B. C. MEDICAL CENTRE LIBRARY Box 22

# Seventh Annual Report

of the

# British Columbia Hospital Association

#7

Including the proceedings of the Seventh Annual Convention held in the Empress Hotel, Victoria, B. C.

August 28th 29th & 30th, 1924

A. H. TIMMS, PRINTER VANCOUVER, B. C.

# A Dependable Diet

CORRECTLY BALANCED
EASILY ASSIMILATED
CLEANLY PREPARED

# HORLICK'S MALTED MILK

RICH UNIFORM MILK
CHOICE WHEAT EXTRACT
HARDY BARLEY MALT

## HORLICK'S MALTED MILK CO.

**Racine, Wis. Slough, Bucks, Eng. Montreal, Can.**

**1922**

**SPECIALISTS IN**

# Nitrous-Oxide and Gas Machines

**AND**

## Nitrous Oxide Gas of Quality.

## ASH TEMPLE CO. LTD.

**801 London Building Vancouver, B. C.**

# Seventh Annual Report

of the

# British Columbia Hospital Association

Including the proceedings of the Seventh Annual Convention held in the Empress Hotel, Victoria, B. C.

August 28th 29th & 30th, 1924

# British Columbia Hospitals Association

## Officers and Executive Committee of the British Columbia Hospitals Association for 1924-25.

**Honorary President**—The Honorable, the Provincial Secretary, Parliament Buildings, Victoria, B.C.

**Honorary Life Member**—Dr. M. T. MacEachern, American College of Surgeons, 40 East Erie St., Chicago.

**President**—Charles Graham, Esq., Canadian Collieries, Cumberland, Vancouver Island, B.C.

**First Vice-President**—Dr. G. B. Brown, Earle Block, Nanaimo, B. C.

**Second Vice-President**—E. S. Withers, Esq., General Manager, Royal Columbian Hospital, New Westminster, B.C.

**Treasurer**—George Haddon, Esq., Business Superintendent, Vancouver General Hospital, Vancouver, B.C.

**Secretary**—Ethel Johns, Dept. of Nursing and Health, University of B. C., Vancouver, B.C.

## Members of the Executive Committee in addition to the above:

**For Vancouver Island**—George McGregor, Esq., President, Board of Directors, Provincial Royal Jubilee Hospital, Victoria, B. C.

**For Vancouver**—Rev. W. P. O'Boyle, 646 Richards Street, Vancouver.

**For Coast Mainland**—Dr. George Darby, Bella Bella, B. C.

**For Fraser Valley**—Dr. A. D. Buchanan, 352 Hospital Street, New Westminster.

**For Yale Cariboo**—M. L. Grimmett, 1435 15th Ave. W., Vancouver, B.C.

**For Okanagan**—George Binger, Esq., Secretary, Kelowna General Hospital, Kelowna, B.C.

**For Kootenay West**—George Johnstone, Esq., Secretary, Kootenay Lake General Hospital, Nelson, B.C.

**For Kootenay East**—Mother Nazareth, Superior, St. Eugene Hospital, Cranbrook.

**Grand Trunk Pacific**—Harry Birch, Esq., Secretary, Prince Rupert General Hospital, Prince Rupert, B.C.

## Convenors of Standing Committees: and therefore members of the Executive Committee:

**Medical Affairs**—Dr. F. C. Bell, General Superintendent, Vancouver General Hospital.

**Business Affairs**—R. A. Bethune, Esq., Secretary, Royal Inland Hospital, Kamloops, B.C.

**Nursing Affairs**—Miss Pauline Rose, Superintendent, Nanaimo Hospital, Nanaimo, B.C.

**Constitution and Bylaws**—J. H. McVety, Esq., 714 Richards St., Vancouver.

**Convener of Committee on Municipal Affairs**—J. J. Banfield, 327 Seymour Street, Vancouver.

## OFFICERS, 1923-24

Honorary President.....Hon. J. D. MacLean, Provincial Secretary.
Honorary Life Member.....Dr. M. T. MacEachern, Chicago
President.....Charles Graham, Cumberland
First Vice-President.....George Haddon, Vancouver
Second Vice-President.....E. S. Withers, New Westminster
Secretary....Miss E. Johns, University of British Columbia, Vancouver
Treasurer.....Mrs. M. E. Johnson, Bute St. Hospital, Vancouver

### EXECUTIVE COMMITTEE

Dr. H. C. Wrinch, Hazelton.
George MacGregor, Victoria.
Dr. G. Bell Brown, Nanaimo.
J. J. Banfield, Vancouver.
Rev. Father O'Boyle, Vancouver.
George Binger, Kelowna.
J. H. McVety, Vancouver.
J. T. Robinson (since deceased).
M. L. Grimmett, Merritt.
R. A. Bethune, Kamloops.
Miss J. F. MacKenzie.

### STANDING COMMITTEES

#### Medical Affairs

Dr. H. C. Wrinch, Hazelton Hospital, Hazelton (Convener).
Dr. F. C. Bell, Vancouver.
Dr. W. B. Burnett, Vancouver.
Dr. E. M. Pearse, Victoria.
Dr. G. K. MacNaughton, Cumberland.

#### Business Affairs

R. A. Bethune, Royal Inland Hospital, Kamloops (Convener)
G. T. Carver, Victoria.
E. S. Withers, New Westminster.
Dr. G. Bell Brown, Nanaimo.
Arthur P. Glen, Ladysmith.

#### Nursing Affairs

Miss J. F. MacKenzie, Jubilee Hospital, Victoria, (Convener)
Miss K. B. Stott, New Westminster.
Miss K. W. Ellis, Vancouver.
Sister Mary Anna, Victoria.
Miss A. L. Boggs, Kamloops.

#### Constitution and By-Laws

M. L. Grimmett, Merritt, (Convener.)
J. H. McVety, Vancouver.
George Small, New Westminster.
Dr. H. R. Storrs, Vancouver.
George McGregor, Victoria.

## THE CONVENTION

The seventh convention of the British Columbia Hospitals Association was held under the distinguished patronage of his Honour the Lieutenant Governor, Honourable Walter Cameron Nichol, in the Empress Hotel, Victoria, August 28th, 29th and 30th, 1924. The ballroom was generously placed at the disposal of the Association by the management of the hotel without charge and proved an excellent convention hall. Ample space was provided for the exhibits which were a specially interesting feature and to which reference will be made later.

The following institutions were represented by one or more delegates:

Abbotsford-Matsqui-Sumas Hospital.
Bute St. Hospital, Vancouver.
Chemainus General Hospital.
Chilliwack General Hospital.
Cumberland General Hospital.
Columbia Coast Mission Hospitals.
Hazelton Hospital.
Kelowna General Hospital.
Kings Daughters Hospital, Duncan.
Lady Minto (Gulf Islands) Hospital.
Ladysmith General Hospital.
Mission Memorial Hospital.
Nanaimo General Hospital.
Nicola Valley General Hospital, Merritt.
Penticton Hospital.
Provincial Sanitarium, Tranquille.
Provincial Royal Jubilee Hospital, Victoria.
Prince Rupert General Hospital.
Royal Columbian Hospital, New Westminster.
Royal Inland Hospital, Kamloops.
Roycroft Private Hospital, Vancouver.
R. W. Large Memorial Hospital, Bella Bella.
St. Joseph's General Hospital, Comox.
St. Joseph's Hospital, Victoria.
St. Mary's Hospital, New Westminster.
St. Paul's Hospital, Vancouver.
Vancouver General Hospital.
Vernon Jubilee Hospital.

The following Women's Auxiliary groups were represented:

Chilliwack General Hospital Ladies Auxiliary.
Cumberland Hospital Ladies Auxiliary.
Nanaimo General Hospital Women's Auxilary.
Penticton Hospital Women's Auxiliary.
Provincial Royal Jubilee Hospital Women's Auxiliary.
St. Joseph's General Hospital, Comox Women's Auxiliary.
St. Joseph's Hospital, Victoria, Women's Auxiliary.
Vancouver General Hospital Women's Auxiliary.

The following public and professional bodies were represented:

The Provincial Government.
The British Columbia Medical Association.
The Graduate Nurses Association of British Columbia.
The Graduate Nurses Association of Victoria.
The Department of Nursing and Health, University of British Columbia.

Most interesting and instructive exhibits were prepared by the following.
Provincial Royal Jubilee Hospital, Victoria.
Vancouver General Hospital.
Victorian Order of Nurses, Victoria.
Red Cross Work Shops.
Health Centre, Saanich.

Commercial exhibits were made by the following firms:—
Chandler and Fisher Co. Ltd., Surgical supplies.
B. C. Stevens Co., Surgical Supplies.
Victor X Ray Corporation of Canada, Radiological and X Ray supplies.
Simmons Co., Adjustable Bed.

The experiment of last year in reducing the duration of the convention to two days was not repeated this year. Probably it was felt that the charming surroundings and kindly hospitality afforded by Victoria merited at least a three days visit. No meetings were held in the evening and the consensus of opinion seemed to be that this innovation was generally approved and should form a precedent for future conventions.

The luncheons were, as usual, most popular. They afforded opportunities of visiting both the hospitals. The delegates very thoroughly enjoyed the joint luncheon arranged by the Rotary Club and did not neglect the golden chance of telling their troubles, financial and otherwise to a most sympathetic and interested group of business and professional men.

Many took the opportunity of visiting the Columbia Coast Mission boat which was in harbour throughout the Convention. The Rev. John Antle was most kind in according every privilege.

Very much to the regret of the members of the Association the President, Mr. Charles Graham, of Cumberland, was prevented by illness from being present. His place was taken, at the last moment, by Mr. George Haddon, the First Vice-President, who conducted the sessions in an admirable manner.

The local committee on arrangements consisting of Mr. George McGregor, President of the Jubilee Hospital, Dr. E. M. Pearse, superintendent, and Miss J. F. Mackenzie, Director of Nursing, left nothing undone which could add to the comfort and pleasure of the delegates. The Superior and Sisters of St. Joseph's Hospital were equally kind and hospitable. On the last afternoon of the Convention the Rotary Club arranged for cars to take the visitors to the Butchart Gardens. Tea was served and a pleasant social hour enjoyed.

It was inevitable that the sudden death of Dr. R. H. Mullin, on the very day that he was to have addressed the convention, should have cast a shadow of regret over the meetings. The social activities which had been planned were curtailed and in part abandoned in respect to him. But the Convention carried on in the true hospital spirit, that spirit which was so characteristic of the man whose passing is so severe a loss to the cause he had at heart—the quest of health and the alleviation of human suffering.

In spite of all the convention was a success. The discussions were frank and friendly and gave evidence of the slow development of a true spirit of unity and mutual understanding.

## Morning Session, Thursday, August 28th.

The meeting was called to order at 10 a.m. by the First Vice President, Mr. George Haddon.

Reginald Hayward, Esq., Mayor of the City of Victoria, extended

a very hearty welcome to the delegates which was cordially responded to by Dr. H. C. Wrinch, M.L.A., of Hazelton.

The chairman referred regretfully to the illness of the President Mr. Charles Graham of Cumberland and requested Mr. T. Mordy of Cumberland to read the presidential address. The secretary was instructed to telegraph Mr. Graham conveying the sympathy of the members and wishing him a speedy recovery.

## PRESIDENTIAL ADDRESS

Ladies and Gentlemen:—

Today marks the opening of our seventh annual convention, the very satisfactory attendance at which shows a growing realization on the part of the hospitals of the need of getting together in an earnest endeavour towards solving their common problems.

We are prone to think that the problems which confront us in our individual hospitals, large or small are peculiar to ourselves and can only be solved by ourselves in the light of our local experience, but the major portion of the problems confronting us have a common base and therefore a common solution. We have not yet clearly realized how best to solve these problems, but as we gain in experience we are gradually working towards their solution. With an organization such as this, provincial wide and affiliated with similar organizations national in their scope, the exchange of information as to operating conditions and facts given frankly and in the proper spirit will help every hospital, whatever its size may be and aid all hospital workers to know better their field and work.

Before proceeding further I must refer to the great loss which the hospital world has sustained in the sudden death of Mr. J. T. Robinson, President of the Board of Directors of the Royal Inland Hospital, Kamloops, and a members of the Executive of the British Columbia Hospital Association. He was an untiring worker and his interest in all matters pertaining to Hospitals was keen. The Association will miss his advice and assistance and I am sure that the sincere sympathy of all members goes out to his relations.

The work of the Executive will doubtless be dealt with by Miss Johns in her report so I will only touch briefly on our efforts to secure some further Government aid.

For the past two years we have met the Government with requests and resolutions passed by the Association. We have on each occasion been flatly turned down. Not only have we been turned down but on each occasion we have had something taken away from us.

Before appearing before the Government on the last occasion we had a conference with some of the Executive of the Union of B. C. Municipalities. While the session was friendly enough we did not get much sympathy. The Union of B. C. Municipalities is frankly not interested in anything that might mean the expenditure of money by them.

The Municipalities conducted a very strong lobby during the past two years and got something from the Government each year, but everything they obtained was at the expense of the Hospitals. First the Government gave them 10 per cent. of the liquor profits originally intended for Hospital purposes. Last year at the request of the Municipalities the Government reinserted the word "indigent" into the Act, thus practically relieving the Municipalities of all responsibility for the class of patient from the cities, who cannot or will not pay for hospital service.

In looking over the program for this convention I feel sure that you will have a very interesting session. A careful and thorough

discussion of the various papers will prove of the utmost benefit to Hospital organizations throughout the Province.

From the business point of view there are three very important items on the program, just as important as that of finance which is usually given the most prominent position.

*First*, The Legal Liability of Hospitals in British Columbia is to be the subject of an address by Mr. R. L. Reid, K.C.

*Second*. Round Table Conference, some aspects of the Provincial Government Regulations Governing the Granting of Public Aid to Hospitals.

*Third*. Responsibility for Maintainance of Isolation Hospitals.

These subjects are well worthy of the most serious consideration and discussion by the delegates and I trust that out of the discussion will come a policy which can be adopted by the Association for the guidance of hospitals in these very important matters.

I am extremely sorry that I cannot be with you on this occasion but the state of my health will not permit.

I trust however that the Convention will be the most successful yet held and that each delegate will go home feeling that he has gained something and that the Convention has accomplished something towards better Hospital service.

With my best wishes for a successful Convention.

CHARLES GRAHAM,
President.

The minutes of all executive meetings held since the last Annual Meeting were read by the secretary and on motion of Mr. T. Mordy, seconded by Mr. E. S. Withers were declared to be correct.

The secretary then read her annual report.

## REPORT OF THE SECRETARY — 1923-24.

Mr. President, Members of the British Columbia Hospitals Association:

The report of the Secretary is submitted herewith.

*Meetings of the Executive Committee*:

Five meetings of the Executive Committee have taken place as follows:

On August 31st, 1923, at the Incola Hotel, Penticton, at the close of the sixth convention of the association.

On September 21st, 1923, at the Vancouver General Hospital.

On November 6th, 1923, at the Vancouver General Hospital.

On November 15th, 1923, at the Vancouver General Hospital.

On April 22nd, 1924, at the Vancouver General Hospital.

A resume of business transacted at these meetings may be of interest as showing the activities of the Association during the past year.

The meeting held in Penticton dealt with matters of routine arising out of the convention. A committee was appointed to act in advisory capacity to the Secretary in the preparation of resolutions to be submitted first to the membership of the Association and later, after due revision, to the Provincial Government. The members of this Committee were, Messrs. George Haddon, J. H. McVety, and E. S. Withers.

At the second meeting held on September 21st, 1923, Mr. Charles Graham, the new President, occupied the chair. .Dr. F. C. Bell, Superintendent of the Vancouver General Hospital, and Dr. M. T. MacEachern were also present. The tentative questionnaire and covering letter regarding resolutions passed at the Convention in Penticton were submitted by the Secretary, approved without change, and ordered to be forwarded to the various hospitals. These were as follows:

(a) Are you in favor of an increase in the schedule of grants made to hospitals under the hospital act as outlined in the accompanying resolution?

(b) Are you in favor of the suggestion that a hospital commission be appointed?

(c) Are you in favor of the suggestion that the hospitals act be amended to provide that municipalities must, within seven days either accept or repudiate responsibility for patients resident within their borders?

(d) Are you in favor of the suggestion that an increased rate be charged for patients entering hospitals under the Workmen's Compensation Board as set forth in the accompanying resolution?

(e) Is your institution willing to delegate to the Executive a Legislative Committee of the British Columbia Hospitals Association power to negotiate on your behalf in connection with the matters dealt with in the accompanying resolutions.

