A REPORT BY

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After Visiting Hospitals in the United States and Canada

Some Observations after a visit to Hospitals in The United States and Canada

by

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FOREWORD

Through the generosity of King Edward's Hospital Fund for London, last year I was able to visit several of the teaching, general and chronic hospitals in the United States and Canada.

This little booklet gives an account of my main impressions of the hospital services in these two countries. It is published in the hope that it will interest and encourage my hospital friends and others on both sides of the Atlantic Ocean.

In addition to acknowledging the debt I owe to the King's Fund, I would like to thank Captain J. E. Stone of the Division of Hospital Facilities and Sir Allen Daley of the London County Council for their help with my itinerary, and to thank all the hospital and public men and women in the United States and Canada who gave ungrudgingly of their time and experience on every occasion.

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I

HOSPITAL PRACTICE, ADMINISTRATION AND MANAGEMENT

1. THE NEW WORLD AND NATIONAL PLANNING.—In America the government of the individual States, and in Canada the provincial governments are responsible for the health services provided, and not the Federal or Dominion governments. Because of this, and the size of the two countries, the conditions under which the hospital services are carried out are very different from those in this country. In Great Britain, under the National Health Service a disciplined—or possibly an authoritarian—hospital system is taking shape under circumstances of restricted national economy; in Canada and particularly so in the United States there are less comprehensive facilities with much variety in the aims and purposes of the hospitals and the standard of their services.

2. Many Americans do not realise that this difference in outlook is not due to one political party, that it is a national development, and, in fact, is largely an old world or European point of view as compared with the present transatlantic one. Socialised medicine is the subject of endless discussion. The National Health Insurance Act of 1911 has to be explained, and it is not realised that even before 1939 many in this country were deeply concerned about the changes which would be necessary to meet the increasing complexity and cost of hospital services. While the Americans are unanimous in their admiration for the prescience which laid down the foundations for this service in the stress of the late war as part of the National Insurance system, most are critical and gloomy about the results which may follow the subservience of these activities to Parliament and to bureaucratic methods of control. Informed critics appreciate the political genius of this country and the ability of the civil service, but it is impossible to satisfy them on the methods by which control of policy and finance may be retained centrally by the government

of the day, and at the same time allow sufficient resources and freedom for enterprise by the responsible Boards of Governors and Hospital Management Committees on which the rate of progress will depend.

3. VOLUNTARY, MUNICIPAL AND PROPRIETARY HOSPITALS IN THE U.S.A.—In the United States, there are voluntary hospitals, State and County hospitals, and proprietary or private hospitals. The teaching hospitals are generally voluntary hospitals, but there are exceptions : for example the University Hospital at Ann Arbor is part of the State university, which administers it on behalf of the State of Michigan, and the Bellview Hospital is administered by the city authorities of New York. The teaching and other general hospitals often have considerable accommodation or ward blocks for infectious, tubercular and chronic patients. There are some very large general chronic and mental hospitals managed by the local civic authorities. As yet such public authority hospitals and health services are not so developed and comprehensive as those, for example, administered by the London County Council before July, 1948. In fact, the municipal hospitals are sometimes very overcrowded, indifferently staffed and ill-equipped in contrast to the voluntary hospitals.

4. PAYING FOR TREATMENT.—It must be pointed out that the voluntary hospitals do not treat so large a proportion of general patients (termed " ward " or " medically indigent " patients) as did the former voluntary hospitals of this country. The American donor has been generous in making donations for capital or building purposes, but the maintenance of the American voluntary hospitals depends largely upon the accounts paid by patients for services rendered. The number of private and semi-private beds in these hospitals is much higher than in Great Britain, and is often forty per cent. or more of the total bed complement of particular hospitals. Most, if not all, members of the community in regular full time employment use such pay-bed accommodation ; about one-quarter of the population of the United States are now members of mutual insurance or provident schemes, generally run by voluntary organisations, and often called " Pre-payment " or " Blue Cross " plans. Great efforts are being made to encourage

membership of these " Blue Cross " schemes in order to combat legislation for socialised medicine. It is significant that the members of these schemes and their dependents are almost always treated in pay-wards ; in fact treatment in wards with not more than four beds is often stipulated by these schemes, and the customary medical professional fees are paid. It is noteworthy too that prominent insurance companies compete successfully by special policies with these " Blue Cross " plans. These organisations are the American adaptation of the British contributory schemes. As they are designed to provide the cost of paying patients, or benefits for them, their objects follow more closely those of the more recent provident schemes established. Contributory schemes for ward patients, whereby in Great Britain charges are not made for professional services, have not proved popular in America.

5. As has been stated, the beds available for ward or medically indigent patients are more limited in the voluntary hospitals, and the accommodation in the State and County hospitals is often so overcrowded that ward lobbies and passages have to be used. In the voluntary hospitals such patients are admitted without payment of professional fees, but the hospitals often require a payment for other costs which by British standards is heavy ; out-patients are confronted with a clerk and cash register in the receiving room, in the X-ray department and in the pathological laboratory, and ordinary or ward in-patients receive an account complete with all extras. Great efforts are now being made to encourage State and County authorities to pay the cost of all medically indigent patients treated at voluntary hospitals.

6. SPECIALIST TREATMENT.—A more important and fundamental difference is that although the voluntary hospitals in the United States and Canada are staffed by honorary part-time specialists (called the " active " or " attending " staffs), assisted by whole time junior staff, the visiting specialists seldom undertake regular weekly sessions in the out-patient clinics. Great Britain has reason to be proud of the services of the most distinguished physicians and surgeons given week by week to their out-patients. The honorary staffs of the American hospitals do render great services to their hospitals ; they organise and direct their departments with close attention, they supervise their juniors, many are

painstaking teachers, and they carry out clinical research on a very lavish scale. The expenditure and concentration on clinical research and the facilities available for it are particularly noticeable at all the major teaching hospitals. Although the visiting staff may undertake in-patent services for medically indigent patients, they do not generally hold out-patient clinics. As a result there is a lack of continuity of treatment of particular patients, and ward patients do not receive the same experienced service as private patients. In this connection it must be remembered that the average American, in good times, expects to see his consultant or specialist privately, and members of the senior staff frequently have consulting rooms for paying patients on the hospital premises. The general practitioner does not occupy the same place as in this country, consultative services are given without reference from him, and there are more medical specialists and pseudo specialists.

7. New Construction.—This country has, of course, a long start in providing hospital services, and those in the United States and Canada are not as yet so extensive, especially in the rural areas. Most of their hospitals were built or greatly extended after the 1914–1918 war and, particularly in the United States, considerable hospital construction is now taking place. With all the resources of the United States, the Federal Government is encouraging hospital construction by the individual states and voluntary authorities, and since the war, many hundreds of millions of dollars have already been spent on this. One-third of the cost of approved schemes is met by Federal funds, the balance being raised by state taxes and voluntary contributions, and these federal grants are made both for ward patients' and pay-bed accommodation. Emphasis has been primarily made on rural hospitals, but the Hospital Construction Act is now being extended also to meet hospital deficiencies in the larger towns and cities. Extraordinary progress is therefore being made, both in the United States and Canada, in making available full hospital services under conditions suitable for the economy and political traditions of the North American continent.

