ASEPSIS AND FEVER NURSING.*

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I have chosen the subject—Asepsis and Fever Nursing—for two reasons. Firstly, because it is one in which an experience in dealing with cases of infectious disease extending over some years, many of which were spent in charge of a large fever hospital, has led me to take a great interest; and secondly, because I think that a study of its principles may indirectly contribute to the solution of a problem which is beginning to trouble the community, namely, the so-called shortage of fever nurses.

I shall accordingly first point out the importance of asepsis clinically, and then make a few suggestions from the administrative point of view.

I will begin by going back twenty years to the time when I first came into contact with fever work. What were the conditions then? Well, I think I shall be safe in saying that the surgery of the notifiable infectious disease was practically non-existent. If the intestine of a man suffering from enteric fever gave way owing to the perforation of an ulcer, the case was regarded as hopeless. He was given opium to ease his pain, and he died. If a child with scarlet fever developed a discharge from his ear, it was treated as a sort of medical Charley's Aunt, and allowed to go on running, without let or hindrance. His case, it is true, became interesting in a left-handed sort of way from the administrative point of view, because he was apt to figure in the list of patients who had remained in hospital over three months, and subsequently his statistical interest was transferred to the department of the investigator of return cases, who found him to be responsible for the infection of other children, after the hospital had at last got rid of him. As for discovering the dead bone that was responsible for the suppuration, and treating it as any surgeon outside a fever hospital would, such a thing was never heard of. Even examination of the ears with a speculum as a routine practice was practically non-existent.

And what of the nursing? For all the throats in a large ward to be syringed daily with a Higginson, or rubber ball syringe, using the same nozzle for each patient, was quite a common practice, the results of this pernicious practice being recorded with unfailing statistical zeal as either secondary tonsillitis or post-scarlatinal diphtheria. Both were regarded as complications—Heaven save the mark!—of scarlet fever. As for the nurses' hands, it was thought that they had been disinfected when they had been rinsed for a few minutes in a weak solution of carbolic acid, and even this little bit of ritual was often omitted. In short, fevers were regarded as belonging to the domain of medicine pure and simple, and anything in the nature of an operation—with the exception of tracheotomy, for laryngeal diphtheria—was thought to be unjustifiable, on the ground that it would not be safe to make an incision, as it would not heal in an *atmosphere* of infection.

I lay stress on the word "Atmosphere," for this was the key to the views on the origin of infection which were current in those days. Long after Lister and his followers had abandoned the air as a potent factor in the dissemination of infection, we in fever hospitals held tenaciously to the view that in scarlet fever, and remember that we are dealing here with the same class of organisms, namely, the streptococcal group, as were being fought against daily by surgeons in dealing with the problems of wound infection—we believed that in these streptococci we had a sort of pestilence which flew about through the air and hit one patient or another pretty much haphazard.

And what was the effect of this teaching on the class of fever nurses in general? Why, the whole service was in a sort of water-tight compartment, and bore little or no relation to the general field of medicine or surgery outside. It was in the same position as Lunacy. The main function of a fever hospital was to isolate patients from the community, and the nurses were a special class, who began in a fever hospital, and stayed there until they were released by marriage or superannuation. They did not come from or go to the general hospitals. The junior nurses were engaged for no definite period. Often they only intended to stay a few months, and little or no attempt was made to teach them. As they were only *employed,* it is little wonder that even those who were originally keen on their work did not stay.

In fact, the main safeguard against infection of the patients with one another's diseases was held to be in the structure of the hospital. Very often those responsible for the administration of the hospitals thought that all they had to do was to provide expensive buildings, and they then proceeded to economise in the most unsafe manner in the *personnel* and

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* Read at the Nursing and Midwifery Conference, London, April, 1914.