At the meeting held on November 6th, the Secretary reported a tabulated analysis of the replies received to the foregoing questionnaire:

Total questionnaires issued: 60; total replies received: 42; unanswered: 16.

Of those failing to reply, five hospitals are more or less privately owned and operated. Three are very small and frequently closed. On the whole therefore the replies received might justly be considered to reflect hospital opinion throughout the province.

All replies received approved the recommendation that increased grants be made to hospitals by the Provincial Government.

Eleven objected to the appointment of a hospital commission.

Four objected to a time limit being set which would force municipalities either to accept or repudiate responsibility for patients within a given period.

Four objected outright to any advance being made in the rates charged the Workmen's Compensation Board. Several other institutions, while not actively opposed, cast grave doubts upon the advisability of such action being taken.

The Executive Committee after consideration of this report crystallized its findings into a statement which was placed before the Provincial Secretary on November 20th, by a committee consisting of the President, Mr. Charles Graham of Cumberland, Messrs. George Haddon, and J. Banfield of Vancouver, Dr. G. B. Brown of Nanaimo, Mr. George McGregor of Victoria and Mr. E. S. Withers of New Westminster.

Owing to the pronounced opposition to the appointment of a hospital commission and to the division of opinion as to the increase of rates to be charged the Workmen's Compensation Board, both these proposals were omitted from the final draft and the statement included only such material as had the unanimous support of the hospitals of the Province, viz:

*1st.* That an increase of fifty cents (50c) per diem be granted to the public hospitals in this Province in addition to the amount set out in the sliding scale.

*2nd.* That the Hospital Act be amended to provide that all muni-

cipalities shall, upon receiving notice of the admittance of a patient, and within a period of fourteen (14) days, notify the hospital that the said municipality is either responsible or otherwise for the care of such patient.

And further, in the event of the municipality being not liable, that such information as may be in its possession shall be given to the hospital to enable it to follow up the account.

*3rd.* That legacies to hospitals be exempted from Sucession and Probate Duties.

*4th.* That Clause 19 of the Act to Amend to Poll Tax Act, 1920 be amended to provide that monies collected from the Poll Tax in any municipality shall be definitely apportioned in equal amount to hospitals and schools, and that monies so granted to hospitals shall be in addition to other grants made.

And further, that monies collected by Cities or Municipalities under this Act be distributed on or before the 31st day of January in each year.

In support of the request contained in paragraph 4, it is pointed out that a division of the funds on an equal basis is justified insofar as hospitals are concerned, municipalities being given certain power to fix the rates for school purposes, whilst hospitals have to depend upon raising money from independent sources.

The delegation also arranged with the Legislative Committee of the Union of B. C. Municipalities for a joint meeting at which a full and frank discussion of mutual problems took place.

With the possible exception of a better understanding with the Union, the efforts above described were almost without result. In spite of the fact that the hospitals displayed a united front and that their claims were urged with energy and conviction, only one of the requests was granted—that dealing with the remission of legacy duty.

The Executive Meeting held in April, 1924, dealt with convention plans and need not be considered further.

Interest in the Association has been well sustained during the year. The Annual Report met with a measure of approval. Its cost was greatly reduced in comparison with other years and this reduction was accomplished without impairing its interest or value. Requests for copies have been received from many parts of Canada and the United States, especially from governmental departments. Requests from individual hospitals for information have been received and dealt with through the Secretary's office. In one instance a tentative constitution and by-laws for the governing of a hospital had to be prepared at short notice.

Sixty hospitals appear in the Secretary's official lists and of these over fifty are in good standing. Summerland Hospital withdrew from membership, but is being urged to reconsider this action.

The Secretary wishes to record her cordial appreciation of the courtesy and kindness shown her by the secretaries of the hospitals throughout the province. Their prompt replies to questionnaires and their willingness to respond to all the demands made upon them have made her work a pleasure.

All of which is respectfully submitted.

ETHEL JOHNS,
Secretary.

The adoption of the secretary's report was moved by her and seconded by Mr. E. S. Withers.

The report of the treasurer, Mrs. M. E. Johnson, Vancouver, followed. She introduced the report with a few explanatory remarks dealing with the measures taken to ensure a credit balance. These included careful collection of accounts payable, as well as economies in printing

and stationery expenditures. In seconding the adoption of the report Dr. A. D. Buchanan of New Westminster complimented Mrs. Johnson very highly and moved a vote of thanks which was passed unanimously.

## ABSTRACT OF RECEIPTS AND DISBURSEMENTS

For the year ending 30th June, 1924.

| RECEIPTS | | | |
|---|---|---|---|
| Cash on hand, 30th June 1923.... | | | $78.16 |
| Membership Fees &c.:— | | | |
| Institutional | $665.25 | | |
| Less Refund | 5.00 | | |
| | | $660.25 | |
| Individual | | 7.00 | |
| Women's Auxiliaries | | 42.50 | |
| Exhibits | | 75.00 | |
| Advertising | | 90.00 | |
| | | | 874.75 |
| | | | $952.91 |

| DISBURSEMENTS | |
|---|---|
| Secretary's Salary | $275.00 |
| Stationery | 59.18 |
| Printing Circulars and Stamps therefor | 22.70 |
| Stamps &c. | 45.00 |
| Exchange on cheques | 4.75 |
| Printing 6th Annual Report | 164.30 |
| Secretary's expenses to Penticton and Victoria... | 60.95 |
| Badges | 7.05 |
| Typewriting | 3.00 |
| | $641.93 |
| Cash on hand — 30th June 1924 | 310.98 |
| | $952.91 |

Vancouver, B.C.,
13th August 1924.

*Certified Correct.*

BUTTAR & CHIENE,
Chartered Accountants.

An informal Conference of Women's Auxiliary groups followed. Mrs. G. W. Swaisland described the organization and activities of the Vancouver General Hospital Women's Auxiliary, mentioning the various divisions of its work and outlining briefly the scope of each. She laid special emphasis on the work of the Social Service Department which is supported entirely by the efforts of the Auxiliary. Mrs. G. Bell Brown spoke on behalf of the Auxiliary of the Nanaimo Hospital. stating that this body has representation on the Board of Directors of the hospital. She also mentioned that a substantial sum had been raised with a view to assisting in the equipment of the projected new hospital.

Mrs. R. M. Thompson presented an interesting report of the work of the Auxiliary of the Chilliwack General Hospital, showing over one hundred members on the roll and a total expenditure of $2440.64. Mr. T. Mordy in the absence of Mrs. Jeffery, the official representative of the Cumberland Hospital Auxiliary, spoke of the excellent work done by this group.

Mrs. W. Stevens reported on behalf of the Auxiliary of St. Joseph's General Hospital, Comox, showing that $1152.00 had been raised and that an ambulance is to be purchased through their efforts.

The report of the nominating committee, prepared by Mr. T. Mordy of Cumberland, was then read by him.

At the conclusion of the report of the nominating committee Dr. H. C. Wrinch suggested that this committee continue to function until the time of elections. Mr. Mordy stated his willingness to comply with this request.

Convenors of Committees were appointed by the Chair as follows:

Resolutions, Dr. H. C. Wrinch; Press, Mr. E. S. Withers.

Mr. J. D. MacGregor of Victoria was requested to act as scrutineer with the privilege of naming his own associates.

Miss J. F. Mackenzie, Victoria, spoke briefly on behalf of the Local Committee on arrangements. Several members voiced their appreciation of the work done by Miss Mackenzie, especially in connection with the exhibits.

The meeting adjourned at noon in order to attend the luncheon of the Rotary Club. The delightful musical programme was greatly enjoyed. Mr. George Haddon spoke briefly on the aims and objects of the Association and the Secretary outlined a few hospital problems having a direct bearing upon community responsibility.

## AFTERNOON SESSION, THURSDAY, AUGUST 28th.

The programme for the afternoon session was arranged by the Committee on Business Affairs of which Mr. R. A. Bethune is convenor. He was invited by the chairman to give a few introductory remarks respecting the programme and at their close introduced Mr. E. W. Carr-Hilton of Duncan, who spoke briefly on the special problem involved in the care of cases of tuberculosis and of infectious disease in small hospitals.

Mr. W. H. Smith, of Vernon, called attention to the resolution forwarded for endorsation to the hospitals of the province by the Vernon Jubilee Hospital, the text of which follows:—

WHEREAS among the hospitals of the Province there are many which serve large areas of unorganized territory;

AND WHEREAS many of the residents of such areas are transient laborers and those who are developing the land and are thus among

those least able to pay for hospital service when such becomes necessary;

AND WHEREAS hospitals receiving Provincial aid have no option but to treat and care for all who may require the services of such institutions, whether they are able to pay for it or not;

AND WHEREAS any deficits which exist in the finances of such institutions are almost invariably due to the large number of such charges which it is impossible to collect;

THEREFORE BE IT RESOLVED that in the case of hospitals so situated, and where the foregoing conditions exist, such hospitals be granted special consideration by the Provincial Government, on a basis which may be found adequate to counteract the losses from these causes;

AND BE IT FURTHER RESOLVED that a competent official be appointed whose privilege and duty it shall be to investigate all claims which may be made for financial aid by hospitals, and whose duties shall include inspection of financial matters, nursing and other operations. Such official to report and make recommendations to the department in charge of hospital affairs.

Several members took part in the discussion and it was moved by Mr. Thompson of Chilliwack that action be postponed until after the report of the Committee on Resolutions had been presented.

Mr. R. L. Reid, K.C., of Vancouver, then delivered an address entitled:

## HOSPITAL LAW IN BRITISH COLUMBIA

The word hospital comes to us from the old French "hospital", modern "hopital" and in the olden days meant a place of shelter, a lodging. Edmond Spencer in his "Faerie Queen" (II-ix-10) says:

> "Whereas they spied a goodly castle, placed
> Forby a river in a pleasant dale;
> Which chusing for that evening's hospital
> They thither marched."

From this it came to mean a building for the reception, care and treatment of those persons who from any cause were unable to support or provide for themselves, and were therefore more or less dependent on the help of others. It is closely connected with the word "hospitality", both implying benefits conferred on others and that, I think, is the aim and object of all those engaged in the occupation to which you have devoted yourselves, the service of your afflicted fellow man. In modern times a hospital has been defined as "an institution for the reception and care of sick, wounded, infirm and aged persons," and it is of institutions dealing with the first two classes and the law applicable to them in British Columbia that I have been requested to speak to you this afternoon.

In the first place, as you know, there are two kinds of law applicable to hospitals, as well as to all other institutions: the common law, which we find in the decisions of the Courts, and which is the application to all transactions of certain rules of decision common to all those jurisdictions in which English law has authority.

> "The lawless science of our Law
> That codeless myriad of precedent
> That wilderness of single instances."

as Tennyson somewhat sarcastically says. This Common law is not found in any written code, but is developed by the Courts as questions arise from time to time to be decided. As opposed to this we have Statute law which is the specific regulations laid down by the Legisla-

tive Assembly from time to time to meet the peculiar circumstances which have arisen in this particular Province owing to our municipal organizations in settled districts, or the want of them in our great empty spaces. As specific legislation is always followed where it varies or alters the rules of the Common law it will be well to discuss in the first place the Statute Law of British Columbia on the matter of hospitals, and then to deal generally with the other.

The first general legislation of British Columbia on hospitals was passed in the year 1902. It became evident that the monies received from patients together with private donations were not sufficient to carry on the benevolent work of caring for the sick, both those able to pay and those who were not, and that it was necessary to supplement these sources of revenue by Government grants in aid. That this aid might be equitably allotted to the various institutions of this kind in the Province, the "Hospital Act, 1902" was passed and came into force on the first day of July in that year. In this Act a "Hospital" to which the Act applied was defined as:

> "An institution founded for the reception and treatment of persons diseased in body, and in which they are treated either at their own expense, or by charity, in whole or in part, and which institution is in receipt of aid from public moneys appropriated for that purpose."

You will see from this definition that the only hospitals included were what may be called "Public Hospitals", viz., those which gave treatment not only to the well-to-do but also to the sick who were unable to pay for the services rendered to them and therefore were the objects of charity, and (in order that a certain control might be retained) only those which received aid from the Provincial Funds. It did not cover those institutions which only admitted patients who were financially able to pay the cost of their care and treatment and which, therefore, did not need Governmental assistance, and which may be styled "Private Hospitals."

The granting of aid was subject to the Hospital being approved by the Lieut.-Governor in Council, which is a legal expression, really meaning the Government in power in the Province for the time being. When a Hospital was approved it was entitled to receive aid from the Province according to the number of days treatment given by it to patients during the year for bodily disease, but did not include the care of anyone on account only of old age or merely indigent circumstances, and who were not in need of medical attendance. This aid ran from a minimum of $500 to Hospitals where the days treatment per year ran from 365 to 500, on a gradually descending scale from one dollar per day to thirty-five cents per day according to the number of days treatment given per year. The greater the number of patients treated, the less per capita was given. No aid was to be given to any Hospital which refused to admit any one on account of his inability to pay. Any Hospital within the Act was to be at all times subject to Government inspection, and was compelled to have its regulations approved by the Lieut-Governor in Council.

The framers of this Statute failed to remember that there were isolated portions of the Province which could not comply with its provisions but from the very sparseness of the population in the vicinity were peculiarly in need of help, so in 1908 the Government was given power to make grants in such cases as might be deemed advisable. In 1910 the minimum allowance per day was increased to forty-five cents.

In 1913 only one Hospital in each municipality was eligible for aid except another was established with the approval of the Government. In the Statute this year we find the section which has probably caused more friction between the Hospitals and the surrounding Municipalities than any other part of the Act. The Hospitals had found that even

with this assistance from the Government they were not able to comply with the demands made on their revenues owing to the number of indigent patients which had to be treated and requested that provision be made for a payment to them of one dollar per day afterwards increased to $2.50 in 1920, for each indigent patient by the Municipality in which they had resided for the last thirty days before admission. This liability was imposed; the Superintendent of the Hospital being required to notify the Municipal Clerk immediately an indigent patient entered the Hospital in order that he might be enabled to make enquiries in respect thereof and decide as to the Municipality's liability. If any sums were so paid by it the patient was liable to repay, if at any after time he was able to do so. In lieu of this, a fixed grant might be agreed upon between the Municipality and the Hospital.

The difficulties which then arose were rather questions of fact than questions of law. Of course if the Municipality denied liability and action was taken in the Courts, the burden of proof was on the Hospital to show that the particular patient in question was indigent, that is, so destitute of property or means that the claim of the Hospital could not be enforced. It imposed a heavy burden on the staff of the Hospital. In many cases the patient had left the hospital without paying his account and could not be found; evidence of his financial status was difficult and expensive to procure; the municipalities, weighed down by incessant demands for local expenditure, were not too anxious to help out the hospital authorities, and a great deal of trouble was experienced on both sides. Claims had to be dropped or compromised, but the drain on the funds of the hospital went on just the same, for the sick and suffering had to be attended to whether payment was received or not.

The hospital authorities went to the Government with their grievances and in 1916, the Municipalities were made liable for the treatment of *all* patients who had resided within their boundaries for thirty days before admission, whether indigent or not, leaving them to recoup themselves by collecting as much as they could thereof from the persons who had been treated. It was now the turn of the Municipalities to protest, and they did so vigorously. Patients were very slow in repaying the Municipalities its expenditure on their behalf, an epidemic of "indigence" swept over the communities, and the large hospital bills and the small collection per contra, appalled the local authorities. Again the Government was deluged with complaints so that in the last session of the Local House another attempt was made to remedy the trouble. "Indigent person" was given a statutory interpretation. It was defined as:

> "A person who by reason of being poor and destitute is unable to procure suitable surgical or medical treatment."

How this helped matters I am unable to see. Any dictionary would have given the same information as did this new provision of the Statute. The Municipalities are again only obliged to pay for "indigent" patients and that on notice being given by the hospital to the Municipal Clerk within seven days after admission, "or as soon as practicable thereafter" (whatever that means) with "such particulars as may be ascertainable to enable the Clerk to identify the patient." The burden of ascertaining the worldly wealth of the patient, or rather the lack of it, is again laid upon the hospital, and the vagueness of the provisions as to what particulars the notice must contain makes the position of the hospitals as bad or worse than it was prior to the amendment of 1916.

There are also provisions in the Act of 1923 for the representation of the Hospital Boards of representatives of the Municipality in which it is situated and, if the Lieut-Governor in Council deems it advisable, of an adjoining Municipality.