8. Hospital Management.—The detailed control of executive functions by committees, so typical of local government practice in Britain, is not as yet prevalent in the United States and Canada.

Similarly, in the hospitals, there is not close supervision of the day-to-day activities and departmental expenditure by the Board's of Directors, or by sub-committees. The Boards of Directors are mainly content to consider matters of policy, and the broader aspects of administrative practice and financial control ; they are able to keep themselves well informed through the activities of powerful and wealthy voluntary organisations, and also by attendances at conventions or conferences which are very popular in the United States and Canada. Owing to the war, nationalisation and the winding up of the activities of the British Hospitals' Association there has been no national conference of hospital governors or committees of management here for over a decade.

9. Hospital Administration.—The senior medical staff, the hospital superintendents and the directors of nursing do not readily understand the necessity for, or the advantages of, this close supervision of executive, managerial and purchasing functions by committees and sub-committees of individual hospitals. The central administrative staffs of the hospital are, on the whole not large, and hospital superintendents pay great attention to the efficient and economical operation of the various departments of their hospitals. In view of the high rates of pay of all staffs and their itinerant habits, and the great knowledge of organisational problems, there is a concentration on methods by which expenditure on salaries and wages, and particularly manual labour costs, may be reduced.

10. Training of Hospital Staff.—Generally, the duties of all members of the staff are carefully prepared and regularly revised. In the case of departments employing large numbers of staffs (for example domestic assistants), job analyses and time study investigations are undertaken. Preliminary training is given and written directions are supplied of the way in which the duties are to be carried out, and in the use of all mechanical equipment. In this country there is, as yet, no counterpart to the manuals prepared by the Cleveland Hospital Council on hospital procedure or on training hospital employees.

11. University Training in Administration.—In addition to their medical, dental and nursing schools the Americans are

giving careful study to the training of all hospital staffs. There are no fewer than nine university schools of training for hospital administrators ; there are college courses for social workers, medical librarians and, of course, for dietitians. Paradoxically the training of physiotherapists has not received the attention it has in this country. The training in hospital administration lasts two years, and university degrees are awarded. Many of the students have already graduated in some other faculty, and a few are doctors. In several of these schools the scope of the curriculum is impressive. The recent development of King Edward's Hospital Fund for London in the sphere of training for administration is obviously fulfilling a most necessary function for this country.

II

HOSPITAL DESIGN AND EQUIPMENT

12. With few exceptions, the hospitals built in the United States and Canada are not designed to grow old gracefully, and the exteriors of the buildings are as uninspiring as the post war flats built by our hard pressed local authorities. Internally, and particularly in detailed planning, equipment and sometimes in the design of furniture and furnishings, there is much to impress the visitor.

13. VERTICAL AND HORIZONTAL PLANNING.—Hospitals built in the centres of the large cities are of the multi-storey type, because of the high cost of sites and to conform with their surroundings. Elsewhere, in the inner and outer suburbs, they follow the horizontal design fairly similar to the hospitals of this country, though the blocks may have eight to ten stories. Architects and administrators were often of the opinion that skyscraper hospitals are not likely to prove so popular in the future. Apart from the heavier cost of the upper floors in blocks of say twenty storeys or more, it is becoming clearer that multi-storey buildings are not so satisfactory for hospitals as " skyscraper " blocks are for offices and apartment houses. True vertical planning on restricted sites is likely to result in a " straight jacket," and to make future adaptation and alteration, inevitable in a progressive hospital or factory, unduly complicated.

14. However many lifts or elevators are provided, often at almost astronomical cost, American experience shows that they often tend to become inadequate in the tallest hospital structures. At one recently built hospital, patients' meals are already being cooked three-quarters of an hour earlier than would otherwise be necessary because of the inevitable delays in transporting them up the service elevators.

15. WARD UNITS.—Possibly owing to the extremes of climate, and the number of small wards and single rooms common in the

American Voluntary Hospitals, natural and cross ventilation is not taken so seriously as in this country. This lack of ventilation, including the non-opening of windows, and the high temperature of the rooms, sometimes makes the atmosphere in patients' accommodation, service rooms and elsewhere oppressive. On the other hand, great attention is given to lighting and to the prevention of unnecessary noise. All the rooms, halls and passages are cheerfully and often brilliantly lit. The acoustic treatment of corridors, halls, lecture rooms and offices is widespread, and acoustic tile ceilings are now being provided in some large wards.

16. While in the County and State hospitals there are many large open wards, often overcrowded, in the new voluntary hospitals the wards are being steadily reduced in size. There were large numbers of single rooms and the planning of the many connected ward units and four-bedded cubicles for semi-private patients is often impressive. Most of the newer hospitals have wider wards than are common in this country, to allow of three or four rows of patients' beds, the beds being placed fore and aft to avoid facing side windows. Some of these layouts reduce the area of the exterior walls and economise in the cost of the engineering services. Much emphasis is given to the provision of toilets. These may be attached to single rooms, one may be shared between two single rooms or may be built adjacent to four bed units. In conjunction with the use of commode chairs for wheeling to sanitary annexes, they reduce the use of bed pans to a minimum. All this saves much distress to patients, and much labour to the staff.

17. NURSING STATIONS.—The design of these small ward units and the American conception of nursing has brought about the development of the nursing station which is either a lobby separated by a counter from the ward corridor, or a room at the end or centre of a nursing unit. The medical and nursing records are kept at the station where there is generally a secretary, a telephone and often a loudspeaker calling device. Here the nursing and junior medical staff spend much of their time, and the number of records and chits compiled and of messages exchanged is extraordinarily large.

18. As new hospitals can only be built gradually in this country, the existing hospitals will continue to serve our needs

for a very long time indeed with such adaptation and improvement as can be carried out with modest expenditure. The wards in the acute general hospitals can be greatly improved by partitioning them into four or six bed units or by providing bed curtain cubicles. This, together with better sanitary arrangements for the patients, will ease the work of the nursing staff and add to the comfort and privacy of the patients.

