

This paper is very incomplete and it would be more incomplete if nothing was said of still another side to this inexhaustible subject. The scientific or physiological is urgent enough, but, with all this, if the cost of such is beyond us, a practical use of our knowledge is in vain. Also, if this food is not palatable, we turn from it in disgust. Let us, therefore, consider six cardinal essentials to scientific dietetics:—

- 1—It must have ample vitamins.
- 2—It must have proper proportions.
- 3—It must have a proper caloric value adapted to the needs of the individual.
- 4—It must be appetizing, well-cooked and digestible.
- 5—There must be a variety.
- 6—There must be suitable conditions under which we eat our food, such as pleasant companionship, leisure and surroundings.

In spite of all this scientific research on food, millions allow religion or racial custom to dictate, and food fadists still abound. On the other hand, of what value is all this knowledge if we do not put it into practice? We are the teachers of health today.

To Improve Certain Teaching Methods, when there is no Doll in the Class Room.

BY MISS GRACE JOHN, SISTER TUTOR STUDENT AT THE MISSIONARY MEDICAL COLLEGE HOSPITAL, VELLORE.

I was asked to teach second year students how to give gastric-lavage. I did not find a doll in the practical class room, and the patient refused to stay there. So I asked one of the students for the Post-graduate course for Sister Tutors to be my patient. Instructions were given to her before the class hour as to what she should do. Keep every necessary thing beside the patient. Put the patient in Fowler's position. Place a hot water bag with a little water in it on the left side of the patient and ask her to hold it in position.

The students then came and stood round the patient. A mackintosh was placed with care under the chin to protect the bed linen, then a mouth wash was given. The tube was lubricated and I pretended to insert it, as I had previously shown the students on the anatomical chart. I directed it under the mackintosh. My patient took hold of the rubber tubing and inserted into the hot water bag, for about 16 inches, after which the funnel was lowered and I collected the stomach contents *i.e.*, water from the bottle in a sterile receptacle. Then the solution was poured in to the funnel which was raised about a foot and a half higher than the level of the stomach, and ten ounces of solution was run in and the funnel lowered. The fluid came out through the tube just as though it came out of the real stomach. The siphonage was repeated three or four times and then the tube was pinched near the mouth and removed. A mouth wash was then given to the patient.

Nurses were so interested to see how it worked, so I showed them the hot water bag which had served as a stomach.

II Class. Artificial Feeding

Another time I was asked to teach the same group about artificial feeding. This time I took the skeleton as a patient and placed it on the bed. A cloth was placed over the lumbar region and also an empty hot water bag without a stopper near the epigastric region. The hot water bag was kept tilted little bit. Then I took a fairly long rubber tubing and inserted one end of it into the hot water bag and the other end was brought through the thoracic cavity, in front of the ethmoid and sphenoid bones and into one of the nostrils. This was done with great caution because of the turbinate bone. The end of the rubber tubing was not shown outside. It was right inside. I then covered the whole cavity of the mouth with brown paper so that the tube should not be seen by others,

and also in order to show the students that there is connection between naso-pharynx and oral-pharynx. The skeleton was covered with brown paper from mandible to the hip. This was done in order to show the students how to administer nasal feeding. Second year students cannot grasp the gastrostomy feeding if they are not taught by demonstration, so I thought of making an artificial opening and of the exact way in which a patient would be dressed after operation.

I made a small opening in the brown paper which was on the skeleton near the epigastic region, placed the eye of the N. 12 catheter in the hot water bag and brought the other end through the opening made in the paper and clamped it. A dressing was placed round the wound and also over the tube and a many-tailed binder applied; then the skeleton was covered with a sheet and the head with a towel.

This is the way in which the demonstration was shown on a skeleton.

Nasal Feeding

The food was strained first, the temperature was taken, mackintosh and cover was placed under the chin. The nostril through which the tube was to be brought was cleansed. I fixed the funnel and rubber tubing glass connection. The catheter which was lubricated, was inserted gently and quickly into the nostril and into the rubber tubing, in a backward and downward direction. It was very interesting to do because the catheter was directed exactly in the way in which we insert it the case of an ordinary human being. After inserting the catheter the mouth should be opened to see whether it had come forward and curled up in the mouth. As this was not the case and as it was in position, I first poured some water and then the strained food into the funnel and gave the feed slowly. Having given eight ounces, I poured some water to finish up the procedure. Then the catheter was pinched firmly near the nostril after letting the water run through up to the glass connection and the catheter removed quickly and steadily. The nostril was cleansed and dried I and made the patient comfortable. I next inserted the catheter into the other nostril and allowed it to curl up in the mouth. I then opened the mouth of the skeleton and the students saw how the catheter curled up in the mouth. I then proceeded to tell them why it is important to open the mouth after inserting the catheter to make sure that it is in the oesophagus or not.

Gastrostomy Feeding.

I asked one of the pupil sister tutors to be the unsterile nurse and asked her to strain the feed, to take the temperature of the feed and also to undo the binder. In the meantime I scrubbed my hands. I next arranged sterile towels, one above and one below the wound after removing the top dressing. I then connected the funnel, rubber tubing and glass connection and asked the unsterile nurse to pour in the feed into the funnel and expell, the air and fix the connecting tube into the rubber tube which was left in the wound unscrew the clamp and let the food flow into the stomach and finish the feed by letting in some sterile water. The tube was clamped and the whole apparatus removed. The dressings were opened and the wound examined for any sign of redness. Liquid paraffin was applied (ice water) round the wound (*i.e.* on the brown paper representing the wound, and a new dressing and binder were applied, leaving the tube and clamp outside the binder. The rubber tubing was covered with a piece of gauze so that the next feed could be given without undoing the binder.

Public Health Section.

Social Service Work in Hospitals

Medical and surgical care are not alone sufficient for the patient's recovery if he cannot have the kind of diet, accommodation and repose which he needs.

Consider, for instance, the example of a workman suffering from an ulcer of the stomach. He goes to the out-patients' department at the hospital, he is given medicine and told to drink several pints of milk a day. Who will supply him with this costly food when, because he cannot work, he loses his wages?