Notwithstanding the requirement that the hospital should give notice to the Clerk of the Municipality, there is no burden put upon the Municipality to make any reply or return to the hospital. If the Municipalities are only to pay for indigent patients, I should suggest that they should be compelled, within a reasonable time after receipt of notice from the hospital, to make enquiries as to the financial standing of each patient concerning which they have received notice. They have a Police force which could make the necessary enquiries and obtain the requisite information speedily and at a much less cost and with less trouble than the hospitals can. If the Municipality on making enquiries notified the hospital that they had agreed that the patient was indigent, no further steps need be taken; but if they denied this condition, the hospital would then be put upon enquiry itself while the evidence was available. If the Municipality made no return within a time to be fixed by the Statute, it should be taken as conclusive evidence that indigence was admitted.

So much for the Statutory Law relating to Public Hospitals. Now let us consider the common law relating to the relations between these institutions and their employees and between them and the physicians whose duties call them to treat patients being cared for by them. In doing so, I will treat first of the hospital employees generally; then of the nurses on the nursing staff, and of special nurses; and lastly of the Hospitals' relations with medical men, including both those on the staff of the hospital itself and with outside practitioners.

EMPLOYEES:

The liability of the hospital for its regular employees is exactly the same as the liability of any other person or corporation. An employer, be he the owner of a hospital or otherwise, is responsible for the damages sustained by a third person for any acts by his servant, provided it be done in the ordinary course of his employment; and this is so whether such acts are those of omission or commission, whether they be negligent, fraudulent or deceitful, and even where they are done in direct violation of the master's orders and are positive acts of misconduct, or even amounting to criminal deeds: (although in the latter case, of course, the master is not liable criminally) and it makes no difference whether such employer be a natural person or a corporation.

It will be noted, however, that this liability is confined to acts done "in the course of his employment." If a servant goes out of his way to do some act which he had no authority to do, and which is not within the scope of the duties which he was employed to carry out, the employer will not be liable, just because the wrongdoer happened at the time to be in his employment. Thus an orderly negligently injuring a patient while carrying out his duties in the hospital as such would render it liable for damages. But if an orderly went out of his way to do an act which was in no way connected with or in the course of his duties as such, the corporation would incur no liability by reason thereof, but the injured person's remedy would be solely against the wrongdoer himself.

It will be remembered that negligence is always a question of fact, the law being that negligence is:

> "The omission to do something which a reasonable man, guided upon those considerations which ordinarily regulate the conduct of human affairs, would do, or doing something which a prudent and reasonable man would not do."

I think most people will look upon this as a very vague rule by which to measure one's acts. Our ideas vary so much as to what that ideal reasonable man will or will not do under a certain set of circumstances. But when we consider that no two sets of circumstances ever are or will be exactly the same, and yet that negligence must be avoided in them under penalty, in case of injury to another, of paying

damages, we will see how impossible it is to frame a rule which will cover all cases in anything else than the most general words. We can only lay down a general principle and apply it as best we can under the circumstances of each particular case.

A case in our own Courts (Brandeis v Weldon, 22 B.C.R. 405) where damages were claimed against a medical practitioner, who was also the proprietor of a private hospital, for the death of the Plaintiff's wife, illustrates this, and may be of interest to the members of this association. A Mrs. Brandeis, a Bohemian lady, speaking no English, was ill with pelvic inflammation, and on the defendant's advice was removed to his hospital for treatment. When taken there, her temperature was 101 1/5. The following evening her temperature had gone down to 100 4/5 and she was apparently improving. At 10:00 p.m. a nurse attended her and she was apparently normal. At 11:00 p.m. the nurse visited her room and found she had disappeared. She immediately told the matron, who telephoned the doctor. The Plaintiff's husband lived about a mile from the hospital. It was supposed that she had gone home, so nothing more was done till the next morning when her clothes were found on the bank of a river about 200 feet from the hospital, and her body about a mile down the river.

In the action two grounds of negligence were alleged: (a) that the hospital was negligent in not preventing the patient from leaving the hospital, and (b) that her husband should have been notified as soon as her absence was discovered without waiting till the next day. The jury found the hospital negligent and gave a verdict for damages. The Court of Appeal set aside the verdict and gave judgment in favor of the defendant, holding that under the circumstances, the condition of the woman, apparently normal at 10:00 p.m., and the hourly attendance, that escape from the hospital was not owing to lack of care, and that the best care had been given that could have been given by the physician and nurses "in the circumstances." Note those last three words, for it is quite possible that under other circumstances a different conclusion might have been arrived at by the Court. On the other ground, the lack of notice to the husband, the finding was that as there was no evidence to show that the patient was not already dead when the nurses discovered her absence, the lack of notice was no evidence of negligence. In an English case where a Plaintiff suffering from fits was put in the proper ward, and in the absence of the nurse, broke a window, squeezed through the bars, threw himself down and was killed, the hospital was held by the Court of Appeal not to have been negligent.

NURSES:

The liability of a hospital for acts of the nurses which it is instrumental in obtaining for the treatment of its patients, is always dependent on the question, whether the contract between the hospital and the patient is one to supply nursing or is merely to supply nurses. If it is to supply nursing, and the nurse in attendance is negligent, the hospital is liable; if it is to supply nurses only, the hospital is only liable where it has supplied nurses who are not properly qualified.

If the contract is to supply nursing, the selection of nurses, in accordance with the usual practice, having the usual qualifications by reason of training, etc., is not sufficient, but the hospital incurs liability in case the nurse employed does not perform her duties properly and the patient is thereby injured. The leading case on this point is Lavere v Smith's Falls Public Hospital (35 O.L.R. 98-26 D.L.R. 346) a case which was decided in the Court of Appeal in Ontario in 1915, and which is worthy of being carefully studied by those in charge of an institution of this kind, as the reasons for decision given by the judges in that case discuss the relations between the hospital and its nurses in a most thorough manner.

The facts in this case were as follows: The Plaintiff went to the Smith's Falls hospital for an operation. This was successfully performed, after which, and while under the influence of the anaesthetic, the patient was put to bed and a hot brick placed against each foot. One of the bricks must have been overheated, for when she recovered consciousness, there was found to be a serious burn on the right foot. The result of this burn was considerable pain and a certain amount of disability which could only be removed, if at all, by an operation, the result of which was considered by her physicians to be so uncertain as to render it inadvisable.

An action was brought against the hospital which was dismissed by the trial judge, but the Court of Appeal reversed his decision and gave judgment for the Plaintiff for $900.00 damages and costs.

In this case the nurse in attendance was on the regular staff of the hospital. She received her board and a certain money allowance. She was under the control of the superintendent of the nurses, who selected them, hired and discharged them, subject to the approval of the Hospital Board. The superintendent of nurses alone selected the nurse in question, the patient having nothing to say as to what nurse should attend her. There were no direct instructions from the physician in charge as to what the nurse should do. There was a standing order as to warming the bed in such cases; the mode of doing this was taught to the nurses during their training. It was the duty of the attending nurse to see that this was properly done. Under these circumstances the Court held that the contract was a contract for nursing, *not* to supply a nurse, and that the negligence of the nurse was the negligence of the hospital, for which it was liable.

But what if the physician in charge of the case orders such a nurse to do a certain act, and the nurse in carrying it out according to his instructions, injures the patient? In such a case the nurse ceases, temporarily, to be the servant of the hospital and becomes, so far as carrying out his directions are concerned, the servant of the physician. Suppose, for instance, an operation is being performed, and a nurse is present, acting on and subject to the directions and orders of the operating surgeon. Under such conditions she is bound to act precisely as the surgeon directs, and the hospital is under no liability for her acts. In the Lavere case above mentioned, if the Doctor had ordered a brick, heated to a precise and certain temperature, to be placed at the patient's foot, and his instructions had been complied with and thereby injury had been caused to the patient, the hospital would not have been liable. But as the routine nursing was left to the hospital, to be carried out according to the usual practice, it was liable for the nurse's negligence. On this point the Lord Chief Justice of England says in another case, speaking of nurses at operations:

> "Although they are such servants for general purposes, they are not so for the purposes of operations and examinations by the medical officers;—as soon as the door of the theatre or operating room has closed on them for the purposes of an operation (in which term I include examination by the surgeon) they cease to be under the orders of the defendants (i.e., the hospital authorities)——the nurses—assisting at an operation cease for the time being to be the servants of the defendants, inasmuch as they take their orders during that period from the operating surgeon alone."

But in order to protect herself and the hospital by which she is employed, a nurse in taking orders from a physician, must be quite sure that she understands them correctly, and as he intends them. If she obeys his orders, she cannot be negligent; if there is any negligence in such a case, it is his and not hers. But she must be sure that she understands the orders given her and must not act on what she *should* know to be a slip of the tongue. She holds herself out, and the hospital holds her out, as being possessed of competent

skill and undertakes that she will use reasonable care. If any command of the surgeon appears to be out of the usual practice or dangerous to the patient she should call his attention pointedly to the order. If she does this and he makes it clear that she understands his order as he understands it, and intends it to be carried out, she must obey and it is not negligence for her to act on the belief that he has greater competence and skill than she has. A physician should appreciate the necessity for and commend such action on the part of the attending nurse.

A case which exemplifies the necessity for the nurse to take such precautions is that of Armstrong v Bruce, (1904) 4 O.W.R. 327. In this case a doctor was being sued for malpractice in having had applied to the person of a patient a "Kelly Pad" filled with "boiling" water when it should have been filled with hot water. The nurse gave evidence that the boiling water had been put in by the direct orders of the defendant, the attending physician. This was denied by the defendant and two other medical men present corroborated his statements. The Court found for the defendant, and held that the directions were not as stated by the nurse but that the usual directions, to fill the Kelly pad with hot water, were those which had been given, and that the negligence was that of the nurse, not that of the doctor.

If the duty taken upon itself by the hospital is only to procure nurses, as is the usual course when special nurses are retained, the patient or his attending physician should, as a matter of precaution, be consulted as to the nurse or nurses to be employed unless, for some reason they cannot do so, or desire to leave such selection to the hospital authorities. It should also be made a rule of the hospital, so that all persons dealing with it, both patients and medical men, may distinctly understand it, that as to special nurses the hospital takes upon itself no other responsibility than that of engaging those who are properly qualified, and that otherwise the matter of the nurses and any liability for their acts is solely between the patient and the attending nurse or nurses. I think this is the law, even without such a specific rule, but it may avoid question if the limit of the hospital's responsibility is clearly made known in that way to all parties interested.

The rule that there is no liability where the contract is to *supply nurses* and not to *furnish nursing*, except for negligence in selection, is illustrated by the case of Hull v Lees (1904) 2 K.B. 602. The defendants were a voluntary association, in part supported by charitable donations, to provide for the supply of duly qualified nurses to attend the sick in a certain neighborhood. They appointed and paid salaries to their nurses, for whose services they made charges to persons on whose application the nurses were supplied if they were able to pay, in other cases gratuitously. By the negligence of one of the nurses a hot water bottle, used to prevent collapse after an operation, came, when very highly heated, in immediate contact with the plaintiff's body, instead of being shielded, as it should have been, by the intervention of a blanket or other covering, whereby she was severely burned. She sued the association for damages by reason of the negligence of the nurse. The jury found for the plaintiff and assessed the damages at £300.

The Court of Appeal set aside the finding of the jury and entered judgment for the defendants. One of the Judges thus distinguishes between the effect of a contract to supply nursing, and one to supply nurses:

> "The question is therefore raised, whether the Association who supplied the nurse is responsible to the patient for the consequence of her negligence. That question in the last resort is a simple one, and depends, I think, upon the true effect of the contract between

the association and the person to whom the nurse is supplied. If the Association undertook to nurse the patient, then they are responsible for the failure of the person by whom they nursed her, to use due care. If on the other hand, they only undertook to supply a competent nurse to the patient, then, if they exercised ordinary care and skill in the selection of the nurse whom they supplied, their responsibility is at an end, and they were not responsible for her failure to exercise care and skill."

Under the circumstances they found that the contract made by the Association came within the latter class, and therefore it was not liable.

PHYSICIANS ON THE STAFF:

Whatever may be the liability of a hospital for the acts of Medical practitioners, acting in the capacity of and merely as administrators of the hospital, and this would seem to be on the same level as other employees, in their capacity as professional men, although on the hospital staff, the hospital is under no liability for their acts as such. A servant is a person over whose acts the employer has control. The master has a right to say what his servant shall do or shall refrain from doing and the latter is bound to act as he is directed. This cannot apply to a physician or surgeon in his professional capacity, whose acts cannot be supervised or directed by the governing authorities of a hospital. Over the exercise of their professional skill and ability the hospital has no control. The provincial authorities, under the provisions of the "Medical Act," have provided for the examination and registration of trained specialists as duly qualified practitioners of medicine, surgery and midwifery in British Columbia. These authorities refuse to allow any person other than a registered practitioner to be a house surgeon or house physician in any hospital.. Such duly registered practitioners are therefore considered to be skilled persons over whose professional qualifications and conduct the hospital authorities have no control or supervision and therefore they are under no liability for their professional acts and such practitioners are in no sense *servants* of the hospital, and this notwithstanding they are on the staff of a hospital and are selected by its governing Board. It does not treat its patients through the *agency* of its physicians but only *procures* for them the physician's services. It is true that the hospital may in the discretion of its governing authorities, dismiss them, but it has this power not because they are its servants, but because of its control over the institution where their services are rendered. They would not, and in the nature of things, could not under any circumstances recognize the right of the hospital, while retaining them, to direct them in their treatment of patients.

The layman is presumably incapable of judging the right treatment to be adopted by medical men, and accordingly he is not required to interfere with them or is he in any sense warranted in doing so. On the contrary the governing body, whoever it may be, would without doubt be guilty of gross negligence if it attempted to do so, and if it did, and injury resulted from such interference, it would be liable in damages. The duty of the hospital, and its *only* duty in respect to its medical staff, is to use due care and skill in selecting them, and this duty is fully carried out when selection is made of those persons who have been certified under the "Medical Act" to have the necessary qualifications for practice within the Province, so long as it has no knowledge of any specific unfitness owing to bad habits or conduct on the part of the practitioner appointed, and has provided its staff with reasonably fit and proper apparatus and appliances for proper care and treatment of its patients.

The leading case on this point is Hillyer v The Governors of St. Bartholomew's Hospital [(1909) 2 K.B. 820]. The Plaintiff in this case was himself a medical man who had entered the hospital for the

purpose of being medically examined under an anaesthetic. The examination was conducted by a consulting surgeon on the staff of the hospital. During the examination the Plaintiff was placed on the operating table in such a position that his arms were allowed to hang over its sides, and thus his left arm came in contact with a hot water tin projecting from beneath the table, which caused a serious burn on his left arm. During the examination his right arm was also bruised by the operator or some other person pressing against it, with the result that traumatic neuritis and paralysis of both arms followed, rendering him unable thereafter to exercise his profession. The Court of Appeal held that there was no liability on the hospital. One of the judges said:

> "A public body is liable for the negligence of its servants in the same way as private individuals would be liable under similar circumstances, notwithstanding that it is acting in the performance of public duties, like a local Board of Health; or of elemosynary and charitable functions, like a public hospital.——The first question then is, were any of the persons present at the examination servants of the defendants? It is, in my opinion, impossible to contend that Mr. Lockwood, the surgeon, or the acting assistant surgeon, or the acting house surgeon, or the administrator of anaesthetics, or any of them, were servants in the proper sense of the word; they were all professional men, employed by the defendants to exercise their profession to the best of their abilities according to their own discretion; but in exercising it they were in no way under the orders or bound to obey the directions of the defendants."

And again:

> "No surgeon would undertake the responsibility of operations if his orders and directions were subject to the control of or interference by the governing body."

This case was followed in our own Courts in the well known case of Thompson v Columbia Coast Mission, 20 B.C.R. 115. Here the Plaintiff paid $1.00 per month to the defendant Mission for hospital treatment in case of illness. Following an accident he had trouble with his shoulder and went to the defendant Mission's hospital where he was treated by the doctor in charge, who diagnosed his complaint as rheumatism and treated it accordingly. Not improving in health, he went to the Vancouver General Hospital where it was found that he was suffering from a dislocated shoulder, but owing to his advanced age and the length of time since the accident, it was not considered advisable to remedy the trouble by an operation and he consequently remained seriously injured. The jury which heard the case found against the Mission, but on Appeal the case was dismissed as against it, the Court holding that the doctor in charge of the hospital was not, in his professional capacity, the servant of the hospital.