19. WARD EQUIPMENT.—The equipment in the wards, of American hospitals, particularly in the single rooms for private patients, was on the anticipated lavish scale. The attention now being given in this country to the setting up of higher standards of construction and design for hospital bedsteads, bedside lockers and other equipment is encouraging. The painting, lacquering or processing of metal suitable for patients' bedsteads in American hospitals could not be expected to stand much over ten years of hard usage in the busy acute wards. Apart from a comfortable bedstead, a good internally sprung or sponge rubber overlay mattress and a bedside locker the most needed articles of furniture for bedfast patients are bed-tables. In America they are generally of the four-leg type, made either of wood or metal and fitted with good castors. These tables are often adjustable in height, with or without a bookrest and fitted with a shallow drawer, and a heat and stain resisting top. In the wards, in day rooms, or in adjacent lobbies dining tables and chairs for ambulant patients are provided. At some general hospitals in this country, ambulant patients are expected to eat their meals from their bedside lockers, or on trays placed on the beds while they sit at the side. In a few isolated instances patients remain in bed until the mid-day meal has been served because of lack of facilities. The mass produced furniture supplied to American hospitals is generally superior in design, is often better made than the British post-war article, and is not permitted to become so shabby.

20. OUT-PATIENT DEPARTMENTS.—The general out-patient services in America, with few exceptions primarily serve only the " medically indigent " and are not so extensive as those attached to the large general hospitals in this country. In view of the need for new standards of accommodation, privacy and reception required here, it is a little disappointing that there appears

comparatively little to help in the construction and equipment of future out-patient departments. Some or many out-patient clinics will be attached to the ward units of the specialist services concerned, as at the Westminster Hospital, while at other hospitals the out-patient services will mainly be centralised. There is, of course, great scope for making these departments more inviting and more efficient functionally in view of the part consultative and specialist services have to play in the future health services of this country.

21. In the American hospital, the out-patient generally enters a spacious and cheerful hall complete with an open Information Desk. It is unlikely that general hospitals will again be built in this country with a gloomy and inadequate side entrance for the thousands of out-patients and in-patients hospitals serve. Equally, it is hoped that never again will an extravagant entrance hall be provided for the sole use of the senior staff and visitors. The appearance of much of the patients' waiting accommodation and of the facilities provided for enquiries in American hospitals is impressive. Even where the out-patient services are mainly centralised it would appear that in new hospitals the single floor out-patient department common to many large hospitals in this country should be replaced by a building with three or more storeys. To permit of expansion and adaptation most American hospital authorities agree that the out-patient department should be housed in a separate block, but should be connected to the main hospital on one or more floors. The largest separate out-patient department visited in America consisted of a block of thirteen floors, separate from, but connected with the main building. It must be remembered that as the senior medical staff do not often conduct regular out-patient clinics, there is not the same stress given as in this country to the desirability of the in-patients being seen by the same medical staff in the out-patient department previous to admission.

22. There are so many variations of the internal planning of the examination rooms or cubicles, patients' dressing cubicles, and waiting accommodation for individual clinics, that little comment on the American arrangements seems necessary here. Where a main Assembly Hall for out-patients is provided there is almost always separate waiting accommodation for the individual

clinics. This waiting accommodation may be provided with current periodicals, but invariably the toilet arrangements are modern and scrupulously clean. Facilities for X-ray diagnostic services, for simple pathological tests and for pharmaceutical supplies are often available in the out-patient department to avoid interruption of the in-patient facilities.

23. TRAFFIC.—By reason of the higher buildings, the national disinclination for walking, and the enthusiasm for time-saving and orderliness, much care and almost scientific investigation is given to the planning of traffic and transport arrangements. The stores and kitchens are mainly in the basement or on the ground floors, corridors are often wide, and elevators or lifts are around or off a central lobby, but seldom in batteries of less than two. Nevertheless the delays in waiting for lifts are time wasters as great as walking really lengthy corridors, and much less satisfactory. Service lifts for patients' meals and for supplies are frequently inadequate and it is surprising that operating theatres are being built many floors away from the surgical wards.

24. The entrances, lobbies and corridors are always well sign-posted, adequately lighted and insulated from noise, generally by the use of acoustic tiles in the ceilings. On the whole the nursing staff have less walking to and from wards and staff quarters to their dining rooms than in the large hospitals in this country. This may be offset, however, by the time and energy spent going to and from the nursing station for records, requisition slips and messages. There would however appear to be advantages in building ward blocks taller than has been customary in the older hospitals of Great Britain.

25. NURSING STAFF QUARTERS.—The lay-out, equipment and furnishings for the nursing and other resident staff are often luxurious. Many of our nurses' homes have the appearance of barracks and are planned in a way more suitable for schoolgirls than for adults undertaking responsible and arduous duties. As, sooner or later, the building of a large number of nurses' homes must be carried out in this country, together with the extension of others, it would appear desirable to give greater attention to ensuring more privacy and independence for both trained staff and student nurses.

26. Although America has been more successful in encouraging trained staff to live out, for those who are resident generous arrangements are made. If, because only limited funds are available for capital expenditure, we provide makeshift and unimaginative buildings, equipment and furniture, it will add to the difficulties in the successful recruitment of student nurses and in the retention of the highly trained nursing staff.

27. In the United States and Canada, the senior nursing staff are supplied with separate sitting rooms and there is sometimes a small kitchenette attached, or the kitchenette and bathroom may be shared with another member of the staff. The bedrooms of other nursing staff are tastefully furnished and may be supplied with divan beds for use as bed-sitting rooms. In any case, the bedsteads, dressing chests, writing bureaux and other furniture, although of simple construction, are generally more attractive than those purchased for nurses' homes in this country, and gay curtains, rugs and bedspreads help to make cheerful rooms. There is, of course, adequate central heating in all rooms (including bedrooms) and corridors. Wash basins are fitted to all bedrooms or suites, and bathrooms are provided in varying ratios between 1 to 2 and 1 to 6.

28. LIGHTING.—Fluorescent strip lighting is increasingly used and this, together with the high intensity of illumination by comparison with British practice, makes the hospitals cheerfully lit and bright. It is claimed that the cost of improved standards of lighting is partly offset by a gain in efficiency and output by the staff. Most of the night lighting in the wards is now given by recessed lights fitted about one foot above the floors, and this practice reduces the disturbance of patients to a minimum.

29. HEATING.—Operating theatres are largely air conditioned and great care is now being taken to provide high humidity. Otherwise, hot water radiator systems are mainly in use in preference to panel, floor heating and other forms of central heating. In Washington and elsewhere, air conditioning is being seriously considered for offices and even wards, largely to afford some means of relief during the severe hot weather.

30. Open fires are not tolerated and (by contrast) it would seem that the burning of raw coal in the wards and offices in some

of the hospitals in this country should be abandoned. As soon as possible, central heating plants must be modernised to eliminate the need for supplementary heating and, where this may still be thought necessary, or desirable, either modern gas fires of the horizontal fuel type should be substituted or coalite or other smokeless fuel burnt. A saving in the cost of labour laying and feeding coal fires, in daily cleaning and in the redecoration both of the wards and departments and of the exterior of the hospitals will follow.

31. As fuel oil is cheap in America, oil firing of the boilers in the central plant for heating and domestic services is common, and for this and other reasons, the back areas of American hospitals are cleaner and tidier than is usual in this country.

