"SIGHT & SOUND NEWS"

A Bi-Monthly Journal of

THE ROYAL VICTORIAN EYE AND EAR HOSPITAL

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HOSPITAL – CONTRACTORS SIGN

Monday, 27th September, saw representatives from the construction firm of Clements Langford Pty. Ltd., the Committee of Management and the Architects signing a contract for the building of five new operating theatres on the Gisborne Street frontage (reported in our July issue). It is anticipated it will take approximately 12 months to erect the new building at a cost of £237,341. Included in the contract is the re-location of the doctors' change rooms above the Orthoptics building to the rooms formerly occupied by the Matron. The Melbourne City Council has permitted official car-parking on the west side of Morrison Place, and this area has been allocated to members of the Honorary Medical Staff to compensate the loss of the former parking area. Our picture shows Mr. J. B. Fisher of Stephenson & Turner, Mr. T. L. Webb (Treasurer, Committee of Management), Mr. G. L. Allard (President, Committee of Management) and Mr. J. Burnett, Managing Director of Clements Langford Pty. Ltd.

EDITORIAL

SCIENCE OR SERVICE?

The most important person in the world of commerce is the valued customer; it is he who is wooed and feted. The patient in hospital whether he is admitted to a public, intermediate or private ward, has no less status in terms of a human being, yet it must be conceded that he is not revered in just the same manner.

While hospitals have, in recent years, been transformed and diversified from institutions for the poor to medico-scientific centres of healing, whose doors are open to all levels of mankind seeking medical ministration, and where teaching and research now form an integral part of the hospital curriculum, let not the fact inadvertently escape notice that the public they serve also have undergone a mature change. In this enlightened age, archaic thinking by society on the subject of medicine has disappeared, and the impact of so-called ethical advertising, the effects of television and contemporary literature have all played a significant role in educating the public to understand medical matters hitherto regarded as mysterious and beyond their comprehension. Today, the prospective patient has become more sagacious to a degree that he will no longer accept vague explanations relating to his personal condition.

This, too, is the era of the scientist and the technician; of electronics and complicated apparatus and, in keeping with the age, medicine has become very much a speciality where more and more time is being devoted to the development of instruments and complex equipment. But along with the enthusiasm of keeping abreast of technological progress, there also emerges a grave danger of losing touch with the patient and his problems. In the wake of perfecting our scientific systems and processes, it would be a pity if we become so immersed in this new concept in medicine that it may cause us to lose sight of the basic stimulus which has made it all very necessary — THE PATIENT. He should not become the means to a particular end but surely, the end in itself. *I.S.P.*

"HOSPITAL ADMINISTRATORS SHOULD BE HIGHLY QUALIFIED"

—Sir Arthur Stephenson

At the Annual Meeting of Contributors last month, the guest speaker referred to three specific aspects in the hospital field, **Hospital Administration, Ward Planning,** and the **Food Service.**

Our system without question, was basically patterned for the English method where the Government has taken certain responsibilities to itself, Sir Arthur said. It was only in recent years that the pattern had changed due to the influence of thinking in the United States of America.

One of the first moves made by America was to recognise the importance of hospital management. While the School of Administration in New South Wales was making some attempt to train future adminstrators, it was a poor substitute for the American system. Sir Arthur said that the control of our hospitals began with the Boards of Management, with the Secretary carrying out their wishes, but it was incorrect to look to its members to become sufficiently knowledgeable to direct hospital affairs. It was necessary to employ Managers with adequate qualifications who would advise Boards of Management on the conduct of hospital affairs.

On ward planning, Sir Arthur said our system was influenced by the efforts of Florence Nightingale after the Crimean War. Almost everywhere in the world today, however, hospitals were planned to accommodate no more than two patients to a ward. In modern hospital design, the whole requirements for the patient were within the ward area: cross corridor traffic by patients and nurses being thereby avoided. Ward planning was a complex one, and dominated the whole of the structure.

Comment was made on the trend overseas to dispense with nurses' homes, and to allow nursing staff to live at their own homes. Here in Australia the nurse was paid at award rates, trained, housed and fed. No other country provided such overall accommodation for its nursing staff. This system was wasteful and uneconomic.

Finally, Sir Arthur referred to Food Services. He advocated central dining rooms and cafeteria style service, meeting everyone's needs in one area. Average cost of the hospital food service was from about 11% to 14% of the total budget and this was one of the principal targets for economy. There were a number of hospitals today where food according to the menu, was proportioned for every individual serve, and cooked ready for service in a radar range.