The Chief Justice puts the question of the liability of the hospital very clearly. He says:

> "A professional man cannot in the performance of a professional service be the servant—of anyone, certainly not of a corporation or of a non-professional employer, because, in the exercise of his professional skill and care, he could not properly be subject to the control of a master, and hence, when a patient enters a hospital, whether as a paying patient or not, the hospital must not be negligent in those matters which they control, but as to their professional employees, they must be deemed to have performed their duty to the patient when they have taken care to select and provide a competent medical man to treat him, and that the ordinary rules of law as to the liability of a master for the negligence of a servant do not extend to professional employees exercising professional skill and care.'.'

As to what is a "competent medical man" in B. C., Mr. Justice

McPhillips says:

> "All those whose names are on the British Columbia Medical Register must be deemed to be persons of professional competence. Possibly cases might arise where there would be responsibility if it were known that the practitioner employed in a hospital were, owing to habits or conduct, unfit to properly discharge the duties entrusted to him."

But this rule would not apply to any other than fully competent medical men. In the Thompson case, the Chief Justice refers to a case in the American Courts where damage was occasioned by the unskilful act of a surgical interne or house pupil, who himself treated the patient instead of calling in a surgeon, as it was his duty to do. Here he was negligent in his ministerial duty to call in a surgeon, and the hospital was held liable for such act.

An interesting case arose in Quebec, (Boilard v Montreal, 18 D.L.R. 366), where a child who had been vaccinated, was shortly after found suffering from infantile paralysis. There were a number of theories brought out in the course of the trial as to the cause of this; whether the vaccine was infected, or whether the vaccination had anything at all to do with the matter. We are not here concerned with either of these theories, but in the course of the Appeal the Court held that as the City bought the vaccine from the Institute of Vaccination at Montreal, who had prepared it subject to the examination of the Provincial Board of Health, and received it in hermetically sealed bottles, it was not responsible for any defect in its quality; and also that it was not responsible for any negligence on the part of the physicians administering it, unless it were proven that it had been guilty of negligence in the choice of such physicians.

There are many other cases in the Reports bearing on the same question, but the ones quoted are sufficient to show the line following by the Courts in dealing with the liability of a hospital for its medical staff.

PHYSICIANS NOT ON THE STAFF.

If this is correct as to the liability of the hospital for the acts of medical men who are on its staff, a fortiori it follows that there is no liability on the part of the hospital for negligence of physicians not on the staff, who are attending patients there. The patient can only look to the doctor himself, and his acts, or any acts of the nurses in obedience to his directions or demands, are entirely a matter between himself and his patient, with which the hospital has no concern whatever, and the fact that some of the acts so authorized are carried out by persons who, in other respects, and when not so engaged, are in the direct employ of the hospital and are truly its servants in every sense of the word, whether as nurses, orderlies or otherwise, makes no difference.

Another question which I was requested to discuss was as to whether a Public Hospital has the right to refuse to admit or to continue to keep a patient. I can find no decided cases on this point. A patient could not be excluded from a public hospital, merely because he was unable to pay for his treatment, because if this was done, the hospital would be excluded from receiving Government aid, the Statute specifically providing that:

> "No aid shall be given———to any hospital which refuses to admit any patient on account of his or her indigent circumstances."

There may be cases when the hospital is full and has no accommodation for other patients in which it might be justified in refusing to accept any more whether indigent or not. It is bound to provide for the isolation of those suffering from infectious diseases if it accepts them, and the provision for the isolation of smallpox patients is com-

pulsory under the Act. Not being a medical man, I cannot say whether or not there are any other classes which should not be admitted, but if there are, proper bylaws should be passed in respect thereof, giving the hospital such powers as may be necessary and these should be approved by the Lieut.-Governor in Council as provided by the Act. Generally speaking, however, I should say that if the hospital has the necessary accommodation it should not, unless under the most exceptional circumstances, refuse the admission of any person requiring its services.

If a patient continues to need treatment the same rule would apply, but the hospital is not obliged to keep patients after they have ceased to require its services. This is a question for the attending physician or, if there is none, the medical staff, and if the hospital acts on their advice, it will be protected.

Such are some of the points which will commonly arise in ordinary practice and as were suggested to me by Dr. Bell. I do not suggest that it covers all the cases which may come up from time to time; that would be impossible for me to do in such an address as this. Neither am I, or any other person able to foresee what may, at one time or another, be the combination of circumstances which will confront you. The greatest difficulties which you will meet, will be questions of fact, not questions of law, and those can only be met and solved when and as they arise. I have endeavored in a general way to outline the general principles of the law relating to hospitals, exemplifying them by some of the decided cases, but you may not find it always easy to foresee how the courts may apply them under many varying circumstances for which there may be no precedent among cases which have been decided up to this time. The knowledge of these principles may, however, assist you to some extent, perhaps, to avoid trouble to the institutions which may be under your direction.

There is always, however, this thought to encourage you. Troubles only arise because you are actually doing something. And it is your duty as I have no doubt it is your pleasure, to be of some good to the world, by actually being of service to it. In doing so, many questions must necessarily be continually arising which will be unpleasant. Shall we, therefore, do nothing, because we foresee that by acting difficulties will arise? I think not, for inaction would be the greatest mistake of all; not merely a mistake, but worse than that, a moral crime, when the needs of our poor humanity are so great and the demands on your skill and attention are so enormous. May I wish you all Godspeed and success in your task.

---

Mr. Reid's masterly address was received with prolonged applause and the discussion which followed was animated. Numerous complicated legal questions were brought forward for his consideration by Messrs. T. Mordy, R. W. Thompson, G. R. Binger and Drs. Bell, Darby and Wrinch.

The discussion of the hospital care of infectious diseases was resumed. Dr. A. D. Buchanan, of New Westminster, speaking of himself as a "Municipal Man," pleaded for a better understanding between the municipalities and the hospitals regarding this and other problems. It was useless to expect a satisfactory solution unless all parties got together and showed a spirit of mutual sympathy and understanding.

Mr. T. Mordy spoke of conditions in Cumberland, and Mr. A. Tyrell, of Kamloops, gave an interesting description of the efforts of the railway men's organizations to outline a sound plan of caring for cases of infectious disease. Mr. W. W. Cory, representing the Canadian National Railways Employees' Association, further explained this project.

Mr. R. L. McCulloch, of Abbotsford, deprecated the tendency shown to "pass the buck" to the government. He urged educating the municipalities to recognize their responsibilities.

Dr. F. C. Bell outlined the plan being worked out by the Vancouver General Hospital that the government be requested to re-insert the word "indigent" in the hospital act so as to force municipalities to acknowledge the just claims of the hospitals for the payment of accounts incurred by this type of patient. As an outcome of this discussion it was moved by Mr. E. S. Withers, of New Westminster, and seconded by Mr. E. M. Cook, of Chemainus, that a joint committee with representatives from the Hospitals Association, The Union of B. C. Municipalities and the Provincial Government enquire, during the coming year, into the various points at issue mentioned during the afternoon session The motion carried.

The meeting then adjourned.

## FRIDAY, AUGUST 29th, MORNING SESSION.

As soon as the meeting was called to order, the Chairman announced the death of Dr. R. H. Mullin, which had occurred at 5 a.m. at St. Joseph's Hospital. The assembly arose and remained standing for one minute in silence as a token of sorrow and respect.

Dr. F. C. Bell was then requested to take charge of the meeting which dealt with medical service in hospitals.

The first speaker was Dr. W. B. Burnett of Vancouver, his subject being "What we can do to improve obstetrical practice in hospitals." Dr. Burnett outlined the requirements of a modern obstetrical department with respect to equipment and facilities, emphasizing especially the necessity for the segregation of infectious cases and for adequate provision for nurseries.

He deplored what he felt to be the attitude of the modern nurse toward this important and interesting branch of nursing practice. That they no longer displayed the interest they should was due, he thought, to certain defects in the present system of training in large hospitals which did not permit the nurse to follow through her cases in a sufficiently thorough manner to ensure her acquiring skill and judgment in obstetrical nursing. The students in small hospitals had all round experience and on the whole tended to develop better. Dr. Burnett advocated the special training of graduate nurses in the more advanced phases of obstetrical nursing, such as abdominal palpation, rectal examinations and pelvic measurements and even the administration of anaesthetics. He deprecated the tendency toward a set routine in the care of maternity patients and urged a more personal and sympathetic attitude on the part of the nurse. He spoke of the problems associated with the question of visiting and strongly urged the exclusion of all children from maternity wards, and emphasized the importance of careful case records.

In conclusion he again urged reform in the present method of training student nurses and appealed to graduate nurses to aid in supplying a highly efficient personnel for this important branch of nursing.

Dr. George Darby of Bella Bella, in discussing Dr. Burnett's paper thanked him very cordially for the compliment paid the small training schools. He endorsed Dr. Burnett's plea for nurses trained in the advanced phases. It was frequently necessary for the nurse in his hospital to give anaesthetics and it would be very helpful if they also could be trained to do simple examinations. Occasionally it was necessary for them to deliver patients themselves in the ab-

sence of both physicians. Mr. T. Mordy discussed the question from the director's point of view. He stated that in small hospitals it was practically impossible to command the services of highly trained specialists and urged that the preparation of the ordinary graduate nurse should be as thorough as possible.

Mr. George Binger of Kelowna stated that to his opinion the ordinary nurse learned to adapt herself to local conditions fairly quickly. Dr. H. C. Wrinch also thanked Dr. Burnett for his compliment to the small hospitals and suggested such an interchange of pupils between the large and small schools as would permit the former to gain the practical experience afforded in the small hospitals.

A paper was then read by Dr. Ridewood of Victoria, entitled:

## WHAT THE SURGEON EXPECTS FROM THE HOSPITAL

He expects a great deal.

The surgeon sees the patient at his office or at the patient's house where he examines, and makes his notes of the patient.

He decides the patient should go to the hospital for diagnosis or treatment, or operation. He is apt to be met by the patient's prejudice against hospitals in general or some tale about neglect at the hospital in question, or some complaint about the food received when the patient was last in the hospital. There should be no justification of any such complaint and the food should not only be the best, but should be put up in the most appetising way before the delicate palates of the sick. The question of expense is also apt to trouble the patiest. He wants to know how much it is going to cost him. The hospital must be economically run, no excessively expensive buildings or fittings, and the rate per bed or room should include all the usually necessary examinations and treatments so that as far as possible there are no extra charges except in the case of special nurses. With the increasing cost of sickness some form of state health insurance alone will equalize this burden—for the indigent this does not compensate the patient for the time he is out of work.

The patient deciding to go into the hospital, on telephoning the hospital, the surgeon should be able to be immediately told if there is a room or bed vacant—should be able to give orders for the patient—and if an operative case, should be able to find what time he can list the operation. In a small hospital, one telephones the matron who can arrange everything and give all information straightway. In a larger hospital, it sometimes means telephoning to the hospital three times. First to arrange a bed—then to arrange the operation—then orders for the patient; each time a certain amount of delay. This should not be. An admitting office and admitting officer should do this.

When the patient is admitted there is the question of the notes of his case. The surgeon has his own notes. In the record department there should be a stenographer, specially trained for the purpose of knowing medical terms, who can take the dictated notes in shorthand and transfer these to typewriting at leisure.

We will take an operative case next. Operations, except emergencies, are generally done in the morning. This sometimes leads to congestion. There should be a sufficient number of operating theatres—a sufficient theatre staff to cope with the congestion in the larger hospitals. The surgeon should be punctual, but cannot always be so. An operation may prove to be a much longer one,

as regards time, than was anticipated, and this may throw the theatre list out of gear. After an operation it takes some time to clean things up in the theatre and get ready for the next—if however, a spare theatre is available, things can be got ready there, while the last operation is in progress. The surgeon should have to wait no unreasonable time for the patient to be brought from the ward or for an anaesthetist—it generally takes some time for the patient to be anaesthetized and unless things are well run there is a good deal of time consumed that is not actually operating time. The theatre nurse is a very important person. So important to the surgeon that the surgical staff should be consulted in her selection. She must be able to train the nurses in aseptic technique, in the names and care of all the instruments and appliances. A nurse cannot be trained in this way in a day, consequently the nurses in training, in the operating theatres, should only be changed one at a time at regular intervals so that there is always a large proportion of partly trained and not a bevy of helpless, raw hands. In the larger hospitals there should be more than one fully trained operating nurse, since one cannot properly supervize more than one major operation, to say nothing of the minors.

The surgeon expects the hospital to provide a satisfactory supply of surgical instruments with which all ordinary operations can be performed. A satisfactory supply of sterile towels, sheets, gloves, gowns, aprons and masks. That the cutting instruments be kept sharp, and other instruments intact and in working order. Also satisfactory anaesthetic apparatus so that the anaesthetist can give either warmed ether vapour or gas and oxygen if needed.

All pathological material removed should be examined in the laboratory without any extra charge except the extra charge for the use of operating room. If the material is not so examined, cases of cancer, etc., will be overlooked or mistakes will go incorrected since the surgeon is tempted to spare the patient extra expense and the hospital loses its right to be called Class A in hospital standardization.

For fracture cases the surgeon expects a satisfactory series of splints, for all purposes, to be readily accessible.

He expects the apparatus for saline infusion—tracheotomy—and other emergencies to be always ready for use, and accessible and these days also the apparatus for blood transfusion and a list of properly selected donors.

In the after case of operative cases in the wards, he expects the ward supervisors to be specially trained in the care of surgical cases—so that he shall be informed of any serious changes in his patient's condition.

He expects instruments for dressing, drainage tubes, dressings, syringes—lotions to be always ready so that he can do all his dressings properly without unnecessary delay. Also a steriliser always boiling so that any special instrument etc., can be boiled without delay. Also sterile rubber gloves, readily accessible, in the wards for occasions when they are required.

He also expects that the charts of the patients be kept conveniently arranged so as to be readily accessible on his rounds—together with history forms, prescription blanks, X ray forms, pathological forms, etc.

He also expects a well trained male nurse to look after male cases after spinal operations and a well equipped and efficient X ray and laboratory service.

In concluding his remarks, Dr. Ridewood spoke of the desirability

of larger hospitals loaning expensive apparatus, not constantly in use, to smaller institutions and spoke appreciatively of courtesies extended by the Vancouver General Hospital.

Permission was requested at the close of this address by Dr. A. D. Buchanan, to introduce Reeve Lockley of Esquimalt, President of the Union of Municipalities. This was granted by the Chair and Reeve Lockley delivered a brief address. He referred humorously to the fact that he might not be safe in a hospital gathering when it was known that he was the President of the Union with whom such sharp issue had been taken, but he described himself as having as one of his principal aims: "to get the hospitals, the school trustees and the Union together" so that some amicable conclusion could be arrived at and some constructive policy formulated. He emphasized the necessity for co-operation and a united front, if governmental action is desired, and urged the appointment of a joint committee to consider the problem from all angles. His remarks were very cordially received by the members present.

The morning's program was concluded by the following paper prepared by Dr. F. C. Bell, General Superintendent of the Vancouver General Hospital

## THE PERSONAL FACTOR IN HOSPITAL ADMINISTRATION.

By Dr. F. C. Bell.

The greatly increased interest which individuals and communities now display in matters of public health has led, by comparison with conditions of twenty years ago, to a corresponding demand for institutional facilities for the treatment of disease. Such demand has in part arisen from the activities of institutions themselves, the result of a consciousness on the part of the hospitals of the problems they must face. The physical side of the hospital—its construction, equipment, service, finance and administration make a multitude of pressing everyday difficulties which develop that need for consultation, and search for advice which are tangibly expressed by the fact of gathering together as we do now.

In surveying the whole hospital field it is often one of our perplexities that the benefit of service given so many individuals fails of recognition by the community as a whole, and that there so often appears to be a lack of sympathetic public support of our institutions. I want to suggest to you that this condition of affairs is contributed to by the oft repeated failure on the part of hospitals themselves to appreciate the human problem of the patient. Too often we are slow to recognize the fact that it is through the patient that we establish most of our contact with the community, and that patients leave our institution with a resultant dissemination of their hospital experience among their friends.

"Treat not only the disease, treat also the man." These words of Virchow, the great pathologist, seem to me to set the standard for the highest form of hospital service. The hundreds of patients who are daily in the hospitals of British Columbia, present the hospitals not only with a variety of bodily ills, but with problems of personality and environment which are as varied as human nature, and which influence vitally the ultimate success of the hospital's mission to maintain, as well as to restore health.

Virchow's words appear to set, not only a standard, but express a warning, for one of the hospitals' great dangers is over specialization—concentration on pathology and the overlooking of personality.

