A HISTORY OF THE GOOD SAMARITAN HOSPITAL
OF PORTLAND AND ITS PLACE IN THE
COMMUNITY

by

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A HISTORY OF THE GOOD SAMARITAN HOSPITAL
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Introduction

On a Sunday in 1874 the Right Reverend Benjamin Wistar Morris made the following announcement from the pulpit:

We propose to establish in your city an institution which will combine under one management the care and nursing of the sick, and the training of orphaned and neglected children. It is surely time that the city was provided with such an institution. It is time that the Protestants, as well as others, were engaged in the eminently Christian work of caring for the sick. The general character may, in great part, be learned from a name that has been suggested and which will be appropriate: The Good Samaritan Hospital and House of Mercy. The title Good Samaritan suggests that no conditions are to be required for admission but those of want and suffering. How free then must be the admission to doors over which this name may be written. The doors must be closed against no one in human form. It will hold no inducement to those enfeebled in mind and dependent on its care to change their faith in an hour of weakness and alarm. (84, p. 250)

If it is true, as has been said, the "Il n'y a pas d'Histoire, mais seulement des histoires." (98, p. 8)

A study and recording of the history of the Good Samaritan Hospital of Portland, opened in 1875, is of value for several reasons. First among these is the fact that the history of the hospital essentially parallels the history of the city, for its doors were opened twenty-four years after the incorporation of the city...and only thirty-three years after the erection of the first log cabin.
Secondly, the period following the Civil War marked a turning point in the development and expansion of hospitals throughout the United States, largely made possible by advances in the fields of science and medicine, accompanied by marked social and economic changes. The Good Samaritan Hospital is palpably a part of the entire movement and may be considered representative of many of the better hospitals then established. It is of especial interest because it is likewise a Church hospital, which was a significant phase of the hospital movement.

A third reason in justifying the study is that many thousands of people have received care in the institution, and the hospital has played a certain role in the delivery of new citizens. Investigation of standards and methods of care is appropriate.

Further justification of the value of the study lies in the realm of finances. Because the existence and expansion of the services of the voluntary, non-profit making hospital has historically been dependent upon benevolence, the quality of its record must be the criterion for continued financial assistance whether from private or public sources.

During a five year period of association with the Good Samaritan Hospital, in the departments of nursing education and nursing service, the writer frequently experienced a need of more specific knowledge and understanding of the hospital and its history than was easily available. In the belief th
others may have had a similar experience, this study has been undertaken.

A sincere attempt has been made to reduce a nursing bias; the inherent nature of hospital activities, however, is such that the ramifications of nursing are many. It is hoped that this work may prove to be a useful tool to students of hospital activities at some future date, and enlarge the breadth of understanding of the nature of the many hospitals as a result of study of the one.

It is the thesis of this study that the Good Samaritan Hospital history proves that its role has been far greater in importance, albeit of a different nature, to the community than Bishop Morris could possibly have prognosticated in the light of the knowledge of his day, and that its continued existence is vital to Portland and to Oregon.

Objectives in the compiling of this history are:

1. To record the story of the hospital, its progress and developments in the various areas relating to the care of the ill, and some of its contributions to the community.

2. To investigate the original purposes in founding the hospital and to note significant changes in purpose in accordance with social and medical changes in general.

3. To enquire whether such an institution as the Good Samaritan Hospital fills, and has filled, a basic need of the health and welfare of the community.

In point of time, the present period (1951) appears to be singularly appropriate for a review and analysis of the
earlier aims and accomplishments of the Good Samaritan Hospital...now over 75 years old. The building program under way, which is designed to care for more than 500 patients and to provide modern technical and medical services, is a major physical manifestation of progress. Perhaps not so obvious, but a very meaningful change, is that of financial under-writing of the building costs. For the first time federal funds have been received to augment private monetary gifts.

The period is characterized by the continued growth of prepaid medical and health plans, by state and industrial health and accident insurance programs, by increased Social Security benefits. New health concepts and practices, as distinguished from the care of the ill, are evident. These are among the contributing factors which have influenced the course of the hospital, and of its policies, and which have given rise to questions pertaining to the place of the Church and charity in Church sponsored hospitals.

The hospital strike of 1951 (in which the non-professional workers participated) has dramatized a difference in concept of the moral responsibility contiguous with the care of the sick.

Investigation of the hospital history has led to certain conclusions.

1. Despite apparent violation of the original intent of the Bishop to have the hospital dispense care free and freely, the hospital still continues to be the medium for giving large amounts of charity,
even though the individual assumption of financial responsibility for care is the general rule.

2. The essential nature of modern medicine, both preventative and therapeutic, demands modern hospital facilities for its success and for the health of the community. Deprivation of these would offer a serious threat to the safety of all.

3. Its clinical facilities provide essential experience for adequate preparation in the medical and medically allied professions, and so ultimately benefit society in general.

4. Its standards of care are, and have been, compatible with those established for a well-managed hospital by medical and hospital accrediting authorities.

5. It fulfills the functions of a general, voluntary non-profit-making hospital as defined by the Commission on Hospital Care; i.e. patient service, education, research. (45, p. 66)

6. Its history shows it has been characterized by weaknesses as well as strengths; that, in general, it has not sought a position of leadership.

7. Although title to the hospital and hospital property is held by the Protestant Episcopal Church, Diocese of Oregon, the hospital is, in actuality, the property of the community under the guardianship of the church.

8. The public is justified in placing its confidence in the method of administering the hospital; social responsibility and moral integrity have been demonstrated throughout the course of the hospital's existence.

The aforementioned are among the reasons for considering it a good time to look backward with a view toward the future.

Oman has in his book a statement of the purpose of history as defined by the Venerable Bede which is certainly applicable in reading the history of the Good Samaritan Hospital. "If history relates good things of good men, the
attentive hearer is excited to imitate that which is good; but if it mentions deeds of evil men, the pious reader learns to shun that which is hurtful and perverse, and is excited to do things which he knows to be good and pleasing to God." (98, p. 34)

The "good" things accomplished by such "good" men and women as Bishop Morris, Mrs. Wakeman and Miss Loveridge, who were the forerunners of the many who have given long and generously of themselves to further a venture and a cause in which they had great belief, should not be forgotten; neither their deeds nor their influence.

In procuring data for this study major use has been made of the Reports of Proceedings of the Diocesan Conventions, the Annual Reports of the Board of Hospital Trustees, together with the Report of Good Samaritan Hospital, the files of The Oregonian, unpublished script of Miss Emily Loveridge, hospital statistics, and various histories relating to Portland, Oregon, and the Northwest. Interviews with persons who have had acquaintanceship with the hospital over extended periods of time have been most helpful, and the writer wishes to express her deep appreciation to the many who have given her generous assistance.
CHAPTER I
THE FIRST QUARTER CENTURY, 1875 - 1900

Portland, Oregon, The Community into which the Hospital was Born

The Good Samaritan Hospital: Conception and Maturation

The history of Portland, wherein the Good Samaritan Hospital was presently to function, is one of rapid growth and expansion. The first dwelling, a log cabin, built in 1942, (117, p. 266) might well have been remembered by some who witnessed the building of the hospital. (Gaston, incidentally, includes in his history a picture of a cabin, designated as the first, which was built in 1844 at Front and Washington streets.) (62, p. 198)

In 1845 Asa Lovejoy and Francis W. Pettygrove "laid off sixteen blocks of the townsite and named the place Portland." (117, p. 266)

The population of the city increased in numbers from a total of 821 in 1850, at the time of the passage of the Donation Land Law, to 2,874 in 1860, to 8,293 in 1870. Its composition was rather homogeneous - there were few Orientals, and the 1870 census of Oregon listed 163 colored people only. However, sailors from foreign ships in port lent a certain cosmopolitan air to the town and composed a constant percentage of the hospital patient census during its early years.
Perhaps because many of the leading pioneers were from New England and the Eastern states, certain of the early New England stereotyped characteristics seem to be observed. For example, the population was predominantly Protestant in religion, and Samuel Bowles, following his visit to Portland (probably about 1871) wrote:

The population of Portland is now from eight to ten thousand, who keep Sunday with as much strictness almost as Puritanic New England does, which can be said of no other population this side of the Rocky mountains at least... and they seem sure, not of organizing the first state on the Pacific Coast, indeed, but of a steadily prosperous healthy and moral one, -- they are in the way to be the New England of the Pacific Coast. (36, p. 457)

It is noteworthy that a contrast of impressions existed for Bowles, for he also wrote:

When the Puritans settled New England, their first public duty was to build a church with thrifty thought for their souls. Out here, their degenerate sons begin with organizing a restaurant, and supplying Hostetler's Stomachic bitters and an European or Asiatic cook so that the seat of the empire, in its travel westward, changes its base from soul to stomach, from brains to bowels. (36, p. 462)

Quiett has described the general tone as similar to that of Philadelphia and wrote that the residents of Portland were reluctant to have the city change. (112, pp. 395, 397)

A behavior pattern which might be considered characteristic of 19th century New England was exhibited by Henry Failing, following the great fire of 1873. It was an extensive one, burning a total of twenty-two blocks with an estimated loss of two and a quarter million dollars. Failing, as chairman of the relief committee, declined financial aid from
such sympathetic sister-cities as San Francisco. He justified his action to critics by stating "that it was not meet, even in sore distress, for a rich city like Portland to accept charity; and that the manly thing, and the right and proper thing to do was for the rich men to put their hands deep down into their pockets and discharge their duty to the honor and credit of the city." (62, p. 249) Mr. Failing subscribed a sum of ten thousand dollars to the relief fund, thus following his own prescription.

That a narrowness of Protestantism and racism prevailed may be deduced from contemporary writing. The writings of a Methodist minister, the Reverend G. Hines, is replete with anti-Roman Catholicism, (72, p. 105) and early copies of the Oregon Churchman carried editorials conspicuously critical of the Unitarians, whose doctrine was apparently anathema to the Episcopalian mind.

Evidence of wider horizons of empathy, however, are evident. In 1873 The Oregon Churchman contained an item criticizing the Willamette Farmer which had described a railroad accident in which there was only a Chinaman hurt, and on another occasion protested the tendency of condemning an entire Indian tribe as a result of an individual act. (164, p. 1)

Interpolation, at this point, of a short review of the Episcopal Church in its early days in Oregon is necessary to fully appreciate its ambitions and accomplishment.
The first Episcopal clergyman to come to Oregon was the Reverend St. Michael Fackler, who came to the country in 1847 in search of health primarily but was later made a missionary in the Diocese, settling in Oregon City. The primitive conditions of the period he has ably described. "I occupy a room in a shanty, merely clapboards, quite open to the air, with a rough, unplaned, ungrooved floor; no carpets, no plastering, no ceiling. For this I pay twelve dollars a month, three dollars (fifteen was the price) having been deducted by the landlord on account of my mission. I also do my own cooking, and gather my own wood out of the forest behind me; and yet my expenses will be as great as in a good boarding house in New York." (172, pp. 2, 3)

It was in April of 1851 that the Reverend William Richmond of the Diocese of New York received his appointment—the first missionary of Oregon. When he arrived in Portland in May, he found it necessary to hold services in the Methodist Church, for there was then no Episcopal church in the city. (62, p. 415) Following this service, Trinity parish was organized—the first parish in the Diocese of Oregon and Washington Territory, comprising two or three families.

In October, 1853, the Reverend Thomas Fielding Scott, of Georgia, was appointed Bishop. He died in 1867. "His genial manners and his marked ability as a preacher won for him the affection and commanded the respect of all who had ever heard him preach, or had been personally acquainted with him." (62, p. 416)

Among the important episodes marking the enlargement of the church were the Resolution to have a Convocation of Clergy and Laity of the Protestant-Episcopal Church in Oregon and Washington Territories in 1854, the consecration of Trinity
Church in September, 1854, and churches in Milwaukie and Salem in 1855. Whereas the total membership in parishes where services were held was 79 in 1859, this number had increased to 321 communicants in 1870.

Not until June, 1869 was B. Wistar Morris appointed a successor to the late Bishop Scott as Bishop of Oregon. It is difficult to appraise Bishop Morris in any but glowing terms, for his initiative, untiring energy and inspired enthusiasm seem extraordinary in view of his nearly fifty years, and his past experiences in the old, wealthy city of Philadelphia—hoary with years and rich in cultural heritage—and the decided change to the raw uncouthness of a very young city. He accomplished much in a short time following his arrival in Portland in June—accompanied by his wife and three sisters. By September, St. Helen's Hall School for girls had been opened, under the tutelage of the Misses Rodney, and in 1871 the Bishop Scott Grammar School for boys was completed with Mr. Bernard Cornelius as principal.

While the foregoing selections may promote understanding of certain of the social climatic aspects, a listing of the city's business enterprises include: (1880; population circa 36,000)

29 Hotels (located on First, Second and Third Avenues)
30 Boarding Houses
21 Restaurants
9 Coffee Houses
3 Oyster Saloons
103 Liquor Saloons

67 Physicians
63 Attorneys
34 Editors (sic)
4 Ferries (plying the river)
7 Saw Mills
3 Flour Mills
Development of public utilities for the growing city was laggard although the first Portland streets were laid out, parallel to the river, in 1845. Canyon Road, so valuable an adjunct in transporting valley produce to the city for sale and shipping, was built in 1849. (116, p. 206) Nevertheless, the general condition of the deep, muddy streets during bad weather later presented a serious obstacle to both patients and physicians in getting to the hospital, besides being a source of considerable expense to the hospital which was forced to improve nearby streets. Kipling, who expressed great enthusiasm about a fishing excursion up the Clackamas, was much less enthusiastic about the roads. In his American Notes he wrote: "Half a mile from this city of fifty thousand souls we struck (and this must be taken literally) a plank road that would have been a disgrace to an Irish village." (78, p. 61)

The Willamette River then, as now, was an obstacle to inter-urban transportation. Ferries long provided the only means of river crossing and Stephen Maybill, in his ditty, Willamette Bridges: "They're going to build, I feel it yet, a bridge across the Willamette," (62, p. 344) voiced the common feeling of protest at the continued inconvenience.

Public transportation within the city was provided by horse car lines—the predecessor of the modern bus system—
and as good as any horse car line could be. To get up the hill at Market Street or Third, a boy was stationed with an extra horse to help out the single nag that trotted along with the tender little cars holding a dozen passengers at best. The Washington Street line put on considerable airs from the very start, had a pair of horses, regular flyers from King's big stock ranch in Lake County, and they changed teams every three hours, made fast time on the street, and in fact started the boom in building and prices on Washington Street which has been going ever since. (62, p. 307)

The street cars, which existed until supplanted by gasoline buses in 1950, had their first tracks laid in 1872 on First Street.

Services affecting the city's health were tardy. As late as 1885 Mr. Scott complained of the lack of solution for adequate disposal of refuse and garbage, and sewage was emptied into the Willamette at a point near the center of the town. Besides the unpleasantness of odors emanating from the river, drinking water for the population was shockingly contaminated and undoubtedly accounted for a high incidence of typhoid fever.

The lines of communication with other parts of the country were long and tedious. The launching of the Lot Whitcomb and Columbia in 1950 introduced a profitable era of water transportation which reached its peak in 1860. In an effort to compete with water transportation, the Corbett Company advertised a journey from San Francisco:

Overland mail route to Oregon
Through in Six Days to Portland
Avoid risk of ocean travel
Most beautiful and attractive as well
As bold grand and picturesque scenery
Stages stop one night at
Ureka and Jacksonville for passengers to rest
Lay over at any point and continue journey
Within one month.

July 20, 1866

H. W. Corbett & Co.
Proprietors, Oregon Stage Lines.

The stages yielded to steam. In 1883, the Northern Pacific had its lines connecting with Portland; the Union Pacific in 1885, and Southern Pacific in 1888, with their terminal at the present Union Station—once Couch Lake. (116, p. 261)

Other innovations, the telegraph and the telephone, shortened lines of communication with the country at large. The Oregonian, which existed as a weekly paper from 1850-1861, (62, p. 591) printed a special edition March 5, 1864 containing its first news received by telegraph from the East...astonishingly new for it was only twenty hours old. (112, p. 392) The use of the telegraph system, incidentally, was not inexpensive. The rate from Portland to San Francisco was three dollars for the first ten words, and a dollar and a quarter for every extra five words or fraction thereof. (62, p. 254) (These charges correlated with those of telephone service. The cost per month was five dollars, with an additional fee for every call made.)

The preceding aspects of the city of Portland have been presented as a means of understanding something of the general nature of the city. Some consideration should be given existing social agencies and the state of medicine at the time of Bishop Morris' proposal of erecting a hospital.
The Children's Home, under the sponsorship of the Ladies' Relief Society, was opened in 1872, and the Neighborhood House was organized in 1874 by the Jewish Women's Benevolent Society. (62, p. 466) In 1861 a temporary Insane Asylum was established on Taylor, between First and Second Avenues, which was later moved to the East Side (84, p. 548) and in 1872 a State Institution for Deaf Mutes was begun in Salem.

In turning to the topic of medical practice of the era, the following excerpt from a short history of Medical Journals of the Northwest (taken from an item in the Dental Register of Cincinnati, Ohio, 1869) is graphic:

In some respects this is a good country to practice medicine in. The prices are almost double those charged East, payable in coin, but no attention is paid to medical ethics; each does what he considers right in his own eyes. There is a medical school at Salem, the capitol. The number in attendance is small and the graduates few and not very well qualified. The Physicians and Surgeons of the regular schools in the cities of Portland and Salem are well qualified and will compare favorably with those of any Eastern city. They are generally graduates of English, New York and Philadelphia Schools. (81, pp. 5, 6)

(The furor among Oregon physicians occasioned by this publication needs no comment.)

Whereas Scott reported 63 practicing physicians in Portland in 1880 (116, p.168) Larsell's figures are 9 in 1860 and 14 in 1864 (84, p.169) with a steady increase thereafter--many of whom provided the backbone of the Willamette Medical Department, and its successor the Oregon Medical School. The larger group, undoubtedly, comprised many self-styled
physicians (or "quacks") which group would logically have caused the unfavorable criticism resulting from unethical practice. The caliber of doctors associated with the Good Samaritan Hospital was representative of the qualified physician as will be shown.

In conceiving the idea of a need of a hospital and orphanage, Bishop Morris was not without precedent, either in his church or in the national picture. Of the national trend toward church operated hospitals has been said: "In the latter half of the century churches gained in strength and to no small degree were responsible for the tremendous growth in that period." (45, p. 448) As regards the prevailing influence of the church: "The advent of the Christian religion with its emphasis upon man's responsibilities toward his fellowmen gave great impetus to the humanitarian and altruistic care of the sick." (45, p. 425) According to the same source: "The development of the hospital during the past hundred years as a health and social agency is one of the outstanding achievements marking the advance of civilization." (45, p. 424) With these definitive statements in mind, it will be well to inspect the place of the Good Samaritan Hospital in the total picture.

The Protestant Episcopal Church had assumed an active role in the total hospital movement, for three hospitals had been successfully established in the East prior to Bishop Morris' arrival in Oregon. The hospital in Philadelphia was
caring for as many as 200 patients a month. (166, p. 1) In 1872, under Bishop Tuttle, St. Mark's Hospital was established in Salt Lake City—the first of the Episcopal sponsored hospitals in the far West and which created an immediate precedent for the Oregon undertaking.

The church membership in Portland was small (742 communicants at the time of the opening of the hospital in 1875) but it had able and energetic leadership, reflecting the spirit of the church throughout the country, where marked emphasis had been placed on the building of schools and charitable institutions as a tangible means of spreading its influence. Zeal had been mandatory for Episcopalians in the United States for

It would be difficult to imagine a more desperate situation than that of the Episcopal Church at the close of the Revolution. Her members were a seemingly hopeless little band compared with the Puritan hosts about her... she was the offspring of the State Church, and therefore to be suspected. (38, p. 212)

In extending its membership and work, the missionwork field had received generous support. For the Episcopal Church, the mission field was "The World," divided into two categories, Domestic (such as Oregon) and Foreign. This clarity of design explains the willingness of Eastern church members to help finance such Oregon projects as the Good Samaritan Hospital, even after the western part of the state was officially changed to a status of diocese. The extraordinary energy of Bishop Morris in starting schools and founding a hospital—
all within a short span of time—was a result of not only his personal drive and ambition, but that of the Episcopal Church.

The purpose of the orphanage was to fulfill the Christian tradition of social obligation, and was in accordance with nineteenth century techniques of caring for dependent children—a distinct gain over previous methods used, such as work-houses and apprentices. (61, pp. 17-18) Its alliance with the hospital was logical, in the light of the prevailing concept of the purpose and activities of a hospital.

In announcing that it was "High time a hospital was established with the best in nursing" (165, p. 2) under the jurisdiction of the Protestant Episcopal Church, an almost traditional pattern was being disturbed. The frequency of success associated with Roman Catholic Church hospitals fostered the belief that hospitals were inherently Catholic projects. That this belief was an obstacle in raising money for the Good Samaritan Hospital is evident in the warmth of the Bishop's 1875 address:

One great difficulty in the undertaking, from the beginning, has been in the prevalence of the sentiment that ministrations to the sick and orphans belong especially to the Romish Church and that system alone, with its order and sisterhoods, its economy and self-denial, is competent to conduct such works as these. (124, pp. 20-22)

A query which might arise is whether anyone other than Bishop Morris sensed a need for a hospital in Portland. The answer is negative; no evidence can be found which would indicate that the medical profession, nor that the public,
singly or en masse, wanted one. The desire was inherent with Bishop Morris as a Protestant church project...for the care of the sick and unfortunate. The highly specialized modern hospital, a proving ground for skillful and scientific medical practitioners, is a product of the twentieth century. Its roots are in the church.

A first step taken in the actual construction of the hospital began with the purchase of three and one half acres of the Couch estate from Dr. R. Glisan, in 1873—the land lying between Twenty-first and M and L streets (Marshall and Lovejoy). This was later enlarged to a total of four and a quarter acres (somewhat more than four city blocks) at a cost of $2,800.¹ Bishop Morris, in after years expressed repeatedly his deep gratitude for the generous cancellation of a $500 note long overdue Captain H. Flanders, which was part of the original cost. (178, p. 8) Undoubtedly the kindness of the gesture was the greater because of the disheartening task of getting financial backing.

The actual building site was a virtual wilderness, but it was described as healthful and high and "will command an extensive view of Portland and its surroundings when the brush is cleared off." (165, p. 2)

Money, as has been suggested, was essential if the

¹Lockley, in his history, gave the original purchase price as $15,000 with an additional $800 for the extra half acre of land. These figures do not seem to correspond with those found elsewhere. (86, pp. 520, 521)
hospital was to exist. A practical man, Bishop Morris had formulated specific methods of money raising. These included:

1. Direct contributions. (He himself was prepared to pledge $2,000.)

2. Annual subscriptions, to be used for maintenance, Twenty dollars for each church member was suggested.

3. Annual church offerings and collections.

4. Endowments of free beds; Memorial beds to cost $3,000 "U. S. coin."\(^2\)

5. Paying patients. (167, p. 2)

With certain exceptions, the second proposal, the annual subscriptions technic, did not gain popular acceptance, but other methods were adopted to the great benefit of the hospital.

Aspirations became reality with the laying of the hospital corner stone on Ascension Day in 1874. The building was to be a two story wooden structure, in the shape of an H, with one wing set aside for the hospital; the other for the orphanage. The two wings were separated, with the kitchen placed in the center, servicing both. The total building cost was some $10,000 (about double the estimate), $1,500 of which was unpaid at the time of completion. The total expenses were quoted as $20,010.78. (123, p. 31)

\(^2\)The wisdom of endowing a bed at $3,000, even in those days, is questionable, and the beds later proved a source of misunderstanding and ill will when hospital costs and reduced interest income played havoc with hospital finances.
During the year, work on the construction was interrupted by complications which arose while the Bishop was attending the General Convention but was resumed upon his return. In 1875, he reported on its progress:

The building is now so far completed as to allow its occupancy by a family, with a superintendent, Mr. George Boyd, a candidate for the ministry, whose studies have been temporarily suspended on account of failing health. It is proposed to open the hospital and orphanage with appropriate ceremonies on next Saturday afternoon. In anticipation of this, six children have already been admitted. (124, pp. 20-22)

For a church with a total membership of less than 800 (1874 - 703 communicants; 1875 - 742) in the jurisdiction of Oregon and Washington Territory, this was an astonishing feat which would hardly have been possible without the Bishop's driving force. Of him, Bancroft later wrote: "The energy of Morris and the liberality of the people of Portland placing the Episcopal society in the foremost rank in point of educational and charitable institutions." (33, p. 686)

It is worthy of note that the Episcopal Church was not alone in beginning a hospital. Almost concurrently with the Good Samaritan Hospital building, St. Vincent's Hospital was erected (12th and Marshall streets) largely through the generosity of the St. Vincent de Paul Society of Portland, and undoubtedly rivalry must have existed between the two churches. On June 24, 1875, three weeks before it was actually dedicated for service, its first patient was admitted. With the existence of two hospitals in Portland, a new chapter
was opened in the care of the sick.

