numbers of the nursing staff. But I will leave this point now, as I shall have to return to it later on.

By degrees, however, we began to see that the main factors in the dissemination of infection in such a disease as scarlet fever were the hands and instruments of those who touched one patient, and then went on to another, and we began to regard our rubber syringes with suspicion. The interior of these weapons was certainly infected every time they were used, and they could not be boiled or adequately disinfected, so they were replaced by the douche-can, and a separate recently boiled nozzle for each patient.

This, coupled with the recognition of the fact that any one case of scarlet fever might be infectious to any other, soon began to have a beneficial effect; in the words of an old nurse in charge of one of the wards in which the experiment was first tried—"A bad throat no longer goes round the ward." Could we incidentally have a better example of the "pestilence that walketh in darkness"? In other words, a mild attack of scarlet fever remained a mild attack throughout the time of its possessor's stay in hospital, and was not "complicated" by such preventible incidents as secondary tonsillitis, unexplained rises of temperature, and so forth.

Then we began to do various operations for the relief of conditions prejudicial to recovery, such as the removal of enlarged tonsils and adenoids, while the patients were still in hospital, and we found that the patients did very well indeed in the ordinary large wards, and that infection did not supervene, provided that the ordinary surgical precautions were taken.

We then turned our attention still more carefully to the hands of the nurses, and in the enteric wards rubber gloves were employed to protect the staff from infection when handling soiled linen, &c., and in carrying out the treatment of the mouths of the patients. It was in 1902, I think, that I first ordered them for this purpose at Monsall Hospital, and we noticed a marked diminution in the incidence of enteric fever amongst the staff employed in the wards devoted to that disease. After this, the use of gloves became more general, and they were employed in the scarlet fever and diphtheria wards for all throat treatment and any dressings. Before commencing her round, the sister of the ward sterilized her hands in the usual way with soap, followed by turpentine and methylated spirit, and then put on a pair of recently boiled rubber gloves. After she had finished the treatment of the throat of the first patient, she held her gloved hands under running water for two minutes, followed by immersion in a weak solution of Izal, this process being repeated between each patient.

But I need not elaborate this point further; the routine consisted simply in the observance of ordinary surgical procedures, which would have been obvious enough in any general hospital. From time to time, the methods were modified mainly in the direction of simplicity, but the principle remained the same.

The adaptation of aseptic methods for administrative purposes came next. With the recognition that safety lay in clean hands, instruments, and clothing of the medical officers and nurses, rather than in bricks and mortar, we began to admit to the general wards for scarlet fever and diphtheria, patients suffering from other diseases, or those in whom the diagnosis was doubtful, and we soon found that cross infection did not occur, provided that all utensils, instruments, &c., were marked and kept separate for the particular patient, and that the nurse put on rubber gloves and wore an overall whenever she did anything, feeding, bed-making, or what not for him. The results were most gratifying. I can recall no instance of any patient so labelled either contracting disease from, or infecting, any other case in the general ward. In other ways, too, the practice was most useful; it avoided, for instance, the locking up of two nurses in a small isolation ward in attendance on perhaps only one patient, and thereby also withdrawing them during the period of their training from the more valuable experience in the larger wards. Then it enabled us to admit, and if necessary, safely retain, a much larger number of doubtful cases, admitted to ordinary wards with no division whatever.

Now this, be it noted, was not the cubicle system at all. There was no structural separation of patients whatever. Some years after the system had been in routine employment at Monsall Hospital, it was re-discovered under the name of bed-isolation, or something of that sort. But there is, of course, nothing new in it; it is simply the employment of ordinary surgical asepsis in a fever hospital.

I do not wish here to imply that glass cubicles are, in themselves, objectionable. Obviously anything that makes for asepsis is to be welcomed, and the cubicle gives a certain amount of protection against infection through the air. I feel, however, that they should be unnecessary, provided that the nursing staff are aseptic in their ways—and (a most important point) their ideas also. The ideal is, of course, that every patient should be kept and

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