There is a similar problem to be grappled with in the field of medical education where the production of the coldly scientific and wholly selfish type of practitioner is causing not a little concern to his elders. Sir William Osler was one of the first to draw attention to danger of over emphasizing the scientific side of medicine to the exclusion of an education of sympathy and humaneness.

Those who are accustomed to the hospital atmosphere too often fail to recognize how new and strange an experience, to the average patient, is the first contact with a hospital. The admission procedure, the unfamiliar antiseptic odors, the sight of many sick people, the preoccupied business-like efficiency of hurrying nurses and doctors, and their chance words of comment dropped in conversation, fill many a patient with vague and uncertain ideas of what may be going on behind the many closed doors, and what may soon be happening to himself. Courage and self reliance seem easily lost in the strange institutional atmosphere. The educated man who is familiar with hospitals, having previously been a visitor or a patient, and who is self confident and at ease even during sickness, is in quite a different position from those who have rarely required medical or hospital attention; or the timid woman, the sensitive child, or the man harrassed by family cares.

It does not seem to be that hospitals or their personnel lack kindness in the treatment of patients. It is surely their stated business to be helpful and they generally are, but it is rather helpfulness in a professional and technical way not always to the exclusion of that helpfulness which contributes to the ease of mind of the patient and makes for explanation of the intent of the treatment given. While the patient is generally full of worrying questions he would like to have answered, or forebodings which it would be desirable to dispel, and of states of mind which depress him he does not know to whom to turn for explanations of questions which are rarely anticipated as natural ones, and which remain unanswered if unexpressed. Such forebodings and states of mind require not merely a general attitude of kindness but sympathetic insight, facility of analysis, and definite action, to dispel. Apparently we have a new task confronting us, that of adjusting the Hospital regime to a treatment of physical, racial or temperamental needs which are additional to the conditions now so scientifically considered. In those hospitals where there is evidence of some appreciation of these facts, and a sympathetic attitude of convincing the patient of its friendly interest, its ability in diagnosis, its skill in treatment and its intelligent appreciation of the relation of personal problems to disease, there is also evidence that the Hospital's work is worth while. The patient leaves such an institution in a grateful frame of mind and the experience has probably been of "permanent educational value to him in the matter of personal and public health, and in the growth of a sense of participation in a modern social and economic movement."

The result is different when the hospital has no specific machinery for getting at the back of what is in the patients' mind and making the somewhat inflexible and mysterious hospital routine less of a puzzle to him. If the patient has any skepticism as to whether hospitals are good places for him such is apt to develop into a large doubt. This is further enlarged by his friends who have trouble in being understood at the enquiry desk, or in asking their way to a ward, obscurely situated; who may be unable to talk with the doctor or to get a diagnosis. If the cases are medical ones the patients worry through a retarded convalesence and go home glad to be free—but wondering. Once outside, their impressions of hospital matters are translated into definite complaints which shake the confidence of those who hear them. If the cases are surgical

there is sometimes the climax of protest against the vast unknown of perfected hospital machinery in a refusal to permit operation, or at least a violation of rules framed for the treatment of cases. These patients frequently leave against advice, grateful for a somewhat peremptory discharge from hospitals, which in turn feels affronted by its lack of ability to deal with an unresponsive or unreasoning attitude of mind.

One important relation of the hospital to the Community is the furnishing of information about the condition of patients. Patients themselves not only wish to know how they are getting on, but also that their friends and relatives may have information. Hospital Staffs and administrators must of course use their discretion in what they tell the patients or relatives, just as private physicians do, yet the hospitals often fail to give elementary and necessary information or to give it cheerfully in a way which will be helpful or even useful.

Interpretation of the hospital's work, rules, and results to the public is part of the hospital's function. That public includes patients, their relatives, and friends, and also the broader circle of the Hospital's supporters, or any one in the community, in fact, who has a reason to be interested in the hospital's activities. The interpretation is made partly in the hospital's formal report, and partly through its daily relations with its patients and those interested in them. Too little attention has been given to the spreading of correct information about hospitals through the channels of its routine contact.

We may also note that the degree of the patient's lack of understanding of the hospital is comparable to the hospitals' lack of understanding the patient. The patient can be greatly helped and better understood if there is right procedure at the time of admission. There should be tact in obtaining what data are then required, but seem senseless, or irrevelant to the patient, especially if similar particulars are again required from him on the wards. There is an irritating sense of being indexed and classified as if the subject were an inanimate one rather than human and animate. Hospitals do not always meet the evident responsibilities resting on them either completely or wisely because of failures to assign sufficiently trained or responsible persons to the task of sympathetically receiving the individual patient.

The critical moment, for the patient, from the standpoint of disease, is after the time of admission to hospital but the critical time for the patient from his standpoint, as a person is usually at, or a little before the discharge. Having become adjusted to his hospital environment (sometimes unfortunately over hospitalized) the patient often views with some dismay the necessity for recommencing his particular battle of life. Ofttimes he may still be in need of some definite form of medical care, either at home, in attendance at an Out Patient Department, or a convalescence which the hospital is neither equipped for nor established to give. In these cases it seems to be the responsibility of the hospital to refer the patient to some existing organization which is prepared to meet the difficulty, and it is just here that the Social Service department nurse can best come in and assist the hospital Staff by securing the essential facts regarding the patient's personality, the family housing, home conditions and finances. If this information is then taken in conjunction with the facts known concerning the patient's condition it should enable the responsible member of the staff to formulate a programme for the after care. Not all hospitals can however find themselves in a position to carry on extensive work of this nature, but if they are unable to do so they should still recognize responsi-

bility for providing the patient or friends with an explanation of the case, and know into what channels to direct the patient to further assistance. Co-operation with charitable agencies in behalf of their patients is a particularly significant responsibility for all hospitals since no inconsiderable proportion of ward patients are likely to be adversely affected by lack of it.

In the long run, the degree of support accorded the hospitals of this Province will depend upon the degree to which their work is appreciated by the community. The elaborate facilities, equipment, staff and organization needed for the thorough study and treatment of disease require a commensurate high degree of appreciation on the part of the community of just what hospital work is, what it requires, and what it costs. The foundation of appreciation in these matters is understanding. Anyone grasps the beneficent service of a hospital to the emergency accident patient, but understanding of the less obvious, and more typical cases, which constitute the majority of the whole, is not so easy. The patients lack of understanding of the hospital at the time of discharge is a misfortune to the patient as well. Only on the basis of mutual understanding can adequate public support for the best hospital work be built up and maintained.

---

The meeting adjourned for luncheon which took place at the Provincial Royal Jubilee Hospital under the auspices of the Woman's Auxiliary of the hospital, the President, Mrs. C. W. Rhodes having charge of the arrangements. Out of respect to Dr. Mullin, the social features of the luncheon were abandoned and a question box was conducted. Below will be found some of the many questions submitted, which may prove of some interest.

(1) Can hospitals protect themselves with respect to liabilities arising out of accidents or injuries to patients?
No one present knew of any company which would offer to insure against such risks.

(2) Should women be allowed to be members of hospital directorates?
The opinion was almost unanimously in favor of their so doing.

(3) Should Women's Auxiliary Associations have representation on the Hospital Board.
The majority felt that they should.

(4) How long should case records be preserved?
The answer given was "Several years at least if they are to be of any use to the patient or to the hospital."

(5) Has the association considered the feasibility of establishing a central purchasing bureau?
The reply was in the affirmative, but that many hospitals felt they could not utilize such a bureau since they were obliged to make all purchases locally.

(6) What vacations should be granted annually (a) to graduate staff nurses, (b) to pupil nurses.
To graduates, one month; pupils, three weeks.

(7) Should not the doctor be penalized rather than the hospital in cases of the Workmen's Compensation Board cases remaining in the hospital too long?
No definite answer was forthcoming to this question, but the opinion was expressed that the responsibility of the doctor to the hospital in this connection should be brought forcibly to his attention.

(8) Has the hospital any redress when the Workmen's Compensation Board repudiates charges for hospital service to

patients authorized by local medical men?
The consensus of opinion was that at present the hospital has no option but to submit to the decision of the Board.

Space does not permit of all questions being recorded here. The last and most hotly debated was: "What stand does this convention take on bobbed hair?" Discussion became so animated that the chairman hurriedly brought the proceedings to a close after a very cordial vote of thanks had been passed and tendered to Mrs. Rhodes and her associates and to Miss J. F. Mackenzie for the delightful luncheon.

## FRIDAY, AUGUST 29th, AFTERNOON SESSION.

The afternoon session was devoted to Nursing affairs and was held at the Provincial Royal Jubilee Hospital. Miss K. W. Ellis, Director of Nursing in the Vancouver General Hospital, took charge of the meeting and presented the following report on Nursing Progress.

## REPORT ON NURSING PROGRESS

I beg to submit the following report on nursing affairs and in it to bring to your notice what the past year has seen accomplished by the three sections of the Graduate Nurses' Association of B. C. viz: Private Duty, Public Health and Nursing Education. The convenors of these sections now attend all executive meetings and report fully on the work done by their committees. The steadily increasing membership, the co-operation of the various sections, together with interest shown in topics brought up for discussion is encouraging.

Private Duty Section Meetings possibly have not been attended as well as those of other sections, owing to the fact, no doubt, that frequently calls of the private duty nurse do not permit of the regular attendance. Last summer a Refresher Course was held at the University of B. C. under the direction of Miss Ethel Johns. This course was well attended, thirty-three nurses having enrolled and those who were able to take advantage of the lectures and conferences expressed their appreciation of the benefit derived therefrom.

Public Health Section—An institute extending over a period of three days for members of this section was held at the University of B. C. in April, 1924, also under the direction of Miss Johns. A generous invitation to attend many of the lectures was extended by the University authorities to members of the Nursing Association, other than those belonging to the Public Health Section. It was gratifying to note that the Government acknowledged the value of such a course by recalling public health nurses in this province to attend. Further recognition has also been made of the value of special instruction in this branch of the work by the fact that a resolution was passed by members of the nursing association requesting that in making appointments to public health positions prior consideration be given to those who have taken a special course or have obtained the equivalent in practical experience.

Nursing Education Section—Regular meetings have been held by this section and have been well attended. The revision of the standard curriculum dealt with at some length in last year's report has been completed and may now be obtained in printed form, a copy having been sent to the various hospitals throughout the Province.

It is to be hoped that this may be of some assistance in establishing a more uniform standard in the Training Schools, both as regards

the requirements for students entering and also the course of instruction given.

To aid in this objective, it has been felt by members of this section that standard lesson plans might prove of value and the consideration of standard records, including application forms, for general use in hospitals throughout the Province has also been suggested.

Several matter of common interest have been discussed at various meetings during the year:—

(a) Health insurance. A committee being appointed to keep in touch with the further development of this scheme.

(b) The desirability of a travelling dietetian to visit the smaller hospitals at regular intervals and give a course of instruction in dietetics. Possibly Miss Randal will give us some information as to the response this suggestion has met with.

(c) Affiliation—how may the present system be improved upon.

A demonstration of practical nursing procedure followed, arranged by Miss Gregory-Allen of the Jubilee Hospital. Miss C. Veysey, a student in the second year, showed the method of applying hot compresses to the eye, and Miss Phinney, a first year student, demonstrated the application of a mustard plaster.

Miss A. Shafer, Dietitian of the Jubilee Hospital, then read the following paper:—

## THE DIET DEPARTMENT IN THE HOSPITAL

Upon the diet department rests the responsibility of feeding the entire hospital personnel including the patients, staff and help; and the manner in which this is done has a lot to do with the popularity of the hospital as far as publicity from ex-patients is concerned and also has a great deal to do with the contentedness of the staff and help. The success of diet therapeutics depends almost entirely upon the manner in which these diets are administered and in the educating of the patient concerning his special dietary needs. Financially, the commissary department presents the largest item of expense. Dietetics has a place in the nursing profession and the subject has been placed on the curriculum in training schools. From this you will see that the diet department is no small part of any hospital, regardless of size.

No one doubts the importance of good food in a hospital but very few have any conception of the difficulties to be overcome in serving food in the best possible manner. Most people are in the habit of eating three meals a day every day of their lives, unless something seriously is the matter, and I believe it is because food enters so commonly in our every day lives that we do not attach to it the importance which it deserves. I do not wish to be understood that people do not appreciate good food, they do—but they accept it as a matter of course, and as far as applying the principles of good nutrition and facilities for preparing and serving food efficiently we are just a bit behind.

Several weeks ago I was told that the food service was the weak spot in most hospitals. The patient and staff all present a more or less critical attitude toward the food. There is more dissatisfaction about the food than from all other sources put together. This is rather a big pill to swallow, but unfortunately the criticism is true in varying degrees in most hospitals.

The two chief points in the criticism toward hospital food is

that the variety is limited and the food is too often served cold and unattractive. The conditions which make for unsatisfactory food service must be overcome and the principles are applicable in all institutions regardless of size. If you want good service you must make conditions for it possible.

The suggestions to be made which tend toward better food service will be covered under five heads, namely:

1. Good supplies necessary.
2. The kitchen staff.
3. The location and equipment of the kitchen.
4. The serving of the food after it is cooked.
5. Co-operation with other departments.

At this point you will probably be wondering what it is going to cost you and you will likely say that you cannot afford the necessary changes. The money part is very important and cannot be ignored but you must give at least as much thought to the service as you do to the financial end, instead of putting expenses down to the very lowest figure and considering the results of secondary importance.

Now, in the first place it is necessary to have good supplies. This will depend somewhat on the markets and merchants in your locality. Have the merchants enough interest in your institution to give you good service or do they treat your hospital as a sort of a safety valve with which to get rid of surplus or undesirable goods? Are the supplies checked on delivery to see that you get the goods you pay for? Does the financial position of the hospital enable you to buy good supplies or must you accept an inferior article because of price? Proper storage facilities are necessary, particularly for perishable goods as meat, milk, butter, eggs, fruits and vegetables.

Even more important than the buying of good supplies is the preparation of food and this will depend on the kitchen staff and their workshop. Good materials to begin with, are of no avail if they are spoiled in the cooking. A good kitchen staff and proper equipment is necessary. The chef is a skilled man and will demand the pay of a skilled person. There is no economy in employing an inexperienced cook at a low salary as he wastes more in the month than would pay the difference in his and a better man's salary. The chef's job is no small one. He works in front of a hot stove, the three meals must go out like clock work day after day, he must have a good appreciation of cleanliness, and economy must be exercised by all people in the department to prevent unnecessary waste. There is a tendency for people handling things not their own to be more or less careless and wasteful. The kitchen is a place where small leaks amount to goodly proportions by the end of a month. A hospital cook is not so much required to make fancy dishes as to cook plain foods well. He must be an expert in cooking meats, be able to cook potatoes and other vegetables properly, to make a custard without holes, etc. Last minute failures on the part of a cook are an avoidable waste and are usually due to inexperience or carelessness.

The kitchen must be planned and equipped so that the work can be done efficiently. Instead of the kitchen being planned as a part of the hospital, it is so often only an after-thought and placed in the part least suitable for anything else. Perhaps the ventilation or the light is poor. Or perhaps it is so placed that the noise and odors cannot help but escape and permeate through the rest of the building. The equipment must be such as to allow the work to be accomplished most efficiently.

The serving of the food is also very important and this is where many fail in their efforts for good service. Food is so often cold or dried up and unappetizing when it reaches the patient. There is too great a gap between the time the food is cooked and the time it is served, and during this time it is being kept hot with the result that flavors are lost, food overcooked or dried out. Meats particularly, dry and toughen when kept hot for a time after being carved and potatoes become soggy. There are two systems commonly used in serving trays in hospitals and they have their advantages and disadvantages largely in the location of the kitchen to the rest of the building or in the efficiency by which the system is carried out in that particular place. The oldest and most common method is to send the food all ready to be served from the main kitchen to the ward pantries where it is dished upon the patients' trays under the supervision of the head nurse who knows all her patients and what they require. Serving should begin the minute the food arrive from the kitchen but how often is the food just set aside until the nurses have time to dish up. Perhaps even one of the doctors is holding up the works while he has come to visit a patient or to do a dressing at mealtime. The central service system requires that the kitchen be so placed as to be accessible to all the floors by food elevators. Here each tray is prepared directly from the stove, thus preventing lost flavors by reheating.

There must be the closest co-operation between the diet department and other departments in regard to the ordering and serving of foods. There may be a rigid system of regulating the requisition for supplies in other parts of the house but the general impression in hospitals is that the kitchen is managed on the short order restaurant plan and that anything desired should be obtained at any time. We must recognize that the commissary department is an organized part of the whole scheme with which every other department is more or less intimately connected.