The Hospital and Orphanage was formally opened on October 9, 1875. The first hospital patient was admitted on October 10, and five months later a total of five male patients and eight children had been cared for in the new institution. (170, pp. 2, 3)

The simplicity of the equipment and supplies of the early hospital reflect the simplicity of hospital care given. It has been stated, and the Good Samaritan Hospital as a selected sample bears this out, that the period between 1840 and 1900 was one when hospitals underwent a drastic evolution in purpose, function, and number. From supplying merely food, shelter and meagre medical care to the pauper sick, to armies, to the insane, and to those requiring emergency treatment, they began to provide skilled medical care to all people. (45, p. 571)

The Good Samaritan Hospital, started at almost the median point, its underlying philosophy on numerous occasions declared by Bishop Morris:

I was sick and ye visited me;
I was a stranger and ye took me in,
fits neatly into this historical pattern. Tangible evidence of its domiciliary characteristics is found in public requests for such articles as bath bowls and pitchers, strips of carpet, illustrated texts, a fresh milch cow, clothes-wringer, and garden tools, (169, p. 2) and earlier, requests had been for furniture, mattresses, coverlids, and bed linen. (168, p. 2)
Charitable aspects were paramount, in contrast to the financial self-sufficiency of the modern hospital, and the church then superceded medical science.

Reverting to the physical phase of the hospital, presumably its needs were adequately satisfied, for two years later the Bishop reported "good progress in the past year... the two buildings are now furnished throughout. The Hospital is a well appointed establishment not inferior to many in the Eastern States." (125, pp. 20, 21) Allowing for his bias, nonetheless it is evident that good progress had been made.

Before going farther into the hospital story, a brief outline of the orphanage (1875 - 1883) is in order, and the probable reasons for its closing.

The building itself was designed to accommodate about thirty children, with separate sleeping quarters for boys and girls. The term orphanage was a misnomer; modern classification of the children would place them rather as dependent or neglected, for "those who are really orphans being the smallest class in it. It is a place for destitute and homeless children whether they are orphans or not." (126, pp. 27-28)

There seems to have been, in the beginning, sufficient need for the institution to warrant its support. In 1875, twenty-five children received care in the orphanage. In 1876 fifteen were in residence at the time of the Diocesan Convocation, but in 1878 the number had dwindled to twelve. The
reduction in census cannot be attributed to unpleasantness of surroundings, for the Matron in charge (a Mrs. Smith) was reported as able and well-liked by the children, and the Visiting Committee noted a happy and orderly environment.

Bishop Morris made valiant attempts to prime the pump of interest in the Orphanage among the church people, and refuted criticism that "it ought to be discontinued as a burdensome and useless task" (128, p. 41) by the fact that thirty-two children had been cared for in 1881 and that seventeen were in residence at the time of the meeting. Nonetheless, in 1883 it was decided to restrict the admission of children to the sick and to divert the orphanage facilities to the hospital. (44, p. 5)

Altogether a total of 195 children received care in the Orphanage, most of which was essentially free. Rates charged were $10 per month for those who could pay; few did. In the year ending September, 1880, for example, $296 was the total amount collected for the children's care. Supplemental funds had to come from the church members predominantly.

Two conjectures are submitted as reasonable for the failure of the orphanage:

1. The institution was not needed, either because of the scanty population of the city or because of duplication of existing facilities.

2. There were too many demands for charity from a small church membership.

Although the organization which assumed the care of the children after the Orphanage was closed was not designated by name,
it is probable that the Children's Home (established in 1872) had space for them. Because underprivileged children offer a unique appeal, based as commonly on emotions as intellect, it is unlikely that so much difficulty would have been encountered in raising funds for the Orphanage, had there been no alternative existing institution.

In contrast to the lost cause of the Orphanage, the hospital was proving its worth. A former patient recalled it in rather an appealing manner as a large, frame building without much ornament, possessing four wings, a tower and balconies. Both sides of the river could be seen, and also Mt. Hood. The interior of the hospital was well fitted, and the ward where he stayed had both closet lavatories and commodes. This patient was especially enthusiastic about the linen, for clean towels are distributed among the patients that each may use his own and not be compelled to dry himself on linen that has been used by other persons, a thing abhorrent to anyone with average self-respect, but which too frequently happens. I must add also that these towels are changed before they have a chance to get badly soiled. (171, p. 1)

(Those were the days of the roller towel and communal drinking cup.) Bishop Morris and Superintendent Boyd were also said to be deeply loved by all the hospital patients (among whom were a doctor, woodsman, steamboatman, two Germans and a boy). (171, p. 1) Pictures of the hospital reveal it as dignified and in good taste. Bishop Morris spoke of it lovingly: "It has ample, beautiful grounds, the hospital has become a well-appointed institution, and would be considered
such in any part of our country. It has, and is, a sweet quiet place where the sick and suffering have every need and comfort." (126, p. 26)

In her unpublished manuscript, Miss Loveridge incorporated a picture of the hospital as it looked to her.

Coming to Oregon April 27, 1890, and to Good Samaritan Hospital, Portland, Oregon, May 1, 1890, I found myself one of three graduate nurses in a city of 70,000 inhabitants.3

The hospital was a large two story frame building facing L, now Lovejoy Street, which stood on the corner of what is 23rd Street. It was six blocks from a streetcar, a horse car that came up G, now Glisan Street. I know because I came as far as I could on a G Street car, and walked carrying my bag the remaining six blocks.

The place looked small enough after the big rambling buildings of Bellevue of which hospital I was a recent graduate, but the grounds consisting of two double blocks gave us plenty of room to expand. On the day of my arrival services were being held to celebrate the completion of the endowment of the Queen Victoria Diamond Jubilee Commemoration Bed.

Our patients were in all parts of the hospital except the recent "new part" and attracted the nurses by means of tap bells. There was no wiring for electric bells.

On the first floor were the Superintendent's office containing also the bookkeeping department and the safe, the reception room, doctors' lounge, the drug room, a mere pigeon hole of a place, and a linen room. On this same floor, back of this were three small women's wards, one of which was our maternity department, our two interne rooms, operating room, and seven private rooms for patients. On the second floor were four men's wards, a smoking room, convalescents' dining

---

3Gaston's figures are 46,385 - Portland
for that period: 6,742 - county outside city
room for men, two bathrooms, pantry, two "cells" and four private rooms. In a hall over the main entrance was our improvised chapel, having in it a prayer desk, lecturn and primitive altar. (87, p. 4)

Convincing evidence that the hospital was needed is contained in the following table, which shows the annual rise in patient census:

<table>
<thead>
<tr>
<th>Year</th>
<th>Patient Census</th>
<th>First Quarter Century</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Number Patients</td>
<td></td>
</tr>
<tr>
<td>1875</td>
<td>51</td>
<td></td>
</tr>
<tr>
<td>1876</td>
<td>139</td>
<td></td>
</tr>
<tr>
<td>1877</td>
<td>120</td>
<td></td>
</tr>
<tr>
<td>1878</td>
<td>100* (nine mos.)</td>
<td></td>
</tr>
<tr>
<td>1879</td>
<td>180</td>
<td></td>
</tr>
<tr>
<td>1880</td>
<td>241</td>
<td></td>
</tr>
<tr>
<td>1881</td>
<td>265</td>
<td></td>
</tr>
<tr>
<td>1882</td>
<td>267</td>
<td></td>
</tr>
<tr>
<td>1883</td>
<td>156</td>
<td></td>
</tr>
<tr>
<td>1884</td>
<td>223</td>
<td></td>
</tr>
<tr>
<td>1885</td>
<td>294</td>
<td></td>
</tr>
<tr>
<td>1886</td>
<td>348</td>
<td></td>
</tr>
<tr>
<td>1887</td>
<td>708** (fifteen months)</td>
<td></td>
</tr>
<tr>
<td>1888</td>
<td>614 (ten months)</td>
<td></td>
</tr>
</tbody>
</table>

*Year hospital closed during winter-time because of dreadful condition of roads.

**Date of Convocation changed; figures presented at meeting.
The foregoing table suggests other problems which had to be faced, in enlarging the hospital and finding money to do so. Among the improvements made during the first years were:

<table>
<thead>
<tr>
<th>Year</th>
<th>Improvements</th>
</tr>
</thead>
<tbody>
<tr>
<td>By 1878</td>
<td>$5,000 spent on various improvements about hospital grounds.</td>
</tr>
<tr>
<td>1881</td>
<td>Laundry, fumigating room, enlarged kitchen and two dining rooms; nurses quarters and office enlarged.</td>
</tr>
<tr>
<td>1882</td>
<td>Mortuary built; north and west sides of grounds fenced in.</td>
</tr>
<tr>
<td>1884</td>
<td>Hot air furnace for East Wing; orphanage moved next to hospital; new wing for women and children completed.</td>
</tr>
<tr>
<td>1885</td>
<td>Mortuary moved and re-built; $80 spent on sewage system; plank roadway into hospital grounds.</td>
</tr>
<tr>
<td>1889</td>
<td>Four cottages built on Northrup (for income).</td>
</tr>
</tbody>
</table>

Investigation of the hospital financial resources reveals that the original objectives of the hospital were being adhered to, i.e. need alone as the admission criterion, and that only through charitable gifts could the hospital expand. This is borne out by reports of the hospital.

In 1880, the rates for care were:

<table>
<thead>
<tr>
<th></th>
<th>1880</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward Beds</td>
<td>$7 per week</td>
</tr>
<tr>
<td>Private Rooms</td>
<td>$1.25 - $2 per day</td>
</tr>
</tbody>
</table>

1883

<table>
<thead>
<tr>
<th></th>
<th>1883</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward Beds</td>
<td>$5-7 per week</td>
</tr>
<tr>
<td>Private Rooms</td>
<td>$10-14 per week</td>
</tr>
</tbody>
</table>

("city" cases were being cared for at a daily rate of 50 cents).
During the year 1879, of a total of 135 patients reported, 40 were free: 95 paying. The total number of days of care was:

<table>
<thead>
<tr>
<th>Year</th>
<th>Paying Patients</th>
<th>Free</th>
<th>Total Hospital Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>1879</td>
<td>2,772</td>
<td>1,494</td>
<td>4,266</td>
</tr>
</tbody>
</table>

In short, almost half the hospital patients during the year 1879 were charity. In 1880, of the total number of admissions, 56 were free, and in 1881 of the total 170 "paying" patients, 47 gave less than a dollar a day. The amount of charity dispensed was actually larger than the report indicates.

<table>
<thead>
<tr>
<th>Year</th>
<th>Paying Patients</th>
<th>Free</th>
<th>Total Hospital Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>1881</td>
<td>3,433</td>
<td>2,553</td>
<td>5,986</td>
</tr>
</tbody>
</table>

To offset the running expenses, an annual Thanksgiving offering had been instituted early in the various Episcopal parishes. Contributions included both money and gifts "in kind" -- including candles, Irish moss, drawers, brooms, apples, wine, etc. (Up to and including 1932, the Annual Reports tabulated all gifts received.)

It will be recalled that bed endowments had been considered a method of underwriting hospital expenses. A first concerted effort to raise money for one was occasioned by the unfortunate death of Rodney Morris, the adolescent son of the Bishop who had died in an attempt to rescue two men who were drowning in a sewer. No finer expression of sympathy could
have been evolved—so close to the Bishop's heart was the welfare of the hospital.

In 1886, a Sunday School class of children in Corvallis, initiated the first "Children's Comfort Cot" by raising $8.00 in their Christmas collection. This sum was used as the nucleus of the $2500 estimated necessary for a bed endowment. The gesture was so charming, and the amount of money so large for them, that it seems fitting that their names be remembered.

Ida M. Ray Johnny Swifel
C. L. Johnson Joe Alexander
Willie E. Cameron Fred Booth
Bick (sic) Vanbibler Chippy Nash
Alice M. Booth and
Percival Nash fifteen others.
Dick Grobserm
Willie Johnson December 20, 1886 (199,p.8)

A dependable source of income, for a time, was provided by a Federal contract for medical care of Marine patients. This, however, was lost in 1878 when St. Vincent's Hospital made a bid of 67-1/2 cents a day against the 70 cents bid of the Good Samaritan Hospital. It was about this time that the Bishop was so harassed over the $636 hospital debt that he was tempted to sell the hospital. A quotation from Bishop Morris clarifies some of his difficulties in getting financial help.

"It has come to my hearing that the sympathies of many persons have been alienated from the work of the hospital on account of the antecedents and character of some of those who have been received as its inmates." (126, p.27) These "questionable" patients may have been the sailors from foreign
ships in port; possibly unmarried mothers may have contributed to the criticism levelled at the hospital.

Five years after the opening of the hospital, Bishop Morris declared:

"When I glance over the work of the past year, I cannot agree with some of our friends that the work is a failure."

*(175, p. 3)*

Notwithstanding difficulties encountered, the total amount of endowment funds in 1890 was $39,500 *(131, p. 55)* and in 1889 the state of indebtedness was reported as $2,700. *(130, p. 4)*

The aggregation of wealth, just mentioned, as also the ever growing hospital census, leads to a discussion of the methods of controlling the growing institution. As early as 1874, "The Good Samaritan Association" was formed—its functions, as defined by Bishop Morris, were to assist in the problems of administration and management. This association appears to have been the precursor of the present Board of Trustees (1891). In the first "Board of Managers", prior to incorporation, the strength of support the Bishop had from outstanding community leaders is evident.

Hon. M. D. Deady  
Rev. Geo. F. Plummer  
Mr. C. H. Lewis  
Capt. Geo. Flanders  
Dr. R. B. Wilson  
Dr. R. Glisan  
Mr. James Laidlaw  
Mr. Henry Hewett  
Gen. J. H. Eaton, secretary  
Mr. Ivan R. Dawson  
Mr. Henry Failing  
Mr. George Goode, treasurer  

*(62, p. 448)*

At the Diocesan Convention of 1890, Judge Deady presented
the following resolution to the assembly:

Summary of Resolution

Be it resolved by the Protestant Episcopal Church of the Diocese of Oregon in Convention assembled: (131, pp. 15, 16)

1. The Board of Hospital Trustees to consist of five members which would include the Bishop as chairman, plus two members of the clergy and two laymen (i.e. non-clergy).

2. The Board would have the power and the right to "take, receive, hold, possess, manage, expend and dispose of the real and personal property... of the Good Samaritan Hospital.

3. The right to manage and control the hospital.

4. Vacancies in the Board would be filled by the Convention.

5. The Bishop of Oregon to be the chairman of the Board.

6. Meetings to be held at regular stated intervals.

7. "Said trustees may become incorporated under the laws of Oregon, applicable thereto, by the name of The Board of Hospital Trustees." (131, p. 16)

The first Board of Trustees, elected by the Convention, were:

Rev. T. L. Cole
Rev. W. R. Powell
Bishop B. Wistar Morris, Chairman

George Wilson, M. D.
S. E. Josephi, M. D.

(131, p. 18)

The actual date of incorporation was January 22, 1891. The Board the "next day acquired title to the double blocks 304 and 303 in Couch's Addition to the City of Portland on which
the Good Samaritan Hospital and other buildings are situate." (132, p. 15) Also at this time duties were defined for the hospital staff, which was made up of:

Superintendent   Apothecary
Chaplain         House Surgeon
Matron           Medical and Surgical
Superintendent of Nursing  Staff. (132, p. 15)

The incorporation of the hospital is a logical point for a brief summary of major accomplishments thus far.

1. By 1891, some 4500 patients had been treated. In a city of 46,385 inhabitants, there was still only one other hospital--St. Vincent's.

2. It, in conjunction with St. Vincent's Hospital, cared for the county poor. The Paupers' Farm (now West Hills Golf Course) had no facilities for the acutely ill, or those requiring surgery. The rate of care was a dollar a day. (84, p. 527)

3. A Nurses' Training School was established in June, 1890.

The inauguration of a nursing school was of basic importance to the success of the hospital and in line with a prime original objective to provide good nursing care. Before tracing this development, however, some review of the hospital and its administrative and medical facets is necessary for full comprehension of the nursing ramifications.

At first, hospital patients were predominantly male. In 1877 a group of women of Trinity Parish fitted up a ward expressly for women patients and subsequently urged the readers of *The Oregon Churchman* to circulate the news among their friends. (It is of contemporary interest that new babies shared their mothers' rooms--although the method was
not as scientific as the modern "Rooming In" plan; it was then a simple, natural expediency."

In the classification of diseases medical patients were more numerous with Typhoid fever, Malaria, Tuberculosis and common diagnoses. (119, p. 12)

Records were minimal in content and generally limited to: (Taken from an early hospital ledger)

<table>
<thead>
<tr>
<th>Name</th>
<th>Nationality</th>
<th>Religion</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Admission</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnosis (often given as &quot;fever&quot;)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Temperature (when recorded---frequently limited to the admission temperature)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of Discharge (or death).</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This information was neatly recorded in fine, old-style penmanship in a large ledger, totalling a few lines for a patient's hospital stay.

Medical care was given by visiting physicians, who rotated in caring for the non-paying patients.

In 1884 Dr. A. C. Panton received the first appointment of a house staff doctor. (84, p. 181) He had received his medical training in Trinity Medical College and the University of Toronto.

Until his death in November 1883 of Typhoid fever (age 36 years) the hospital was administered by the Reverend George Boyd. He was succeeded by Sister Hannah and the Reverend J. D. Ferguson, who filled the position until 1884.
when Mrs. E. J. Wakeman was appointed, and of whom Miss Loveridge was later to write "one of the best women on earth."

The problem of nursing the hospital patients was very real. In an effort to solve it, Bishop Morris had made many attempts to procure religious Sisters. In 1881, he was successful in inducing Sisters Hannah and Mary to come to Portland. Sister Hannah, as has been stated, was presently to take charge of the hospital but there is no evidence to indicate that she had any vocation for the work other than her religious training. This was not true of Sister Mary, who was a graduate of St. Luke's hospital where:

The Rev. W. A. Muhlenberg, Rector of the Protestant Episcopal Church, New York, introduced the deaconess movement into the Episcopal Church of America by organizing its first Sisterhood and opening a dispensary in connection with the Church of the Holy Communion in 1852, which became St. Luke's hospital in 1858. (45, p. 458)

Her influence was soon felt in the hospital.

We think much of the improved condition of the hospital is due to the efficient administration of Sister Mary. She was duly trained and graduated from one of the New York hospitals, and has thoroughly devoted herself to the work. We owe it to the Women's Auxiliary of the Board of Missions that we enjoy her services here. (127, p. 47)

During the Sisters' regime a Training School was started. Although the school initiated by Miss Loveridge was to prove permanent and fruitful, the roots of its success may well lie in the failure of the earlier one. Very few details can be found about the school under the Sisters, but the Bishop reported that a training school was established under the
Sister in charge and that two Christian women were enrolled. (129, pp. 21-22) No explanation was learned from the records as to its reason for failure. Analysis of probable reasons for failure of the school suggests the following as plausible:

1. Inadequate preparation for a training program, and/or lack of sustained interest on the part of the Sisters. Their total length of stay with the hospital (1881-1884) was too brief to have been permanently productive.

2. The school candidates were more strongly motivated by their Christian faith than by nursing interest or aptitude.

It is quite probable that the later success of the nursing school was due to lessons learned during the first experiment. Certainly, the records show more evidence of preparation; suitable living arrangements were made for the students ($1500 was spent—a fairly sizable sum, for the day), (176, p. 5) and a well trained graduate nurse was employed to initiate the course...Emily Lemoine Loveridge.

Miss Loveridge was born in Hammondsport, New York on August 28, 1860, the daughter of an Episcopal clergyman. Although she liked to say in later years that she decided upon a nursing career in five minutes, the pattern of her life belies the implied impetuosity of her decision.

Following her graduation from the Norwich, New York High School,

When she decided to become a nurse she thought it would be best to have a few dollars in the bank before starting this hard work. So she taught school a few years, saved what she did not give the home folk and entered Bellevue in 1888. (148, p. 7)
The Bellevue Training School was one of the earliest in this country (1873) and was strongly influenced by the "Nightingale School" system wherein Miss Nightingale had stressed "two aspects of equal importance. First, the acquisition of knowledge which was properly tested by the passing of an examination; second, the development of character which could not be tested by the passing of an examination." (197, p. 328) The permanent imprint of these tenets is evident throughout the life of Miss Loveridge. Her experience as a school teacher was to be a useful complement to her nursing education in pioneering the Good Samaritan Training School. Actually, her preparation was not unlike that of the eminent Isabel Hampton (Robb), for she, too, had taught prior to nursing and was only twenty-six years old when she became Superintendent of the Illinois Training School in 1886. (77, p. 408) The pioneer nature of nursing education and the small number of graduate nurses placed enormous responsibilities on the shoulders of the early leaders.

The exceeding good fortune of Bishop Morris in securing Miss Loveridge was accentuated by several of her unique attributes. In addition to her teaching and nursing experience as the daughter of the Reverend Mr. Daniel Loveridge (Eugene, Oregon), her religious faith satisfied the requirements of an Episcopal church institution. All key appointments previously made had been to members of the Episcopal Church, and there can be little doubt that the
underlying idea of the institution as a church organization
was paramount.

Upon her arrival in Portland, Miss Loveridge wasted no
time in making and completing her preparations for the
Training School. The first students were admitted June 1, 1890.

Nursing and the school of nursing will be discussed
elsewhere, but extracts from her reminiscences of the hos-
pital when she first knew it are included in order to fully
appreciate the magnitude of her task.

Our first operating room, we called it "surgery"
in those days, had a double window at the end and
a single one at the side. The floor was painted
and later covered with linoleum. Mrs. Wakeman con-
ducted the first operation after my arrival, and my
Bellevue training of even that period received a
shock. She told me that in an operation that she
had recently witnessed in another hospital she was
impressed by the convenient way they handled the
sutures; the threaded needle of both silk and cat-
gut were stuck in the window shade.4 (87, p. 8)

Our needles which were threaded with silk were woven
into a piece of bandage and boiled with the rest of
the instruments.

Soon the Bellevue operating room technique of that
day was installed. Our towels were boiled, then
soaked in 1-1000 bichloride (of mercury) all night.
After an operation we had to wash the blood out of
them, otherwise the laundry that did the hospital
work would refuse to do our washing. Our sterile
water was boiled in the diet kitchen, at first over
a wood or kerosene stove, later over gas. The cold
sterile water was boiled by the night nurse in this

4 The practice was common throughout the country in the "pre-
aseptic" days, although Larsell states that "By the middle
1880's antiseptic or aseptic surgery appears to have become
universal in the state." (84, p. 155)
same diet kitchen. Each kettle had to boil hard for fifteen minutes, then was emptied into a large covered granite can previously scalded or steamed. When a labor case came in the night nurse had no time to cook supper, which was part of her duties. The hot water was carried in porcelain pitchers, each one covered with a bichloride towel. (87, p. 8)

Our first abdominal operation made a lasting impression on me. It was such hard work to get towels enough to run it, and we were short of many other necessary things, so it took us several days (author's italics) to get ready for it. After all the trouble it was of no use. The next day the patient died of internal hemorrhage—a ligature slipped. We were all heartbroken.

The field of operation was covered with a rubber sheet soaked the night before in a bichloride solution. Over this rubber sheet were placed our bichloride towels. Every surgeon irrigated, using a well boiled rubber irrigating bag. Mops were used to get the water off the floor, sometimes during the operation, always after it. As I was usually first or second assistant, they often accidentally irrigated me also, and usually after a morning spent in the operating room all my clothing, even my shoes, had to be changed. How we scrubbed and cleaned everything and rinsed them in bichloride. This scrubbing process included even the field of operation; nothing was spared. Unless the patient's skin was red, we felt it had not been properly prepared. We kept bichloride solution in gallon bottles; 1:1000 solution was stained blue; 1:3000 was stained red. All pans were boiled in a wash boiler kept for that purpose.