Sir Arthur said that high expenditure was inevitable both for capital and running costs, but well trained, effective management was essential. It was not the function of Boards to await the direction of Government, but rather to explore every avenue in reduction of costs.

Wherever you go take KODAK FILM

MUSAK HATH CHARM

"Say It With Music" can now mean infinitely more than an adventurous expression of sentiment. Today, music is being used as a therapeutic medium in the field of medicine and particularly as an adjunct to post-operative care.

With this in mind, the hospital recently installed a music service known as "MUSAK" at seven different points:— in the general waiting area of the Outpatients' Departments, Wards 4, 5, 6 and 7, and in the E.N.T. theatres No. 1.

What then is Muzak? Let's establish one factor—it is not the style of music designed for organised listening. It does not enter the field of the "Top 40" nor does it set out to extol the brilliance of Grand Opera. It consists of tunes especially selected, arranged and recorded, and played through speakers in such a manner to become almost subliminal. It is neither stimulating nor depressing, but is scientifically balanced so as to create a psychological atmosphere of relaxation, and to reduce the type of hyper-tension which patients, and perhaps staff could be subjected. It aims to minimise patient apprehension, ease waiting and to relax patients before diagnosis, therapy or surgery.

In 300 million miles of tape turned out in the U.S. each year by Musak, there is not one serious piece of music, symphony or concerto. It uses brighter music such as that of Cole Porter and Richard Rodgers. These are not the popular melodies, but those that could pass affably by your ear, almost unnoticed.

Recommended by the Honorary Medical Staff, Muzak has been installed on a three-month trial basis. If the system is accepted it will be extended to other areas of the hospital.

Post Graduate Seminar 1966

Early next year, D.I.R.U. staff will participate in a Seminar on Deafness and Communication Disorders which is being arranged by the Post Graduate Committee of the Australian College of Speech Therapists.

The purpose of the Seminar will be to acquaint practising Speech Therapists with the main diagnostic problems in this field and to outline, in broad terms, significant advances that have been made in recent years. In order to provide the widest coverage of the problems, speakers have been selected from a variety of disciplines, industry, medicine, audiology, psychology and education.

Mr. C. G. Baird, Manager, supervising the appending of the seal on the builder's contract, referred to on page 1.

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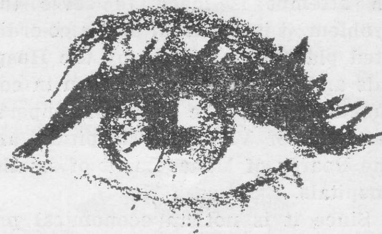

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Our picture shows six of the staff of ten members of the Accounts Department. In previous issues we have depicted many facets of the hospital complex, but like all systems of management, it would indeed be almost impossible to function effectively without efficient financial control.

The financial statement for the year past has revealed the smallest deficit in many years, and this, without doubt, is due in no small way to the guidance and reporting by the Finance Officer, Mr. W. K. Shaw and his staff.

The Accounts Department is responsible for recording and handling of many thousands of individual transactions each year, the aggregate of which is in the vicinity of a million pounds. The four main sections of the department are Pay Office, £360,000; Patients' Accounts, £130,000; Creditors' Accounts, £160,000; Cashier, £390,000. Superimposed on the detailed work is the analysing of all entries to maintain effective budget control.

Our purpose in relating the work of lesser known aspects of the hospital is to remind readers that **all** members of staff have an important role in patient care. While they seldom appear in the forefront of the hospital's public life, their work nevertheless, is recognised and remembered as an integral part of the system.

Hospital Sunday

As in previous years, the hospital will be open to the general public on Sunday, 24th October, from 2 p.m. till 4 p.m.

This Sunday is set aside for the benefit of all metropolitan hospitals. Friends, and relations of members of staff will be welcome to visit the hospital on this day. Staff will be available to conduct visitors through the hospital.

HOSPITALS AND MEDICAL RECORDS

By A. J. WERNER (Org. Adv., Holland)

Although Medical Record keeping has greatly improved in the last decennium, particularly in large hospitals, not a great deal has been done to improve methods of record keeping in smaller hospitals.

It is a fact that most hospitals employ modern techniques in their accounting, and machines are widely used to assist management in the preparation of financial reports. As a result costs are often reduced.