32. PLUMBING.—Some reference should be made to the excellence of American plumbing. Chromium plated and stainless steel taps and valves are universal, wash basins and sinks are replaced when crazed or pitted, and toilet accommodation for all grades of staff and patients is modern and is always scrupulously clean. Washing facilities with linen or paper towels are provided adjacent to all water closets and urinals, including those for out-patients.

33. In particular, automatic bed pan washers are always available in place of sluice sinks and this is a great convenience for the domestic staff and nursing aides who deal with the bed pan service to patients. Heated cabinets or racks are not generally installed, as individual bed pans are kept in the bottom of the patients' lockers and except in special cases are normally sterilised only after the discharge of the patients for whom they have been reserved.

34. FLOORS AND WALL FINISHES.—Quarry tiles and terrazzo are the usual floorings for kitchens and operating theatres. Asphalt tiles have become very popular for corridor and ward floors and on this account particular notice was taken of those floors which had been in use for some time. Occasionally they showed little signs of wear, but elsewhere after hard use, the edges of the tiles had pitted or crumbled slightly. Asphalt tiling is cheaper in

America than linoleum but may not give the same length of service as battleship linoleum of first class quality.

35. Plastering is dispensed with on many walls in basements, service staircases, corridors and laboratories and in other cases it was sometimes indifferently rendered. Neither was there the same concentration on well finished paintwork or the use of high gloss first class enamels as commonly used in Great Britain for wards, operating theatres and most departments to withstand repeated washing down. As a result repainting is carried out at more frequent intervals, and at some hospitals the walls are not washed down before a first or priming coat is applied. It is, of course, argued that it is more economical to repaint every four to seven years up to a fair standard than to attempt high class work. Incidentally, the interior walls of American hospitals do not require such frequent washing down as the hospitals in our smoke-ridden towns and cities.

36. BUILDING.—The speed at which buildings are erected, equipped and opened in America is in great contrast to that common in hospital extensions under post war conditions in this country. Quite apart from restrictive controls and the shortcomings of the building and supplies industries, there is in this country a lack of pride and sense of urgency in the individual hospitals to put the buildings into use in the shortest possible time.

RECOMMENDATIONS

1. *Acute general hospitals should not be built on restricted sites. For a new* 500 *bed hospital it would appear a site of about twelve acres is the minimum, probably half as much again for a teaching hospital, and a fair proportion of the site should be left free and unallocated for future development.*

2. *Better provision should be made for the initial reception of inpatients, outpatients and casualties. Adequate entrance halls and waiting lobbies should be built for patients and their visitors, and in particular the accommodation should include a comfortable room or rooms in which in-patients may be received in the first instance. By*

contrast, staff entrances and halls, if separate, should be relatively simple and inexpensive.

3. *Research should be encouraged in the design of out-patient and casualty departments to avoid the regimentation which is often unavoidable in the present overcrowded clinics. The physical relation of the out-patient department to the wards, pathological, X-ray and other services should receive special consideration and space should be allowed for future services.*

4. *As and when possible existing wards in acute general hospitals should be partitioned or curtain cubicles provided. Bedtables and well designed lockers should always be available, and there should be sitting and dining accommodation for ambulant patients. Any development of the nursing station on American lines should proceed with caution.*

5. *Much can be done to improve some of the oldest hospitals by adaptation and the installation of modern equipment. Such new equipment should include more and quieter lifts, up-to-date kitchen plant, curtained cubicles, automatic bed pan washers, and in addition where not adequate, internal telephones, etc., should be provided to relieve the duties of the nursing staff.*

6. *The engineering and plumbing services should be modernised, central heating systems should be overhauled and old fashioned bathroom and toilet facilities for patients and staff should be replaced.*

7. *As and when new nurses' homes are built, they should be planned with distinction and furnished with taste and care.*

8. *Greater attention should be paid to the prevention of unnecessary noise. The most promising single development appears to be that of fitting acoustic tiles in ceilings or false ceilings.*

9. *In addition to encouraging improved accommodation for out-patients and casualty patients, King Edward's Hospital Fund might give useful service by publishing recommendations for approved equipment and furniture, e.g., hospital kitchen lay-outs, nurses' home furniture, curtain rails for cubicles, etc.*

III

HOSPITAL NURSING AND NURSE TRAINING

37. THE GENERAL PICTURE.—In spite of the shortage of nurses in both countries, there are two essential differences in the conditions under which hospitals are staffed in America. Student nurses pay fees for the training, although they are maintained by the hospital, and personal service is less popular than it is here. Whatever may be the position in a few years' time, American teaching and other general hospitals are shorter of candidates for professional or full training than similar hospitals in this country. Large and world-famed teaching hospitals with elaborate and costly methods of training have comparatively small schools of nursing by our standards, and the students generally number from eighty up to two hundred.

38. These training schools are in charge of the director of nursing or the matron, who is the Dean of the Faculty of Nursing where the school is associated with a University or University College. On occasion there is also a Dean of Nursing or other principal of the school who is independently responsible for the teaching and control of the student nurses. To conform with the ambition of Americans to have a college education or its equivalent, the schools of nursing model themselves somewhat on the medical schools. In some cases the training lasts for four or five years with a baccalaureate or bachelor's degree in nursing from its university or university college. A few schools offer further training for a master's degree or doctorate. Such schools may be staffed by ten or fifteen whole time assistant professors, lecturers and teaching staff.

39. Elsewhere, the course of training is one of three years and the nurses register as fully trained nurses after passing examinations conducted on behalf of the authorities of the particular State in which the hospitals are situated.

40. STATUS OF STUDENT NURSES.—At the present time, the hospital world is greatly impressed by the report on " Nursing for

the Future " prepared by Dr. Esther Lucile Brown which seeks to establish professional nursing on the basis of collegiate schools of nursing and by the report of the Ginzberg Committee. Whether the training is one of three or five years, the result of this approach to nursing is that the student nurses are largely supernumerary members of the staff while in the wards and hospital departments. Even in the teaching and acute general hospitals much of the bedside nursing care is left to the non-professional or practical nurse with one year's practical training, as far as this grade of staff is available, or mostly to the nursing attendants or aides and the orderlies.

41. The student nurses are thus primarily students undergoing a more theoretical and scientific training in what is accepted in America as professional nursing and they are trained as skilled technicians, and often become first class administrators. During training student nurses are not the essential part of the ward team as they are in this country, neither have trained or student nurses responsibilities and functions, as nurses or as bedside nurses, identical to those of the nursing staff in Great Britain. This is perhaps primarily due to the fact that the student nurses are not regarded as apprentices as well as students, and there is much reluctance to carry out repetitive duties during training.