At first we used sea sponges for sponging, bleaching them with oxalic acid and permanganate of potash and then washing them through many waters, trying to get out every particle of sand, then soaking them in bichloride solution. Soon we made gauze sponges, bought unbleached gauze by the roll and bleached it with chloride of lime, rinsed it thoroughly, boiled it, shook it dry and folded it, thus making our sterile gauze. In bleaching, care was needed not to use too much chloride of lime, and having it dissolved, as in either case, the gauze would be rotted; if not enough lime was used our gauze would be yellow and stiff. How big and how important was a roll of gauze in those days. From the sterile gauze we made iodoform gauze which was used on most wounds with a plentiful sprinkling of powdered iodoform underneath the gauze. The
nurse who made the iodoform gauze was usually very unpopular with her neighbors on account of the odor.

During each operation one nurse was official brow-wiper—no face masks in those days. A few of the surgeons objected, preferring to let those beads of perspiration fall where they would, but their objection was overruled. One surgeon dropped his eyeglasses into an abdominal cavity. We irrigated more than usual and if I remember rightly the wound healed by "first intention"—not even "laudable pus" in it. Catgut was cut in yard lengths and wound on pieces of glass rods, put in glass (mason) jars covered with alcohol and boiled an hour in a water bath for four successive days apart. Preparing the catgut was my job, and rather nervous work. We had several explosions with no bad results. (author's Italic) While boiling it we corrected examination papers and charts, copied histories, etc. (87, p. 9)

In Miss Loveridge's recollections, the first use of rubber gloves was forgotten. However, they were introduced at Johns Hopkins in 1889—as a means of counter-acting the skin irritation of the hands resultant from the use of mercuric chloride solution—by Dr. William Halstead. Aseptic Surgical Technic was published in 1894 and it may be postulated that the use of gloves would have been introduced soon thereafter. (70, p. 246)

The magnitude and number of changes within the lifespan of Miss Loveridge may be readily assessed by the fact that in 1892, five appendectomies were performed, and twenty-eight cases of lacerated cervix were reported. (84, p. 521) Of the total number of 8,717 patients admitted in 1929 (the last full year of her tenure) 4,530 were classified as surgical.

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5 The exact dates of introducing such standard equipment as sterile gowns and rubber gloves is not known. Mrs. Mona Fraser remembers that the nurses donned clean uniforms at the "last minute" and the surgeons wore butchers' aprons.
In reverting to the topic of the nursing school and the source of its origin, isolation of the single causative factor appears to be the Bishop again, in his desire to ensure competent nursing care for the hospital patients.

A statement in The Oregon Churchman says, in effect, that the school was an answer to a need. There is no available evidence that this demand was expressed by those who might have been concerned: the public, the doctors, or members of the hospital staff. This is understandable. As there were few training schools in the country, the public in general would not have been likely to know much about trained nurses. Public remonstrations had been made regarding the nature of certain of the patients treated in the hospital (139, p. 3) which would logically rule them out as policy makers. In spite of an existing recommendation of Dr. S. D. Goss, Chairman of the committee of the American Medical Association to study nursing problems—that large and well organized hospitals should conduct nursing schools—(68, p. 157) doctors had been tardy in promoting them (even to the point of active resistance in England), (197, p. 233) and there is no reason to believe they were active in starting a training school at the Good Samaritan Hospital.

The conclusion is, as with the hospital itself, that Bishop Morris was inspired by his ambitions to conduct a successful Protestant operated hospital, and that the quality of nursing care must be at least the equivalency of that provided
by the Catholic Sisterhood. His attempt to gain his objective by Episcopal Nursing Sisters failed, although he was more successful with teaching Sisters at St. Helen's Hall. The non-religious nursing school program was opportune and needed by patients and by young women throughout the country and was a source of un concealed pride that "it will be the only institution of this kind on the coast north of San Francisco." (176, p. 5)

If, to the modern nurse, the embarkation upon a nursing education program appears somewhat naive in concept and preparation, comparison with Medical education (then free of standardization restrictions or requirements) will preclude any tendency toward adverse criticism.

A review, or summing up, of noteworthy changes during the first twenty-five years of the hospital's existence shows that:

1. The Orphanage was closed as an unnecessary appendage.

2. The steady climb in patient census proved that the city needed the hospital.

3. The incorporation of the hospital as a non-profit making institution confirmed its objectives.

4. The successful introduction of a nurses' training school ensured hospital patients of good care, the public a nucleus of graduate nurses, and young women of an acceptable and satisfying professional career.

Most assuredly, a great deal had been accomplished.
CHAPTER II

THE NEW CENTURY, THROUGH WORLD WAR I, 1900 - 1920

The laying of the cornerstone of the Lewis Memorial on May 24, 1900 was a colorful and dramatic introduction to the history of the hospital of the twentieth century, and augured well for its future prosperity. The building was made possible by a gift of $20,000 from Mrs. C. H. Lewis as a memorial to her husband. This was the first large donation of money to the hospital and was most welcome for the continued policy of the hospital to give generously of free care (ranging from 25-33% of its total care per annum) meant that there was little financial margin for necessary expansion and improvements.

Mr. Cicero H. Lewis had been a successful and prosperous merchant in Portland (he was said to have been the greatest merchant in the Northwest). (140, p. 4) A wholly respected and upright citizen and a staunch Episcopalian—all characteristics calculated to enhance the value and prestige of the Memorial.

Although the total cost of the entire new building (West Wing) was reported as $48,523.53, the single large gift was a precedent and the Bishop was determined that it be acknowledged in a fitting manner. He was quite possibly as anxious to create interest in further contributions to the
hospital as to show appreciation for what had been received.

That the ceremony was conducted in style may be deduced from the three full columns found in The Oregonian, in addition to the diagram of the proposed building plan. (It is not entirely an irrelevancy to recall that the day was one of another celebration—the 81st birthday of Queen Victoria. The hospital had enjoyed a $3500 Endowed Bed in honor of the Queen's Diamond Jubilee.)

The procession to the service was impressive. It was made up of Masons and Knights Templars in full regalia, boys from the Bishop Scott Academy in their grey uniforms, a large choir singing the processional, Bishop Morris and other members of the Episcopal clergy in their stately costumes. The Redmen took part, wearing their regalia, and members of the Board of Trustees, Ladies Aid, Eastern Star members and, of course, the nurses were in uniform. A large attending crowd included the Mayor and City Council. Most Worshipful John Milton Hodson, grand master of the Masonic Order of Oregon placed the cornerstone in position with the copper box containing the contents of the first cornerstone in addition to those commemorating the second ceremony.

Two principal classifications of articles predominate: the Church and benevolent organizations. The inclusion of Church manuals and publications emphasized the historical expansion of the Church, for the Connecticut magazines commemorate the Rev. Samuel Seabury, D.D., the first Bishop of
the United States, whose jurisdiction was Connecticut. (56, p. 125)

The embracing of the benevolent associations was an understandable method of soliciting future interest in the hospital’s charitable objectives.

Contents of Cornerstone - Lewis Memorial

The Calendar of Hartford, Connecticut, March 13, 1852. (This contains the name of Daniel Nash who was one of the first people confirmed by Bishop Seabury.)

Chronicles of the Church, New Haven, Connecticut, January 3, 1840 and April 15, 1839.

Church Journal, March 1, 1899.

Report of Good Samaritan Hospital, 1899.

Portrait of Bishop Morris.

Portrait of Rev. George Boyd.

Photographs of the present building.

Programme of the Second Annual Convention of the Order of Eastern Star.

Officers of Oregon Commanding No. 1 Knights Templar.

Masonic Directory for 1900.

Spirit of Missions, May 1900.

Oregon Churchman, May 1900.

Oregon Sunday School Tidings, May 1900.

The Pacific Churchman, 1899.

Catalogues: Bishop Scott Academy and St. Helen’s Hall, 1899.

Portait of C. H. Lewis, with sketch of his life taken from The Oregonian, May 23 and May 24, and Evening Telegram, May 23.

Proceedings of the Organization of the Oregon Historical Society of first annual meeting.


Program and invitations for present exercises.

Program for Nurses' graduation, May 23, 1900.

List of members, Ladies Aid Committee.

List of nurses now in the hospital.

Telegram of regret and greeting: Grand Lodge Independent Order of Odd Fellows.

Letter of regret: Count Webfoot, No. 4 Foresters of America.

Fifty-cent piece minted in 1900.

Second Oregon Volunteer Souvenir Button. (141, p. 8)

After placing the box in the stone, three vessels containing corn, wine and oil were each poured over it, with the blessing of permanency and prosperity.

In his talk, the Bishop openly exulted in the changes from the days of the stumped wilderness to the charming grounds with their lovely trees and pleasant walks of the hospital site, and the growth of the hospital—as also the city had matured and grown. (141, p. 8)

Later in the year (1900), another dramatic event occurred which might have been disastrous—fire. Readers who recall the horrors of such fires as the recent dreadful tragedy of St. Anthony's Hospital of Illinois, will find the
account of the Good Samaritan Hospital fire prosaic. A fire broke out in one ward at noontime. The patients were evacuated. The fire was completely extinguished by three o'clock. No one suffered injury or untoward effects.

The true drama lay in the methodical procedure, in the rigid preparation of the hospital staff for emergencies, the harmonious team play during the fire—-from the Chinese cooks who manned the hose to Miss Loveridge who carried out patients, and to the surgeon who composedly finished his operation before carrying the patient from the hospital.

According to The Oregonian:

Not a moment's confusion, not an instant's delay and not an indication of fright among the rescuing party at the head of which were the Superintendent, physicians and nurses of the hospital staff who directed the volunteers who rushed to their aid as coolly as if they were merely cleaning house. (143, p. 8)

Only such a perfect system and such admirable management of apparatus could have made headway against the flames for the building is frame and could hardly have lasted an hour had the fire got beyond that one Wing. (142, p. 8)

The warm, fine day and the readiness of help from the Medical College, and the Sisters from St. Vincent's Hospital, contributed to a swift and happy ending to what might have been a tragedy. The hospital staff had demonstrated its ability to care for the patients, and the people of Portland, cognizant of their good fortune, were quick to engage in fund-raising activities. (The Elks, for example, netted $1200 from a benefit carnival.)
Hospital Census

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1900</td>
<td>1,417</td>
</tr>
<tr>
<td>1905</td>
<td>3,246</td>
</tr>
<tr>
<td>1910</td>
<td>4,923</td>
</tr>
<tr>
<td>1915</td>
<td>5,861</td>
</tr>
</tbody>
</table>

(Figures taken from Reports of Convention Proceedings and/or Hospital Annual Reports.)

With the years came an urgent need for the new adjuncts of medical care—rooms and equipment for X-ray, laboratory, diet department, surgeries. The enlarged hospital staff placed a heavy strain on existing housing, particularly for the student nurses. Pride of accomplishment must have been the spur which ever drove Bishop Morris, Bishop Scadding, and later Bishop Sumner to raise money for new buildings. The Hospital Annual Reports, the Diocesan Convention Proceedings, the Oregon Churchman, all read pitifully alike in their pleas for financial aid. That a certain amount of success was met is apparent in the ensuing years. When the Lewis Memorial was completed in 1901, Mrs. Lewis contributed another $3,000 toward the cost of furnishings. (A former student recalled the Haviland china purchased for patient use.) She later gave $10,000, to which Miss Mary Couch also added for the John H. and Mary Couch Memorial Surgery. This was located on the fifth floor, on the corner of N. W. Marshall, now the unit designated 5th Center, which was completed
in 1905.

"The floors, wainscotting seven feet high of glass of special manufacture and the dazzling whiteness of the entire room suggests the extreme of surgical cleanliness." (115, p. 10)

Among other improvements was the first elevator in the West wing. Miss Loveridge wrote: "We were all inclined to operate it and were proud when we were able to make good landings." (87, p. 43)

The present Center building was started in 1907, as a Memorial to the late Bishop Morris, and had installed the long desired Chapel. The building cost some $115,000 and also included a Children's Ward as a memorial to Dr. Rodney Glisan, which was the only segregated children's department in the city.

In 1901, ground was broken for the much-needed Nurses' Home. The raising of money for the dormitory had been tedious. Mrs. Wakeman had years before started a fund with a sum of $140. The housing shortage caused not only overcrowded and unsatisfactory living conditions, but also limited student enrollment. The education program was hampered by lack of classrooms. Because hospital dormitories do not offer a popular appeal for philanthropy, when the new one was built its size was circumscribed by the amount of money on hand.

And so the building and remodeling continued. The
entrance to the hospital now faced Marshall, a heating plant was completed in 1914, room was found for an X-ray department in 1915 and a Pathology Department in 1917. The carpenters' shop (above which is now located the nurses' science and diet laboratories) was completed in 1916. Not until 1906 did the hospital maintain its own laundry; prior to that date, a commercial laundry did all the work. (Again, to borrow from Miss Loveridge, she found it restful to help out with the mangle, when the laundry was behind in schedule.)

Two basic needs were yet to be neglected for some time—a Maternity Department, and a fireproof building to replace the wooden East Wing structure. Despite the success of the hospital business, as determined by its ever-increasing patient occupation, its non-profit making status combined with its large percentage of free or partly free care made it difficult to accrue funds for building.

As the years passed, so also passed many of the early leaders and loyal supporters of the hospital. Perhaps a first major loss was that of M. L. B. Cox, who had served on the Board of Trustees for many years. Mr. J. E. Simpson described him as one of the best friends the hospital ever knew, and in the Board's resolution following his death:

We recognize that the new buildings of the Good Samaritan Hospital are the result of the energy and zeal of Mr. Cox. It is owing to his activity that they stand where they do today, great and permanent additions to the strength of the Church of Oregon, and great and permanent means of usefulness. (8, p. 14)
Another loss was sustained by the resignation of Mrs. Wakeman due to ill health (and who died in 1907), after twenty years' service as superintendent of the hospital. Gaston described Mrs. Wakeman as the hospital's "faithful and beloved Superintendent." (62, p. 448)

Mrs. Wakeman had been induced to accept the position by Bishop Morris, after her account to him of her hospital experience as a patient in New York. Notwithstanding her patent lack of especial preparation she had not only a natural aptitude in this field, but a particularly pleasing and effective personality. The quality of her success may be gauged by the sound financial status of the hospital; her personal effectiveness by the frequency of receipts presumably ascribed to her in the hospital Annual Reports. For example, the 1897 report: $2,967.36 was received aside from income from paying patients, and in 1898, $4,264.24. (6, p. 1) There can be no doubt of the deep affection and respect for her, held by Miss Loveridge and patients and staff. Miss Lillian Boot, a graduate of the first nursing class, many years later (1950) remembered her as one who had not only encouraged her to enter training, but had been a fine influence and a fine friend.

The position of Superintendent was subsequently filled by Miss Emily Loveridge.
Miss Emily L. Loveridge  
Supt. of Training School for Nurses & Acting  
Supt. Good Samaritan Hospital  

Dear Madam,  

At a meeting of the Board of Hospital Trustees of the Diocese of Oregon, held yesterday afternoon, the resignation of Mrs. Wakeman, as Superintendent of the Good Samaritan Hospital, was accepted to take effect January 1/05 and you were unanimously chosen to be promoted to the Superintendency of the Hospital for one year from January 1, 1905. Miss May Welsh was chosen to be promoted, for the same period to the position of Superintendent of the Training School for Nurses. Please indicate to me, in writing, your acceptance or otherwise of the position of Superintendent.

Yours very sincerely,  

S. E. Josephi  
Secretary, pro tem

(A copy of the letter of appointment, which fortunately for the hospital, was accepted.)

Because of the length of her stay in the hospital and the magnitude of her influence and accomplishment, considerable biographical detail is presented concerning Emily Lemoine Loveridge (1860-1941).

Photographs, so often misleading, seem to reveal with some degree of accuracy the changes of a maturing personality. Pictures of the young superintendent show her as one who was idealistic—her idealism blended with sternness and lack of compromise. During the passing years she emerges with softer, yet capable, maternal qualities—ultimately grandmotherly in nature. These appear to correlate with anecdotes and memories of those who knew her.

Dr. DeVighne, who was associated with the hospital as a medical interne, has given an admirable portrait of Miss
Loveridge and the hospital under her administration—which affords insight to the secure place she held in the esteem of hospital personnel, patients and the public.

The large motherly woman, perfectly poised, impeccably clad in white, smiled when I entered her office, then settled back in her chair to look me over. (52, p. 186)

However greatly hospitals may differ in size, furnishings, rates and regulations, personnel and clientele, the difference is in degree rather than in kind. The drama of life in continuous performance on their wards and in their theatres is not played in the same key and tempo, but the directors and managers, stars and understudies and trained assistants all take their cues from the same script, run through their lines to the same accompaniment of misfortune and suffering.

In the Good Samaritan Hospital the tempo was an unhurried orderliness and its pitch to a restful murmur. Miss Emily, the Superintendent, held to the simple theory that hospitals should be operated with due regard for the comfort and welfare of patients. Therefore she ruled out everything incompatible with that objective. She tolerated no disturbing noises, no unnecessary delay in doing what was to be done in the simplest manner and with the least commotion. (52, p. 188)

The practice of medicine as I had imagined it agreed rather closely with what I found in this smaller semi-private institution. Miss Emily saw to it that when her nurses were on duty they nursed, that her internes carried out the visiting staff's orders promptly and expertly. We still were students, she reminded us. In medical school we had studied human bodies and their diseases. We must now study human lives and learn how to lighten some of their burdens. (52, p. 189)

Evidence that the welfare of the patients was of primary concern to Miss Loveridge is contained in her inflexible rule of a daily visit to each patient--from the era of the small hospital, to the later days of the 300-bed hospital. Patients
remembered long after their hospital stay, that "Miss Loveridge visited me when I was in the hospital."

This practice was the result of conviction and not blind habit. Miss Loveridge reported, after her return from a hospital convention, that other administrators thought her old-fashioned. It was with some evident relief that she told of another administrator who also believed in the importance of this type of superintendent-patient relationship. So she continued her own way unruffled.

Every effort was directed toward maintaining an atmosphere beneficial to all patients--so that when President Taft visited Judge George H. Williams (former member of President Grant's cabinet) a Good Samaritan Hospital graduate nurse recalled with some feeling that "he came during visiting hour, too."

In the course of an address "Our Debts," given by Miss Loveridge to the Washington State Nurses' Association in 1925, she said,

The first bill that presents itself is, of course, what we owe the patient--to whom we must render intelligent, willing, thoughtful care, graciously given, a scientific service, but science alone cannot fill the bill. We must 'have a heart' whether we give this care by personal touch, or by long distance to those under our instruction. If we fail to impart the human touch we lose our greatest power for good. The nurse who attracts in the right way is the one who is wanted, and not the nurse who metaphorically whips the patient into line. We owe the best there is in us to anyone who may come under our care, irrespective of race, creed, social position, wealth or its absence, also without regard to place.
Many are the evidences that her spoken words were no finer than her actions. Of the numbers of known kindly acts, a few will suffice in picturing the nurse—and the woman.

In 1919, when a blood transfusion was a rare medical procedure, Miss Loveridge donated blood to a patient in the hospital. She minimized the gift, implying that the blood scarcity was merely a matter of blood type.

Others, however, told a different story. The hospital, it was learned, had advertised for days for someone to give Ashby, who is suffering from endocarditis, a pint of fresh blood. Twice the surgery had been prepared to receive men who had agreed to sell their blood, but at the last moment these weakened, and the operation had to be postponed.

Because blood donations have become commonplace, the graciousness of the gesture must not be underestimated; others were afraid; Miss Loveridge gave of herself.

Dr. DeVighne described her kindliness in his account of her help in getting him a post as a doctor in Alaska. She not only furnished him with necessary credentials, made him a personal loan for his travel fare, but equipped him with instruments which had been discarded for hospital work.

In those days (sic) temperamental surgeons eased the strain on their nerves by hurling to the operating floor, or at a nurse, any instrument not in perfect edge and order. These were dutifully salvaged, stored in the basement and given to impoverished internes upon leaving the hospital. Miss Emily led the way down to this treasure-room, where I selected enough surgical instruments to stock a small hospital. We packed them in a large box along
with an old obstetrical bag also stuffed until its crumbling sides must be bound with wire to keep them from bursting, then filled all corners and empty spaces with surgical dressings and emergency supplies. (52, p. 194)

Long afterwards when Miss Loveridge had retired, she and her niece, Mrs. Barnekoff, visited the doctor in Alaska where he had had a happy and successful career.

The foregoing is related to Miss Loveridge's professional life, but her personal life was no less admirable. She reared three children, two of whom were her deceased sister's children, and one whom she adopted. This assumption of responsibility was quite in character, and not an entirely unfamiliar one in her family. Emily's mother was the adopted daughter of Bishop Uphold of Indiana, and it is quite likely that Emily, who lost her mother when she was only four years old, (39, p. 417) would have been doubly inoculated with a feeling of kinship for motherless children.

Ernestine Heslop, who graduated from the University of California, died during the influenza epidemic. Paul Heslop, a civil engineer, graduated from Cornell University. Mrs. Eleanor Barnekoff, who is the adopted niece, was a source of infinite comfort and joy to Miss Loveridge throughout her life, particularly after the death of her greatly beloved niece.

The benefit of association with a leader of such caliber, upon the impressionable minds of the student nurses, was incalculable. On the wall of the present entrance to the hos-
pital (M. W. Marshall) is a tablet with an inscription taken from Joyce Kilmer's "Love's Lantern."

To Emily Lemoine Loveridge, our living inspiration, guide and counselor—we the Alumnae Association of the Good Samaritan Hospital, dedicate this token of our love and devotion: "God set upon her lips a song, and placed a lantern in her hand."

Miss Loveridge was a product of the rigid early training schools and of the prevailing ideas of sternness of professional decorum. Evidence, therefore, of levity or parity in dealing with employees or student nurses is lacking in contrast to her unfailing kindliness, fairness and understanding. Long years after graduation, a former student, recalled an embarrassing incident when she had overturned a cabinet drawer scattering the contents about the floor, the accident coinciding with a visit of Miss Loveridge. She made no comment then, but in a later encounter said to the student sympathetically, "I know just how you must have felt."

Perhaps the foregoing has provided some appreciation of the character of the woman who played so key a role in shaping the course of the hospital.

On April 7, 1906, the Rt. Rev. Benjamin Wistar Morris died at the age of 86 years, having served as Bishop of Oregon since 1869. The obituary in The Sunday Oregonian says of him: "His tirelessness of purpose, combined with the wisdom of his administration, marked him as no ordinary man, and gave him great influence in every part of the Oregon Country." (160, p. 2)
A later editorial described him as "loved and revered in Oregon for more than a third of a century" and that he was "efficient rather than brilliant"...that "he was here to do his duty as he saw it—as the church commanded—and he did it." (143, p. 2)

The following extract is taken from Gaston's history.

The unfortunate death of Bishop Scott left the Episcopalian flock in Oregon without a shepherd for two years before Bishop Morris was chosen and sent out. The church in the East carefully scanned the whole field before selecting their man; and then called him from one of the wealthiest and most desirable places in the whole church—the parish of Germantown, a suburb of Philadelphia. All favoring circumstances seemed to combine to mark the selection as the favorite of destiny. Talent, genius, eloquence, high birth, a great name, a pure and unselfish heart, he was to be one of the greatest, if not the greatest Bishop of his church.

Full of charity and good work, not only to his church, and to his own people, but to all men, he entered upon a great and trying field with confidence; and never did one achieve a larger or more signal success. (62, p. 438)

Besides the general atmosphere which prevailed under Bishop Morris' influence, evidence of his perspicacity and acumen are in the hospital report of the fiscal year ending in 1907. The total income was $168,419.14, of which but $79,853.48 was received as payment for hospital care. The acorn which the Bishop had planted had, indeed, grown into a great oak.

The next Bishop of Oregon was Charles Scadding, consecrated in September, 1906, and by virtue of his position,
Chairman of the Hospital Board of Trustees.