Auditors do not find it difficult to audit books of account where proper records are kept, and mistakes, if any, are certain to be detected. Unfortunately, records of medical management in hospitals do not receive the same attention from management, nor medical staffs. They are often useless as an aid to diagnosis, and do not form a proper basis for medical research or medical audit, the statistical value of a large percentage of records is therefore, neglible. Medical records are an important aid in practising medicine and should provide a basis on which patient care is planned. They become the medium of communication between the physician attending the patient, nursing staff and auxiliary medical departments such as Pathology, X-ray, Pharmacy and others. They establish a proper means for patient identification and hold information regarding physical examination; the type of illness from which the patient is suffering, treatment, details of surgery performed, patient's reaction to treatment, and so on.

The quality of medical records is an important pointer as to the quality of patient-care administered at the Hospital concerned. Larger hospitals are in a stronger position to cope with problems of record keeping because the number of records involved warrant the appointment of specially trained staff. These hospitals are able to provide summarised medical information to other hospitals and physicians as requested. They are limited only by the availability of Medical Officers to summarise records, and the trained clerical staff to type them.

Re-writing of medical case-histories in summarised form is a dangerous practice and even if done properly, the abstract of this record is not complete. Most hospitals do not like to part with original X-rays, electrocardiograms, etc., but the absence of complete records could easily lead to duplication of tests and even to errors in treatment. To illustrate the position, let us say that a person who is ill is admitted to hospital. The results of the medical examination are written in a medical record, and from time to time, as new information becomes available, the record is updated. After the patient has been in hospital for some time, the physician decides to transfer him to a larger hospital. A summarised medical record is usually sent in advance; as soon as the patient is admitted, routine examinations and laboratory tests are carried out, the results of which are entered in a fresh medical record at that hospital. If the patient is returned to the original hospital for post-operative care, a summarised record of the medical work is usually sent to the referring hospital.

Should the patient suffer a relapse and be admitted into a third hospital, the case would be even more complicated, because in order to compile a third record, information would be required from all hospitals where the patient had previously received care. **But remember none of the hospitals will have a complete medical history.**

Another point to remember ,is, that, summarising medical information is a costly process, and is a limiting factor in many hospital record systems.

Many, if not all, of these problems can be solved with more basic uniformity in records by assisting smaller hospitals in the setting up of a medical records section; by training suitable personnel in the use of the best techniques of record keeping, and reproduction of records. But before an attempt is made to solve this problem, it is essential that a co-ordinated plan be developed by the Hospitals and Charities Commission in conjunction with the Medical Superintendents of Victorian Hospitals, and the Boards of Management of smaller hospitals.

Since it is not an economical proposition to insist that every hospital have its own Medical Records Librarian, consideration must be given to an arrangement whereby Medical Records Librarians are appointed to Regional Base Hospitals. The Regional Medical Records Librarians should assist hospitals in the region to set-up and maintain proper medical records. This will not only ensure that effective Medical Records are kept and processed in the same manner, but will also keep costs to a minimum. Furthermore, a practical working Medical Records Section will stimulate the overall efficiency of any hospital, and this, in turn, will ultimately be of benefit to patients.

The Medical Records Librarian could manage the Medical Reference Library, serving that area, which would result in the availability of more complete medical information, thus reducing the total cost of the Medical Library Service. The Medical Records Librarian should also play a part in the conversion of written information into input-data for automatic data processing in the field of medical research, diagnosis and medical statistics.

To keep the space for storage of Medical Records, including space needed for X-rays, within prescribed limits, the formation of a microfilming service for metropolitan and Base Hospitals on a cost-basis should be considered. Microfilming can be successfully employed not only for written records, but also for X-ray film.

To avoid risks inherent in the re-writing of Medical Records and to save costs, the Hospitals and Charities Commission should promote the use of a simple copying device to enable hospitals to supply **full medical information when and wherever needed,** at low cost and without relinquishing their original data.

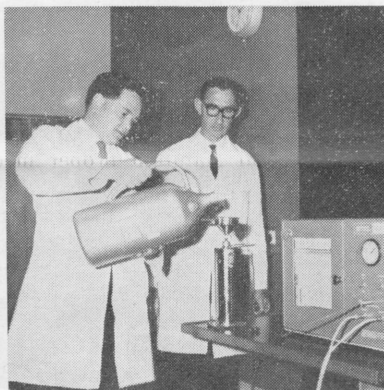
There is, however, one provision: records must be written in legible form or be typewritten.

