minimum *Wartime* Public Health Nursing Service
Records and Reports, Nan Cox Hare
Applied Democracy in Inter-Group Relationships, William H. Kilpatrick, Ph.D.

"I am the Nurse"

I am the nurse.
I walk with him
In his world of pain.
He is the warrior
become a boy again
Returned to us
in the backwash of war.
By God, given back to us,
to make whole.
I am the nurse.
But I am so few and he . . .
your wounded man . . .
is legion!
Women, mothers of men,
. . . stand with me
in the dark of night
. . . and listen.
Do you hear the murmur
of a million lips?

Do you hear . . .
the call for help,
rising in pitch
Above the death-belch of
cannon . . .
Calling from the heavens,
through the whine
of crushed wings . . .
Bubbling through the ocean's
swell . . . touching
at every shore?
Yes, you hear it . . . the call
of hurt.
You are a woman and hearing,
you must heed.
When his teeth are clenched
in pain . . . upon a woman's
name . . .
Mine is the hand that soothes.

When his eyes are set
upon a woman's face
cherished image plucked
through space,
Mine are the words that calm.
I am the nurse,
Stricken in heart with
the single fear
That against the growing need
my numbers cannot prevail.
For I am so few and he . . .
is legion
who asks our aid.
Add your hands to mine
women, mothers of men,
Lest I be too few,
lest victory hang
like a mocking mask
Upon our Nation's honor!

FRED METHOT

RPB

U. S. ARMY NURSE CORPS