42. This approach to nursing must not be judged against the background of Great Britain, and unfortunately the criticism that members of some of the nursing schools in this country are treated less as students than as a supply of cheap labour or as extra pairs of hands is a valid one. All may still be well in the United States and Canada if their schemes of training practical or non-professional nurses of one year's duration or longer are a success, and if a sufficiently large number of practical nurses competent to take over many of the responsibilities and duties of bedside nursing are thereby produced.

43. At the teaching and larger general hospitals, the director of nursing has the support of nursing supervisors responsible for the nursing administration of the medical, surgical and other departments or may be of ward blocks or floors containing fifty and sometimes up to one hundred beds. In charge of the ward

units of twenty to thirty beds are head nurses assisted by a few trained nurses (often non-resident), by practical nurses when available, but mostly relying on the assistance of nursing attendants or auxiliaries, any assistance from the student nurses being for the most part nominal. It will be seen that much of the bedside nursing is often left to nursing attendants or aides whose initial training lasts for less or rather more than one month before taking up fully paid duties in the wards.

44. HOURS OF DUTY.—The hours of duty of the professional nurses, the practical nurses and untrained nursing staff, and the time spent at lectures, preparation and ward duties by student nurses vary from forty to forty-five hours weekly, and only occasionally do they reach forty-eight hours. The two shift or "split" duty system is not in operation and three shift systems of duty are general, often for a five day working week. The directors of nursing of many hospitals are greatly impressed by the heavy responsibilities and long hours of the ward sisters and other nursing staff in this country. As will be seen, the functions of the British ward sisters are shared between the nursing supervisors and head nurses, the head nurse being relieved by the dietitians of responsibilities and duties over food service and patients' diets. In some hospitals, also, the domestic services and ward cleaning are supervised by the housekeeping supervisor, and as the officer in charge of these services she assumes direct responsibility for the cleanliness of the wards. Finally, much of the practical training of the professional student nurses in the wards is carried out by the teaching staff attached to the school of nursing and not by the head nurse.

45. A visit to America confirms one's admiration for the sisters of the hospitals in this country. But if the hospitals are not continually to train students most of whose services are lost to them after training, neither the sisters, the trained staff nor the student nurses can continue indefinitely to bear the burdens they are now carrying. The care of the sick and seriously ill patients, especially in the acute hospitals, will always impose a great strain on the nursing staff, and the conditions under which their services are performed should be improved. It must be recognised that the sickness rate of nurses in the larger cities is

relatively high in spite of the careful selection of student nurses after medical examination for physical fitness and robust health, and the safeguards and close medical supervision under which they work.

46. There is probably no other profession or occupation responsible for maintaining a continuous service throughout the week which works the two shift or "split duty" system. This undoubtedly prevents many married women and others from assisting as ward sisters and staff nurses in a non-resident capacity. It may be one of the reasons why some nurses, carefully trained at the expense of the hospitals, later on choose other less onerous appointments not only in nursing, but in allied professions. In America there is generally a higher ratio of trained professional staff in the wards, and many of the trained nurses are non-resident. In fact, it is not unusual for a nursing supervisor or head nurse to be non-resident, and occasionally the appointment of a director of nursing or matron is a non-resident one.

47. The directors of nursing and the senior staff and tutors in the United States and Canada are gifted women and very capable administrators. The rapid extension of hospital facilities of all kinds is adding to their difficulties, and to meet their somewhat different aims and circumstances, they are making an imaginative and far sighted contribution to the problems of staffing, the training of nurses, and dividing nursing duties into what are essential nursing functions and those which can be discarded. At Windsor, Canada, a notable experiment by way of a highly intensive two years' course of training in professional nursing duties is being carried out.

48. Division of Nursing Functions.—Nursing duties as largely accepted in this country and shared at many teaching hospitals by fully trained nursing staff and student nurses may in America be regarded as being divided into the five following categories :—

1. Professional, technical and administrative services (often somewhat in the capacity of medical auxiliaries).	By the professional nurse.

2. Bedside nursing (where such nurses are available).	By the non-professional practical nurse.
3. Bedside nursing and services (in place of or in addition to the professional nurse).	By the nursing assistant or aide after 3–6 weeks' initial training.
4. Assistance to (1) and (2) mainly as supernumeraries.	By the student professional nurse.
5. Food services in the wards and sometimes the supervision of cleaning.	By the dietitian and housekeeping supervisor.

49. Cost of Nursing Services.—To a visitor the total cost of nursing appears high and it would seem that the separation of nursing duties among four grades of nursing staff in the general hospitals (five grades if food service is included), is leading to high expenditure where the standard of nursing service remains the same. As has been stated one of the causes is the fact that educated women in America are very unwilling to devote themselves to a profession which combines scientific and administrative training and practice, and constant personal attention to patients which sometimes can be irksome.

50. Recruitment in this Country.—The difficulties in this country are not yet so acute, and British bedside nursing practice on the whole has not as yet been carried out at the sacrifice of the assistance given to the various medical specialties in advanced nursing and medical procedures. In view of the increasing demands of the medical profession there is, however, an obvious need to relieve the pressure on the student nurses; though American experience seems to indicate quite clearly that student nurses who are not trained as an essential part of the ward team (such as might result from the proposals for a shortened period of training) would not share the present outlook and standards in bedside nursing.

51. The recruitment of nurses for full training and the retention of state registered nurses as hospital staff nurses will inevitably become more difficult unless considerable relief is given to the nursing profession. Rather than a radical change in the type of training now provided for state registered nurses it would

seem that real progress would best be obtained by the introduction of the three shift system and/or a further reduction in the hours of duty, by taking away certain responsibilities and duties now regarded as essential to nursing care, and by greatly improved equipment for the wards and departments. This necessary improvement in working conditions cannot be delayed indefinitely because of the difficulties the change will undoubtedly create, it is hoped only temporarily, in the staffing of beds in many hospitals. Some encouragement also would follow the building of improved staff accommodation with more scope for privacy and independence, following the practice of women's colleges (see also under Staff Quarters—Hospital Design and Equipment).

52. WARD STATION.—A considerable feature of American hospitals is the ward station, which is regarded as an essential unit (described under Hospital Design and Equipment). In spite of the need for relieving the nursing staff of unnecessary clerical work, it would appear that such a development on American lines for general wards is by no means economical. Briefly, the clerks are irregularly employed, and the nursing staff occupy themselves there rather than with their patients; there is duplication of effort and by British standards clerical procedure and record keeping develops on a scale which is hardly justifiable.

RECOMMENDATIONS

1. *Boards of Governors and Hospital Management Committees should give greater attention to their responsibilities for the management of schools of nursing.*

2. *In the development of methods of training for state registered nurses and assistant nurses, care should be taken that the characteristics and reputation of British nursing should be fully retained.*

3. *As and when possible at particular hospitals, the two shift or " split duty " system of staffing both for the student nurse and for trained staff should be discontinued.*

4. *Proposals for the relief of the responsibilities and long hours of the nursing staff and particularly of the ward sister should be*

sympathetically considered. The services of non-resident trained nurses, whether married or single, in the wards should be actively encouraged.