OBITUARY

It is with profound regret that we record the passing of Mrs. J. G. Cumming, 25 years a members of the Auxiliary Movement, and 20 years as President of Kew Auxiliary. Mrs. Cumming had been seriously ill for some months.

CRYOTHERAPY IN OPHTHALMOLGY

Experimental work now in progress indicates that the application of low temperatures in the treatment of certain ocular conditions is of benefit.



Dr. Galbraith and Professor G. Crock demonstrate the Cryosurgery apparatus.

The technique of freezing a specific tissue is being used more frequently in medicine, and particularly in Ophthalmology. Its increase in popularity is due to improvement in methods for delivering a controlled temperature. Also, research has shown this technique can be used for tissue solidification and production of inflammation of certain tissues, while the surrounding ones are completely unaffected by freezing. Immediate solidification of tissue has been employed in obtaining histologic specimens and in extraction of the lens. Freezing to produce an inflammatory reaction followed by localised aseptic necrosis has been employed in treatment of retinal detachment, retinal degeneration, and retinal holes; and it holds promise for the treatment of glaucoma and ocular tumors.

In 1933 Bietti used a mixture of carbon dioxide in a metal probe applied to the sclera and produced a choriortinal adhesion similar to that obtained with diathermy. Deutschmann produced the same effect with carbon dioxide snow. The first cryogenic cataract extraction was reported by Krwawicz in 1961, using a metal probe dipped in a mixture of dry ice and alcohol. This method, however, proved too unsafe and it was not until 1963 with the experiments of Kelman, and Cooper and Lincoff, McLean and Nano that applicators were designed to produce extreme ranges of cold. In 1962 the Cooper-Linde Unit was developed for the treatment of parkinsonism. This apparatus could deliver a range of from plus 37 to minus 180 degrees C. The temperature could be controlled and could be applied to a specific tissue in an effort to produce the ideal therapetuic lesion. There was a heating mechanism in the probe of the instrument which enabled the operator to release and re-apply the probe quickly.

Experimental studies with animals have shown that no change is visible immediately after the freezing has been applied, but within 24 hours there is a mild congestion of the choroid, edema of the retina, and dilation of the retinal vessels. After three days there is little change, but after a week there is definite pigment migration into the lesion. This can be demonstrated both in gross and microscopic sections. After three weeks a punched-out lesion can be well demonstrated and there is a large amount of pigmentation. The final histologic appearance shows destruction of the retina and formation of well pigmented and fibroglial scar.

The advantages of cryotherapy in retinal detachment can be summarised as follows:—

1. Application can be made under direct visualisation with the indirect opthalmoscope. At the present time this is the only method other than transcleral diathermy that can be applied in this manner.

2. Application can be made through the full thickness of the conjunctiva, muscle and sclera without apparent damage to these structures.

3. Apparently there is no damage to the large vessels, although capillaries are destroyed.

4. There has been no evidence of vitreous retraction or other severe changes, as with intensive diathermy and intense photocoagulation.

5. If re-operation is necessary, the cryotreated areas remain healthy and easier to handle.

The disadvantages of cryotherapy in retinal detachment are:—

1. Present instruments are still in the experimental stage. they should be less elaborate and more practical, particularly the probe, which is large and cumbersome.

2. The instruments are not easily sterilized.

3. While the freezing can be visualised as an ice ball, there is no permanent or immediate effect of the application and the operator cannot tell exactly where he has made it. Evidence of the application does not appear for 24 hours.

(Ackn.: Sight Saving Review).

YOUR VOICE

By SHIELA DRUMMOND, L.A.C.S.T.

The quality of human voice descends from the thrilling beauty of a Joan Sutherland aria, to the raucous huskiness of the newsboy. In the midst of this range is a level of normality where ordinary humans use their voices to communicate, to sing, and to cry out in anger, sorrow, joy or fear.

Why are voices so different? Even with the aid fo the most modern research equipment, there is dissension as to the exact nature of voice production, but we do know that air from the lungs is vibrated through a space in the voice box, or larynx, and this space changes its shape and extent through the muscular movement of the vocal folds or cords. Aristotle compared the larynx to a flute, but recent acoustical analyses have regarded it as a high impedance generator.