The department should have at its head a person who is directly responsible for the entire food service including the making of all menus, special diets, control over the supplies and the supervision of the preparation and the serving of all the food. It is necessary that this person have a knowledge of nutrition and experience in handling foods. If the hospital is not large enough to justify the employment of a dietitian, the work may be combined with that of another member of the staff, but it is necessary that she have special training in diet work. The head of the department must have enough imagination to introduce variety in the meals, athough the number of employees in the kitchen, their competency and the equipment modify the menu very much. The head of the department must also be open minded enough to receive and profit by criticisms.

I hope that I have not given you the impression that good food service must necessarily be a costly one but that to make it function efficiently it must be given other consideration besides cost.

---

The following paper, prepared by Dr. Walker, was read by Dr. E. M. Pearse, Medical Superintendent of the Jubilee Hospital.
Mr. President, Ladies and Gentlemen:—

I am not responsible for the title of the paper affixed to my name on the programme, and I am as unprepared to take up the subject of Insulin from a theoretical or research point of view as most of you would be to listen to such a discussion.

In any laboratory engaged in routine work, research problems form the substance of one's dreams, for sustained research is not

possible at the end of a telephone which anchors one to earthly matters of fact.

I therefore propose to discuss briefly the larger problem of the treatment of Diabetes, and lay special stress on the use and limitations of Insulin in this field.

As you all know, Insulin is a product of those cell inclusions known as the Islands of Langerhans, which are found imbedded between the digestive cells of the pancreas. If one analyses the records of post mortem findings in cases of clinical diabetes, one is struck by the fact that fibrosis of these cells is not a constant finding, and therefore one could scarcely expect that Insulin would be of equal value in all such cases as a remedial agent.

In other words, diabetes is not invariably due to changes in the pancreas, and therefore Insulin cannot be regarded as a specific remedy. It is of enormous value, however, in most cases occurring in early life and especially in those giving a history of diabetes following Mumps; and appears to be of some use in all cases. This lessened value might be expected if we assume that those cases not due to pancreatic disease are due in part to disease of other ductless glands, whose functions may be carried on to some extent by the combined efforts of members of the group.

Now let me sketch the treatment of a typical case, and comment on matters as they arise. We will suppose that a patient is admitted to hospital with characteristic history and symptoms, and is found on admission to have a blood sugar content of 400 mgms per 100 ccs.

Our practice is to place such a patient on a diet which will provide basal calories, maintain nitrogenous equilibrium, and prevent any increase of acidosis. For this purpose age, weight, height, and sex are obtained, and the diet calculated in terms of Proteid, Fat and Carbohydrate so that 0.66 gms of Proteid per kilo body weight are given and 100 per cent. basal calories yielded, and the total glucose bears a ratio to the fatty acid of 1 to 1.5.

Such a diet might consist of Proteid 42 gms, Fat 129 gms, Carbohydrate 53 gms.

This prescription is sent to the diet kitchen and worked out in terms of actual foodstuffs, which are provided and served on special trays by diet kitchen for rooms and wards. The patient is consulted in likes and dislikes by the dietitian so that meals will be pleasing.

It is usual to give such diet and estimate the carbohydrate tolerance of the individual before calculating the dose of insulin that may be required, but if this be done considerable time will be lost, and greater expense to the patient incurred. Knowing that the blood contains an excessive amount of sugar it seems a much more rational procedure to administer insulin immediately such fact be known, and reduce the figure to normal range at the earliest possible moment. Moreover the carbohydrate tolerance will invariably be found somewhat higher if the blood sugar is first reduced to somewhere near normal level. Consequently it has been our practice for some time to administer insulin as soon after admission as possible to a patient in the condition sketched, while waiting for the diet to be worked out. The response made to this preliminary dosage, checked of course by blood sugar estimations, enables one to estimate roughly the value of insulin, per gm. of sugar for the individual. In many cases it will be found that no further insulin is required at all. Patients who were apparently severe diabetics on admission are found able to hold their blood sugar to normal range on calculated diets, even though wide choice of foodstuffs is allowed.

There is no doubt whatever, that education of patients in dietetics

is infinitely more important than all else combined. While in hospital they are taught how to choose their food so that they can work out the prescription given them in terms of Proteid, Fat and Carbohydrate, varying their meals each day. They are supplied with charts of food values, and given notes on calculating diets, as soon as they make response to treatment. If they need Insulin they are taught to administer it themselves As soon as they are up they are placed on increased calories varying with the activities of the individuals. Before they leave hospitals they are taught how to test the urine for presence of sugar, and are provided with Benedicts solution and test tube for this purpose. Each patient is advised to purchase a balance for weighing food before leaving hospital and the balance we have found most suitable for this purpose is that made by the Eastman Kodak Company for weighing photographic chemicals. It is graduated on a beam for weights below 5 gms, and has a set of weights in gms up to 100 gms. It is compact and is sold at a price about one-third of any other balance we know .

There are two case records that I should like to show. One indicates the extreme ease of dealing with a highly educated patient with a mathematical mind, and the other brings out some points on the relative inertia of Insulin. The first patient had been under treatment for a few months before I saw him. At the time of his first visit to me his blood sugar was 400 mgms per 100 ccs. He came into hospital for two days, receiving 40 units of Insulin and basal calorie diet. He was discharged with a blood sugar of 133 mgms and during his stay had been educated so well that his blood sugar has remained normal ever since. During the past three months he has had this test made seven times. I should think that not more than ten hours work have been devoted to this patient.

The second patient I saw in September last year, when he arrived in Victoria from the Vancouver General Hospital where he had been treated for two or three weeks. Those in whose care he had been sent me a letter concerning him, advising me of the great gravity of the case. The boy's mother had been given a hopeless prognosis, and I took the same view of his condition. He went steadily down hill till Christmas as an out patient, and then I got him to come into hospital as his blood sugar was up to 500 mgms. In bed on basal calorie diet Insulin was pushed to the limit of usefulness without reducing the blood sugar below 283 mgms. I gave him 1 grain of parathyroid by mouth at 11 a.m. on 21/12/23. His blood sugar fell within four hours to 103 mgms, and on less Insulin than before and an increased diet, with the addition of 1-10 gn. of parathyroid daily he remained well for three months. Then he went down hill again and returned to hospital in coma on 31/3/24. Both Insulin and parathyroid were pushed without lasting effect, but he carried on in poor shape until May. At this time he was given 5 grs. of Didymin daily, in addition to 60 units of Insulin and the effect of extract of orchitic substance has been just as marked as the parathyroid. Since May he has been quite a different being, and always expresses himself as feeling fine. I was moved to try the effect of Didymin in this case in consequence of the success I had with Ovarian substance in a diabetic whose illness followed X ray treatment of a fibroid uterus, where the history pointed to diabetic symptoms being due to the effect of rays on the ovaries.

In conclusion I would emphasise the necessity of education of patients in dietetics and insist on the need for accurately weighed diets for the dose of Insulin, if this be required, is only to be measured against the difference between the amount of sugar taken as food and the amount the patient can burn up unaided. Since sugar is formed on digestion by all food stuffs—Proteid yields 58%,

Fat 10% and Carbohydrates 100%—it is quite impossible to treat diabetes intelligently by recommending some article of food as permissible and barring others.

---

The following paper was then read by Mr. George R. Binger:

## THE LADY SUPERINTENDENT AND HER PROBLEMS

Mr. President, Ladies and Gentlemen:—

When I received Miss Ellis' letter saying that the Nursing Section of this Association wanted me to read a paper on the Problems of a Lady Superintendent and asking me to place myself in the position of one of them, I remembered my school days and that a very argumentative gentleman by the name of Euclid after making all sorts of wild and silly statements ended up with "Which is absurd." This I always thought was the most sensible remark his books contained.

It is not altogether that I do not wish to be a lady superintendent, but how could I or any other mere man ever hope to possess the qualifications necessary to fill one of the most trying positions a human being could ever voluntarily occupy. I have often asked myself "Why do they do it?" and the only answer I can make is "just because they are women."

I thought when I began this paper that it would not be a difficult matter to mention several problems which face a lady superintendent which would open the way to discussion, but when I began to think the matter over I found it beyond me to pick out matters which are of outstanding importance and could be solved by this Convention. I then tried to pick the brains of some of the lady superintendents of the nearby hospitals but found that they seem to be in the same predicament.

There are so many small things cropping up all the time which in themselves are not very much like the mosquito, are not very big but their continuous buzz and occasional nip get on the nerves and it must require more than ordinary self control on the part of a lady superintendent not to let her temper get the upper hand and say something which would cause trouble.

I am afraid therefore that I shall simply have to generalize and endeavour to give you a short sketch of what a lady superintendent of a small hospital is up against.

In my opinion, of course I may be wrong and am open to correction, her sister in the same position in one of the large hospitals, where there are heads of different departments who are responsible to the Board for the proper management of those departments, has an easier task than she who has sole charge and has to oversee everything from seeing that the institution is efficiently run to the ordering of two-pennyworth of soap. It would take up too much of your time were I to try to enumerate all she has to think of and do from the time she gets up in the morning till she is asleep at night. Her duties are never ended for even when she has her hours off she is always on call if wanted.

A lady superintendent of a small hospital is in the unenviable and almost hopeless position of having to try to please everybody and at the same time do her duty and carry out the rules of her hospital, for if these rules are not carried out she runs the chance of being jumped on by her directors. She has to consider the efficient running of her hospital and do her utmost to have it equipped in an up-to-date manner, this is no easy task in the present impecunious state of most of the hospitals of the province, where the

unfortunate directors are turning grey in their endeavour to keep down expenses and find enough money to pay the actual running expenses.

There are the little differences between members of the staff to be settled, oil to be poured on the troubled waters so that the waves of discord may be calmed and everything once more be made to travel over a smooth sea. This she must do without showing the least favoritism, for it is fatal to discipline where ones likes and dislikes are allowed to weigh in any decision that has to be made, and the fair sex are very quick in seeing any signs of favoritism being shown and naturally resent it.

Normally the patient is just the ordinary type of human being but when sickness overtakes him is like a chameleon and in the changing of his skin takes on many different characteristics

Some are patient under suffering, appreciative of the care and attention they receive and do everything in their power to make things easier for themselves and those looking after them. They make one of the bright spots in nursing. Others are a real trial and tribulation. They become restless and impatient. Nothing is right, their bell is continually ringing and they think they are the only pebble on the beach and should receive the attention of the whole staff, though they are probably not nearly as bad as others. This is where the lady superintendent having previously looked in the glass to see that she is not showing any signs of annoyance and having put on her sweetest smile, walks in and does all in her power to smooth things over whereas she would no doubt much prefer to administer a dose which would forever quiet their grumbles.

I think one of the real thorns in the flesh is the Public with a very large capital "P." I do not know if other secretaries have noticed the fact that the word hospital in the opinion of the ordinary man on the street should never have had a place in the English language. If not I envy him from the bottom of my heart. It is an extraordinary thing how ready people are to pick holes in the management and believe rumors which are absolutely without foundation and on the face of them are absurd. Probably they like to believe these things as giving them as an excuse for not supporting the hospital. The lady superintendent comes in for criticism from people who know nothing about the running of a hospital and evidently do not wish to learn. These unfounded rumors generally come to the ears, through some misguided friend who thinks she is doing her a good turn in letting her know what is going on and though she knows there is no truth in them it must be very annoying to one who is doing her utmost for the comfort of her patients and the good of her hospital.

Where there is a Training School in connection with the hospital her trials are greatly increased, as she has ten or twelve young girls to handle who have to be taught what proper discipline means besides the hundred and one other subjects which go for making the finished article a good capable graduate who will be a credit to her Training School.

It is quite an education to watch a young girl from the time she first arrives in hospital. The way she walks down a corridor, enters a ward, handles her tray, are absolutely different after she has been training for a short time and all these small details a lady superintendent has to watch and correct besides looking after the welfare and proper behavior of the pupils giving lectures, correcting papers, and in fact doing all that a head mistress of a boarding school has to do and this on top of her professional duties.

She is of course, responsible to the Board who are as a rule

a hard headed lot of business men and look at things from a business man's point of view. Here I would like to give as my opinion that a great many of her difficulties would be made easier by closer co-operation between herself and her directors. She should be able to understand their difficulties and they should be able to look at things from her point of view and the only way that this can be accomplished is by frequent personal discussions of points which arise from time to time.

The Secretary is generally the go-between and is asked to put the lady superintendent's wishes before the directors and the directors instruct the secretary to give certain instructions to the lady superintendent. This sounds easy and in many cases is all right but there are occasions where the secretary knowing both sides of the question and, if he is any sort of a man, being able to look at things from both viewpoints feels that a much better understanding could be arrived at if the matter were discussed personally. You all know, I am sure, how difficult it is in every day life to explain things satisfactorily between two people. With every good intention on your part, you cannot give that personal touch to what you say and probably one or other gets the impression that you are trying to favor the other fellow, which does not tend to a proper understanding. So it is in the case of a lady superintendent and her directors.

In conclusion I would like to say that every graduate, however good a nurse she may be, is not fitted to fill the position of a lady superintendent of a hospital whether large or small, as it takes a woman of outstanding ability to be equal to the task.

This is my idea of the qualifications of a lady superintendent: She should have executive ability, be a good disciplinarian, but able to lead those under her rather than drive. Her disposition should be cheerful and sympathetic, always ready with a smile and a kind word. Be tactful, for want of tact often causes many troubles. She should have the patience of Job. In fact, that much tried individual would have lost out had he been up against some of the trials and worries our lady superintendents are asked to face and come through smiling. She should be a good judge of character, be able to see through a brick wall without showing she is trying to do so, be just in all her decisions, especially so where she is in charge of a School and last, but by no means least, have her work thoroughly at heart, for, unless she has, her life is one long drudgery and she is bound to go under.

This look rather like a perfect woman doesn't it, But thank heaven there are still such women in the world.

---

An animated discussion took place concerning the requirements laid down by the British Columbia Association of Graduate Nurses with respect to educational requirements for admission to Schools of Nursing in British Columbia. This provision calls for the successful completion of two years high school or its equivalent. Correspondence was submitted from Mr. A. P. Glen, writing on behalf of the Ladysmith General Hospital, stating that this requirement was unjust to the smaller schools, since it prevented women without the necessary educational requirement, but otherwise suitable, from entering. Several delegates endorsed this view. Miss Helen Randal defended the entrance requirements, pointing out the necessity of maintaining nursing standards at least as high as those which obtain in other provinces in Canada, if the nurses of British Columbia are to compete with them on equal terms. Miss Johns pointed out that a certain elasticity of interpretation could be made in the word "equivalent" and that often applicants lacking the necessary standing, could at

least approximate the standard by undertaking special studies. It was finally decided that the matter would be brought to the attention of the Graduate Nurses' Association with a view to mutual adjustment.

The rival merits of Prince Rupert, Nanaimo and Vernon, as the next place of meeting were placed before the Association most eloquently by their respective representatives, but as the hour was late final decision was postponed till the following day.

## SATURDAY, AUGUST 30th, MORNING SESSION.

The final session of the Convention was called to order at 10 a.m. Mr. George McGregor announced that he had requested Miss M. E. Johnson and Mr. R. A. Bethune to serve with him as scrutineers.

The election of officers then took place. This is the first occasion upon which elections have been held since the revision of the constitution providing for regional representation and the preparation of a formal slate by a nominating committee. It has therefore been thought wise to publish in full the following statement prepared by the nominating committee under the very able convenership of Mr. T. Mordy. This material should be of assistance in conducting nominations and elections on future occasions.

To The President, Officers and Members of The B. C. Hospitals Assn.

We beg to present for your consideration the following as the report of the Nominating Committee for the Election of Officers at the Convention held in Victoria on August 28, 29 and 30, 1924.

On May 29th, a circular letter was sent out to all the hospitals in B. C. stating the date of the Convention, the various offices open for nomination, term of tenure of office of the same, qualifications necessary, etc., and inviting nominations to be sent in at as early a date as possible.

Only three institutions made any attempt to nominate a complete slate, and nominations were made on the floor of the convention up to the very last minute.