5. *The retention of student nurses for a fourth year as resident or non-resident trained staff might be included in the agreement for training.*

6. *As and when nurses' homes are extended and new ones built the arrangements should ensure more privacy and independence both for trained staff and students alike so that a nurse may have a place of her own for use without restrictive regulations. A warm bed-sitting room for the student nurse and a separate sitting room in addition to a bedroom for trained staff with private washing facilities are far more useful than numerous common rooms and sitting rooms for general use.*

IV

HOSPITAL CATERING

53. The standard of the catering or food services in the hospitals visited in America is much higher than in this country. Of course, more money and time is spent on the buying of food, on its preparation or cooking and on the service of meals to the patients.

54. STAFF.—Almost without exception, a dietitian is in charge of the catering of both patients and staff ; sometimes the supplies officer, or purchasing agent, of a particular hospital may order the food on behalf of the dietitian. The senior dietitian, however, accepts full financial responsibility for her department.

55. The dietitian-in-charge is very highly trained and experienced, and in many cases she has the help of a large number of qualified dietitians. In the largest hospitals, there may be as many as twenty to thirty therapeutic and administrative dietitians who are also assisted by student dietitians spending a year as hospital interns before finishing their training. The training for dietitians is, therefore, longer and more comprehensive than in Great Britain and is covered by a five years' course. Better training and experience is given in large scale catering, in the selection of food and in the management of kitchen and dining room staff. As a result, dietitians are occasionally appointed to take charge of commercial restaurants and their services are in great demand by colleges, residential establishments and other institutions. One formed the opinion that the training in the competitive purchase, selection and preparation of food is not adequate to carry out the responsibility for such a large proportion of a hospital's expenditure, but it is understood that the American Association of Hospital Dietitians is aware of this criticism and will improve the training in this connection.

56. Improvements made in hospital catering in this country during the past twenty years are largely due to the substitution of hotel and restaurant trained catering supervisors for housekeeping sisters in charge of the food services. These catering supervisors are often practical chefs, many are careful buyers of

food and they have shown enterprise in organising and re-equipping their departments. A visit to America reinforces one's concern that most present day hospital catering supervisors in this country have not received a thorough training in nutritional standards. While the salaries payable will ultimately attract well qualified women, some of the best of the men will inevitably return to posts in hotels and restaurants carrying higher financial rewards.

57. On the other hand it is not considered that the cooks and kitchen staff in American hospitals generally are better trained or more experienced than in Great Britain, and in fact the staff is more itinerant. The food service is however carefully, even scientifically, organised and there is detailed supervision of every meal. This supervision in the large teaching hospitals is almost invariably carried out by the trained dietitians who are on duty every day for early and late meals according to a rota. Consequently, if there is the least doubt about the wholesomeness of a dish, or if it is imperfectly cooked, the food is condemned in the kitchen and an alternative course provided.

58. Considering the quality and variety of the meals it is suprising that the number of chefs, cooks and manual staff is not appreciably more than the average in British hospitals, though the number of supervisors acting as administrative and therapeutic dietitians is, of course, considerably higher. This standard is achieved by up-to-date equipment and layout, by careful organisation of the work of the cooks and kitchen staffs and by the devoted supervision of the administrative dietitians. The staff is always carefully trained in the use of labour saving equipment so that a definite saving in the weekly wages bill may result from the capital expenditure incurred.

59. DIETARIES.—As is to be expected in the United States and Canada, the quality of the food is good, there is a great variety, every advantage is taken of refrigeration and the food is very clean and well wrapped. The American public demands good, varied and well cooked meals, and those served in hospitals conform to the general standard ; on the other hand the standard of catering in hospitals, schools and other institutions in this country lags behind that of a well-conducted private household.

60. The place of well cooked vegetables, salads, cooked and fresh fruit and fruit juices should be noted. Of course, the freezing of perishable foods is common, and one cannot help contrasting the choice of vegetables throughout the year with, say, the regular serving of wet cabbage in the summer in this country. The Americans make full use of their fruits for serving fruit tarts and pastries of many kinds, and fresh fruit in season is often available at all meals, including breakfast. Finally, real salads are regularly served with both hot and cold dishes alike at luncheon and dinner.

61. LAY-OUT.—The kitchens are generally placed on the ground or basement floor and are not overlarge by British standards. Although electricity is used more frequently for cooking, the ovens and steamers do not appear more efficient than our own when modern. There is an abundance of labour saving equipment and this makes all the work lighter and more amenable.

62. It is here that the Americans are far ahead of us. The care with which architects' drawings and engineers' lay-outs are prepared and tested is only matched by the thorough surveys and attention given to organisational problems in every department. In the kitchen and preparation rooms, the heights of tables and sinks are closely studied, there are adequate racks and shelves, ingeniously designed trolleys, automatic washing and conveying equipment, and stainless steel is of course everywhere. The plumbing is bright and easily cleaned and, as always, there are excellent washing and toilet facilities for the staff of the department.

63. WARD SERVICE.—The catering or food service department is generally responsible for the complete service of the meals to all patients, although the dietitians and their domestic staffs or " Dietetic aides " may occasionally be helped by the junior nursing staff. With the engagement of professional dietitians, it is held that they should be fully responsible for their departments, although the different outlook of the nursing profession and the shortage of nurses of all grades has assisted in the change.

64. Administrative or student dietitians are attached to the ward floors or units varying from twenty to a hundred beds, and with the assistance of their own domestic staff they serve the meals.

As is common in this country, the food service is generally decentralised. In other words, the different foods are put in bulk in separate dishes or containers in the food trolleys and taken to the ward kitchens or serveries. The food trolleys are often made throughout of stainless steel, they are fitted with hot and cold divisions and the hot compartments are heated by electricity. The trolleys are seldom taken to the wards, and even in large wards no instance was observed where a meal was served from one of the trolleys at the bedside of a patient.

65. It was refreshing to see the care with which the individual trays were prepared for the patients, particularly in the case of the private patients. There is almost invariably a tray cloth and table napkin of linen or paper, and the crockery and cutlery is dainty and carefully chosen. A small vase of flowers may be added.

66. CENTRALISED FOOD SERVICE.—A centralised food service has been installed in some of the latest hospitals though caution is now being shown before its general adoption. Centralised service avoids the double handling of the food, and the patients' trays are prepared in the main kitchen. The empty trays are generally put on a travelling belt installed in a lobby or separate room attached to the kitchen with serving tables or trolleys alongside. The crockery, cutlery, condiments, food and drinks are placed on these trays which are then taken as quickly as possible by dumb waiters or " trayveyors " to the wards. There are many adaptations of this form of service, and although its full operation is only suitable for multi-storey buildings it is in use on a small scale in one or two hospitals in this country. Even in the well-heated transatlantic hospitals with wards designed around a central lift shaft it is difficult to keep the food hot until it reaches the patient. When the wrong meal is served for a patient or when some item of food, drink or cutlery is omitted the delay is exasperating.