Because of the limitation of Bishop Morris' activities during his later years, there was much to be done among the various parishes of the new Bishop. Yet he had time to give practical help and oversight to the hospital. During the course of an Eastern trip he visited some outstanding hospitals among which were the Toronto General Hospital, Massachusetts General Hospital, and St. Luke's in Chicago, returning with specific criticisms of the Good Samaritan Hospital. Among these were:

1. The superintendent should not have to write "Thank you notes" for every gift received, but that auxiliary members could do this.

2. The Nurses' Home was built for fifty, but there were ninety students in the school.

3. The laundry was planned for a one-hundred bed hospital but the current capacity was 230 beds.

4. The Diet Laboratory in a Cincinnati Hospital suggested means of improving that of the Good Samaritan Hospital. (180, pp. 24-27)

Conservative administration, without false economy in the Training School or in the Hospital characterized the philosophy of Bishop Scadding. (179, pp. 7-10) Gradually, with the recognition that willing hands and kind hearts were not enough, the novel idea of applying business administration techniques to the hospital situation was evolved—hastened by the growth of the hospital capacity and expenses.

<table>
<thead>
<tr>
<th>Year</th>
<th>Census</th>
<th>Expenditures</th>
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<tbody>
<tr>
<td>April 1, 1913 to</td>
<td>6,167</td>
<td>$277,387.84 (14, p. 19)</td>
</tr>
<tr>
<td>March 31, 1914</td>
<td></td>
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</table>
An efficiency expert was employed to study and advise on methods of management, which seems to have stirred up resentment.

During the year the object of the Board has been that of greater efficiency. To that end experts have been employed with the view of bringing the administration of the Hospital up to the highest possible standard. If large, so-called up-to-date business houses feel the necessity of such action, your Trustees cannot be criticized for following a similar course. It was with great satisfaction that the Trustees learned that sterling honesty has been found everywhere, and with changes in certain details your Trustees believe that the methods now used in the Hospital are modern and will give the efficiency the Board desires. (14, p. 19)

The connection of Bishop Scadding with the hospital was short. He died of pneumonia on May 27, 1914, having been in Oregon seven and a half years altogether. He was considered a person of zeal and activity. A scholar and a devout Christian, the church fared well under his leadership. (144, p. 9)

Walter T. Sumner was consecrated Bishop of Oregon on January 6, 1915. Of him was said, "Dean Sumner, Bishop elect, is one of the foremost figures among the clergy of the Church and one of the foremost citizens and social workers of Chicago." (181, pp. 4, 5)

In the two major emergencies associated with this period, World War I and the influenza epidemic, the hospital participated creditably. This was due to its training programs, graduate nurses and physicians who were prepared for the national emergency of war.
The depletion of the medical staff caused by the exigencies of military need, necessitated the use of medical students to act as substitutes in the hospital. It was during that time that Dr. F. J. Clancy was associated with the hospital.

As senior medical students, we had substituted as internes during the last year. The regular internes had long ago departed for military posts, stripping the hospitals of needed help and cutting short training that, for many a doctor, would never be regained. (42, pp. 38, 45)

<table>
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<tr>
<th>World War I</th>
<th>Base Hospital 46</th>
<th>Military Service</th>
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</thead>
<tbody>
<tr>
<td>Nurses</td>
<td>26</td>
<td>62 = 88⁶</td>
</tr>
<tr>
<td>Doctors</td>
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<td>4 = 15</td>
</tr>
</tbody>
</table>

Members of Base Hospital 46 saw service in France; others were engaged in this country as well as Europe. Three of the nurses were with troops in Siberia.

The role of the hospital during the influenza epidemic was far from passive. From October 1, 1918 to September, 1920, a total of 48,146 cases of influenza were reported in Oregon with 3,675 deaths (106, p. 3) and from October 15, 1918 to January 27, 1919, 867 cases were treated at the Good Samaritan Hospital. In addition to nursing hospital patients, nurses were sent from the staff to help care for patients in

⁶Contemporary reports stated that 103 nurses served in the Armed forces, which may be the fact. The figure arrived at is achieved by counting names of nurses officially reported in service.
the new Municipal Auditorium, where some 1200 patients were treated in the Emergency Hospital set up there. (182, p. 24)

Miss Loveridge reported that recently remodeled small wards, intended for recovery rooms for surgical patients, were used for the influenza patients only. The Bishop stated that:

In the battle for life which has followed the entrance of the flu, our nurses in training have proven as good soldiers as the boys in the trenches—not a slacker among them. One hundred and fifteen (author's italics) have had the disease, yet I have never heard a voice among them that complained of the danger of contagion or desire to be released from their extremely arduous duties caused by the shortage of nurses and the great amount of extra work, because almost every case needed a special nurse. (15, p. 22)

The total student enrollment then was reported as 130. Two of the students died—Miss Harriett von Eaton and Miss Minnie Nissen. Unquestionably the prolonged hours of nursing duty over a lengthy period of time, with lack of sufficient rest and a minimum of communicable disease technic, if any, observed—all placed a heavy drain on the physical stamina and resistance of the young women. The burden placed upon them was further weighted by the work at the Auditorium. Bishop Sumner reported that

from the Superintendent down, and every nurse, graduate and undergraduate, heroically worked day and night. Not only was this done in the hospital itself, but as well in the organization, manning and maintenance, largely of the emergency hospital at the Municipal Auditorium. (15, p. 22)

The Bishop reported that 4 nurses died of influenza, as did also The Oregon Churchman of September, 1919. This
is not substantiated by Miss Loveridge's account.

It is a curious anomaly that the Good Samaritan Hospital (and St. Vincent's) should have been objects of adverse criticism, as a result of the epidemic. Nonetheless it was so. In the course of some rather vitriolic criticism of Commissioner Mann (Health Department) by the City and County Medical Society, because of failure "to enact a public masking law," Dr. Coffey stated "that as a result of systematic masking not a solitary case of influenza had developed in the Portland Surgical Hospital, whereas the other hospitals were full of it." (145, p. 3) Dr. A. J. Mackenzie, who wrote a public rebuttal to this invidious comparison, commended Dr. Coffey for his success, but noted that in contrast to the Portland Surgical Hospital policy of restricting its admissions to surgical cases, the other hospitals were full of the "flue" because they chose voluntarily to admit them in order to do their duty to the city and prevent the wanton loss of life.... in the course of their ministration to public needs because of the epidemic, at least 20 of the Sisters and 166 nurses of St. Vincent's Hospital, not less than 50 nurses of Good Samaritan Hospital and the usual quota of physicians and students had been ill with the disease and that of these quite a few died. (146, p. 10)

The following table demonstrates, unequivocally, the benefit rendered the community by the Diocese in maintaining a hospital. The tremendous strain placed on its hospitals in time of great need was apparent to the public and offered a bulwark in its subsequent campaign for building funds.
### 1918 City of Portland Hospital Statistics (general hospitals)

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Number beds</th>
<th>Number Patients Treated</th>
<th>Number Deaths</th>
<th>Number Operations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emmanuel</td>
<td>90</td>
<td>2,428</td>
<td>71</td>
<td>1,484</td>
</tr>
<tr>
<td>Good Samaritan</td>
<td>300</td>
<td>9,163</td>
<td>471</td>
<td>3,500</td>
</tr>
<tr>
<td>Multnomah County</td>
<td>100</td>
<td>745</td>
<td>93</td>
<td>350</td>
</tr>
<tr>
<td>Portland Sanitarium</td>
<td>75</td>
<td>1,468</td>
<td></td>
<td>617</td>
</tr>
<tr>
<td>Selwood General</td>
<td>50</td>
<td>832</td>
<td>48</td>
<td>483</td>
</tr>
<tr>
<td>St. Vincent's</td>
<td>400</td>
<td>8,238</td>
<td>459</td>
<td>4,460</td>
</tr>
<tr>
<td><strong>Total Beds</strong></td>
<td><strong>1,015</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Hospital Statistics

(Good Samaritan Hospital)

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Number Admissions</th>
<th>Bed Capacity (approx.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1875-1876</td>
<td>51</td>
<td>30</td>
</tr>
<tr>
<td>1920</td>
<td>8,345</td>
<td>300</td>
</tr>
</tbody>
</table>

Total number Medical Internes trained: 67
Total number Nurses trained: 510
Good Samaritan Hospital

Admissions and disease classifications of patients (selected years)

<table>
<thead>
<tr>
<th>Year</th>
<th>Surgical</th>
<th>Medical</th>
<th>Obstetrical</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1915</td>
<td>4,122</td>
<td>1,551</td>
<td>188</td>
<td>5,861</td>
</tr>
<tr>
<td>1920</td>
<td>6,216</td>
<td>2,151</td>
<td>252</td>
<td>8,589</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Number Hospital Days</th>
<th>Percent Hospital Occupancy (approx.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1915</td>
<td>67,929</td>
<td>63%</td>
</tr>
<tr>
<td>1920</td>
<td>94,810</td>
<td>90%</td>
</tr>
</tbody>
</table>

Two observations are permissible from these tables:

1. While the hospital beds had increased 10 times in number, the number of patients had multiplied 163% from the first year of operation to that of the most recent.

2. The increase of hospital occupancy in a 5-year period proved the need of the hospital for larger quarters to satisfy a trend in the use of hospitals on the national as well as the local level. As 80% occupancy is commonly considered "full," the limited bed space was a danger threat to the community.
CHAPTER III

TO THE MID-CENTURY 1920 - 1950

The period under consideration begins, as it ends, with major building programs under way--providing a convenient historical cycle for study. The need for hospital expansion was dramatized in both instances by the exigencies of the preceding wars. During World War I the influenza epidemic was a unique feature straining hospital facilities to the utmost; World War II gave rise to phenomenal industrial production with an associated rapid increase in population--which in turn placed great demands for hospital care.

In general, to reiterate, Portland's hospital growth has been a cross-section of the national picture. The remarkable increase in the number of hospitals throughout the country between the years 1910 and 1930 has been explained by "prosperity of the times, the rapid advance of medical science, the trend toward urbanization of the population, and the increase in public confidence in hospital service." (45, p. 63)

Statistically, the national total of hospital beds in 1947 was forty-nine times those in 1873 with thirty-six times as many hospitals. (45, p. 507)
New buildings, as a phase of the historical process, are overt manifestations of inward, fundamental changes. In focusing attention on the subject of study, certain specific implications may be found. Perspective concerning the growth in population and need of a larger hospital may be gained from the following table:

<table>
<thead>
<tr>
<th>Mulnomah County</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1910</td>
<td>1920</td>
<td>1930</td>
<td>1940</td>
<td>1950</td>
</tr>
<tr>
<td></td>
<td>226,261</td>
<td>275,898</td>
<td>338,241</td>
<td>335,099</td>
<td>471,537</td>
</tr>
</tbody>
</table>

During the 1920-1950 period there were many changes among the personnel, changes in methods of patient care and new developments in administrative practice—all concomitants of a busy, growing institution in a time of great historical significance. Possibly, however, the keynote of the era for the Good Samaritan Hospital lies in the fact that it was transformed from a purely church organization to one of community responsibility and concern. Proof of this is evident in the hospital financial resources, in the rise of medical and medically-allied professional groups, the enactment of state and city legislation affecting the hospital, and finally the composition of the staff and patients.

Consideration, first, of the important building projects of the 1920s (Wilcox Memorial Hospital and East Wing) points up the use of two distinct methods of financing them. The one was the fulfillment of aspirations of Bishop Morris;
the other was a unique characteristic of the twentieth century democracy. One comprised large, individual gifts; the other multiple, smaller gifts.

The gift of $100,000 from the Wilcox family in memory of Theodore B. Wilcox, with an additional donation of $25,000 for the equipment and furnishings of an obstetrical unit (19, p. 15) made possible the specialized obstetrical department, separated from the rest of the hospital in accordance with modern practice. It was officially opened on January 23, 1922. Eighteen years later it was found necessary to enlarge the hospital (1940) and a $175,000 re-modelling job was started which

when completed, this hospital will be the only maternity department found in its own individual building in the Pacific Northwest. It is simple in plan, but it is a simplicity based upon thought and experience in utilizing modern scientific development. (29, p. 20)

An explanation for the need of re-modelling within a comparatively short space of time lies in the domain of obstetrics. Its rise as a medical specialty, a hallmark of the twentieth century, has resulted in the prevailing use of the hospital for confinement rather than a home lying-in. This transition has affected all income groups. Because the original Wilcox Building had no low cost facilities, an attempt to satisfy the demand for them had been made by revamping one of the hospital wards (East 1). This was unsatisfactory, not only because it violated the principle of
segregating obstetrical patients from others, as a safety measure, but because of the resulting inefficiency in running two obstetrical units. This explains why less expensive rooms, as well as more delivery rooms were necessary. That this situation was not unique is shown by the new hospital built at about the same time on the other side of the continent. Baker Memorial Hospital, Boston, was erected for the middle income group. (70, pp. 409-412)

The history of this department has shown two distinct characteristics. First, the hospital was built by money which was not church in origin, and secondly, the evolution of a medical specialty which was affecting all social strata.

The East Wing also points up a dual nature. The growth of scientific surgery created a demand for hospital beds and surgeries (1914 - 4,122 surgical patients; 1920 - 6,216 surgical patients) and the condemnation of the old wooden East Wing by the Fire Department made it mandatory that a new and safe building be put up.

Money was raised in two ways: by an individual large donation, and by public campaigning. The former was the generous gift of Mrs. Joseph Clark, who gave $50,000 for the Joseph Kithcart Clark Surgeries, and who later set up a trust fund of $10,000 for instruments and equipment for the eight surgeries located on the fifth floor of the present East Wing. (114, pp. 512-516) Public subscription was used as the technic of obtaining money for building the Wing itself, and be-
cause, in essence, the same method was used later (1950) the following account, apparently an address to hospital administrators, is presented:

"How Shall We Finance the Building and Maintenance of our Financial Campaign - Their Organization and Operation"

We put on a drive to build our East Wing. This was managed through an agent on a percentage basis, which percent was paid out of other money than the subscription funds, which was given us for that purpose. This agent did not make personal appeals for gifts. He perfected the organization by making himself, with a secretary, the central figure which functioned by the recommendations of the personnel. There was a formation of a central committee consisting of men prominent in the community.

Each committee man solicited pledges from friends and others interested in the hospital, or from anyone with whom they had influence. Other friends of the hospital also solicited. We raised about $225,000, $12,000 of which was not paid—men who had promised it and failed.

It is evident that realization of the true status of the hospital as a community enterprise was gradual, for those of Episcopal Church affiliation and for people in general, and that the task of maintaining it was too herculean for a single group.

Although the Episcopal Church has been responsible for the entire development of Good Samaritan Hospital up to the present time, the services of the institution are now so vitally important to Portland that funds...will be raised by popular subscription. (184, pp. 8-9)

In the December issue of the same paper, a statement was made that this campaign was the first time in the forty-five years of the hospital history that the people of Portland had been
Evidence that there was public cognizance of community responsibility is found in contemporary headlines which show that there was general interest and concern about the welfare of the hospital.

"More Hospital Facilities," Morning Oregonian January 27, 1920

"Good Samaritan Hospital," Portland Telegram January 22, 1920


Existing ambiguities of statement show the need of investigating the exact role enacted by the church in underwriting the expenses of the hospital. The magnificence of the Church in its undertaking and maintaining the Good Samaritan Hospital through its individual membership will not be undermined, but the contributions of the many, many individuals who have helped support it will be acknowledged by some brief scrutiny of its financial backing.

The original hospital was possible because of contributions of socially conscious community leaders. Among the original list of donors:

General Eaton
Colonel McCrake
Samuel Sherlock
S. Pennoyer
Dr. R. B. Wilson
G. S. Brooks
Lloyd Brooks
Mrs. Couch
Judge M. P. Deady

W. Wadham
S. G. Skidmore
Mr. and Mrs. C. H. Lewis
George Goode
Elijah Corbett
H. W. Corbett
James Laidlow
G. E. Wethington
Hodge Calef and Company
Mrs. Hewett  James Steel
William Sherlock  D. P. Thompson
Mrs. Corbett  Henry Failing
Weeks and Morgan  and
Ladd and Tilton  others
Dr. Glisan

Also the churches of:

Trinity and St. Stephens of Portland
St. Peter's of Albany
St. Paul's of Oregon City
St. Mary's of Eugene
St. David's of East Portland, and

Certain of these represented the church; they also represented the community.

The Hospital Report of a sample year, 1922, includes the following information:

Total Number of Patients admitted and treated: 7,326
Total Number of Patients declared Episcopalians (i.e., 1:30#) 256
Income from paying patients $300,727.41
Income, total hospital 651,029.72
Assets (endowed beds, special funds, cumulative etc.) 192,123.54
Total disbursements 644,539.56
(19, pp. 5-14, 18)

Population of Multnomah County, 1920 275,898
Population of Oregon 1920 783,389

Of the perpetually endowed beds, only one can be classified as a purely church project: that of Trinity Church.

Others may be church associated, in entirety or through its membership, as for example, the Queen Victoria Diamond Jubilee
bed (Church of England) but beds endowed by the Masons, or by "Strangers" are not likely to be backed by members of the Protestant-Episcopal Church predominantly.

A "hidden" income source, in the past, was from private room patients where hospital rates were scaled to help offset the financial loss from ward patients—a practice which has generally been discarded in favor of the more equitable rate adjustment calculated with relation to actual cost of care. Bearing in mind the 1:30 ratio of Episcopalians to non-Episcopal patients, the income derived therein was in proportion at best.

Further elucidation calls to mind the long established custom of the Annual Thanksgiving Diocesan Offering for the benefit of the Good Samaritan Hospital. These were balanced on the other hand by the practice of annual solicitation of money or gifts from the business houses of the city—which was continued up to and including 1938, according to the annual hospital reports. The facts seem to be clear: hospital income, whether from patients or other sources, came from members of the community who may or may not have been members of the church.

In summary, it is apparent that the building of the East Wing was a landmark in the developmental progress of the hospital as a community hospital—not only because of the multiple gift technic which made the building possible, but also because it was serving an ever larger proportion of the
public. It is also significant that the city safety codes were developed to demand that safer buildings for the hospital were essential.

Because the hospital reports for many years contained pleas for a graduate nurses' home, it may be worthwhile to investigate the extent of the need for the graduate nurse dormitory which was completed prior to World War II, and about the time of the remodelling of the student residence.

The completion of the long desired dormitory was somewhat of a paradox. For many years it was customary, in hospital planning, to provide meals and lodging to members of the hospital staff as a perquisite to modest salaries. The origin of this practice was not primarily penurious, but rather lay in the guardianship role of the hospital toward its employees. For the nurses, the precedent had been established by the Nightingale School influence and the influence of the nursing Sister and her religious vocation, too, was undoubtedly a factor. From the practical point of view there can be no question of the mutual convenience for the hospital and its employees in the custom of living on the premises in the light of the prolonged working hours and interrupted work shifts.

Certain changes took place during the course of time. Higher nurses' salaries, the freedom and independence of women and the larger number of married nurses on the hospital staff were among the contributory factors which made the graduate
Nurses' Home (begun in 1936 with a sizable proportion of its expenses paid through the Winslow Ayer estate) an anachronism. Hospital authorities seem to have been oblivious to changing trends when they built. Nonetheless the additional housing space was to be highly prized in the days of the World War II period and an overcrowded city—not only for women employees but for the larger number of student nurses enrolled in the school.

In turning from the subject of buildings and focusing attention on some of the key persons of the hospital hierarchy who contributed vastly to the success of the hospital, Dr. S. E. Joseph is identified. Dr. Joseph was not only treasurer of the Hospital Board from 1890 to 1930, the year of his retirement, but was one who exercised great influence on medical practice. This he accomplished not only through his ability as a practicing physician but through his exertions in initiating and participating in the University of Oregon Medical School program, as will later be shown.

Some estimate of his achievements as the hospital treasurer is contained in the following quotation. "In all these years not one dollar of the endowment funds of the hospital has been lost. Very few members of this convention realize the enormous amount of detail work that has been done by him in connection with the office of treasurer." (23, pp. 18-19)

Mr. Dean Vincent was appointed to the position of treasurer, following Dr. Joseph's retirement, and filled the
position for many years, including those of the depression.

Because of her inherent qualities of greatness, as well as because of her long tenure as Superintendent of the hospital, further biographical detail about Miss Emily Loveridge is presented that her influence may be correctly gauged.

Characteristics necessary for one in any form of managerial work—such as keenness of intellect, an enquiring type of mind, a sense of proportion, native ability in business detail, financial acumen, poise and self-assurance—and above all, the ability to meet and deal with "all sorts and conditions of men," were essential in the administrator of a rapidly growing hospital business. For, humanitarian considerations aside, the status of a hospital as a business enterprise can scarcely be questioned.

As Superintendent of the hospital for a quarter of a century, Miss Loveridge stood at the apex of its development, and progress would have been seriously hampered had she been deficient. Such specific accomplishments as Accreditation of Good Samaritan Hospital by the American College of Surgeons (1921), the general state of hospital solvency, the remarkable good will of the public—all bespeak her success.

Successful administration of the finances of the hospital was no mean accomplishment—particularly as the hospital policy continued to give twenty-five to thirty percent of its care free. 7 Miss Loveridge was aware of the problems

7 It is important to recognize that the hospital in its own right has no charity to give; the hospital is the distributing agent for others.
entailed, and the success of her technics may be gauged by a description of her by Dr. Charles Manlove as "the greatest humanitarian Portland has known." Selected illustrations show why.

During depression periods Miss Loveridge accepted payment "in kind" from those who found themselves in the medically indigent category. If appropriate work needed to be done about the hospital, labor was accepted as part payment. (She also permitted chopping of wood, painting, etc. as payment for meals during times of hunger and unemployment.)

In an address given by Miss Loveridge (circa 1925) she shows herself entirely realistic in hospital financial matters.

We live in an age when everything, even our babies, are paid for on the installment plan. We do give credit, allowing patients to pay a small amount a month, sometimes even as small as $1 and running up to a good sized amount, of $25 or more. All this means extra bookkeeping, I admit, but I believe it pays. Many patients cannot afford to pay even a small bill at once. If you force them they cheat you out of all of it, and you also get their ill will. If you give them time you stand a better chance of getting it.

In the many reports of Miss Loveridge and her activities, the qualities of basic goodness and love of people are paramount. What today is pompously designated "Public Relations" was for her the simple Golden Rule—and all under her tutelage were well indoctrinated with this. The accompanying verse which may be sentimental in tone and of questionable literary merit, nonetheless gives expression to the depth of feeling
When Jesus told that ancient tale
That blazed the Good Samaritan trail,
It was a man of gracious heart
Who played the neighbor's kindly part.
For forty years, with gentle grace,
As faithful in her time and place
Miss Loveridge, sister to that man,
Has followed in the Savior's plan.

How beautiful her girlhood dream
To give her life to mercy's scheme!
With what persistent sacrifice
She's earned the Good Samaritan's prize!
A neighbor she, to all in need--
Of every age, or class, or creed;
Her heart incarnate tenderness
That, through her hand, gives sweet caress.

A fight 'gainst ills her life has waged--
What grief and pain she has assuaged!
She's lived 'mid sickness, grief and fear,
And been a source of constant cheer;
She's been a fount of comfort sweet
That's given souls their food to eat,
A Good Samaritan serene
On whom the weak, for strength could lean.

Rare lives, like hers, should make us proud
That we belong to such a crowd.
Our human nature shines anew
In her brave soul, so strong and true;
Her mercy, like angelic skies,
Shows love of God in woman's guise,
The breath of heaven's her native air;
Her love o'erflows in kindly care.

A rather delightful sample of her understanding of people
and ability to hit a nail squarely on the head is contained
in the notes of an address presented at a nurses' graduation
(circa 1927).

You have finished a three year course in the Pacific
Christian Hospital School of Nursing. You have

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8 This presumably was established in 1924 and would have held
its first graduation services in 1927 or 1928. The hospital
later merged with another in Eugene and is now the Sacred
Heart Hospital.
worked hard, I am sure--and have acquired knowledge and skill. You have been taught anatomy, physiology and all the sciences and arts that pertain to the care of the sick—you have studied these branches and also studied human nature. How is your eye sight? For most defects of bodily vision, you can wear glasses, but how about your mental vision?

Can you more readily detect wrong from the many incidents or customs of life which we call neutral—neither right nor wrong?

And about the use of that "little member that no man can tame"—the tongue? Do we all realize the meaning of "hold in confidence" as set forth in the Nightingale Pledge?