The election of officers resulted as follows:—

Honorary President.....The Hon. The Provincial Secretary
President.....Chas. Graham, Cumberland
First Vice-President.....Dr. G. B. Brown, Nanaimo
Second Vice-President.....E. S. Withers, New Westminster
Secretary.....Miss E. Johns, Vancouver
Treasurer.....Geo. Haddon, Vancouver

### CONVENERS OF COMMITTEES

Medical Affairs.....Dr. F. C. Bell, Vancouver
Nursing Affairs.....Miss P. Rose, Nanaimo
Business Affairs, and Accounting.....R. A. Bethune, Kamloops
Constitution and By-laws.....J. H. McVety, Vancouver

### DISTRICT REPRESENTATIVES

Vancouver Island.....George McGregor, Victoria
Vancouver.....J. J. Banfield
Coast Mainland.....Dr. George Darby, Bella Bella
Fraser Valley.....Dr. A. D. Buchanan, New Westminster
Yale-Cariboo.....M. L. Grimmett, Merritt
Okanagan.....George Binger, Kelowna
Kootenay East.....Mother Nazareth, Cranbrook
Kootenay West.....George Johnstone, Nelson
Grand Trunk Pacific.....Harry Birch, Prince Rupert

The tendency to postpone nominations to the very last minute militates against the posting by the committee of a complete list of nominations in time to receive due consideration by the delegates before voting. Also it was not clearly understood by the delegates that they must vote as institutions, not as individuals, hence it was not feasible for any institute to nominate more than one candidate for each office vacant, as their vote could not be split. Many district representatives were nominated by members or institutes not in that particular district; in many cases wrong districts being named, causing a certain amount of confusion, which was aggravated by some of the districts not having their boundaries clearly defined.

We therefore respectfully recommend:

(1) That no nominations be permitted on the floor of the convention later than the session immediately preceding that of the election of officers:

(2) That representatives of districts should be nominated from these districts respectively, and for that purpose we suggest a meeting of the hospitals in each district prior to the meeting of the convention.

(3) That the question of the proper demarcation of boundaries of districts be referred to the Committee on Constitution and By-laws.

In conclusion the Committee wish to express their extreme gratitude to the very able secretary of the Association, Miss E. I. Johns, for the great amount of trouble she took to guide our faltering footsteps in an entirely new departure, and to the delegates assembled in Convention for their very kind and courteous consideration.

Respectfully submitted,

T. Mordy, (Convener)
R. L. McCulloch
H. R. Storrs, M.D
Nominating Committee

Mr. R. A. Bethune of Kamloops gave notice of motion as follows: "That the Committee on Constitution and Bylaws be requested to suggest such amendments to "Article 4; Officers" as may in their judgment be deemed advisable, the same to be submitted at the convention for discussion."

Mr. T. Mordy of Cumberland gave notice of motion as follows: "That a fifth standing committee be formed to be named the committee on Municipal Affairs."

On motion of Mr. T. Mordy, seconded by Mr. H. Birch of Prince Rupert, it was decided that the convener of the committee on Municipal Affairs to be appointed at this meeting shall, for this year be a member of the Executive Committee.

Informal discussion took place concerning the best method of outlining hospital districts in such a way as to ensure representation of all parts of the province on the Executive Committee. It was finally decided to refer this question to the Committee on Constitution and Bylaws.

The report of the Committee on Resolutions of which Dr. H. C. Wrinch, M.L.A. of Hazelton was convener was then considered. A most affecting resolution of condolence with Mrs. R. H. Mullin was first submitted and passed by a standing vote. Dr. Wrinch reported that the original resolutions submitted by the Board of Directors of the Vernon General Hospital had been used as the basis for the folowing report which was adopted in motion of Mr. W. H. Smith of Vernon, seconded by Mr. J. R. Brennan of Penticton.

## REPORT OF COMMITTEE ON RESOLUTIONS

The Resolutions Committee recommends that in view of the expressed desire of the Union of B. C. Municipalities to co-operate with the British Columbia Hospitals Association in matters requiring legislation affecting hospital support, that in the event of the following resolutions receiving the endorsation of this Convention that the same be submitted by a Committee of this Association to the Union of B. C. Municipalities at their Convention at Penticton for their consideration.

AND FURTHER, that in the event of the endorsation of said Resolutions by the Union of B. C. Municipalities, that the Executive Committee of the B. C. Hospitals Association be instructed to arrange for their presentation to the Provincial Government by a joint deputation of the two aforesaid organizations.

BUT, in the event of failure of the Union of B. C. Municipalities to endorse said resolutions, the Executive Committee of the British Columbia Hospitals Association be empowered to deal with the matter in such manner as it may deem advisable.

WHEREAS, the Government of the Province of British Columbia enacted legislation to provide that Municipalities shall be responsible for the care and treatment in hospitals of patients residing in such municipalities.

AND WHEREAS, this legislation has been amended from time to time upon representations made by the Union of B. C. Municipalities.

AND WHEREAS, certain of such amendments have not been in the best interests of the hospitals of this Province.

AND WHEREAS, unless legislation is enacted to provide that Municipalities shall be responsible for the payment of the accounts for the care of their sick, whether indigent or otherwise, the hospitals of this Province must of necessity approach the Provincial Government with a view to changing the present system of financing hospitals within this Province.

BE IT RESOLVED, that the B. C. Hospital Association be requested to give this matter earnest consideration with a view to approaching the Provincial Government towards having the present Act amended in such a manner as to protect the hospitals for the payment of their just debts against the municipalities.

WHEREAS, the maintenance and operation of an Isolation Hospital is in the interest of Public Health of the whole community.

AND WHEREAS, it is considered unfair that the fees for attendance and medical treatment should be a charge on the individual,

THEREFORE BE IT RESOLVED, that the Provincial Government be requested to assume the whole cost of Isolation Hospitals, and that a copy of this resolution be forwarded to the Honorable, the Provincial Secretary, and to all municipalities, and to the Union of B. C. Municipalities for their endorsation and support.

WHEREAS, among the hospitals of this Province there are many which serve large areas of unorganized territory,

AND WHEREAS, many of the residents of such areas are transient laborers and those who are developing the land and are thus among those least able to pay for hospital service when such becomes necessary,

AND WHEREAS, hospitals receiving Provincial aid have no option but to treat and care for all who may require the services

of such institution, whether they are able to pay for it or not,

AND WHEREAS, any deficits which exist in the finances of such institutions are almost invariably due to the large number of such charges which it is impossible to collect,

THEREFORE BE IT RESOLVED, that in the case of hospitals so situated and where the foregoing conditions exist, such hospitals be granted special consideration by the Provincial Government on a basis which may be found adequate to counteract the losses from these causes.

WHEREAS, the financial support of the Hospitals of the Province of British Columbia has proven to be a subject of much controversy between Municipal Governments and the governing boards of the hospitals, with respect to legislation which has been enacted from time to time by the Government of the Province of British Columbia.

AND WHEREAS, this British Columbia Hospitals Association earnestly desires the establishment of a permanent policy for the financial care of hospitals to the exclusion of legislation which may prove to be of a contentious nature and subject to fluctuation from time to time,

AND WHEREAS, it is the opinion of the British Columbia Hospitals Association that an equitable adjustment of the problem cannot be arrived at without a unity of effort between the parties interested in legislation controlling the same,

THEREFORE BE IT RESOLVED, that the British Columbia Hospitals Association in Convention assembled, is in favor of and earnestly advocates the appointment of a committee of enquiry, whose duties it shall be to accummulate evidence of legislation at present in force where similar conditions obtain, together with opinions as to the success and equity of such legislation. And from the date thereby secured to compile recommendations for the good financial government of the hospitals of this province.

AND BE IT FURTHER RESOLVED that the aforesaid committee should comprise representatives of:—The Government of the Province of British Columbia; the Union of the British Columbia Municipalities; and the British Columbia Hospitals Association,

AND BE IT FURTHER RESOLVED that copies of this resolution be forwarded to the Honorable The Provincial Secretary and to the Secretary of the Union of British Columbia Municipalities.

WHEREAS, Section 10 of the Hospital Act makes provision for the inspection of hospitals by a person appointed by the Lieut. Governor in Council for the purpose, such inspection to include the accounts and books thereof, buildings, medical appliances and drugs and any other thing in or about the hospital.

AND WHEREAS, it is that such inspection if made, would continually provide the Provincial Secretary with first hand information as to the difficulties, financial and otherwise which hospitals may experience.

AND WHEREAS public monies have been and are provided under the above mentioned act, and are actually disbursed on the basis of a return of hospital days without any check as to the adequacy of the arrangements made by hospitals for treatment.

BE IT RESOLVED that this Association considers an inspection as provided for, is necessary and now requests the Provincial Secretary to make an appointment for the purpose of giving effect to Section 10 of the Hospital Act.

RESOLVED that a hearty expression of appreciation be extended

to the following whose contributions to the work of this Convention and the entertainment of its delegates has made this Convention the success that it has been:

1. Local Committee on arrangements. Miss J. F. Mackenzie, Dr. E. M. Pearse and Mr. Geo. McGregor.
2. Reeve Lockley, President of the Union of B. C. Municipalities for his address assuring the co-operation of that body.
3. Mayor Hayward, for his kindly words of welcome.
4. Rotary Club for luncheon and transportation.
5. The Provincial Royal Jubilee Hospital for luncheon, etc.
6. St. Joseph's Hospital for Luncheon, etc.
7. To the Exhibitors, both voluntary and commercial.
8. To Mr. R. L. Reid, K.C., Dr. W. B. Burnett, Dr. Ridewood and Dr. Walker for their interesting and instructive papers.
9. To Mr. and Mrs. Butchart for their entertainment of the delegates.
10. The management of the Empress Hotel for their accommodation and courtesies.
11. To the Press for their attention and co-operation.
12. To the Victoria Graduate Nurses Association for their kind assistance at the Registration Desk.
13. To the Retiring Officers.

Dr. Henry Esson Young, Provincial Officer of Health was invited to the platform by the Chairman and gave a short address in which he made reference to the irreparable loss sustained by the Province in the death of Dr. R. H. Mullin. He referred in general terms to problems of hospital finance and described briefly the efforts being made by the Provincial Government toward the conservation of health.

A report regarding the observance of Hospital Day was submitted by Dr. H. C. Wrinch but was not read. Dr. Wrinch had sent a questionnaire to the various hospitals in the province and had received replies from twenty-five. A summary follows:

Seventeen hospitals observed the occasion on May 12th.

Five found another date more convenient.

All hospitals reported an unqualified success.

Four made use of the Sunday following to present their cause in the churches.

All held a reception, in nearly all cases well attended.

Fifteen of the Institutions served refreshments. Two charged a small fee, two accepted voluntary contributions in the other cases no charge was made.

One hospital chose this occasion to hold its graduating exercises.

Four conducted baby shows, in one case this was the principal feature of the day.

Four held a public meeting in the evening.

The question was asked whether a parade was held. One answer was: "Heaven Forbid"—On the other hand one hospital held a Callithumpian Parade which was a huge success.

In this connection it is apparent that the American idea of this feature has not reached our constituency. It has been carried out there in certain cases by a parade of a series of floats, representing some phases of hospital work.

In compiling this report there may be noted a distinct line of progress from striking and spectacular features to the quieter and less obtrusive methods in the nature of receptions, made interesting and instructive by means of music, demonstrations and addresses; all of which may be held where convenient in conjunction with graduation exercises, or opening of new buildings or new departments.

Without doubt, the amusing and attractive events put on in the name of the hospital have a fair place in creating or arousing in the community a recognition of the existence of a hospital in their midst and its claim upon them for their intelligent interest and a fair measure of support. When this interest is aroused it can and is further developed and more intelligently broadened by means of less amusing or striking and more educative features and events.

The development of this idea is aptly expressed in one of the returns of our questionnaire which we quote herewith:

> "According to our situation, our program for celebration of the day appeared adequate, and we feel disinclined to attempt programs which have been followed in other places and appear to us of novel description but not suitable to the public year after year."

After a spirited contest Nanaimo was chosen as the place of the next meeting.

At the close of the session the meeting adjourned to meet at luncheon at St. Joseph's Hospital where the members were entertained by the Sisters of St. Anne and by the Women's Auxiliary of the Hospital. The Right Reverend J. O'Donnell, Bishop of Victoria, presided and at the close of the luncheon, delivered the following address:

## ADDRESS BY BISHOP O'DONNELL

I wish to express my sincere pleasure to find myself associated with the B. C. Hospital Convention and under the roof of this ancient St. Joseph's Hospital. I am here because I wish to testify that the Association deserves every encouragement and every assistance possible not only from the Church, but also from the state. This is true because the object of your association is one that must meet with the approval of every good citizen and tend to the well-being of all.

Your work is holy. In the highest and most noble sense of the word, the work of your association is charity—the work of your hospitals is charity. Do not misunderstand me, I pray you, I do not mean that your endeavor is the mere giving of alms to the needy. No. Alms-giving and such like are only a small expression of God's most beautiful virtue. The charity of which I speak and associate with your deeds for the perfection of hospitals, for the alleviation of miseries to which nature is heir to is something more glorious, it is that love you have for afflicted human beings, based upon the love we all owe to God, our Creator, our Redeemer and our Sanctifier.

1. Nothing is more striking in the history of human society at the coming of Christ as the absolute disregard of man's life, as man. Not that the citizen had not a certain political value as he has to-day, or that wealth was deprived of its natural influence. But I speak of the value attached to the life of a man as a human being. In this light he was become the vilest of all animals. There was no belief in future retribution and the extinction of this belief was the main cause of this disregard. The gladitorial games, the condition of slaves of both sexes, were a striking exhibition of it. For ex-

ample, in the slave war, Crassus crucified 10,000 slaves in cold blood. No one blamed Crassus, but the general of to-day, as we know, who should dare to put to death a single unarmed captive would not only deserve but meet with the world's execration. How was the change brought about? It was brought about by those who shed their blood like water for the sake of their divine belief. They gained by death admission for truth into the hearts of men; they gained for the life so sacrificed a value which it did not before possess. For 280 years, from Christ up to Constantine's decree of toleration, thousands upon thousands of all sexes and conditions and ages, sacrificed themselves for the love of God and truth. Suffering and horrors were born unshrinkingly, riches and beauty and culture were put aside, fame was scorned for One whose lacerated limbs were stretched upon a cross for hours in the sight of a gazing multitude. It is strict truth to say that man learned not to make man suffer because the Son of God had suffered. Man learned to believe the sufferings of his fellowman because he saw in the suffering body the image of his brother—yea more, a brother in Christ Jesus Our Lord. Regard for human life rests upon no other basis than belief in man's future destiny and would not survive the extinction of that belief. Heathenism or a denial of God, and, that man is only a super-animal, even in our own day produce the same effects as they did in the civilized and highly cultured peoples of ages gone. The intense abhorence of pain and necessary suffering, the fear of responsibility, birth control, infanticide are all bitter fruits of neglect of God, the loss of charity, the absence of love of our neighbor because of God.

2. The noblest works for the good of others in which man can be engaged fall under the following three classes: Propagation of the truth of God, Religion; that of forming human character by education; that of administering to human infirmities by acts of mercy. The Catholic Church has held in practice that virginal life adapts itself more readily to the above mentioned works than any other class of humans because of the sacrifices involved in the pursuit of these three vocations. The dedication and sacrifice which lie at the root of virginal life communicate themselves to these works as conducted by it, and will give to them a high and superhuman character, a power of attraction which comes from Christ the Divine Original of sacrifice, whose signet is the virginal life. In this case, no human remuneration will be the spring of these works; neither praise nor power nor wealth will call them forth or reward them. Rather, they will flourish amid poverty, self-denial and humility in those who exercise them, and be the fruit not of political economy, but of charity, love of God, and love of our neighbor. I may advance before you as a brilliant example of this, the work of the Sisters of St. Ann in St. Joseph's Hospital during half a century in this City of Victoria. The same may be said of the religious communities, the directors of hospitals from the dawn of free Christianity. In Canada and United States, 130 Religious Communities are in charge of hospitals. This means over 20,000 nuns, and at least as many nurses under their care and instruction.

3. We are not surprised then to find from the period in the third century when the Church came forth from the catacombs, the commencement of scientific treatment of human misery in established hospitals and the nursing of the sick and afflicted by women specially dedicated to God for that purpose. Tertullian informs us that it was customary in the third century on a certain day of the month, each one contributes small offerings. There is no compulsion, but each one makes his offering willingly for the relief of the sick." This looks as if the hospital auxiliary was an ancient and honorable institution. Eusebius states that during the plague A.D. 264, the

Christians organized for the relief of the stricken. This was in contrast with the indifference of the pagans who left the sick unaided to die like dogs. Julian the apostate who hated the Christians with a diabolical hate, called on the pagans to establish hospitals like the Christians had done and thus overcome their increasing influence. He promised that the State would second their efforts.

These are only a few examples from the first centuries of the Church to show the antiquity of sick relief. Christians then, as to-day, had to undertake this work of mercy, because the law of God, charity, the charter of Christianity, demanded it.