67. Where the orthodox or decentralised service of meals is in use, the ward kitchens and serveries are magnificently equipped, and by comparison many of our ward kitchens appear as out-of-date as the kitchens and sculleries in a Victorian house. In American hospitals there are of course refrigerators, there are

generally stainless steel double sinks, even where automatic dish washers are installed, and there is up-to-date equipment for making coffee and other drinks and for preparing light meals. At some hospitals, the crockery and cutlery is washed centrally to take full advantage of mechanical dish washing and steam sterilising, but in many cases crockery sterilisers and small dish washing machines are provided for the main ward units.

68. STAFF SERVICE.—The general adoption of cafeteria service which reduces the number of separate dining rooms common in this country, saves labour and makes a choice of dishes easier. The cost of providing more interesting and varied meals to members of the staff of British hospitals can be offset by economies in domestic salaries and dining room service. While self service is noisy and requires careful organisation, American dining rooms are cheerful and friendly gatherings attended alike by the most distinguished members of the professional staff and by resident and non-resident workers.

RECOMMENDATIONS

1. *Boards of Governors and Hospital Managements Committees should give greater attention to the place of catering or diet therapy as a definite aid to the treatment, well being and recovery of the patient to normal vigour.*

(*a*) *That the place of vegetables, fruits and salads in hospital dietaries be stressed.*

(*b*) *That where practicable, patients on full diet be given a choice of dishes at all main meals.*

(*c*) *That bed patients be provided with bed tables and their meals daintily served, and meals for ambulant patients served at dining tables in the wards or day rooms.*

(*d*) *That in all hospitals other than the smallest, attention be drawn to the necessity for preparing light meals, making toast, cooking eggs and omelettes, etc., in the ward kitchens instead of in the main kitchen.*

2. *Selected Schools of Dietetics (possibly with the assistance of the Institutional Management Association) should be asked to improve facilities for the training of dietitians in large scale buying and cooking, in the management of kitchen and dining room staffs and in the lay-out and equipment of kitchens.*

3. *In consultation with the Hospital Caterers' Association courses of tuition should be given in nutritional standards and an appreciation of diet therapy to practical catering supervisors and their senior staffs. The methods of training hospital cooks (including apprenticeship schemes for junior trainees) kitchen and dining room staffs be investigated, and in the meantime the larger hospitals should be encouraged to start experimental schemes of training.*

4. *Reports and model plans on the design of hospital kitchens should be prepared by an expert Committee, and advice given in the lay-out of kitchen plant, labour saving equipment, automatic washing and sterilising apparatus, ventilation and so on.*

5. *Joint Purchasing Committees, consisting mainly of catering officers, should be set up in selected areas with the following objects :—*

(*a*) *To improve the quality and variety of the perishable foods purchased.*

(*b*) *To establish good standards for the supply of prepared and other foods, e.g., cooking fats, jams, jellies, ice cream preparations, etc.*

(*c*) *To promote bulk purchase, where no reasonable restriction in choice is involved.*

(*d*) *To assist in the supply of clean food, strict cleanliness in storage and cooking, and the personal hygiene of the catering staff.*

(*e*) *To pool practical experiences of menus, recipes, cooking, service, staff management, equipment, etc.*

APPENDIX

Hospitals and Organisations Visited

NEW YORK

Rockefeller Foundation 49 W. 49th Street	George C. Payne, M.D. Robert S. Morrison, M.D. Miss Brackett	Fellowship Advisor Associate Director for the Medical Services Nursing Council
New York Academy of Medicine 2 E. 103rd Street	Dr. E. H. L. Corwin	Executive Secretary
Presbyterian Hospital 622 West 168th Street	John S. Parke Alvin J. Binkert Margaret E. Conrad, R.N. Joseph E. Snyder, M.D. Etc.	Executive Vice-President Assistant Vice-President Dean of Nursing Professional Services
Hospital Council of Greater New York 370, Lexington Avenue	John B. Pastore, M.D.	Executive Director
Hospital Bureau of Standards 247, Park Avenue	William A. Gately	Executive Director
New York City Department of Hospitals 125, Worth Street	Dr. M. D. Kogel Dr. I. H. Scheffer Miss Mary Ellen Manley	City Commissioner Director of the Bureau of Medical and Hospital Services Director of Nursing
Department of Hospitals:		
Goldwater Hospital Welfare Island	Dr. Chrisman G. Scherf	Medical Superintendent
King's County Hospital 451, Clarkson Avenue, Brooklyn 3, N.Y.	I. Magelaner, M.D.	Medical Superintendent
Bellevue Hospital First Avenue and 26th Street	Dr. W. F. Jacobs Salvador F. Sola, M.D.	Medical Superintendent Deputy Medical Superintendent, Out-Patient Department
Hospital Bureau of Standards and Supplies 247, Park Avenue	William A. Gately	Executive Director
Columbia University School of Public Health 600 West 168 Street	John Gorrell, M.D.	Associate Professor of Hospital Administration

NEW YORK HOSPITAL AND CORNELL MEDICAL CENTRE 525 West 58th Street	S. Bayne-Jones, M.D. Virginia M. Dunbar, M.A., R.N. Dr. Henry N. Pratt	President Dean of the School of Nursing and Director Nursing Service Director
MOUNT SINAI HOSPITAL Fifth Avenue and 100th Street	J. Turner, M.D. Martin R. Steinberg, M.D. Miss G. A. Warman	Consultant Director Superintendent of Nursing
GREATER NEW YORK HOSPITAL ASSOCIATION	Meeting of the Board of Governors Louis Schemweiler Monseigneur J. J. Curry F. Wilson Keller	 President President Elect Secretary

PHILADELPHIA

UNIVERSITY OF PENNSYLVANIA 34th and Spruce Streets, Philadelphia 4, Pa.	Robin C. Buerki, M.D. Elizabeth C. Berrang, R.N. Miss E. Cleves Rothrock Miss Florence A. Hixson	Vice-President Director Director of Nursing Service Director of Nursing
JEFFERSON HOSPITAL 10th and Sansom Streets, Philadelphia 7, Pa.	Hayward R. Hamrick, M.D. Miss Katherine Childs	Medical Director Director of Nursing
TEMPLE-UNIVERSITY HOSPITAL AND MEDICAL SCHOOL Broad and Ontario Streets, Philadelphia 40, Pa.	William N. Parkinson, M.D. Miss Ethel R. Smith	Dean Director of Nursing
WILLS HOPSITAL 1601 Spring Garden Street, Philadelphia 30, Pa.	Melvin L. Sutley	Superintendent
ASSOCIATED HOSPITAL SERVICE OF PHILADELPHIA — (BLUE CROSS PLAN) 112, S. 16th Street, Philadelphia 2, Pa.	E. A. Van Steenwyk	Executive Director
EPISCOPAL HOSPITAL Front Street, and Lehigh Ave., Philadelphia 25, Pa.	Lucius R. Wilson, M.D. Miss Dora V. Mathis	Administrator Director of Nursing
GRADUATE HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA	Mr. Edwin L. Taylor (in his absence)	Administrator
PENNSYLVANIA HOSPITAL 8th and Spruce Streets, Philadelphia 7, Pa.	John N. Hatfield Ralph E. Rehn	Administrator Purchasing Agent
HOSPITAL COUNCIL OF PHILADELPHIA 311, St. Juniper Street, Philadelphia 7, Pa.	C. Rufus Rorem, Ph.D., C.P.A.	Executive Director