When she resigned as Superintendent in 1930, Miss Loveridge received a great deal of recognition, on the national as well as the local level. These are among her specific contributions to society (selected).

Professional:

Established first training school for nurses in the Pacific Northwest.
Superintendent of Training School 15 years.

Promoted passage of State Licensing law for nurses.

Northwest Hospital Association—Charter member.
Former vice-president
Former president.

Western Hospital Association
Former president.

American Hospital Association
Former vice-president.

Personal:

Cared for and brought up three children—two nieces and a nephew.

Was "Aunt Emily" to countless numbers of people.

At the American Hospital Association meeting in Toronto,
Canada, in 1931, Miss Loveridge was presented with a silver plaque as a token of recognition of her thirty years of service in the hospital world. The inscription on the plaque reads:

In appreciation of her contributions to the care of the sick, to nursing education and to hospital administration, the American Hospital Association presents this plaque to Emily Lemoine Loveridge, a member and ex-vice-president of the association, who forty years ago established the first school of nursing in the northwest, and for twenty-five years was Superintendent of Good Samaritan Hospital, Portland, Oregon. (150, p. 7)

Eleven years after her retirement (April 20, 1941) Miss Emily died in her beloved hospital at the age of eighty-one, April 26, 1941.

Of her, The Oregonian said, "The nursing world knew her by an almost Nightingalian reputation built of a career that covered more than half a century and was nationally recognized." (161, p. 19)

It is true of most of us who pass through hospital ordeal and come forth well again that we cherish a memory of the patience and sympathy which we found therein. Some of the older among us remember these traits in Miss Loveridge herself, and the later patients, so long as she was there, were conscious of her direction. (163, p. 8)

Remembrance of the world of a Dunkerque, a defeated Greece, and a defiant Great Britain, armed to the last old man, makes the following tribute profoundly moving:

It was on May 1, 1890 that Emily L. Loveridge arrived in Portland to establish the first training school for nurses in the Pacific Northwest...that date marks the beginning of a great and useful life, a beginning that is related to no conceivable ending. Countless thousands more, who are yet to be born in
far future time and places, may never hear of her living, yet they, with the rest of us, will be the beneficiaries of the work she did through 4.0 active years in the Good Samaritan Hospital... the life of Emily L. Loveridge goes on, in a widening stream of human service, a stream that can never cease widening in depth and power, so long as it carries the spirit of dedication and service that it derives from the labors of the great woman who stands forever as its source... such a life never ends--and that is humanity's greatest cause of faith and hope. (102, p. 12)

Miss Carolyn E. Davis, formerly superintendent of the Everett General Hospital, was appointed Miss Loveridge's successor. She had had a variety of professional experience which seemed to fit her for the position.

No attempt will be made to evaluate Miss Davis's contributions because of the brevity of her stay. Certain factors must have made the position a difficult one to fill. First, obviously, was the long, successful tenure of her predecessor; second, the unprecedented severity of the national depression which greatly hampered many hospital activities, although certain desirable innovations and improvements seem to have been made.

Dr. O. H. Manlove, who had been in charge of the hospital Pathology Department, was Miss Davis' successor, and held the position of Hospital Administrator until he was released for military duty in 1942. At this time Miss Alta Hollenbeck was appointed acting superintendent during the trying period of World War II.

In the death of the Right Reverend Walter Sumner on September 4, 1935 the hospital lost an interested leader and
good friend. The Oregonian editorial said,

He personified friendliness and good will, and that neighborly quality, natural and unstinted, which completes the general affection was his in marked degree—even in this community of good neighbors.... Merry, cheerful, open hearted Bishop Summer, who gave of his friendship so gladly and who seemed so surely a part of the city itself, of its purposes and projects, its humanitarianism.

(186, p. 1)

The present Bishop of Oregon, the Right Reverend Benjamin Dagwell, D.D., was elected on October 10, 1935 and so consecrated on February 12, 1936. (187, p. 10) The depth and extent of his interest in the total welfare of the hospital has been boundless.

Herewith is presented an outline of certain agencies which affect the standards and management of the hospital and which grew up during the life of the Good Samaritan Hospital:

State

Oregon State Board of Health (1903)

Hospitals:

Inspection of Hospitals and Related Institutions (1916)

"Model Law" requiring accurate reporting of deaths, births, communicable diseases, etc. (1916)

Lien law (1931)

License law required of all hospitals and related institutions (1947).

Physicians:

State Licensure law (1899)

State Licensure law amended (1891)
State Licensure law Mandatory (1920)

Nurses--professional:

State Licensure law and accreditation of nursing schools (1911)

Oregon State Board of Nurse Examiners and Licensure

State Licensure Mandatory (1929)

Nurses--practical:

Nurse Practice Act and Licensure (1949)

City of Portland

Board of Health (1894)
Under Department of Utilities (1928)

Ordinances and Codes, re communicable disease control, sanitation, inspection of hospitals, fire, building, etc. etc.

Professional Accrediting and Influencing Agencies (hospital, general)

Oregon State Medical Association (1874)

American College of Surgeons (1913)
Minimum standard for hospitals (1918)

American Hospital Association (1899)

Professional Accrediting for Training

Physicians:

Internes; council on Medical Education and Hospitals.
Residences and fellowships in specialties Hospitals.

Nurses:

Oregon State Board of Nurse Examiners and Licensure

American Nurses Association
National League of Nursing Education

Dietary Internes
American Dietetic Association
Laboratory Technicians
American Society of Clinical Pathologists.

Inspection of the variety of forces, legal and professional, which bear on hospital activities, strengthens the conviction that the community is responsible for the conduct of the hospital, which in turn is subservient to the demands of the community.

The period of World War II was one of considerable reorganization within the hospital, which affected directly or indirectly patient care. Certain changes which were in process were accelerated because of the shortage of professional persons; physicians and nurses, notably. Specific innovations included:

1) Segregation of patients according to classification of diseases.
2) Specialization of services.
3) Use of non-professional hospital workers:
   a. Paid non-professional nursing personnel
   b. Volunteers.

In discussing the first of these, i.e., segregation of patients—neither the concept nor the practice was new to the hospital. In 1908 a pediatric department had been set up in the Center Wing, and remodeled in 1926, largely paid for by the Glisan family, in memory of Doctors Clarence and Rodney Glisan. This had bed space for some twelve to fourteen children. Complete segregation of the obstetrical patients had been effected by the completion of the remodeled Wilcox
Memorial Hospital, and the floors of the East Wing, insofar as was feasible, had been allocated to Medical and Surgical patients, respectively. Other departments, such as Orthopedic, continued to have mixed diagnoses with Orthopedics the specialty.

Advantages of segregated services are several.

1. The clustering effect promotes efficiency for various categories of personnel--physicians, nurses, and others.

2. The training is improved. Improved training for resident physicians and internes by special disease emphasis with consequent concentration of learning.

3. Greater opportunity for proficiency and acquiring skill is provided nurses, students, and graduates.

4. Equipment and facilities are designed for specific categorical needs.

In short, the patient, about whom all hospital activities are centered, received specific benefits.9

The hospital report of 1943 contains a rather complete description of the changes made, which resulted in the present picture (1951).

Specialized, implemental departments instituted or enlarged during the war years were:

- Intravenous therapy and blood bank
- Cystoscopy
- Radiology
- Fracture
- Central supply
- Physical therapy

9Lest it be inferred that this plan was iron clad, it should be understood that the period which necessitated the installation of an additional hundred odd beds to meet patient demands, meant that the principle must often be observed as principle only--not as invariable practice.
The accent on specialization demonstrates the use of the skilled team technic in promoting efficiency of patient care.

The innovation of an Isolation Department deserves attention. Its origin lay in expediency; the badly overcrowded hospital made mandatory some device for reducing the incidence of cross-infections from patients with colds, etc. The small unit designed to isolate such patients presently became a permanent Isolation department. The incorporation of such a department in a general hospital was entirely in accordance with modern hospital philosophy. In an article pertaining to the waste of empty beds in the traditional communicable disease hospital, Dr. Bachmeyer says: "In the light of improved nursing techniques and present knowledge of methods of control of cross-infections in hospitals, there seems little reason why such diseases cannot be cared for in general hospitals." (32, p. 68)

Other authorities also recommend that patients with communicable diseases and certain types of tuberculosis be cared for in general hospitals whenever practical.

By way of summarizing the history of the Isolation department of the hospital, it has been shown that a need was felt, was satisfied, was in line with progressive hospital thought, and was a pioneer innovation among Portland hospitals.

Another department which has made a substantial con-
tribution to the welfare of the city is the Emergency Surgery. In a typical private hospital, such as the Good Samaritan Hospital, the Out Patient Department is relatively unimportant because patients are under the care of their personal physicians. This is not so as regards the Emergency Surgery unit. In conjunction with St. Vincent's Hospital a system has been evolved whereby accidents and illness of an emergency nature can receive immediate treatment, day or night. Such an arrangement is a source of great convenience and financial saving for Portland, which does not maintain a city hospital or an emergency department, as is common practice in large cities. The efficiency of the present method is such that the City Club Committee, in its study of Portland's hospital facilities, was able to report,

All the general hospitals in Portland have provision for the treatment of emergency cases, principally of accident victims.... With regard to the adequacy of emergency facilities, the Committee was advised, and it appeared evident from an inspection made of the emergency room of one of the leading hospitals in Portland, that these facilities suffice qualitatively and quantitatively for normal needs. (41, p. 109)

Problems evolving about patient care were infinite in the record-breaking hospital occupancy of the war years. Perhaps the most urgent was caused by the loss of doctors and nurses to military service. A minimum total of ninety-eight (108, pp. 1-10) physicians, who had been closely associated with the Good Samaritan Hospital, entered the armed forces. Fifty-eight, at least, graduates of the
nursing school are known to have been in service.

In 1943, Miss Hollenbeck reported:

The Army and Navy have taken a large percentage of our nurses and the shortage of nurses has been so critical that a reorganization of the work on the floors has been necessary. Much credit is due the Red Cross Aides, hospital Volunteers and special duty nurses. A better distribution of nursing care has been made possibly by their help. While we have not been able to give luxury nursing, we feel that the care of our patients has been adequate. (30, p. 22)

<table>
<thead>
<tr>
<th>Year</th>
<th>Admissions</th>
<th>Live Births</th>
<th>Daily Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>1942</td>
<td>10,893</td>
<td>1440</td>
<td>270</td>
</tr>
<tr>
<td>1943</td>
<td>13,970</td>
<td>2011</td>
<td>339</td>
</tr>
<tr>
<td>1944</td>
<td>13,646</td>
<td>1922</td>
<td>345</td>
</tr>
<tr>
<td>1945</td>
<td>13,595</td>
<td>1706</td>
<td>356.7</td>
</tr>
</tbody>
</table>

In addition to the generous spirit shown by the many volunteer workers, who helped care for the thousands of patients during the war years, is the evident perception that the hospital and its problems were community problems, and might, therefore, neither be viewed indifferently or ignored. The inestimable contribution of volunteer workers to the sick of Portland has been summarized by Miss Lillie Tracy, former assistant Director of Nurses:

**Average Number of Volunteer Hours of Service given Hospital 1942-1945**

<table>
<thead>
<tr>
<th></th>
<th>Average Hours Per Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red Cross Nurses' Aides</td>
<td>900</td>
</tr>
<tr>
<td>Red Cross Staff Assistants</td>
<td>50</td>
</tr>
<tr>
<td>Red Cross Gray Ladies</td>
<td>50</td>
</tr>
<tr>
<td>High School Girls Groups</td>
<td>128</td>
</tr>
<tr>
<td>Individual Volunteers</td>
<td>300</td>
</tr>
<tr>
<td>Total Average Volunteers</td>
<td>1428</td>
</tr>
</tbody>
</table>
The acute wartime shortage of graduate nurses was the direct cause of a new component of the hospital staff—the untrained hospital nursing attendant—whose usefulness was projected to the post-war period.

Hospital administrators had been urged by national hospital and educational authorities to use less skilled help for the more routine and less technical nursing duties based on the sound principle that skilled nurses' time should be devoted to skillful nursing. Prior to the war very few of these workers had been incorporated on the hospital staff. The low prevailing salaries of nurses and the indiscriminate use of student nurse service time meant that little monetary saving would result. However, the stress of war time accelerated the use of non-professional workers and they now form a permanent and sizable proportion of the staff.

The employment of non-professional hospital workers resulted in a not-unpredictable development—Union pressure for membership. The hospital contract with Local 49, Building Service Employees, American Federation of Labor, was cemented early in the war period, and for many years the relationship was that of mutual respect and accord between the union and the hospital.

In 1950 a change occurred in attitude of the city Union leaders which found expression in a Union newspaper. (191, p. 1) The agitation appeared to be based upon a desire for a Union shop rather than salaries per se. Resentment of the
Board's refusal of a Union shop resulted in a general walk-out January 2, 1951--after several months of restless turbulence among the hospital Union employees.

Curiously, a picket line had been maintained around the Emanuel Hospital since the summer of 1950--and for an altogether different reason (non-Union)--the Emanuel Hospital Administrators were unwilling to discuss with Union leaders the possibility of a Union contract. The only hospital in Portland then which had a Union contract was therefore the only one which could be subjected to pressure. The strike, which was terminated in December 1951, was fruitless for the Union organization. In effect, nothing had been gained for its membership and the quality of patient care had been impaired during the period of adjustment.

In approaching the final phase of this era--the building of a large wing--a main source of concern was the precarious shortage of hospital beds. As early as 1945, the Good Samaritan Hospital had embarked upon a fund raising campaign for a new wing, but it had been abandoned because rising costs had caused a dwindling interest in contributions. It was hoped that in delay a more auspicious time for building would occur. The years between 1945-1950 were used to advantage, however, for many improvements and innovations were made in preparation for the ultimate great hospital.

1946 Fireproof stairway - West Wing (new elevator)
1946 Autopsy Room
1948 Pathology Laboratory
1949 Physical Therapy Department enlarged
1949 Emergency Surgery enlarged
1946-1949 New Laundry and Heating Plant (usurped the last of the original buildings—cottages and greenhouse)

By 1949, a campaign for building funds was well under way. Justifying the need of a larger, modern hospital, these data were submitted:

In the last five years alone, the Good Samaritan Hospital has:

Cared for enough sick people (71,752) to crowd the Public Auditorium 26 times.

Served approximately 1,800 meals a day for a total of 3,251,016.

Carried out 787,935 laboratory procedures to aid in diagnosis or treatment of its patients.

Given training to 174 nurses and 101 physicians.

Supplied space and equipment for more than 20 operations a day for a total of 43,746.

Brought into the world enough infants (10,445) to populate a city the size of Astoria.

Given free care to indigent patients to the value of $331,571.

Spent $8,419,760 for payrolls, supplies and the like.

Treated 46,730 persons in its outpatient department, a number greater than the population of Salem. (64)

The estimated cost of the new six story building was approximately $2,300,000 of which $600,000 had been received from the Rosalie Willman Estate. Funds from the Hill-Burton Act augmented those obtained by public subscription.
The vital need of more general hospital beds in Portland had previously been statistically proven in a comprehensive survey conducted by the City Club, which reported a total of 2,458 general hospital beds for a city (Greater Portland area) of some 425,000 persons, and—

only 1,882 of the total number of general hospital beds in Portland are "acceptable," the balance being unacceptable because the buildings in which they are housed are deficient in one or more of the following respects: (1) obsolete; (2) more than one story high and not of fire resistant construction; (3) not built for hospital use originally and not adaptable to such use; (4) inaccessible; (5) inadequate heating, ventilation, plumbing or water supply; (6) located near a railroad or other disturbing installation; and (7) too crowded in that there is more than one bed for each eighty square feet of floor space. (41, pp. 107, 111)

With the possible exceptions of items 2, 3 and 4, the criticisms were valid for the Good Samaritan Hospital.

At the time of the study, the hospital had planned to build, which would have relieved somewhat the estimated shortage of 2,975 general hospital beds. (41, p. 111)

Except for some expansion of the facilities of Providence Hospital, additional hospital beds were not provided by 1951. In effect, the city requirements of 80 square feet required for each patient had reduced the number of beds available for use (430 beds) in the Good Samaritan Hospital by compliance with the law. However, the building of new hospitals outside of Portland (Seaside and Tillamook) caused some decrease in demands for hospitalization.

In concluding this phase of the hospital history it has
been shown that the explanation for the national development of hospitals may be applied to that of the Good Samaritan Hospital. While reliance has been placed upon population figures as the key to the growth of the city, it has been assumed that correlation can be made between the population and the City of Portland itself in the mid-twentieth century.
CHAPTER IV

SURVEY OF HOSPITAL DEPARTMENTS

The Board of Hospital Trustees

For the purpose of convenience, this group is considered as a departmental unit, although, as will be seen, its authority includes responsibility for all hospital activities.

The Board was not created until after the change of status of the Oregon Episcopal Church from a mission to a diocese. The following is an excerpt from Judge Deady's presentation to the Convention of 1891:

Know All Men By These Presents: That on the 27th day of June A.D. 1890, it was resolved of the Protestant Episcopal Church of the Diocese of Oregon, in convention assembled, that five persons elected by said convention as trustees, to-wit, Benjamin Wistar Morris, Bishop of Oregon, Thomas L. Cole, William R. Powell, Simeon E. Josephi and George P. Wilson were constituted a board to be known as "The Board of Hospital Trustees" and were authorized under the laws of Oregon to file articles of incorporation, incorporating said board, and on the 20th day of January A.D. 1891 in pursuance of the power in them so vested, said persons did duly execute articles of incorporation and have continued as trustees down to the present time. (132, p. 15)

In 1896 the Board was enlarged by two additional members and in the following year (1897) its title became "The Board of Hospital Trustees of the Diocese of Oregon," and provision was made for enlarging or reducing its size according to
need. Its legal prerogatives and responsibilities were defined. During the course of time the membership was increased—in 1951, it totalled thirteen.

Whereas the Bishop has, by virtue of his office, been the legal Chairman of the Hospital Board, a reduction of the Episcopal membership of the Board members has taken place.

The first Board was made up of—

Episcopal Clergymen 2

Physicians (members of the Episcopal Church) 2

Bishop

The Board of 1951 has three members of the Episcopal clergy—others represent the community and are selected on the basis of civic interest, leadership and responsibility. This is concrete evidence, then, of the nature of the hospital as a community one but was slow in accomplishment. The Board members served consecutive terms for many years, and not until 1930 do the Hospital Reports reveal changes in composition, representation and technics.

Board of Trustees - 1951

The Right Rev. Benjamin D. Dagwell, D.D. President
Theodore B. Wilcox, Jr. Vice-President
Dr. H. C. Fixott Secretary
Frederick Greenwood Treasurer
William B. Adams
Harry E. Heathman
The Rev. Lansing E. Kempton
Jack Meier
The Rev. R.A'Court Simmonds

J.C.F. Merrifield
Douglas Polivka
George Powell
Dean Vincent
In view of the fact that the Board has sole legal responsibility for the administration of the hospital and its finances, an institution the assets of which have been given as (1950):

<table>
<thead>
<tr>
<th>Fixed Net</th>
<th>$1,396,247</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>3,662,079</td>
</tr>
</tbody>
</table>

and that private philanthropy is an important source of its wealth, the responsibility to the community is very grave.

The members of this Board are trustees in fact. It is their responsibility to conserve the funds placed in their care and to expend them wisely in the interest of the public. It is their duty to conduct an efficient business administration and to provide a high quality of patient care. (45, p. 70)

In his last report, Dr. Josephi said:

I call your attention also to the low market value of some of our bonds... The market is now in a state of flux and prices low and fluctuating, but we hold our securities for investment and not for speculation. (24, p. 16)

Mr. Dean Vincent reported in 1932:

In view of the general unsatisfactory conditions of almost all investments in general, I wish to make it a matter of record that three times during the past year I have submitted a complete list of the bonds held by the Good Samaritan Hospital in their Endowments and Special Funds to recognized authorities in New York. (26, p. 17)

The record speaks for the competency and trustworthiness of members of the Hospital Board. Their objective service can have been their only satisfaction, for they serve without financial compensation.
In closing this brief discussion of the Hospital Board, a quotation from Dr. Goldwater is pertinent. "I have emphasized the attitude of trustees because the trustees of a hospital are, in theory at least, its policy-making body." (63, p. 177) Later, he states, "It seems clear that in many ways the hospital trustee has the opportunity to make the world a better place to live in, and that he is fortunate above the average man." (63, p. 177)

Administrator

The historical development of modern hospital administration is sufficiently captivating to warrant a backward glance. Attention has been called to the essential qualification of the early hospital administrator or superintendent, that he be of Episcopalian faith. The first superintendent, Mr. George Boyd, was preparing himself as a clergyman and was in Oregon because of poor health. Following his death from Typhoid fever (1883) the position was filled by Sister Hannah until the appointment of the Reverend J. D. Fergusson in May 1884. Although the appointment of Mrs. Wakeman was based on her interest in hospital management (she had had some contacts with hospitals), she could only have made known her interest through her membership in the Episcopal Church.

From the time of Mrs. Wakeman's resignation, the position was filled on a basis of medical or nursing background and this was a definite transition from the church
qualification and denoted the change of the hospital and its patients as of primarily medical concern. Nationally a novel pattern was evolved as hospitals became not only more numerous but more complex--this was the specific profession of the hospital administrator. Preparation for and experience in hospital administration became the criteria of qualification with knowledge of medical affairs of lesser importance. The trend, at Good Samaritan Hospital, has been from church to medical/nursing to business administration as qualifications for the administrator.

Dr. Goldwater has said, "Perhaps the greatest single factor in modern hospital development has been the medical branch and in general hospital administration." (63, p. 7)

A key to the underlying philosophy of modern hospital administration is provided in the Code (adopted in 1941 by the American Hospital Association and the American College of Hospital Administrators, of each of which Mr. Frank Walter is a past President). Its general principles and objectives (in part) are:

To render care to the sick and injured is the primary responsibility of the hospital; financial return and other interests should be of secondary consideration.

In addition, it is the duty of the hospital to advance scientific knowledge, to further the education of all participating in its work, and to take an active part in the promotion of general health. (1, p. 77)

A comparison of the current and the earlier hospital staff point up the complexity of management. In 1891, the
staff members were six, aside from the

Orderly, day and night
Fireman
Houseman
Chinese cooks, two
Seamstress (salary paid by the City Board of Charities)

Presumably there were women in the capacity of nurses until such time as the school got under way. The total payroll was $5,999.34.

An undated Committee Report of the Board (circa 1916 or 1917) in which the duties of the hospital staff are defined lists the following as "officers" of the institution:

Superintendent
Assistant Superintendent
Superintendent of the Training School
Assistant Superintendent of the Training School
Night Supervisor
Chaplain
Bookkeeper
Apothecary
Mechanician
Steward
Matron
Dietician
First surgical nurse
Second "
Third "
Office nurse

The small hospital staff permitted an intimate relationship with and knowledge of the management and functioning of the hospital for its Board. A close control was maintained, a selected sample of which is the method of employing hospital staff people (with the exception of the surgical and office nurse). All "officers" had direct appointments by the Board.
In 1891 the report shows evidence of an incipient job analysis, and rather specific job descriptions are included.

A listing of the departments of the present hospital, nearly sixty years later, with approximately 600 employees on the payroll, may sharpen the contrast of administrative obligations.

Administration
  Medical Staff
  Purchasing and supplies
  Business
  Nursing
    Service
    School
  Chaplain
  Laboratory
  X-Ray
  Dietary
  Housekeeping
  Medical Records
  Pharmacy
  Engineering
  Anaesthesia
  Laundry

The hospital expenses are as dramatic in denoting the magnitude of change. According to an official hospital report:

<table>
<thead>
<tr>
<th>1950</th>
<th>Payroll</th>
<th>$1,316,596</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Equipment</td>
<td>36,867</td>
</tr>
<tr>
<td></td>
<td>Other Expenses</td>
<td>1,946,762</td>
</tr>
<tr>
<td></td>
<td>Other Supplies</td>
<td>593,299</td>
</tr>
</tbody>
</table>

Because the Good Samaritan Hospital is but one of thousands, the importance of hospitals in the business world cannot be overlooked. It has been reported that it is the fifth largest industry in the United States. (43) The earnestness and wisdom imperative for efficient administration of institutions whose income is derived from philanthropy, sorrow and sickness
may not be disregarded.

