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Editorial.

SECONDARY CAUSES.

It not unfrequently happens when patients are admitted to hospital from one disease that the secondary cause of death is stated in subsequent evidence to be a different disease.

We do not wish to dogmatise on this subject, and it is of course possible that a patient suffering from one complaint should already be developing another when admitted; but, speaking on broad general grounds, founded on our experience as a Ward Sister, we have no hesitation in saying that we consider it a reproach to the nursing of a ward if a patient suffering from one disease develops another during his stay in it, in the same way that good nurses take themselves to task if a patient has a bed-sore, with which he was not admitted.

Perhaps some of the commonest "secondary causes" of death are hypostatic congestion of the lungs, bronchitis, and pneumonia. The former, as all nurses know, is very liable to occur in old people confined to bed in a prone position, but much may be done, by good nursing, to avoid it by a frequent change of position. Bronchitis and pneumonia usually result from chill, and therefore it behoves all nurses to guard against the possibility of a chill being contracted.

It must be remembered that sick persons are especially susceptible to influences which would not affect them if in health. Take, for instance, exposure to draught. In their keenness to secure thorough ventilation of the ward—a most important point in the care of the sick—are nurses always sufficiently observant of the effects of partially-opened windows—for the window sashes of wards are rarely thrown wide open—on individual patients? Is there not some danger, in nursing a ward full of patients, of viewing things mainly from the general standpoint, and not to consider individuals sufficiently?

Undoubtedly architectural defects in buildings which are ventilated on obsolete principles, instead of on modern scientific lines, add to the dangers of chill, but if such defects exist they call for increased vigilance on the part of the nurse. Again another fruitful source of chill is to be found in the process of washing where this is hurried and inefficient. It must be remembered that the general washing of patients takes place in the early morning hours when everyone is working at full speed against time. The vitality of the patients is low, the fires have been let down so that the ward-maids may clean the grates, the Sister is not yet on duty, the staff nurses who attend to the worst cases have their hands fully occupied, and the pros. get very little supervision. Is it always certain that the surgical patient, in the "wash all over," which is theoretically necessary, is bathed under a dry blanket and rubbed with warm towels? Does he never lie chilled and comfortless, after a too hasty washing, in the immaculate cotton shirt, and the smooth linen sheets, dear to the heart of his nurses but quite unknown to him in his own home? It is possible that routine and order may be pushed to an extreme to the detriment of the welfare of individual patients.

Neither must it be forgotten that to wash a patient thoroughly from head to foot takes time, and cannot be efficiently done if a hospital is under-staffed with nurses. We should say that at least fifteen or twenty minutes should be given to the washing of each helpless patient, and, though it is rank heresy to say so, when this time cannot be afforded we are inclined to think that there is less danger to his well-being in the rule laid down by Dr. Wilfred Hadley for the guidance of the nurses of the London Hospital, that "all patients should have their faces, necks, and hands washed night and morning, the feet two or three times a week, and the body at least once a week," than in too hasty and sloppy general ablutions.

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