means of which the rural population get modern surgery brought to their doors, and said that the original cottage hospital was started in 1859 at Cranleigh, in Surrey, by the late Dr. Napper and Archdeacon Sapte, at a time when the London, Brighton and South Coast Railway was being made, and many serious accidents were occurring among the gangers working on the line. It was established in the old Rectory, a charming little old-fashioned cottage with four bedrooms, two of which, leading into one another, were fitted up as male and female wards, a third was used for operations and the fourth was occupied by the nurse. The staircase was so constructed that unless patients could walk they had to be carried up on the back of whoever brought them in.

In spite of these difficulties very excellent work was done from the first, and Dr. Napper recorded in the annual report that "under a free exhibition of port wine many patients recovered." From the first it was his intention that the hospital should take in serious cases of accident and disease, and Miss Cancellor enumerated the first six cases admitted at Cranleigh, and those admitted at Frimley half a century later, showing that they had not departed from the founder's ideals. Another first principle was that every patient should contribute towards his maintenance, though in many instances fees were remitted. Most cottage hospitals had one or more private wards, the advantages of which were: (1) they were a source of income; (2) they enabled the doctors to obtain some slight remuneration for their services; (3) they enabled first-class surgeons to be retained as consultants; (4) old private patients were usually staunch friends of the hospital and made admirable members of committee subsequently; (5) it was an excellent thing for the nurses to get some experience in private nursing.

Many cottage hospitals now were built for the purpose, and were models of construction and planning. In numerous instances the Matron was consulted by the architect on many points.

Miss Cancellor quoted Dr. Napper's opinion that the nursing staff should be well trained, though he added that this advantage was sometimes counterbalanced by conceit.

An ideal nursing staff for a hospital of 10 or 12 beds was first the Matron, who had to act as house surgeon, and who should not only be fully trained, but also a midwife, a masseuse, and accustomed to work amongst the poor.

She reminded those who worked in large hospitals that they parted with their patients when they left the wards, whereas in cottage hospitals the patients all remained their near neighbours, and woe betide the nursing staff if they offended one, as all their cousins, aunts, and uncles, lived there too, and any one who had ever lived among a rural population knew what that meant.

In addition to the Matron there should be a fully trained staff nurse, an assistant nurse with at least a year's experience, and one or more probationers. Matrons were comparatively easy to get, staff nurses *very* difficult; they found it dull if from a large hospital, and six months or a year seemed to be the usual limit for their stay. Assistants were fairly easy to get, and probationers were selected from among girls of twenty or so who meant to take full training later, but it must be fully explained to them that they could be given no kind of certificate.

What effect would a Registration Bill have on the smaller institutions? Surely it would make it increasingly difficult for them to obtain junior nurses. Yet they were doing good work, and formed a splendid ground for preliminary training. Could not some plan of affiliation with the County Hospitals be devised, whereby the small hospitals could act as preliminary schools for the probationers, and be supplied with assistants from among the second-year nurses from the County Hospitals and staff nurses from the third-year nurses, or from those who had completed their training? Of course a syllabus of training would have to be adopted, and the nurses examined by the County Hospital examiners, but surely an allied training scheme could be evolved. She thought the County Hospital nurse who had had nine months or a year of her training at a Cottage Hospital would have learnt many valuable lessons in tact, management and self-reliance which she had no chance of obtaining in a large institution; for instance, she might have to cope with serious hæmorrhage, whereas in a large institution it would be her duty to summon assistance.

That was the case for the small hospitals.

### Discussion.

A discussion then took place, in which Mrs. Strong emphasised the necessity for preliminary training to be both practical and theoretical. Miss Norton (N.U.T.N.) suggested that if there could not be affiliation between the cottage and county hospitals the larger hospitals should allow cottage hospital probationers of a year's standing to rank as six months' nurses. Miss Cancellor said that the cottage hospitals would want some sort of return. Miss Thurstan thought that children's hospitals should come within the scope of affiliated training. Miss Cancellor considered that both children's and cottage hospital training should form part of a whole. Miss Huxley said it should not be difficult if the County Hospitals refused to take any probationers who had not received preliminary training. Miss Musson said one of the difficulties was that if the County Hospitals took none but probationers who had had a year's training they would not come in as junior probationers, and there would be no one to do that work. Then there was the inequality of the training in the smaller places. She had tried to push on nurses as much as possible to meet the demands occasioned by the war, and she had established an examination at the General Hospital, Birmingham, for nurses who had had previous training, but many failed. She did not think that a junior nurse in a large hospital would let an artery bleed

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