Knowledge of, and compliance with, recommendations and philosophies of kindred medical-hospital groups (American Hospital Association, American Medical Association, American College of Surgeons, etc.) as well as familiarity with legal regulations is mandatory, as has been pointed out. It is imperative, too, that the administrator be an able representative to the public, for in the last analysis, the hospital is theirs.

The Good Samaritan Hospital has had an active role in the education of future hospital administrators through the residency offered graduates of hospital administration courses. Because their preparation is on a graduate student level, the thesis requirement strengthens the position of the hospital in its teaching and research functions.

Former Administrative Residents

Mr. Max Hunt, 1947-1948
Mr. William Esson, 1948-1949
Mr. James Burdick, 1949-1950
Mr. William Hoppe, 1950-1951

The present administrator, Mr. Frank Walter, came to the hospital in 1945, following sixteen years of experience as administrator of St. Luke's Hospital, Denver, Colorado (also under the auspices of the Protestant Episcopal Church). He has received considerable national recognition of his knowledge of and contributions to the field of hospital management, and is former president of two of the national organizations (American Hospital Association and American College of Hospital
Chaplain

The place of the Chaplain on the hospital staff has been of paramount importance. Although Bishop Morris had asserted that the hospital was designed to provide care for all who needed it, regardless of religious faith, and that no proselytism would be permitted, all official religious services must conform to church practice.

Official duties of the Chaplain, as clergyman, have been regularly reported to the Diocesan Conventions. In recognition of the vital roles of the hospital Chaplain, the Board on occasion has made possible a broader preparation in this specialized field. The Reverend John C. Hatton, in 1925, attended a Conference on Social Work in Denver, and more recently the Reverend Bernard Geiser enrolled in a clinical course given at Wesley Memorial Hospital in Chicago for hospital chaplains.

In addition to clerical duties and services (baptisms, funerals, and even weddings have taken place in the hospital (74, p. 13) ) are those of social service nature. Recommendations are on record in various hospital reports that a qualified social service worker be engaged. To date none have been employed. The hospital Chaplain (aided with funds given by the Women's Auxiliary of Trinity Church) has tried to care for immediate patient needs in the interim.

A valid conclusion is that religious offices have
receded in importance through the years. The early hospital, headed by a clergyman, with services frequently conducted by the Bishop, later had a full time Chaplain to care for the spiritual needs of the patients and personnel. The hospital which had a full time clergyman for some thirty patients, now has two part-time Chaplains for a patient capacity of nearly 400. The present Chaplains are:

The Reverend Bernard Geiser
The Reverend Neville Blunt

Although the hospital can in no sense share his honor in the field of art, failure to mention the Reverend Bernard Geiser's contributions to the culture of Portland would be a grave omission. Not only did he paint the beautiful murals of St. Mark's Church, but his paintings have been exhibited locally and nationally. He has been actively engaged in the activities of the Portland Art Museum. Mr. Geiser's genuine influence in stimulating art appreciation among patients and personnel probably has no parallel in the history of American hospitals.

The purpose of including some brief delineation of the following selected departments is to denote the progress in medicine (and as a consequence, hospitals) from the empirical to the scientific method of the mid-century.

Pathology Department

According to Dr. Larsell, the laboratory facilities were first introduced by Dr. A. E. Mackay (in 1951 the oldest living
ex-interne) in the early 1890's. After the fire of 1900 a laboratory was set aside in the hospital under his direction. Miss Loveridge, in her reminiscences, indicates that some sort of science laboratory existed by that time, for the first X-ray machine was installed in the Pathology Department. This was presumably in 1903 or 1904, for Doctor Ray and Doctor Ralph Matson were then internes. When recalling the early science laboratory, Miss Loveridge wrote, "From a pigeon-hole of a room and the service of an interne the pathological laboratory had developed until it covers one floor of one of the wings, and the intern has been replaced with a full time pathologist and numerous assistants." (87, p. 40)

Contemporary medical personnel will delight in her recollection, "also in this pathological laboratory, I had my first view of a material (sic) germ as it 'wiggled' under the lens, found, of course, by the Matsons. Our microscope was then considered a fine one." (87, p. 40)

The pathology department has undergone frequent renovations in order to meet the demands placed upon it (1918, 1922-1923, 1946-1947). The first qualified pathologist was Dr. Charles H. Manlove (appointed 1923) whose success was so immediate that in 1924 was said, "It is with pleasure we report great progress in our pathological department. Thanks to the efficient manner in which it is handled by Dr. Manlove, we believe it is second to none on the coast. (20, p. 14)
Dr. Larsell has confirmed his outstanding work: "This has subsequently developed into an excellent, modern hospital laboratory, under the direction, since 1923, of Dr. C. H. Manlove." (84, p. 526)

From the 1950 Laboratory Report:

- Number of Gross Examinations: 3,973
- Number of Microscopic Examinations: 2,275
- Number of Autopsies: 254

(Total deaths, 64% of 395)

in addition to the routine laboratory work.

The number of autopsies performed is witness to an educated attitude. Miss Loveridge, in a pithy, forthright statement made before autopsies were commonplace, answered the question, "What should the hospital executive advise about funeral services?" "Avoid sending to undertakers opposed to autopsies and they are everywhere!" (89)

Although the laboratory has offered, in the past, an accredited course in the field of medical technology, a new program has been developed under William Lehman, M. D. in conjunction with Lewis and Clark College—an innovation for Portland. A four year program combines college and the laboratory work preparatory to a Bachelor of Science degree and certification by the Registry of Medical Technologists of the American Society of Clinical Pathologists. (85, p. 48)

The development of so knowledgeable and specialized a profession signifies its importance in the scheme of total
patient medical care.

**X-Ray Department**

History of the X-ray department shows the speed with which scientific discoveries were put to use. X-rays observed in November 1895, reported in December 1895 (70, pp. 67, 68) had been sufficiently developed so that they could be put to practical use on the West Coast of a country thousands of miles away—by 1902.

Doctors Ray and Ralph Matson were our internes at this time and were intensely interested in X-ray, working very hard night and day, sometimes, to get results from this little known branch of the science of surgery. Dr. George Wilson was in charge of that department...today this X-ray would seem a very crude affair, but then it was the best there was and one of the first in the city. So many tubes were broken in the experiments by the twins, but they were tireless, introducing many new ideas that added greatly to this new science. These X-ray tubes were expensive. We had to send East for each replacement (did not have enough money to keep "in stock") and had to spend our time in "weary watching" until the tube arrived. It was first used for bones only. We felt it very wonderful to have a plate of our own hands. (87, p. 40)

These men (Drs. Ray and Ralph Matson) later became eminent medical leaders, serving on the faculty of the University of Oregon, doing considerable research, and specializing in Tuberculosis.

In a sequence rather similar to that of Pathology, the X-ray department has undergone many bouts of enlarging, remodeling, and installing of new equipment (1924, 1943, 1950). Dr. John R. Parson was the first to head the department as a specialty. A practical training course in X-ray technology
has been given for a period of years.

The sharp rise in number of patients benefited by Roentgenograms has been reported by Dr. Boyd Isenhart (the present head of that department) as: (selected years)

<table>
<thead>
<tr>
<th>Year</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1941</td>
<td>3,468</td>
</tr>
<tr>
<td>1942</td>
<td>4,756</td>
</tr>
<tr>
<td>1943</td>
<td>6,466</td>
</tr>
</tbody>
</table>

**Diet Therapy Department**

Real changes took place from the little alcove kitchen where custards and soft diets were cooked on a wood stove and the nurse skimmed cream from the milk pans--to be used for cooking--to the present hospital kitchens. These are not confined to the physical facilities, but more particularly to the twentieth century professional dietitian and the science of dietetics. No longer is the student nurse assigned to the diet kitchen to boil sterile water for surgery, cook the night nurses' supper, etc.

The youth of the profession of Dietetics is significant in the fact that as recently as 1917 the American Dietetic Association was formed. Hospital reports show the first qualified dietitian to have been Miss Annie Sproule (1920-1923), a graduate of Simmons College. During the period of Miss Elizabeth Stewart's supervision, a dietetic training

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10 Sister of Miss Daisy Sproule, beloved House-mother of hundreds of students over a period of more than nine years.
course was inaugurated. Until 1943 it was conducted in conjunction with Multnomah County and Emanuel Hospital. In 1943, the plan was revised and the Internship, approved by the American Dietetic Association, introduced to the Good Samaritan Hospital, one of two in Oregon; the other is given by Multnomah County Hospital. To date, sixty-one college graduates have completed the internship, a prerequisite to membership in their professional organization. They have come from nineteen different states, and one from Canada. (113)

An important group of dietary employees is the cooks. From the days of Mrs. Wakeman on, they have been noted for their loyalty and good cooking. While others are known by hearsay, Mr. Bonnie Yip, the present chef, is known to all current hospital personnel. (151)

It is unfortunate that hospital patients cannot see Bonnie and his helpers prepare the dozens of turkeys for the Thanksgiving and Christmas holidays. His Chinese dishes (served employees), Chow mein and Egg Foo Yong are excellent, but far more meaningful is the rapport he has created in a tradition of long standing. Hundreds of student nurses, also, have gauged the success of picnics by "Bonnie's" brownies which he has invariably found time to make.

Mr. Yip's reputation is not restricted to the hospital. Mr. Lampman incorporated the following recipe in one of his books:
Lee Yee Gung (Carp-fish stew): Clean and skin carp, removing head. Brown on both sides in frying pan, using pork fryings preferably. Place in flat pan, with previously prepared soy beans; put few pieces of fresh side pork or pork fat on fish; add soy sauce, salt and pepper, and some water. Cook slowly, simmer for about one hour.

To prepare soy beans for Lee Yee Gung: Fry dry beans in hot pork fat, stirring constantly, for 20-30 minutes. This will loosen skin. Then soak beans in cold water one or two hours. Rub beans gently between hands to detach skins. It may be necessary to rub beans and change water several times before all skins are removed. (80, pp. 44-45)

It has been shown that the combined strengths of cooking skill and scientific training made it possible for nutrition and diet therapy to develop to the fullest extent.

Medical Records and Library

Preliminary to a discussion of purposes and activities of the Medical Records Department, the definitive statement of Dr. Karl Martzloff, "A Medical Records Department and its library, together with laboratory facilities, form a nucleus around which revolve all scientific activities of a modern hospital" (188, p. 1) is self-explanatory in highlighting its essential nature.

The significant role of this department is a product of hospital advancement. The contemporary medical record is a composite of all factual information pertaining to the total health of the patient, in decided contrast to the early hospital records, from which certain selected items are submitted.
Sample Record

Name.................... Nationality: Norwegian Religion
Admitted: November 6, 1877 to Surgical Ward

Medical History:

November 6. Fracture of the skull without any depression
Pulse 75
A.M. Conscious
P.M. Pulse 75

November 7
9 A.M. Pulse 110 12.M. Very low

November 8 Conscious Sinking

November 9 Unconscious most of the day

November 10 Unconscious Died at 5:30 P.M.
Buried from the hospital

Hospital Record Ledger

This skeletal outline of the patient's illness is as barren of information concerning the hours of medical and nursing care, which he must have received, as it is of data for future reference.

Another sample record will further demonstrate the fact that the hospital emphasis was placed on doing rather than recording, for only with the passing of time was the significance of accumulative information understood as an invaluable tool in medical progress.

Sample Record

Name................. Age 40 B. Ireland Religion
Nativity Irish Trade Mining
Present Occupation...working in Iron Mines at Oswego, Ore.

(cont.)
Admitted: October 1, 1875 to Surgical Ward

One use of patients' records deserves mention: i.e., in providing a classification of patients according to financial, religious and national status. The annual reports (up to and including the last, 1943) contained a tabulation of the religious and national criteria. Its purpose, without doubt, was to re-affirm the fulfilling of the hospital's original objective.

### Hospital Patients

#### Nationalities 1908

<table>
<thead>
<tr>
<th>Nationality</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Americans</td>
<td>2,803</td>
</tr>
<tr>
<td>Austrians</td>
<td>38</td>
</tr>
<tr>
<td>Belgians</td>
<td>7</td>
</tr>
<tr>
<td>Bohemians</td>
<td>3</td>
</tr>
<tr>
<td>Canadians</td>
<td>75</td>
</tr>
<tr>
<td>Chinese</td>
<td>24</td>
</tr>
<tr>
<td>Danes</td>
<td>30</td>
</tr>
<tr>
<td>Indian</td>
<td>1</td>
</tr>
<tr>
<td>Irish</td>
<td>31</td>
</tr>
<tr>
<td>Italians</td>
<td>49</td>
</tr>
<tr>
<td>Japanese</td>
<td>4</td>
</tr>
<tr>
<td>Macedonians</td>
<td>4</td>
</tr>
<tr>
<td>Mexicans</td>
<td>1</td>
</tr>
<tr>
<td>Norwegians</td>
<td>67</td>
</tr>
<tr>
<td>Poles</td>
<td>8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>3,723</td>
</tr>
</tbody>
</table>

#### By Religious Faith

<table>
<thead>
<tr>
<th>Religion</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adventists</td>
<td>15</td>
</tr>
<tr>
<td>Baptist</td>
<td>235</td>
</tr>
<tr>
<td>Campbellite</td>
<td>1</td>
</tr>
<tr>
<td>Christians (sic)</td>
<td>83</td>
</tr>
<tr>
<td>Christian Scientists</td>
<td>5</td>
</tr>
<tr>
<td>Church of the Apostles</td>
<td>2</td>
</tr>
<tr>
<td>Church of the Disciples</td>
<td>1</td>
</tr>
<tr>
<td>Church of God</td>
<td>1</td>
</tr>
<tr>
<td>Hebrew</td>
<td>15</td>
</tr>
<tr>
<td>Hindoo</td>
<td>1</td>
</tr>
<tr>
<td>Lutherans</td>
<td>374</td>
</tr>
<tr>
<td>Macedonian (sic)</td>
<td>1</td>
</tr>
<tr>
<td>Methodists</td>
<td>465</td>
</tr>
<tr>
<td>Mohamnedans (sic)</td>
<td>2</td>
</tr>
<tr>
<td>Mormons</td>
<td>2</td>
</tr>
<tr>
<td>Presbyterians</td>
<td>222</td>
</tr>
<tr>
<td>Protestants</td>
<td>624</td>
</tr>
<tr>
<td>Quakers</td>
<td>2</td>
</tr>
<tr>
<td>Roman Catholics</td>
<td>444</td>
</tr>
</tbody>
</table>

(cont.)
The 1910 Hospital Report was the first to include a classification of patients according to disease. This marks the turn to the modern conception of the patient as primarily a medical problem.

What was the origin of the new attitude toward the value of the patient record—its usefulness extended from the individual patient to medical study and research, evaluation of quality of patient care, and possible legal evidence? For the Good Samaritan Hospital, as for others, it occurred as a result of a general movement toward improving medical education in the United States. The effects of the Flexner report, its unfavorable findings in clinical practice and teaching were felt throughout the hospital world. The founding of the American College of Surgeons in 1913 was the vanguard of the movement to set minimum standards in quality of hospital care. Because medical records provided permanent, tangible evidence of the care administered within the hospital, a high premium was placed on their value in all hospital accrediting programs.

The standards set by the American College of Surgeons required a full time Records Librarian. Miss Laura Shaw (a
graduate of the Good Samaritan Hospital Training School) filled the position until 1940, when Miss Jean Orr, former assistant, became the Records Librarian, and the first Registered Record Librarian. She inaugurated the present standard nomenclature of diseases.

A problem experienced quite generally in hospital libraries concerns itself with the space allocated to patients' records. Storage has recently been simplified by the use of microfilms for the older records—a practice which is feasible in a private hospital.

In relinquishing the topic of patients' records, one point should be underlined: the records, whether in the early days of abbreviated size or in the present state of comprehensiveness, have been subjected to ethical treatment by those who have used them. Certain basic values do not change.

Certain common characteristics among those departments which have been reviewed (Administrative, Dietary, Laboratory, X-ray, Record Library) have been observed:

1. The quality of patient service has been improved as a result of their specialization.

2. The specialization of these departments and subsequent improvement is in accordance with scientific advances.

3. They provide a means of furthering knowledge by providing the laboratory for practice, study and research.

4. The departments are administered by skilled professional personnel, especially prepared in their respective fields.
5. The installation of these departments, with improvement of preparation of personnel and facilities, was, by and large, a result of forces outside the hospital itself. These forces, or agencies, are the result of common bonds of professional interest on a national scale, the ultimate goal of which is to better the care of the patient.

6. An initial and key agency in affecting changes has been the American College of Surgeons with its standardization of hospitals program, which has resulted in the improvement of patient care by more scientific and up-to-date hospital technics. This stimulating action has not been confined to the Good Samaritan Hospital but to all hospitals in the country. Other accrediting agencies have followed in its wake.

Anesthesia and Physical Therapy

These two departments comprise specialized professional personnel, who are unique in their contacts with patients. Of the former, anesthesia, there was no mention of anesthetists until 1925 at which time they were listed as Floor Nurses and Anesthetists. (21, p. 3)

In 1927 five anesthetists were reported as "Anesthetists." Prior to that time anesthesia was limited to ether and/or gas oxygen, administered by a graduate nurse or physician. With the development of new forms of anesthesia came the trained anesthetist—ultimately in two categories; the nurse and the physician—the latter invariably responsible for the safety and success of all anesthesia.

The introduction of the Physical Therapy Department was a pioneer movement in the immediate geographical vicinity. Until 1926 the department was under F. B. Freeland, M. D.,
when it was assigned to the present director, Arthur Jones, M. D., previous assistant to Dr. Freeland.

The report of the total number of treatments given in 1931 was 356. In 1943 some 5,000 treatments were administered. In 1931, Dr. Jones reported:

The department of physical therapy has benefited by the addition of a high frequency machine for the production of therapeutic fever by means of diathermy during the past year. This addition renders the Good Samaritan Hospital the only private hospital in Portland which is able to offer this service to the profession through special equipment and trained personnel. . . . More surgeons have availed themselves of the electro-surgical scalpel, or so-called "radio knife," which is under supervision of the director of the department as a trust from the American College of Surgeons. (25, p. 42)

As with other hospital departments, Physical Therapy has undergone periods of remodeling and expansion as it has served more patients, the last having been completed in 1949. Its value to the community may be assessed by the installation of a modified Hubbard tank for the use of Polio patients, by the local chapter of the National Infantile Paralysis Foundation, and during the year 1950 when the incidence of polio was heavy, was a great asset to the hospital and the community.

This closes the résumé of certain departments which render care directly to, or are closely associated with hospital patients. Although contributory departments, as the pharmacy, engineering, housekeeping have not been included
in this study, it is readily acknowledged that the institution could not function for even a few hours without their competent assistance.
An abundance of authoritative information has been published on the history of medicine in Oregon. Because of this, no attempt will be made to consider general medical developments except as certain individuals and events may be cited in the process of fulfilling the objectives of this study. Neither will an attempt be made to assess specific contributions of the medical staff except as they fit into the hospital pattern of this history.

The hospital exerted a positive role in early medical education, through its staff members. During the vicissitudes of Willamette Medical College (Oregon Medical College, founded in 1865) the existence of two Portland hospitals—Good Samaritan and St. Vincent's—was presented as good reason for its transferral to Portland. When in 1887 the charter for the University of Oregon Medical School was granted, it was not chance alone which induced persons who had been active in the hospital to also promote the founding of the medical school. Many of these were hospital staff physicians, others were community leaders, such as Judge Deady. All but one of the first faculty, Dr. K. A. J. McKenzie of St. Vincent's, was on the Good Samaritan Hospital staff.
First Faculty of the University of Oregon Medical School

Principles and Practice of Surgery and Clinical Medicine,
Holt C. Wilson, Professor

Obstetrics and Diseases of the Mind and Nervous System
S. E. Josephi, Professor

Practice of Medicine and Clinical Medicine
Kenneth A. J. MacKenzie, Professor

Materia Medica and Therapeutics
A. C. Panton, Professor

Physiology and Microscopy
----------, Professor

General and Descriptive Anatomy and Clinical Surgery
Arthur D. Bevan, Professor

Medical Chemistry and Toxology
Otto S. Binswager, Professor

Gynecology and Clinical Midwifery
Curtis C. Strong, Professor (84, p. 362)

The close association of the hospital and medical school was not confined to the academic but extended to the physical. The first classroom buildings were situated on hospital property. Classes continued there until May 29, 1919 when, at the time of removal to Marquam Hill, the building was destroyed by fire. The alliance between the medical school and the County Medical Society had then been completed. (83, pp. 99, 109)

The early, intimate relationship between the hospital and medical school permits the proposal that the existence of the Good Samaritan Hospital (and St. Vincent's) was the causative factor in the successful founding of the school. The first county hospital, Second and Hooker Street, was not
operating until 1909; the present County Hospital on Marquam Hill was completed in 1923. An essential component of effective medical education, clinical facilities, were available in the Good Samaritan Hospital through the offices of the Episcopal Church. Its length of life had allowed it to put down roots of permanency in the community. These facts may not be disregarded in weighing a natural question: "Would, or could, not another hospital have been equally effective?" The fact is that the Good Samaritan Hospital was there and had attracted ambitious, far-sighted doctors who were the same men who were active in the medical school.

Although there was later a dissolution of the hospital-medical school alliance, it may be pointed out at this time that this did not result in a separation of members of the medical staff and the medical school in after years, nor of a reduction of interest in professional education. Of the many staff physicians who hold current faculty appointments, at least nineteen published professional articles in 1950, to cite a single year.

Edgar Murray Burns
Henry C. Fixott
John M. Guiss
Charles E. Gurney
Morton J. Goodwin
Daniel H. Labby
William L. Lehman
John H. Higginson
Martin A. Howard

Arthur C. Jones
Aarne J. Lindgren
Karl H. Martzloff
Thomas R. Montgomery
H. Minor Nichols
Karl J. Poppe
John Raaf
Eugene Rockey
Kenneth C. Swan
Ben Vidgoff (57)

The preceding discussion reaffirms the general professional quality of contemporary physicians, and likewise
strengthens the position of the hospital as a medium for research and education.

To revert to early staff membership, apparently listed members included only those who gave free care, for this seems the only explanation for omission of such known staff doctors as Dr. Josephi.

**Medical Staff**

<table>
<thead>
<tr>
<th>Year</th>
<th>Attending Physicians</th>
<th>Consulting Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>1877</td>
<td>Dr. C. C. Strong</td>
<td>Dr. R. Glisan</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dr. W. H. Wilson</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dr. J. T. Ghiselan</td>
</tr>
<tr>
<td>1880</td>
<td>Dr. C. C. Strong</td>
<td>Dr. R. Glisan</td>
</tr>
<tr>
<td></td>
<td>Dr. T. B. Eaton</td>
<td>Dr. J. T. Ghiselan</td>
</tr>
<tr>
<td></td>
<td>Dr. W. H. Saylor</td>
<td>Dr. W. H. Watkins</td>
</tr>
<tr>
<td></td>
<td>Dr. H. C. Wilson</td>
<td>Dr. R. B. Wilson</td>
</tr>
</tbody>
</table>

**By-Law No. XIII**

It shall be the duty of the members of the Medical and Surgical staff to attend all hospital patients gratuitously, and no member of said staff shall receive a fee for any service rendered a hospital patient. The term "hospital patients" shall be construed as meaning all patients who are admitted to said Hospital by the primary application to the superintendent of the same, without the intervention of any member of the said staff. (65)

In spite of difficulties in traveling to and from the hospital on horseback, through the deep muddy roads, they were conscientious in the care of their patients, as a letter from a former patient attests. (171, p. 1)

Doctors allowed on the staff were restricted in number for many years.
In 1929, the Secretary's report stated:

Owing to the large amount of work done, and for the first time in the history of the hospital, the trustees have felt that a limited number of the best men in the city should comprise the membership of the Visiting Staff and additions have been made so that the staff now numbers twenty-five.

(This statement seems obscure in meaning, for contemporary records show thirty-two staff doctors by actual count.)

Among the contributory factors to the breaking down of resistance to a larger staff (whether this attitude was that of the hospital management and/or the medical staff is subject for conjecture only) are the following:

1. Recommendation for a larger staff by the American College of Surgeon's accrediting agents.

2. Increased hospital bed capacity.

3. Possible hostility toward hospital from new and young practicing physicians who could not use the hospital except by referral of patients.