In Canada and the United States there are seven hundred Catholic Hospitals, comprising more than fifty per cent of the total of available hospital beds.

We have all heard of the Hotel Dieu of Paris, 7th century. and of the Hotel Dieu, Lyons, 6th century. We know that Rome in the 9th century had 24 hospitals. Canterbury, a hospital founded 1070, by Archbishop Lanfranc. St. Bartholomew's, London, 1546. Bethlehem, 1547, St. Thomas', 1553, etc. All this and more may be read in the justly famous "Hospitals and Asylums" by Sir Henry Burdett.

In conclusion let me urge you to bear always in mind the sacred Christian character of your hospitals and your duties therein. The remembrance of this shall destroy the germ of commercialism which is liable to grow and flourish in any holy work in this world. It shall help you to infuse into those under your care and instruction, the Christian view—the only view to be taken of the sick and afflicted, the image of Christ suffering. The Christian outlook also shall develop co-operation between all Christian hospitals and shall destroy all tendencies to pettiness and meanness, in necessary conventions and mutual undertakings for the progress of hospital work. The Christian view shall compel you to see in Christ the Chief Physician, under whose loving direction you labour for the welfare of humanity. I thank you.

At the conclusion of the luncheon, the convention was declared formally closed to meet next year in Nanaimo.

# Constitution and By-Laws

### Article 1—Name.

The name of this Association shall be "The British Columbia Hospitals Association."

### Article 2—Purpose.

(a) To serve as a means of intercommunication and co-operation for the hospitals of this Province.

(b) To increase the efficiency of all hospitals in the Province by establishing and maintaining the best possible standards of hospital service.

(c) To stimulate and to guide intensive and extensive hospital development.

(d) To develop on the part of hospitals a sense of responsibility to the community with respect to education in health matters with special emphasis on the training of nurses.

(e) To keep the people of this province informed concerning hospital problems and to serve as a means of communication between hospitals and those in authority in provincial and municipal affairs.

(f) To frame from time to time suggestions for, additions to, or changes in legislation affecting hospitals.

### Article 3—Membership.

Members shall be all persons connected directly or indirectly with hospitals paying the membership fees hereinafter mentioned, and such members shall be classified as follows:

(a) Honorary
(b) Individual
(c) Institutional
(d) Auxiliary

Honorary members shall be those persons who are held by the Association to have rendered conspicuous service in the hospital field.

Institutional membership may be held by any hospital, public or private, carrying on work within the province. Institutional membership shall include all members of Trustee Boards or Boards of Directors and all persons holding executive positions in hospitals having membership in the Association.

Individual membership shall be all persons connected directly or indirectly with hospital work who are not members of Trustee Boards or Boards of Directors, or who do not hold executive positions in hospitals.

Auxiliary membership. The senior Auxiliary or Women's Organization duly recognized as such by the Board of Directors of the institution it serves may be admitted to corporate membership, provided the hospital with which it is associated is a member of the B. C. Hospitals Association.

### Article 4—Officers.

The officers of the Association shall be:

Honorary President.
President.
First Vice-President.
Second Vice-President.
Secretary.
Treasurer.

The Executive Committee shall be composed of twenty members, as follows:

(a) The Officers of the Association.
(b) The representatives of the districts hereinafter mentioned.
(c) The conveners of the Standing Committees.

The following districts must be represented on the Executive Committee viz., Vancouver Island, Vancouver, Coast Mainland, Fraser Valley, Yale-Cariboo, Okanagan, Kootenay East, Kootenay West, Grand Trunk Pacific.

### Article 5—Fees.

Membership fees shall be due and payable on the first day of July in each year, as follows:

Honorary Members (no fee).

Institutional Membership shall be payable according to the following scale.

(a) Hospitals of ten beds or under, per annum.....$ 5.00
(b) Hospitals of eleven to twenty beds, per annum..... 10.00
(c) Hospitals of twenty-one to fifty beds, per annum..... 15.00
(d) Hospitals of fifty-one to one hundred beds, per annum.. 20.00
(e) Hospitals of one hundred and one beds and over, per annum ..... 25.00

Individual members shall pay a fee of five dollars per annum.

Auxiliary membership fees shall be one-half of that paid by the Institution with which it is associated.

### Article 6—Election of Officers

Election of Officers shall take place at the Annual Meeting each year, and shall be by ballot. All officers shall be elected for a term of one year. Institutional members only shall be eligible for office.

A Committee on Nominations consisting of three members shall be appointed annually. Two of these members shall be designated by the Executive Committee, and the third, who shall act as convener, shall be appointed by the President. No member of the Executive committee shall be eligible to serve upon the Nominating Committee. It shall be the duty of the Nominating Committee to request and to receive from the members of the Association the names of persons suitable to hold office in the Association. Two weeks prior to the Annual Meeting the Committee shall prepare a list of all persons so nominated for the information of the members attending the Annual Meeting. Nominations shall be permitted from the floor at the Annual Meeting.

### Article 7—Committees, Executive and Standing

(a) The Executive Committee shall transact the business of the Association during the year and shall report to the Association at the Annual Meeting, or to Special Meetings when necessary. It

shall act in the capacity of a Membership Committee and shall pass upon all applications for membership in the Association. The Executive Committee shall also act as a Legislative Committee for the purpose of considering legislation affecting hospitals.

(b) **Medical Affairs.** The Standing Committee on Medical Affairs shall consist of five members, the Convener of which shall be elected by the Association at the Annual Meeting. Its duties shall be to investigate and report upon all matters relating to medical service in hospitals.

(c) **Nursing Affairs.** The Standing Committee on Nursing Affairs shall consist of five members, the Convener of which shall be elected by the Association at its Annual Meeting. Its duties shall be to investigate and report upon all matters relating to nursing service in hospitals.

(d) **Business Affairs and Accounting.** The Standing Committee on Business Affairs and Accounting shall consist of five members, the Convener of which shall be elected by the Association at the Annual Meeting. Its duties shall be to investigate and report upon all matters relating to business administration and accounting in hospitals.

(e) **Constitution and By-Laws.** The Standing Committee on Constitution and By-Laws shall consist of five members, the Convener of which shall be elected by the Association at its annual meeting. Its duties shall be to receive, consider and report upon all proposed amendments of, additions to, and deletions from the Constitution and By-Laws of the Association.

(f) The remaining members of the Standing Committees shall be appointed by the Executive Committee at the meeting immediately following the Annual Meeting.

### Article 8—Meetings: Time and Place

The time and place at which the Annual Meeting and Convention shall be held may be decided at the regular meeting of the year preceding or may be left in the hands of the Executive Committee with full power to act. Special Meetings may be called from time to time by resolution of the Executive Committee. Fourteen days notice in advance of the holding of said meetings shall be sent to each member of the Association.

The Executive Committee shall meet at least once a year. It shall meet when called upon to do so by the president of the Association or at the request of any five members of the Association.

### Article 9—Quorum

Ten per cent. of the institutional membership shall constitute a quorum of the Association at its Annual Meeting or at a special meeting. Five members shall constitute a quorum of the Executive Committee.

### Article 10—Amendments to Constitution and By-Laws

The Constitution and By-Laws may be amended at any regular meeting of the Association by a two-thirds vote of members present, providing that notice of motion has been given prior to the meeting to the Committee on Constitution and By-Laws.

### Article 11—Resolutions

No resolution affecting the general policy of hospitals holding membership in this Association shall be presented at any regular or special meeting of this Association unless the same shall have

first been presented to the Executive Committee in writing. No action affecting the general policy of said hospitals shall be taken until the question has been referred to all institutional members, unless the question at issue shall have been unanimously agreed upon by the delegates present at said meeting.

### Article 12—Voting

In any matter of business or policy requiring action by vote of the Association, voting of institutional members shall be in proportion of one vote for each five dollars ($5.00) of membership fee: thus an institution paying five dollars in membership fee shall be entitled to one vote, and so forth. One delegate shall be entitled to record the entire vote of the hospital represented by such delegate.

The combined delegation of any institution or auxiliary body shall agree among themselves as to how that institution or auxiliary body shall vote. No institutional or auxiliary vote shall be divided on any question. If time for deliberation is required by a delegation of an institution or an auxiliary body before casting a vote, the chair shall postpone the taking of a vote for a reasonable time. After postponement for such a purpose there shall be no further discussion of the question before taking a vote upon it.

Honorary Members are not entitled to vote.

Individual members shall not be entitled to vote at the Annual Meeting or at any subsequent meeting of the Association unless the membership fee shall have been paid at least thirty (30) days prior to the holding of the Annual Meeting.

Auxiliary bodies are entitled to half the number of votes cast by the institution with which it is associated .

Votes by proxy will not be allowed.

# HOSPITALS IN BRITISH COLUMBIA

| Name of Hospital | No. of beds | Secretary of Board | General Superintendent | Superintendent of Nurses |
|---|---|---|---|---|
| Anyox General Hospital | 18 | Charles Wing | Dr. Paul Whelan | Miss Edna Swanson, R.N. |
| Armstrong Hospital | 10 | J Wiglesworth | Miss E. A Hayhurst, R.N. | |
| Britannia Beach Hospital | 10 | Dr. A. M. Menzies | | Miss M. McDonald, R.N. |
| Bulkley Valley District Hospital, Smithers | 12 | F. Ockleshaw | Miss M. A. Mulhall | |
| Bute Street Private Hospital, Vancouver | 18 | | Mrs. M. E. Johnson, R.N. | |
| Campbell River General Hospital | 25 | C. H. Fitzgerald | Miss Lillian B. Robson | |
| Chemainus General Hospital | 17 | E. M. Cook | Miss Maud Byrd, R.N. | |
| Chilliwack Hospital | 33 | Peter J. Brown | Miss J. A. Morrice, R.N. | |
| Chilcotin General Hospital, Alexis Creek | 4 | T. C. Lee | | |
| City of Prince George Hospital | 25 | R. C. S. Randall | Miss C. Sage | |
| Columbia Coast Mission as under: | | | | |
| Carriden Bay Hospital | 6 | T F. Barton | Rev. J. Antle | |
| St. George's Hospital, Alert Bay | 24 | | 198 Hastings St. W Vancouver, | |
| St. Michael's Hospital, Rock Bay | 21 | | | |
| Corbin Hospital | 4 | C. W. Reger | Dr. Robt. Elliott | |
| Cumberland General Hospital | 30 | T. Mordy | Miss M. Brown, R. N. | |
| Enderby General Hospital | 9 | A. W. Dill | Miss E. Teece | |
| Fernie Hospital | 40 | Miss E. M. Kirkpatrick | | |
| Golden Hospital Society Golden | 15 | W. Ayres | | |
| Grand Forks Hospital | 50 | | Dr. C. M. Kingston | |
| Hazelton Hospital | 35 | Dr. H. C. Wrinch | Dr. H C. Wrinch | Mrs. A. Mathieson, R.N. |
| Hedley General Hospital | 7 | H. D. Barnes | Dr. M. D. McEwen | |
| Kelowna General Hospital | 36 | Geo. R. Binger | Mrs. M. E. Wilmot, R.N. | |
| King's Daughter's Hospital, Duncan | 44 | W. H. Napper | Miss Charlotte Black, R.N. | |

| Name of Hospital | No. of beds | Secretary of Board | General Superintendent | Superintendent of Nurses |
|---|---|---|---|---|
| Kootenay Lake General Hospital, Nelson | 75 | Geo. Johnstone | Miss A. MacArthur, R.N. | |
| Lady Minto Gulf Islands Hospital, Ganges | 8 | C. S. Stuart Holmes | Miss M Lovering | |
| Lady Minto Hospital, Ashcroft | 12 | E. A. Punter | Miss E. M. Gouldburn, R.N. | |
| Ladysmith General Hospital | 50 | A. P. Glen | Miss Grace Kerr, R.N. | |
| Master Misericordiae Hospital, Rossland | 30 | Sister M Stanislaus | Sister M. Xavier | |
| Matsqui-Sumas-Abbotsford General Hospital, Abbotsford | 15 | T. Bennett | Miss K. Campbell, R.N. | |
| Mission Memorial Hospital, Mission, B. C | 10 | W. H. Mathewson | Miss Grace Burnham | |
| Nakusp Hospital | 10 | Ralph Islip | Mrs. Whitman | |
| Nanaimo Hospital | 50 | John Shaw | Miss Pauline Rose, R.N. | |
| Nicola Valley General Hospital, Merritt | 40 | A. R. Carrington | Miss E. S. McVicar, R.N. | |
| North Vancouver General Hospital | 31 | | Miss G. M. Currie, R.N. | |
| Ocean Falls Hospital | 25 | Dr. A. E. H. Bennett | Miss O. M. Bentley, R.N. | |
| Penticton Hospital | 20 | Herbert Keddell | Miss E. Harrison | |
| Port Simpson General Hospital | 35 | Dr. Wm Sager | Miss D. Newsome, R.N. | |
| Port Essington Hospital | 15 | Dr. Wm Sager | | |
| Princeton General Hospital | 18 | Ernest Waterman | Miss Adelaide Knowlton, R.N. | |
| Provincial Royal Jubilee Hospital, Victoria | 175 | D. D. Muir | Dr. E. M. Pearse | Miss J. F. Mackenzie, R.N. |
| Prince Rupert General Hospital | 60 | Harry W. Birch | Miss E. McCaul, R.N | |
| Queen Victoria Hospital, Revelstoke | 60 | Thos. Steed | Miss Blanch Wells, R.N. | |
| Quesnel General Hospital | 10 | John L. Hill | Miss E. H. Hunter | |
| Royal Cariboo Hospital, Barkerville | 7 | T. Nicol | Dr. Stevenson | |
| Royal Columbian Hospital, New Westminster | 250 | E. S. Withers | Miss K. B. Stott, R.N. | |
| Royal Inland Hospital, Kamloops | 110 | R. A Bethune | Miss A. L. Boggs, R.N. | |
| Roycroft Private Hospital, Vancouver | 20 | | Mrs. M. Beardmore, R.N. | |

| Name of Hospital | No. of beds | Secretary of Board | General Superintendent | Superintendent of Nurses |
|---|---|---|---|---|
| R. W. Large Memorial Hospital, Bella Bella | 25 | Dr. Geo. Darby | Dr. George Darby | Miss M. Taylor |
| Salmon Arm General Hospital | 10 | R. J. Glasgow | Mrs. Rendell | |
| Salmon Arm Maternity Home, Cranbrook | 8 | | Mrs. A. Crawford | |
| Sandon Miners' Union Hospital | 10 | T. B. Robert | Dr. E. E. Topliff | |
| St. Andrew's General Hospital, Atlin | 10 | A. B. Taylor | Dr. C. M. Eaton | Miss L. S. Pringle, R.N. |
| St. Bartholomew's Hospital, Lytton | 15 | | Miss A. G. Wickham, R.N. | |
| St. Eugene's Hospital, Cranbrook | 100 | Sister Gerard | Sister M. Nazareth | Sister Florida, R.N. |
| St. Joseph's General Hospital, Comox | 50 | J. M. Mitchell | Sister Zephyrinus | Sister St. Hugh |
| St. Joseph's Hospital, Victoria | 150 | C. H. O'Halloran | Sister Mary Mark | |
| St. Luke's Hospital, Powell River | 35 | C. Pearson | Dr. C. R. Marlatt | Miss F. Frampton |
| St. Luke's Home, Vancouver | | | Sister Frances | |
| St. Mary's Hospital, New Westminster | 67 | | Sister Tancrede | |
| St. Paul's Hospital, Vancouver | 295 | Sister Bertrand | Sister M. Clarissa | Sister M. Alphonse |
| Summerland Hospital, Summerland | 16 | Percy E. Knowles | Miss Wheler | |
| Trail Hospital, Trail | 18 | W. T. Crispin | Dr. J. B. Thom | Miss Arthur |
| Tranquille Sanitorium, Tranquille | 245 | | Dr. A. D. Lapp | Miss M. Hodgetts |
| Vancouver General Hospital | 900 | George Haddon | Dr. F. C. Bell | Miss K. W. Ellis, R.N. |
| Vernon Jubilee Hospital | 64 | W. A. Rhodes | Miss C. E. Clark, R.N. | |
| Victorian Hospital, Kaslo | 18 | W. H. Burgess | Miss M. Melburn | |
| West Coast General Hospital, Port Alberni | 20 | G. S. Pearse | Miss L. Swanson, R.N. | |
| Windermere District Hospital, Invermere | 14 | Harry B. Gore | Miss Lilian Forrest R.N. | |