The vocal folds in the new born child are 3 m.m. in length, and the frequency pitch range is a few semitones. This increases mainly by the addition of higher tones until a maximum frequency is reached at 11 years when the vocal folds average 9 m.m. in length. The "breaking" of the male voice at puberty is the result of the boy's inability to co-ordinate the rapid structural changes in the voice box with the folds, increasing to lengths ranging from 17 to 23 m.m. At this stage, the male vocal pitch lowers by an octave while the slight change of two notes in the female voice is related to the vocal folds measuring only 12.5 to 17 m.m. After voice is produced, it is resonated in the hollow spaces of the face and throat so that it carries and is pleasant to the listener. Its quality depends on the breath capacity of the speaker, the condition of his voice production mechanism and, finally, his emotional attitude towards expression of self to others. The flat voice of sadness and the high pitch of excitement are eas-

(Continued on page 8)

AROUND THE AUXILIARIES . . . ANNUAL MEETING IN PICTURES

A capacity attendance at the Auxiliaries Annual Meeting on 7th September, assured its complete success. We show below, some of the events.

Lady Delacombe and Private Secretary, Miss L. Pearson, arriving at the hospital.

Miss Alma Pedersen, President of the Executive Council of Auxiliaries, welcomes Lady Delacombe.

Dame Mary Herring is seen chatting with Mr. G. L. Allard and Mrs. B. Garrard.

Afternoon tea in the Hospital's Lecture Theatre.

Mr. C. G. Baird (Manager) is seen here discussing a point on the work of the Hospital with Dame Mary Herring and the Hospital's President, Mr. G. L. Allard.

Junior Vice-President, Mrs. Y. Williams (centre) entertains Lady Delacombe and Dame Mary Herring.

About People . . .

By GLENYS DELACY

NEW CATERING FACILITIES FOR STAFF DINING ROOM ESSENTIAL

Following extensions by the Staff Dining Rooms, Catering Officer, Mr. Metral wishes to apologise to all users for the inconvenience caused. For those who may not realise it, this work cannot be satisfactorily completed without disruption to normal services. The majority of staff express complete confidence in Mr. Metral and his staff who are doing their best to improve conditions, long overdue, for the benefit of all. Mr. Metral's planning is to be commended.

NEW STAFF

The following new staff are welcomed: Miss Georgina Smith, typist, on 27th August; Miss Helen Todd, Secretary to the Public Relations Officer on 24th September; Mr. Allen, Catering Department, on 3rd October; Dr. John Mitchell returned on 1st October to Dr. Brett's Clinic; Miss Heatherbell Glasgow, Pathology Department, on 13th September, as Medical Laboratory Technician-in-Training.

RESIGNED

Mrs. M. McMellon on 4th October, and Miss H. Krap on 7th October, both of Outpatients' Department; Miss Rhondda Williams, Public Relations Department, on 2nd September; Mr. Murray Marshall, cook, in October.

Births.

To Mrs. Deborah Cox (nee Minifie) a daughter, Prudence Elizabeth, on 15th September, 1965.

Congresses.

Orthopotists from the hospital attended the Annual Orthoptic Congress in Adelaide last month.

Miss E. Jellett, Librarian, attended the Library Congress in Canberra during September.

Mr. T. F. Cottier, Clinical Photographer, attended the National Photography Convention in Newport, N.S.W., also in September.

Moves.

The Orthoptic Clinic moved to "Clendon" on 18th October. All other departments vacated the area during September. Demolition work began on 27th September, with the signing of the contract, reported elsewhere in this issue.

Other News.

Remember Vic. Henshaw, one-time Manager of O.P.S.M., at the hospital? We hear he is now Manager of Wentworth District Hospital.

HOSPITAL GOES TO THE SHOWGROUNDS

The Showgrounds had a new exhibitor this year. Six Boards of photographic material supplied by the Clinical Photography Department were transported to the Show, and were manned by "Lions" as part of their recently announced world-wide campaign to prevent blindness.

During the same period, a vacant shop was made available to the hospital in Barkly Street, Footscray, for three months, and again Clinical Photography was able to provide the necessary material.

Our picture shows Mrs. Joan Dudley (nee Kingham) leaving the Methodist Ladies' College after her wedding on 18th August.

Sister Tyres, making a trip to a friend in Hertfordshire (Eng.), found that the neighbour next door was a Mrs. Bennett, whose daughter has been living in Melbourne for some years—Mrs. Sol Brand.

The Hospital's Annual Ball will be held on Monday, 1st November, at The Dorchester.