The changing attitude toward staff membership is seen in the following quotation: "The closed hospital staff is now a thing of the past in cities of moderate size throughout the United States." (114, pp. 512-516) Also the operating rooms were designed for an "open staff," where
there are many visiting surgeons. It had not been long that
there were many "visiting surgeons."

The "imprimatur" received from the American College of
Surgeons in 1921 made a more profound imprint on the hos­
pital and its staff than the simple affirmation that it con­
formed with minimum standards of the Accrediting Board. The
1922 hospital report states that the "Rules and Regulations
Governing the Hospital" would henceforth require the doctors
to verify their qualifications as physicians. (19, p. 15)
Not until 1923 was state licensure a prerequisite to staff
membership, according to the annual hospital reports. This
was a direct result of the accrediting program. Oregon
State had been attempting licensure of physicians since 1889;
the law was supposedly mandatory in 1920. Desire for pro­
fessional approval resulted in compliance with the law.

Another outcome of the American College of Surgeons was
the organization of the staff in 1922, now known as the
"Medical Staff of the Good Samaritan Hospital." (66)
Its 1951 membership totalled 220 (108-A) in categories of
active, associate, courtesy and honorary.

It is a self-governing, self-policing body which de­
fines its own code of membership qualifications and standards
of performance. Members are technically appointees of the
Board; in practice, the Board appoints those recommended by
the staff membership committee. Among others, the Liaison
Committee is important as the intermediary between the
hospital Board and Staff.

The presence of another group of doctors, i.e. medical internes and residents, is meaningful. Not only is it a criterion of the hospital's medical status, with relation to specific accrediting agencies (the council on Medical Education and Hospitals for internships, residencies and fellowships) but their presence ensures a high and continuous quality of care to patients at a relatively small cost to the hospital. Trained physicians on the staff for constant medical attendance could be provided only at prohibitive financial expense.

Another advantage of the training program is its action as a supply line for future doctors who are trained in accordance with the hospital's standards, and who have a deeper interest in the hospital than might otherwise prevail. The total number of doctors who have received training in the hospital was 227 internes in 1944. The first Residency was reported in the 1943 Hospital Report; Annual reports and student yearbooks (located in the Nurses' Library) contain names of former internes.

The seriousness with which the doctors view their educational responsibilities is evident in the following extract from their By-Laws.

**Article #20 - Rules and Regulations**

Negligence of any staff member in performing accepted teaching responsibilities shall be reported to the House Staff Committee, and if negligence is proven
this information shall be forwarded to the Executive Committee for appropriate action. (66, p. 10)

Teaching ranges from formal to informal; from medical to nursing students; from professional to public audiences. An example of outstanding service toward nursing education has been that of Dr. Elmer Carlson who has taught student nurses from 1926, up to and including the present (1951). As example of community education, Dr. Carl Ashley, President of the Mental Health Association (1951) included among its other activities, free public lectures.

Two specific avenues of service made possible through the hospital facilities have been a Cancer Clinic and a Diabetic program. The former functioned for several years until the County Hospital provided such care through its outpatient department and was made possible by anonymous gift of $20,000. (22, pp. 18, 20)

The other, the Diabetic Clinic and teaching program conducted by Dr. Blair Holcomb, permits two accomplishments: the education and training of the Diabetic patient in methods of managing a "normal" life within the confines of his physical handicap and provides, incidentally, educational opportunities for the various student groups within the hospital.

In 1946 a Diabetic Research Foundation was created by patients of Dr. Blair Holcomb and Dr. E. Murray Burns. These people wished to further the medical research from which they had been benefited. While much of the work is done at the University of Oregon Medical School, the Committee of the
Foundation (five members) includes the Administrator of the Good Samaritan Hospital with the hospital acting as trustee of its funds.

An item in The Oregonian of October 8, 1946 illustrates another form of professional contribution of a staff member. Dr. Charles P. Wilson was then custodian for the Portland area of the new "wonder" drug, Streptomycin, still in the experimental stage. (Its cost was then $25 per gram.)

In general, the Medical Staff members have shared the care of the medically indigent, the so-called "city cases," and have participated in such prepaid medical plans as the Oregon Physicians' Service, and the Blue Cross. Portland doctors, together with doctors throughout the country, engaged actively in publicity regarding "socialized medicine." (Two extreme poles of thought may be read in "The Country Doctor Answers the Ewing Report" and "The Easy Chair" - Letter to a Family Doctor.)

The 46th General Hospital (Base Hospital No. 46 in World War I) which had its origin in the University of Oregon Medical School, was staffed by many doctors who were connected with the Good Samaritan Hospital. Its commanding officers were Dr. Yenney in World War I and Dr. Guy Strohm in World War II. The 46th General Hospital was commended by General Jean Laittre de Tassigny for its care and treatment of the Free French military and from General Paul R. Hawley, Chief Surgeon, European Theater of Operations, for performance in Algeria and France.
Further discussion of the Good Samaritan Hospital medical staff contributions is extraneous. The record of medical treatment given the hospital patients speaks for itself. As the hospital is not directly affiliated with a medical school, methods and quality of care given must be determined by the physicians themselves and these must be worthy of the confidence and trust of the Board. The number of doctors on the staff of the Good Samaritan Hospital who are likewise on the Medical School faculty is a fair criterion of their level of professional interests and abilities. Upon the medical staff rests to a large degree the fulfillment of the three major purposes of a hospital-patient service, education and research. (45, p. 66)

As a preliminary to the history of hospital nursing and the nursing school, extracts from addresses given by two doctors who have been associated with the hospital are presented for their value in the interpretation of the doctors' point of view. From Dr. Earl M. Anderson:

I like to think of nurses as sentinels of the night, for it is during the early morning hours that your abilities as a nurse will be taxed to the utmost. When the clock strikes 2 in the morning, it not only strikes the hour of 2, but it also strikes the zero hour of a patient's courage and resistance, and it is then that you can do so much to restore his confidence in himself, in his doctor, and aid him in his battle for life. (31)

From Dr. William S. Knox:

For long after the extermination of the last pathogenic organism, long after we have arrived at a complete understanding of the sympathetic nervous system,
with the malfunction of its associated glands of internal secretion, there will be left, both men and women, with souls that are sick; sick from troubles domestic, from troubles financial, troubles political, sick from fear. There will still be need for real physicians--those who know the art of the practice of medicine. (79)

**Nursing and the Nursing School**

A total of 1591 (including 1950) nurses have graduated from the Good Samaritan Hospital since 1892. They have been represented in many branches of nursing, in widely scattered geographical areas, and in three wars. Because of the influence nurses exercise in the many hospital departments, and in health organizations outside the hospital, a rather specific record of the school history is presented as a means of ascertaining the quality of its contributions. Direct quotations are introduced freely, because of their usefulness in fostering an historical frame of reference in nursing, and also because of the comparative scantiness of detail on hospital and nursing life and methods in the early period than is generally available.

The primary motive in initiating the school (officially designated training school until 1950) was to provide better patient care. Only as a secondary and incidental objective was the education of the nurse professional. This sequence correlates with that of other hospitals generally. Interest in the early training program seems to have been easily aroused for the school did not lack for applicants.
The first students enrolled in the school were:

Helen Eborall  
Margaret Macauly  
Anna Peterson

and of whom Miss Loveridge wrote: "God bless them, for they possessed much practical knowledge of the sick and were fine, high-type women and no kind or amount of work daunted them. (87, p. 7)

These extracts have been selected for their interest in picturing the hospital and school:

Our School of Nursing started June 1, 1890 with six pupils, three of whom were employed in the hospital in nursing capacities at the time the school opened. We carefully studied the characteristics of the young women who went in training and their reasons for taking up that work. We tried them out and weeded out undesirables. One of these took up training because she looked well in uniform. All classes were held in my room in the evening. As instructress, I often wanted to go to sleep, so did those tired girls who had worked hard all day, but we had our hour of anatomy, physiology, materia medica as expounded by our small brown books, or an hour in Clara Weeks' Manual of Nursing. (87, p. 3)

It may be presumed from other sources dealing with this period that the textbooks mentioned were:

Shaw, Clara Weeks, A Textbook of Nursing, Appleton, 1885.
Dock, Lavinia, Textbook on Materia Medica for Nurses, Putnam, 1890.
Kimber, Diana, A Textbook of Anatomy and Physiology for Nurses, MacMillan, 1893 (40, pp. 606-607)

Miss Loveridge also would undoubtedly have had and used a copy of the Bellevue School's Handbook on Nursing, Putnam, 1878.

Details of the nineteenth century provide sharp contrast
to the hospital sixty years later. In the interim great medical supply houses have developed today's highly specialized equipment.

At that time Good Samaritan Hospital had about fifty beds available for patients. Some of these beds were in a new addition not used until after June 1st. Of these, eighteen ward beds were for women, twenty-four for men, eight were private rooms and two "cells" later more politely termed "Guarded rooms." (87, pp. 2-3)

Our first beds were of straw, whose ticks were washed and filled between occupants, and occasionally when a patient was with us for some time this straw had to be replaced or more added to that pulverized by long use. In the making of "standing," i.e. vacant beds we used a long flat stick "a la Bellevue;" in an emergency at times even a broomstick handle was used to flatten and even the beds, and we would often roll the sides of the blankets to give the beds that much desired square effect. Some of our pillows were of pulu, but most of them were feathers. Our night nurses used tallow candles set in tin candlesticks, and it was one of the duties of the "probes," as we called the probationers, to clean these candles daily.

In the sewing room were two sewing machines on which some of us exercised in our leisure moments. I found I could cut and make a man's nightshirt in an hour. Also we had a seamstress sent and paid for by the City Board of Charities.

My first living quarters, a sleeping room, was over one of the women's wards. My salary was twenty-five dollars a month and living expenses...Our bathroom was near the front part of the hospital, just a block away from our sleeping quarters. The rest of the nurses, two or three in a room, were placed in different parts of the hospital in rooms too small or otherwise not available for patients. A little while later some dormitories were added near this same "Ward 3" which provided beds for five women patients on the first floor, and in the floor below were quarters for night nurses. How I did object when the nurses would refer to those basement rooms as being in the pit:
In the treatment of patients for ordinary heat to feet, etc. we used stone jugs, bricks, glass pint and quart bottles all enclosed in flannel covers which were made out of old pieces of blanket or other woolen cast off material. We were always short of corks to fill bottles and jugs. A few choice rubber hot water bags were kept for abdominal applications, etc. Flaxseed poultices were usually very popular, also hot stupes, especially turpentine stupes—both were made over our oil stoves. At first gas was used only for lighting; later it was used in dressing rooms, serving rooms and diet kitchens to replace wood and kerosene stoves. (87, p. 11)

The day after her arrival, Mrs. Mona Fraser (the thirteenth pupil) was assigned a full day of work, which included "doing" the wards, bleaching muslin with chloride of lime, keeping food hot in the wood cook stove, sterilizing the surgical instruments in a pan which resembled (and probably was) a roaster, and making the iodoform dressings which classified them everywhere—in the theatre and street cars as "Miss Loveridge's girls." (60)

The school and hospital were soon integrated, and by 1892 the student nurses "are the only ones in the hospital now."

The 1892 Hospital Report contains a rather comprehensive account of the training program.

The course required for graduation is a two years' term and classes are instructed twice a week. (author's italics) Every nurse has to complete a full two years' course, and no deductions are made for sickness or other absence from the classroom.

Nurses are allowed $10 a month during the first year, and $12 a month during the second year. This allowance is not intended as a salary for their services, but merely for defraying the expense of books,
clothing, etc. All are required to wear the regulation uniform of the school, and all board and lodge at the hospital. The practical advantages of the school are training and experience it gives the nurses in the care of the sick. These nurses are the only ones in the hospital now (author's italics) and the theoretical knowledge they acquire by the study of books is at once put to use by attendance on the sick. The hours are from 8 o'clock in the morning until 8 o'clock in the evening, but every nurse is required to do a certain amount of night duty during the two years she is in school. Juniors are required to pass a satisfactory examination at the end of the first year before they are allowed to enter upon the senior year.

The theoretical training consists of lectures on anatomy, materia medica, physiology and other branches of medicine necessary to successful nursing. During the second year, lectures are given at the medical department of the Oregon State University. Dr. C. C. Strong lectures on gynecology and Holt C. Wilson on surgery, Dr. S. George Wilson and A. F. Giesy on diseases, Dr. Panton on materia medica and Dr. S. E. Josephi on obstetrics. Special lectures are also given by Dr. Eaton on the eye and ear, Dr. Mackay on microscopy and Dr. Cardwell on bandaging. Each physician in this corps of instructors delivers lectures on four successive Mondays. Upon passing a satisfactory examination at the end of a two years' course, nurses are given diplomas, signed by the physicians, surgeons and superintendent of the hospital and directress of the training school. The diploma will be evidence of their qualifications as nurses; and as the course of instruction is as rigid as that of any other training school, it will place them on an equal footing with the best nurses in the country. It has become evident that successful nurses require as much education in their line of work as successful physicians, and often they are able to do more in a case of life and death than the learned medico. Good nursing is more than half the cure, and it is due to the realization of this fact that the Nurses' Training School was established at the Good Samaritan Hospital.

That there is a demand for trained nurses is evident from the fact that Mrs. Wakeman, the superintendent of the hospital, already had more applications for competent nurses on file than the present class of twenty-one can fill. The training school has also proved of incalculable benefit to the hospital. Since
its establishment a remarkable improvement has followed in the care of the sick, and the attending physicians speak in the highest terms of the excellent treatment their patients receive. All the nursing in the hospital is done by the nurses attending the training school (author's italics).... All the nurses are well educated and of good moral character. This is a qualification necessary to admission, as the application blanks require them to furnish references as to their moral character from some clergyman, and also a statement from a physician as to their physical condition....

The following course has been arranged for second-year pupils for 1892-93:

Dr. C. C. Strong:

1, 2. Special nursing in gynecological cases.
4. Food for the sick.

Dr. W. H. Saylor:

1. Emergencies—surgical, fractures and splints.
2. Care of patients before, during and after operation.
3. Theory of wounds, including inflammation, suppuration, erysipelas, septicaemia, pyaemia and gangrene.

Dr. H. C. Wilson:

1. Choice and care of sick room, ventilation, temperature, disinfectants, deodorizers, air and water.
2. Duties and conduct of nurses in private nursing.
3. Principles of aseptic and antiseptic surgery, special nursing for cases of abdominal section, and other important surgical cases.

Dr. G. F. Wilson:

1. Circulation, pulse, respiration and temperature.
2. Special nursing in diseases of thorax and abdomen, including digestion.
3. General medical nursing, including use of leeches, cups, blisters, enemata, poultices and baths.
Dr. S. E. Joseph:  
2,3. Special nursing in obstetrical cases, including complications.  
4. Obstetrical emergencies and care of infant.  

Dr. F. B. Eaton:  
1. Special nursing in diseases of eye and ear.  
2. Special nursing in diseases of the throat.  

In addition to the lectures, by far the most important part of the instruction is gathered day by day in the sickroom. The gentle touch of one accustomed to handle the invalid is not acquired from book or by listening to lectures, but from experience guided by a heart-felt sympathy. (5, pp. 1-2)  

Herein is contained the germ of later conflict: intellectual growth versus manual skills; class hours versus hospital nursing "practice." Expediency blended with genuine belief held by administrative and nursing hospital personnel made long hours and grave responsibilities the rule for students, long after the practice had been criticized as incompatible with professional education.  

"How to Apply for Entrance to the Training School for Nurses"  
All persons desiring to enter the Training School for Nurses connected with the Good Samaritan Hospital of Portland, Oregon, must make formal application either to the Superintendent or Superintendent of Nurses.  

The form must be filled out by the applicant herself; with it she must send: 1st, a letter from the clergyman of the church of which she is a member; if she does not belong to any church, from some minister who knows her. 2nd, one from a physician saying she is in perfect health. 3rd, one from the applicant herself.
When an application is accepted, it is placed on file, and each applicant is sent for in the order her name comes on the list.

Applicants should be between 23 and 30 years of age, possess a good common school education and be willing to devote themselves to the work. They will be received on a month's trial, during which time they are lodged and boarded at the expense of the school, but receive no compensation. They must wear dresses of some washable material; it may be the uniform if desired. Before coming, each should see that her teeth are in good order and that she is effectively vaccinated.

After being admitted they are required to wear the uniform of the school, which consists of a blue and white striped seersucker, white cap and apron. They will need at least three dresses, made so as to launder easily; a dozen white muslin aprons and plain underclothing. (Later instructions specified no lace-trimmed underclothing.) All shoes should have rubber heels,—the course of training is three (3) years. (The actual period of training was still 30 months.)

Nurses will reside in nurses' home, which provides board, lodging and washing, and serve for the first fifteen months as juniors; the second fifteen months they will be expected to perform any duty assigned them, either to act as senior or head nurses in the hospital or to be sent on private cases. (author's Italic) They will have an afternoon off duty each week, hours daily when the work allows, and as many as possible are to go to church on Sunday. Nurses are expected to stay at home evenings, to be in their rooms at 9:30 and in bed at 10, later permission being granted once a week if desired and if considered best by the Superintendent of Nurses.

An allowance of $7.00 a month will be made for the first half and $10.00 a month for the last half of the time; this being intended for books, uniforms and other necessary expenses. Thermometers, individual surgical appliances, scissors, pocket knives, dressing forceps, etc. are expected to be kept by each nurse.

The hours are from 7 till 7. Each nurse is required to do six or eight months of night duty during the course.
The Superintendent and Superintendent of Nurses have full power to decide as to fitness of candidates for the work and the propriety of retaining or dismissing them at the end of the probation month. They can also discharge or suspend them at any time in case of misconduct, insufficiency, insubordination, ill health, or lack of strength.

Pupils will receive instruction during the first part of the course in classes by the Superintendent of Nurses or her assistant. Lectures are given by the Physicians and Surgeons of the hospital during the last part. They are required to pass an examination at the end of each ten months. After graduating they will receive diplomas, also a badge in the shape of a pin. A registry will be kept at the hospital, from which after they are graduated they will receive cases as there is a call for them.

They will have instruction in all the general principles of the care of the sick, especially in surgical nursing, obstetrics and massage.

"Form of Application Blank"

The applicant will answer the following questions:

1. Candidate's name in full and address?
2. Single, widowed or married?
3. If a widow, have you any children? How many? How old? How provided for?
4. Have you anyone dependent on you?
5. Are you free from responsibility so there may be no interruptions in your course?
6. What has been your occupation?
7. Where, if any, was your last situation? How long were you in it? Name and address of last employer?
8. Age last birthday? Date and place of birth?
9. When and where did you last attend school?
10. Height and weight?
11. Are you strong and healthy and have you always been so?

12. Are your sight and hearing perfect?

13. Have you any physical defects?

14. Have you any tendency to pulmonary complaint? Have you any throat, uterine or ovarian disease?

15. Have you ever been connected with any training school for nurses? How long were you with them?

16. The names and addresses of two persons for reference. State how long each has known you.

17. Are you a member of any church? If so, which?

18. Do you understand and are you willing to follow all the regulations of the training school?

Signed

Among the questions asked in the application forms requiring elucidation are those concerning health and education. The first, the "perfect" health qualification will be considered.

Exceedingly long and arduous nursing hours placed a heavy strain on the healthiest individual. Lack of modern scientific knowledge, inadequate communicable disease techniques, excessive fatigue with make-shift sleeping quarters, all demanded extraordinary physical stamina. Not until 1919 were the working hours reduced to 56 hours per week from the previous 63 day and 84 hour night shift. (The author is dubious about the reduction of hours of night duty; the reports are vague and uncertain.)
### Number of Deaths of Nurses; Ten Years After First Graduation

<table>
<thead>
<tr>
<th>Class</th>
<th>Number Graduates</th>
<th>Number Died</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1892</td>
<td>12</td>
<td>2</td>
<td>16.6</td>
</tr>
<tr>
<td>1893</td>
<td>6</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>1894</td>
<td>6</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>1895</td>
<td>8</td>
<td>1</td>
<td>12.5</td>
</tr>
<tr>
<td>1896</td>
<td>7</td>
<td>1</td>
<td>14.2</td>
</tr>
<tr>
<td>1897</td>
<td>5</td>
<td>3</td>
<td>60.</td>
</tr>
<tr>
<td>1898</td>
<td>6</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>1899</td>
<td>7</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>1900</td>
<td>11</td>
<td>1</td>
<td>0.09</td>
</tr>
<tr>
<td>1901</td>
<td>7</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>75</td>
<td>8</td>
<td>10% ave.</td>
</tr>
</tbody>
</table>

### Number of Deaths in Student Group - Ten-Year Period

<table>
<thead>
<tr>
<th>Year</th>
<th>Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>1910</td>
<td>0</td>
</tr>
<tr>
<td>1911</td>
<td>0 (423 total days illness total student enrollment - 90)</td>
</tr>
<tr>
<td>1912</td>
<td>1 (5 resigned - ill health)</td>
</tr>
<tr>
<td>1913</td>
<td></td>
</tr>
<tr>
<td>1914</td>
<td>1</td>
</tr>
<tr>
<td>1915</td>
<td>0 (1 1914 graduate died)</td>
</tr>
<tr>
<td>1916</td>
<td>1</td>
</tr>
<tr>
<td>1917</td>
<td>1</td>
</tr>
<tr>
<td>1918</td>
<td>2</td>
</tr>
<tr>
<td>1919</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>6 Total student deaths in ten years</td>
</tr>
</tbody>
</table>
It is readily conceded that these figures have doubtful value in themselves, unrelated as they are to other vital statistics. It will, however, be as readily conceded that the figures suggest a high correlation with the rigors of the training, and should have been a subject of deep concern to the authorities—which cannot be read in the facts, regardless of what the intentions may have been.

Not until the mid 1930's was vigilance exercised by the authorities by the inauguration of a planned positive health program. This has been productive and was long under the direction of Dr. Charles Wilson, and later Dr. Morton Goodman. During the period 1941-1951 no student died while in the school. One recent graduate, to the author's knowledge, has died (Lillian Clements, class of 1946, of leukemia, 1949). It seems a valid assumption that the shortened work hours, increased vacation time allowance and the definite, positive health program are responsible for the improvement.

Figures are not available on past incidence of tuberculosis among the students. In the past ten years (1940-1950) three students were hospitalized with tuberculosis.

A salient point for consideration is the grammar school educational requirement. Although from the twentieth century standpoint such scholastic preparation would be considered markedly inadequate, this was not true in the nineteenth

111952 - Suzanne Miley died from a malignancy --one of the three students who contracted tuberculosis. She loved nursing and the hospital.
century for good reason.

The free High School State Law was passed in 1901 but scanty funds and large, thinly populated areas made it difficult to comply with the law in many a school district, and the distance in getting to and from school was an obstacle for others. (109, p. 324)

Financial school support was ensured by legislation of 1915 which made mandatory sufficient taxes to pay tuition of children residing in counties without high schools. "The effect of this law was almost immediately to double enrollment in the high schools of the State, and in some counties more than that." (39, pp. 734-735)

In relation to prevailing educational standards it is not, therefore, remarkable that from 1890 to 1912 the training school admitted its pupil nurses with a "good common school" education. Its standards stem from those prevailing.

The eighteen-year old minimum age, now generally imposed, is allied to the high school graduation requirement which had no counterpart when school was finished at the age of fourteen or fifteen, and girls had been employed elsewhere during the intervening period between school's end and entrance to the nursing school. Therefore, the 23-30 year ages set for admissions were determined on a basis of maturity of judgment and emotional stability.

An appraisal of the nursing curriculum is not possible except as certain aspects have been mentioned and need clari-
fication. The total number of nineteen lecture hours seems meager in contrast to the 1950 curriculum which contained 1396 class hours. On the other hand, the early lecturers were the same doctors teaching at the medical school, and were interested in nursing education. Medical knowledge had not yet gained the momentum that it was so soon to gather; nursing knowledge correlated with medical science and practice. It is not, then, surprising that the nurses' training course emphasized the acquisition of skills.

Other obvious factors existed. The long working hours precluded possibilities of more academic teaching and learning. The limitations of the students' educational background penalized them in preparation for future educational growth.