PRESENTED SHORT ADDRESS ON NATIONAL HEALTH SERVICE

HOSPITAL PURCHASING SERVICE OF PENNSYLVANIA 311, S. Juniper Service, Philadelphia 7, Pa.	Donald L. Reams	General Manager
HOSPITAL PLANNING AGENCY 311, S. Juniper Street, Philadelphia 7, Pa.	Donald C. Smelzer, M.D.	Executive Director
NURSING COUNCIL OF METROPOLITAN PHILADELPHIA 311, S. Juniper Street, Philadelphia 7, Pa.	Miss Mary MacDonald Miller	Secretary

BALTIMORE

DELAWARE GENERAL HOSPITAL Wilmington	Arranged by Dr. Crosby	
THE JOHN HOPKINS HOSPITAL Broadway and Monument Streets, Baltimore	Edwin L. Crosby, M.D. Miss Ann D. Wolfe	Director Director of Nursing

WASHINGTON

GARFIELD MEMORIAL HOSPITAL 10th and Florida Avenue, N.W.	L. C. Schmelzer	Administrator
FEDERAL SECURITY AGENCY PUBLIC HEALTH SERVICE Washington 25, D.C.	Dr. Van M. Hoge	Medical Director Chief, Division of Hospital Facilities
	Dr. J. R. McGliony	Assistant Director, Division of Hospital Facilities
	Marshall Shaffer	Senior Engineer Chief, Office of Technical Services, Division of Hospital Facilities
WASHINGTON SERVICE BUREAU, AMERICAN HOSPITAL ASSOCIATION	Dallas G. Sutton Rear Admiral (M.C.) U.S.N. (ret.)	Director of Study Government Hospital Relation
THE GEORGE WASHINGTON UNIVERSITY HOSPITAL 901, 23rd Street, N.W., Washington, 7, D.C.	Victor V. Ludewig Avery M. Millard	Superintendent Assistant Superintendent

CLEVELAND

Guest Speaker at the Alumni Banquet, DIVISION OF GRADUATE NURSES EDUCATION, Columbia University.

UNIVERSITY HOSPITALS OF CLEVELAND 2065, Adelbert Road	W. B. Seymour, M.D. Mrs. M. Fluent	Director Director of Nursing
THE CLEVELAND HOSPITAL COUNCIL 1001, Huron Road Room 910. Cleveland 15.	Guy J. Clark	Executive Secretary
CLEVELAND CLINIC HOSPITAL	Clarence M. Taylor	Executive Director

CHICAGO

American College of Surgeons 40, East Esse Street	M. T. MacEarchern, M.D.	Director, American College of Surgeons
The University of Chicago	Ray E. Brown	Superintendent of University Clinics
American College of Hospital Administrators 22, East Division Street	Dean Conley	Executive Secretary
The American Association of Medical Librarians 22, East Division Street	Miss M. M. Bailey	Secretary
Schmidt, Garden and Ericcson	Carl Ericcson	Architect
Wesley Memorial Hospital 250 East Superior Street, Chicago 11	Ralph M. Hueston Miss Harriet M. Smith	Superintendent Matron
St. Luke's Hospital 1439 South Michigan Avenue	Robert F. Brown, M.D.	Medical Director
The Modern Hospital Publishing Company, Inc. 919, North Michigan Avenue 11	Otho F. Ball Everett W. Jones Robert M. Cunningham	President Vice President Managing Editor
Chicago State Hospital 6500 Irving Park Road, Chicago 34	E. F. Dombrowski, M.D. Sadie E. Randall	Superintendent Director of Nursing
American Dietetic Association 620 North Michigan Avenue	Miss Gladys Hall	Executive Secretary
Chicago Hospital Council 140 West Adams Street	E. E. Salisbury	Executive Director
Cook County Hospital	Ole C. Nelson Fred A. Hertwig	Medical Director Warden
American Hospital Association	George Bugbee Maurice J. Norby Ann R. Saunders	Executive Director Assistant Director Personnel Specialist

BATTLE CREEK

W. K. Kellog Foundation Battle Creek, Michigan	Graham L. Davis	Secretary, Hospital Division

ANN ARBOR

University Hospital	A. C. Kerlikowski, M.D. H. A. Towsley, M.D.	Director Associate Professor Pediatrics

DETROIT

The Harper Hospital 3825 Brush Street	E. Dwight Barnett, M.D.	Director
	Lucy D. Germain	Director of Nursing
Providence Hospital Grand Boulevard and 14th Ave., Detroit 8.	Sister Martina	Superintendent
Henry Ford Hospital	I. R. Peters	Business Manager
	Elizabeth S. Moran	Director of Nursing
Windsor, Ontario	Miss Fidler	

TORONTO

Toronto General Hospital	J. E. Sharpe, M.D.	Superintendent
	M. E. MacFarland	Director of Nursing
Canadian Hospital Council	Harvey Agnew, M.D.	Executive Secretary
Sunnybrook Hospital	Miss F. G. Charlton	Matron

MONTREAL

Royal Victoria Hospital	J. Gilbert Turner, M.D.	Superintendent
	Miss Mary S. Mathewson	Director of Nursing
McGill University	Fred Smith	Dean, Medical Faculty

BOSTON

The Massachusetts General Hospital	N. W. Faxon, M.D.	Director
	J. S. Lechty	Assistant Director
	Ruth Sleeper, R.N.	Assistant Director
Peter Bent Brigham Hospital	Norbett A. Wilhelm, M.D.	Director
The Beth Israel Hospital 330, Brookline Avenue	Sidney Leswood (in the absence of Charles Wilinsky, M.D., Executive Director)	Assistant Director
	Miss Mary C. Gilmore	Director of Nursing
Harvard School of Public Health	Hugh Leavitt	Professor of Public Health Administration
Health Insurance Plan of Greater New York 425, Avenue of the Americas, New York	Dean A. Clark, M.D. (successor to Dr. N. Faxon)	Medical Director

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