We Apologise

We admit to two errors in our last issue. The first concerns the deficit for the financial year which was reported as being £10,000. In fact it was only £1,234. However, "Sight & Sound News" was not responsible for this mistake; the figure was given through the Administration Department.

We accept full responsibility for the second mistake; this was in regard to the profile on Mr. Werner. The position he held in Holland should have read, "Officer-in-charge of Organisation and Methods at the University Clinics Utrecht."

SERIOUS AUDIOMETRY

Since its establishment in 1937, the Myer Hearing Service has always taken Audiometry seriously.

The department has many audiometers, mostly dual channel, which are maintained in close conformity with A.S.A. standards by daily checks, and frequent calibration on our own Bruel and Kjaer sound pressure measuring instruments. Live and recorded speech testing is used routinely. The test environment is quiet 30 D.b. S.P.L. and stable. The entire suite is air conditioned by a special low-velocity system. We constantly strive to maintain and improve our audiometry techniques and equipment. The Myer Hearing Service, 6th Floor, Bourke Street Store, Melbourne. Telephone 661-3934.

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CHRISTMAS CARDS

A selection of six Christmas cards can be seen in the Public Relations Department. These are priced at 1/- each, and for an additional charge, cards may be personalized. For details, contact the Public Relations Officer without delay.

Congratulations

Dr. D. Cairns successfully passed his D.O. examinations this month.

Association Formed

Early this month, the hospital's House Surgeons, with a membership of ten, formed a Resident Medical Officers' Association. Its objectives are to bring together the Eye & E.N.T. House Surgeons as a fraternity, based on common interests. They will be eligible for membership to the Resident Medical Officers' Association of Victoria.

YOUR VOICE

(Continued from page 5)

ily recognised, and a recent American research project has shown graphically the relationship between the vocal pitch patterns of schizophrenic and depressive patients, and their fluctuating condition under psychiatric treatment. With experience, we understand the blustering voice of the bully, but we are irritated by the vocal scratchings of the deaf speaker. He can be assisted to "feel" his voice in the resinators and so monitor it without hearing.

While hoarseness may be due to cancer, non-malignant cell growth in the vocal folds or paralysis, anxiety may cause such muscular tension that vibratory sound becomes impossible.

Physical relaxation follows therapy for this condition, and normal voice may be restored. The tape recorder has made us voice conscious—sometimes painfully.

You cannot alter your physical vocal equipment unless surgery is indicated, but you can use it to maximum advantage, with knowledge and practice, remembering voice is a musical intrument most humans may play well.

PHOTOGRAPHY

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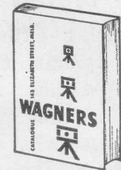

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PSYCHOLOGY TESTS IN DEAF CHILDREN

It is not always easy to diagnose deafness in children, especially in cases where there are other complications. A child cannot tell you what is wrong with him. He cannot say that he doesn't hear very well, or that words are meaningless. You have to find this out for yourself with whatever resources you have at hand.

The parents may be helpful. They will have sensed their child's inadequacies, but may be reluctant to examine them closely lest the final truth be too unpleasant. Sometimes they may skirt around the problem by claiming that the child is simply inattentive or deliberately perverse. The clinician will need to probe carefully to bring all the relevant facts to the surface. His own powers of observation will fill in the gaps in the parents' story.

Shrewd observation is the clinician's greatest single asset, but he cannot hope to observe more than a fragment of the child's behaviour. He must be selective. He watches the child interacting with a controlled environment deliberately designed to highlight specific deficiencies. How the child plays, what he plays with, how he moves, the noises he makes, his response to sound — these and other aspects of his behaviour may hold the key to his problem.

The controlled environment technique has been successfully used for many years in the Jean Littlejohn Deafness Investigation and Research Unit. Recently, however, it has been further refined by the addition of a special language test —The Illinois Test of Psycholinguistic abilities. This consists of a series of games which the child is encouraged to play, but each game is constructed to measure some aspect of language development. At the end of the test the child is assigned scores for his performances and these are then compared with the expected scores of normal children. In this way it is possible to show the particular effects of deafness on language development, but, what is even more important for diagnostic purposes, it is possible to classify scores into broad etiological types. All these additional complications have characteristic profiles that will become apparent in the test scores.

It must be stressed that the Illinois test is not a method for detecting deafness, it is a language test, but may provide indirect evidence of hearing impairment. Usually it is reserved for difficult and obscure cases which cannot be adequately diagnosed by more conventional procedures.

A.N.L.

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