An explicit advantage of the early nurses' training has not since been equalled, for the Superintendent of Nurses personally taught all the technics of bedside care. (Nursing classes, incidentally, do not show in the records.) For many years students were admitted singly or in small groups, as there was bed space available. This practice fostered intimate teacher-pupil relationships which are not possible in large classes. Not only were corners "squared" but a setting of attitudes toward, and understanding of, patients was possible by excellence of example and gentle care.

These values, in contrast to the high pressures of more recent times, have been considered in a timely article:

Everything in nursing education was directed to the single goal of improving the student nurses'
technic with "broom or poultice" and of continuing to train her for that ineffectuality called "trained incompetence" by modern sociologists which passively subordinated her to the physician in charge. In fact, nothing was done to expand the nurses' "Professional" and above all, emotional value to the patient, although it was precisely the similarity between the emotional and the physical needs of patients and babies which led to the development of the nursing profession.

In the course of such a process one of the greatest and most unique contributions which the nurse may make to the healing art has been lost. Caught between nurses' notes, ward rounds, duties as hospital guardian and the alternate swabbing of floors and of patients, the nurse had neither the time, the opportunity, nor the medical sanction to dispense what the ailing, and therefore dependent, patient needs: emotional acceptance, support, and reassurance, that is narcissistic supplies. (194, pp. 614-617)

If the preceding article is sound in philosophy, and there appears to be no basis for equivocation, light is shed on some of the reasons for the secure place "Miss Loveridge's nurses" reputedly held in the city.

The first graduation, held in the Medical School on 23rd and Lovejoy, was an exciting occasion for many, other than the graduating nurses: for Bishop Morris who witnessed a completion of a long-planned project; for Miss Loveridge, who was rewarded by the success of a novel task; for the Rev. Daniel Loveridge who was the guest speaker at a ceremony honoring not only the graduating class, but his daughter for her able fulfillment of an assignment; and finally, for the city which would be benefited in having at hand trained nurses. Of the school, Dr. Larsell wrote: "This was a major step forward since it made available for public nursing a
number of trained women." (84, p. 480)

To borrow from Miss Boot's memories (Class of 1892), the passage selected by Bishop Morris, "Go forth with healing and with hope" was a source of inspiration to her throughout her professional career.

The "badge in the shape of a pin" was the result of collaboration between the Bishop and Miss Loveridge. From her came its general pattern, adapted from Bellevue's pin; from the Bishop came the beaver as a symbol of industry—certainly not inappropriate considering the two previously busy years. The use of the beaver on insignia had by then become traditional in Oregon, for long before, during the Territorial days, "Beaver" gold coins had been introduced as a more useful medium of exchange than gold dust. (39, pp. 407-408)

The graduates of the school were soon to demonstrate their usefulness to their country, for at least eleven saw military service, and Mrs. Fraser recalled that she "took the first government nurses to the Philippines in 1898." (60)

It was during this time that Mrs. Wakeman, concerned about the welfare of her graduates, received a wire in answer to her inquiry:

The government has sent no female nurses to Manila and General Otis commanding troops at that place has telegraphed that he don't want any -- signed Sternberg, Surgeon-General. (119, p. 11)

The forty-two year period since Miss Nightingale's epoch-making work atScutari was perhaps somewhat less than
that in army progress time. Public perception of need of progress appears to have advanced rather more rapidly.

At a later date Good Samaritan Hospital nurses assisted in the double catastrophe of the 1906 San Francisco fire and earthquake. Miss May Welch, accompanied by other nurses and doctors, went down to help.

Interestingly enough, the Board was alert to the significance of the training school in the health of the community. In 1903 an astute and socially-conscious recommendation was made that one month of the senior year of each nurse in the Training School be under the direction of the Visiting Nurse Association of the city of Portland.

The project apparently ended with its proposal. No statement can be found to account for its failure; it is reasonable to suppose that the hospital could ill afford the loss of a student's services. It is also possible that the proposal did not meet with a warm reception from the Visiting Nurses' Association, as has happened more recently. In any case, a worthy idea failed to become a reality.

To summarize accomplishments briefly before tracing later developments, the infant training school shows on one hand a student whose training period consists chiefly of learning by doing, who expects herself, and is expected, to enact a role of almost complete self-abnegation in fulfilling her vocation, but withal anticipates a training which will enable her to earn her own living in a way which will give
her personal satisfaction and some financial independence. On the other hand is the hospital and its training school "officers" engaged in a new and enterprising venture, but, because of the paucity of nursing schools, lacks outside measuring sticks, is completely authoritarian, and is subject to few controls.

This situation could hardly prevail; its continuance would have been an anomaly in this country. The types of authoritarian institutions which have continued to exist, the religious and the military, were not intended as patterns either by pioneer nursing leaders nor by students. Consequently, there was a gradual development of organizations which were to influence nursing generally, and the Good Samaritan Hospital specifically. In 1911 the American Nurses' Association was formed, and the following year, 1912, saw the formation of the National League of Nursing Education.

The significance of the purpose and contributions of these organizations lies in the phenomenal increase in nursing schools throughout the country.

<table>
<thead>
<tr>
<th>Year</th>
<th>Nursing Schools in Oregon</th>
<th>Nursing Schools in the United States</th>
</tr>
</thead>
<tbody>
<tr>
<td>1890</td>
<td>Astoria</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>Coffey</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Good Samaritan</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Portland Methodist</td>
<td></td>
</tr>
<tr>
<td></td>
<td>St. Vincent's</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The Dalles</td>
<td></td>
</tr>
<tr>
<td>1910</td>
<td>1,100</td>
<td>1,100</td>
</tr>
</tbody>
</table>

"Schools" were established in a multiplicity of hospitals as a means of nursing patients, not as a learning activity. The
number of ill-trained nurses caused grave concern throughout the country, but especially to nursing educators.

Miss Adelaide Nutting, in her address to the Superintendents' Society in 1897, quoted from a current periodical which implied that

only about one-third of our graduates turn out satisfactorily; of the remainder some are thoroughly bad, but the majority are mediocre.... It (the periodical) states frankly that there is a growing dislike to trained nurses, so that people say that they will put up with anything rather than have one of these undesirable young women enter their homes. While declining to accept such a depressing statement as anything approaching to a universal truth, it must be confessed that the criticism has some foundation in fact. What can be done to improve the situation? (94, pp. 1-3, 16)

Poorly trained nurses were not tolerated by Miss Loveridge; her students worked hard, but they became skillful practicing nurses.

The Oregon State Nurses Association, the immediate local influence, was formed in 1904 after a preliminary meeting of forty-five nurses. Its first treasurer was Elsie Hamilton (Good Samaritan Hospital, class of 1896). (35, p. 86) This association soon promoted legislation for licensing nurses and for specific standards of preparation for nurses practicing in Oregon. The Nurse Practice Act was passed in 1911, its agent, the Oregon State Board for Examination and Regulation of Graduate Nurses. Of the first fifty nurses licensed in the state, twenty were Good Samaritan Hospital graduates. Margaret Evelyn Woods (1903) received the fourth license issued. (92)
A concomitant of the Board's authority to license trained nurses was its prerogative of setting minimal educational and clinical standards, preliminary to writing the state examinations. A corollary was the accrediting of nursing schools within the state and knowledge of requirements in other states.

The Good Samaritan Hospital Training School was now subjected to various outside pressures in maintaining its position as a school, if its graduates were to avoid penalization or restrictions in the practice of their profession.

Comparative Requirements

<table>
<thead>
<tr>
<th>Oregon State and Oregon State Board of Nurse Examiners</th>
<th>Good Samaritan Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>1901 First High School Law</td>
<td>1912 Grammar School graduation plus one year of High School, or its equivalency</td>
</tr>
<tr>
<td>1911 Creation of Board by State legislation</td>
<td>1917 High School diploma required</td>
</tr>
<tr>
<td>1914 High School diploma, or its equivalency required</td>
<td>1914 3 months probationary period (some nursing responsibilities)</td>
</tr>
<tr>
<td>6 weeks preliminary period without nursing responsibilities - 3 months probationary period</td>
<td></td>
</tr>
<tr>
<td>1915 High School tax funds mandatory</td>
<td>1917 3 year program inaugurated</td>
</tr>
<tr>
<td>1919 Total program - 3 years</td>
<td></td>
</tr>
</tbody>
</table>
It is evident from the above table that the Good Samaritan Hospital was abreast of the state's minimum requirements and in certain instances ahead of them. Through the years the school has received state certification, and its recent graduates can be licensed in all states and territories by reciprocity, without penalty. In 1949, as a result of analysis by the National Committee for the Improvement of Nursing Services (Subcommittee on School Data Analysis), the school was placed in Group 1 for hospital nursing schools, 1,155 schools participating. (76, pp. 34-44)

The period of the 1930's marked a turning point toward a goal of professional education. Whether this can be rightly attributed to national nursing education trends or whether it was simply a by-product of the depression is uncertain. The two were probably interwoven one with the other.

Findings and recommendations of the National Committee of Grading Schools of Nursing (1920's) received widespread publicity, with the closing of many inferior schools a direct result. Among the specific recommendations for improvement of the Good Samaritan Hospital were:

1. Reduce student enrollment to equalize clinical experience for all.
2. Increase curriculum class hours.
3. Improve student health program.
4. Improve dormitory facilities.
5. Employ more graduate nurses.

The official hospital report of the school shows cognizance of the findings and certain remedial steps taken may have been due to this. However, the depression, which came closely on the heels of the report, caused a sharp decline in student enrollment. Expediency demanded that nursing and the nursing school be made attractive.

<table>
<thead>
<tr>
<th>Student Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1931</td>
</tr>
<tr>
<td>1932</td>
</tr>
<tr>
<td>1933</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Student Recruitment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1930</td>
</tr>
<tr>
<td>The work of a nurse is difficult and exacting in both theory and practice and in order to meet the demands put upon them, students are expected in every way to observe the rules of personal hygiene. They must plan their hours off duty so that they receive the necessary amount of sleep, they are to appear at the dining room at the appointed hours, and protect themselves from rain and cold while coming off or going on duty. A student who is persistently underweight will be sent home.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1931</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health program</td>
</tr>
<tr>
<td>Cooperative Student-Faculty Organization</td>
</tr>
<tr>
<td>Glee Club</td>
</tr>
<tr>
<td>Orchestra</td>
</tr>
<tr>
<td>Graduation awards</td>
</tr>
<tr>
<td>(25, pp. 28, 29, 35, 36)</td>
</tr>
</tbody>
</table>
Applicants should be at least fifty-two (sic) inches tall and weight not less than one hundred and ten pounds. If taller than above and weight is not consistent with height and age, applicant will be rejected. Correct weight (author's italics) will be sent upon request if age and height are submitted. It is possible to increase to correct weight.

Neither divorced nor married women are accepted. Widows whose husbands are dead (sic) will be admitted if they meet requirements otherwise. Should a student marry during her course in training, she automatically terminates her connection with the school.

Smoking and drinking are positively forbidden and those who indulge in either are requested not to apply for admission to the school.

During the first three months the record of the student is carefully considered and if found unsatisfactory, the student will not be permitted to continue the course. This is in justice to the student, to the school, and to the profession.

At any time during the course the Director of Nurses may, with the approval of the Superintendent of the Hospital, suspend or expell any student for inefficiency, misconduct, neglect of duty, or failure to develop qualities fitting the profession.

The sharply negative tone in the 1930 information dealt the prospective nurse eliminates any need of interpretation;
only a simple wonderment remains that there were any nurses! Interested candidates would presumably have been successful in a religious order.

Curriculum Content - 1930

First Year
- Principles of Nursing
- Bacteriology
- Hygiene and Sanitation
- Anatomy and Physiology
- Materia Medica
- Bandaging
- Nursing Ethics
- Chemistry
- Nutrition

Second Year
- Dietetics
- Surgical Nursing
- Medical Nursing
- History of Nursing
- Pediatrics
- Gynecology

Third Year
- Obstetrics
- Nursing in Tuberculosis
- Nursing in Mental Diseases
- Nursing in Communicable Diseases
- Orthopedics
- Introduction to Public Health Nursing
- Massage

The working hours of the upper class students continued to consist of an eight hour day (excluding class hours).

The nursing hours were reduced to a 20–24 hour week (excluding classes) for the preliminary students (4–6 months) where they remained essentially unchanged until 1947.

Affiliation with other educational institutions was erratic. The 1928 hospital report contained plans of an affiliation with the University of Oregon Medical School for a combined nursing-college program, which was in effect in 1930. At this time, also, arrangements were made for teaching
of sciences in the basic nursing course at the Medical School. (25, pp. 28-29) In 1936, a transfer was made to St. Helen's Hall Junior College (Episcopal) for basic science teaching; the college program was terminated.

The fluctuating educational policies can only be attributed to (1) a lack of conviction on the part of hospital administration of the value of a collegiate program, and/or (2) the desire for an alliance with Episcopal-Church-operated institutions.

With the change in psychological approach to the prospective nurse came social and democratic practices in the school. These could not have occurred without the sanction of the hospital nursing staff.

Director of Nursing - Miss Bertha Wilson, R.N.
Assistant Director - Miss Lillian Ffenninger, R.N.
Instructor - Miss Christien Larsen, R.N. (G.S.H. 1919)

In 1931 the cooperative student-faculty organization was formed. Its first officers were:

President - Corinne Pennington
Vice-President - Allicia McMillan
Secretary - Buena Wetherbee
Treasurer - Carla Walters

It was on December 17, 1932, that the first of the traditional Capping Services took place in the Nurses' home. Credit for form and charm of service has been given to Corinne Pennington who had done much of the work involved in the new Student Government and in formulating its By-Laws.

The passage of the Bolton Act at the beginning of World
War II with formation of the Cadet Corps of Nurses was of distinct benefit to many nursing schools—and to that of the Good Samaritan Hospital specifically by providing money for more instructors.

In 1940, the minutes of the Oregon State Board of Nurse Examiners show that members felt that no single school in the State had enough instructors for adequate clinical teaching and supervision. (35, p. 59) The teaching staff of the Good Samaritan Hospital totaled seven (excluding Science instructor and physician lectures), all of whom filled at least one other assignment (Student enrollment 110-120; classes admitted semi-annually).

Assistant (to Director) in Charge of Nursing Education
Nursing Arts Instructor
Supervisor of Surgeries and Instructor in Surgical Techniques
Supervisor of the Obstetrical Department and Instructor in Obstetrics
Supervisor of the Medical Department and Instructor in Medical Nursing
Supervisor of the Pediatric Department and Instructor in Communicable Disease Nursing (29, pp. 24-26)

In order to meet the Cadet Corps standards, Federal Aid was granted the school in 1941 ($5,160), (29, p. 25) which was used for two additional instructors (medical and surgical) and the first school librarian (Mrs. Mary Fernandez). Appropriation was also made for the long-needed social service workers, but because one was not available a substitute
instructor was procured.

The value of the Cadet Corps was permanent in several ways. Outstanding was the heritage of the additional instructors who were maintained after the termination of the Cadet Corps in 1948.

Another beneficial result of the Cadet Corps was the reduction in hours of work. This meant a more positive attitude toward nursing education, with the mitigation of nursing service.

In the progress of the school thus far it has been seen that the training school, a child of Bishop Morris' desire to provide quality nursing care for hospital patients, was compatible with a need for trained nurses outside the hospital. For young women the school offered a training in skills which would equip them for earning their livelihood in a field of continuous growth and variance in job opportunities.

The quality of the school program has been such that it matched local minimum standards set by the Oregon State Board of Nurse Examiners. Changes and improvements were introduced as a result of outside forces rather than self-initiated. The law of supply and demand of nurses has affected its policies.

Its continued existence in contrast to other Oregon schools which have closed may be explained severally. In the first place, as the first nursing school in the northwest,
it was well known because of its age, and it was ensconced in the public mind as a reputable school through its graduates.

Again, as a Protestant-sponsored hospital, it offered a certain appeal to girls of Protestant or non-Catholic beliefs, although no religious restrictions ever existed.

The size of the hospital and the strength of its medical staff have been strong factors in the continued success of the school. Finally, the test of its endurance must lie with the quality of the school and the success of its graduates.

Distribution of Graduates, Class of 1892 - Five Years Later

<table>
<thead>
<tr>
<th>1897</th>
<th>Total Number of Graduates - 41</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deceased - 2</td>
<td>Portland 16</td>
</tr>
<tr>
<td>Private Duty - 27</td>
<td>Los Angeles, Cal. 1</td>
</tr>
<tr>
<td></td>
<td>Boise, Idaho 1</td>
</tr>
<tr>
<td></td>
<td>Seattle, Wash. 3</td>
</tr>
<tr>
<td></td>
<td>Denver, Colo. 1</td>
</tr>
<tr>
<td></td>
<td>Helena, Mont. 1</td>
</tr>
<tr>
<td></td>
<td>Olympia, Wash. 1</td>
</tr>
<tr>
<td></td>
<td>Ashland, Oregon 1</td>
</tr>
<tr>
<td></td>
<td>San Francisco, Cal. 1</td>
</tr>
<tr>
<td></td>
<td>Knoxville, Tenn. 1</td>
</tr>
<tr>
<td>Good Samaritan Hospital---</td>
<td>Assistant Superintendent - (1)</td>
</tr>
<tr>
<td></td>
<td>Matron - (1)</td>
</tr>
<tr>
<td>Hospital Superintendent---</td>
<td>Spokane 1</td>
</tr>
<tr>
<td>At Home, married</td>
<td>Salem 1</td>
</tr>
<tr>
<td></td>
<td>Eugene 1</td>
</tr>
<tr>
<td></td>
<td>Seattle 1</td>
</tr>
<tr>
<td></td>
<td>Portland 1</td>
</tr>
</tbody>
</table>

(cont.)
At Home, unmarried

<table>
<thead>
<tr>
<th>Location</th>
<th>Graduates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boise, Idaho</td>
<td>1</td>
</tr>
<tr>
<td>Somerville, Ore.</td>
<td>1</td>
</tr>
<tr>
<td>Portland</td>
<td>1</td>
</tr>
<tr>
<td>Dist. of Columbia, Ore.</td>
<td>1</td>
</tr>
<tr>
<td>Eugene</td>
<td>1</td>
</tr>
</tbody>
</table>

Seven states, the District of Columbia and five Oregon communities had representatives of the Good Samaritan Hospital.

So much for the distribution of the earliest graduates. Where and what were the later graduates of the hospital doing?

**Geographical Distribution in 1934 - Total Number of Graduates - 1130**

(States where one or more graduates were in residence)

<table>
<thead>
<tr>
<th>State</th>
<th>Graduates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona</td>
<td></td>
</tr>
<tr>
<td>California</td>
<td></td>
</tr>
<tr>
<td>Colorado</td>
<td></td>
</tr>
<tr>
<td>Idaho</td>
<td></td>
</tr>
<tr>
<td>Indiana</td>
<td></td>
</tr>
<tr>
<td>Illinois</td>
<td></td>
</tr>
<tr>
<td>Indiana</td>
<td></td>
</tr>
<tr>
<td>Iowa</td>
<td></td>
</tr>
<tr>
<td>Ohio</td>
<td></td>
</tr>
<tr>
<td>Kansas</td>
<td></td>
</tr>
<tr>
<td>Maine</td>
<td></td>
</tr>
<tr>
<td>Michigan</td>
<td></td>
</tr>
<tr>
<td>Minnesota</td>
<td></td>
</tr>
<tr>
<td>Montana</td>
<td></td>
</tr>
<tr>
<td>Nebraska</td>
<td></td>
</tr>
<tr>
<td>Nevada</td>
<td></td>
</tr>
<tr>
<td>New Jersey</td>
<td></td>
</tr>
<tr>
<td>New Mexico</td>
<td></td>
</tr>
<tr>
<td>New York</td>
<td></td>
</tr>
<tr>
<td>North Dakota</td>
<td></td>
</tr>
<tr>
<td>Oregon</td>
<td></td>
</tr>
<tr>
<td>Pennsylvania</td>
<td></td>
</tr>
<tr>
<td>South Dakota</td>
<td></td>
</tr>
<tr>
<td>Tennessee</td>
<td></td>
</tr>
<tr>
<td>Texas</td>
<td></td>
</tr>
<tr>
<td>Utah</td>
<td></td>
</tr>
<tr>
<td>Virginia</td>
<td></td>
</tr>
<tr>
<td>Washington</td>
<td></td>
</tr>
<tr>
<td>West Virginia</td>
<td></td>
</tr>
<tr>
<td>Wyoming</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>30</strong></td>
</tr>
</tbody>
</table>

**U. S. Territories**

<table>
<thead>
<tr>
<th>Territory</th>
<th>Graduates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alaska</td>
<td></td>
</tr>
<tr>
<td>Hawaii</td>
<td></td>
</tr>
<tr>
<td>Philippine Islands</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3</strong></td>
</tr>
</tbody>
</table>

**Foreign Countries**

<table>
<thead>
<tr>
<th>Country</th>
<th>Graduates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canada</td>
<td></td>
</tr>
<tr>
<td>China</td>
<td></td>
</tr>
<tr>
<td>England</td>
<td></td>
</tr>
<tr>
<td>Italy</td>
<td></td>
</tr>
<tr>
<td>Japan</td>
<td></td>
</tr>
<tr>
<td>Northern Ireland</td>
<td></td>
</tr>
<tr>
<td>Mexico</td>
<td></td>
</tr>
<tr>
<td>Sweden</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>8</strong></td>
</tr>
</tbody>
</table>
The fact that many nurses had residence in various parts of the world because of marriage does not preclude the probability that they were engaged in some form of nursing or health activities. Seldom, if ever, is the nurse completely weaned from nursing.

Professional Categories - 1934
Total Number of Graduates - 1130

Administration
  Hospital and allied institutions
  School

Anesthesia

Dental nursing

Clinic

Industry

Institutional
  Staff nursing
  Supervision, etc.

Military
  Army
  Navy
  Marine

Office nursing

Mission, medical

Private duty

Public Health
  County
  School
  Visiting Nurse Association
  U. S. Veterans' Bureau

Public Welfare

Record librarian

Red Cross

Registry - O.S.N.A. Dist. #1

Stewardess - air line

Tuberculosis nursing

X-ray technician
While the high esteem accorded a skillful nurse speaks for the value of her achievement, selection of representative, successful practicing nurses gives a clue to the effectiveness of her preparation together with her natural aptitude.

Helen Fisher (deceased) 1919

Supervisor, School Hygiene Division, City Bureau of Health, Member National Organization of Public Health Nursing, Board of Directors, School Section. Good Samaritan Hospital School of Nursing Advisory Committee.

Mrs. Elizabeth Mouser (Elizabeth Powers), 1927

President, Oregon State Board of Nurse Examiners, 1938-1939.

Mrs. Evelyn Chance (Evelyn Cathey), 1920

President, Oregon State Board of Nurse Examiners, 1946-1947. Good Samaritan Hospital School of Nursing Advisory Committee Instructor of Polio Nursing, National Organization of Infantile Paralysis.

Carey Alice Joseph (deceased), 1911

Director, Registry, Oregon State Nurses' Association, District #1, 1933-1948. Superintendent of St. Helen's Hospital, St. Helens, Oregon, five years.

Mrs. Hazel Foeller (Hazel Cowan), 1922

Superintendent City Isolation Hospital, Portland, three years. Supervisor, School Nursing, 1950.

Bessie Williams, 1921.

Acting Director, School Hygiene Division, City Bureau of Health, Portland.

Mrs. Alice Herzl (Alice McDuffee), 1951

Director of Nurses, Good Samaritan Hospital, 1945-1948. Director of Nurses, West State Hospital, Weston, Virginia, 1948-1949.
Alice E. Nakano, 1930

Staff Nurse, St. Luke's Hospital, Tokyo, Japan, 1934-1938. Evening Supervisor, Good Samaritan Hospital, 1949-

Mrs. Albert Mount (Myrtle Stevens), 1911.

Former Director, State College Hospital, Pullman, Washington.

Celia Bast, 1920

Former night supervisor, Good Samaritan Hospital. Administrator, Holliday Park Hospital, Portland, 1934-
President Oregon Association of Hospitals (2 terms; only woman president). Secretary, Portland Council of Hospitals, 1938-

Mrs. Jean Hamilton (Jean Peterson), 1935

Assistant Director, School of Nursing, Good Samaritan Hospital, 1945-1947. Former Secretary, President, Oregon State Nurses Association.

Alta Hollenbeck, 1919

Acting Director, Good Samaritan Hospital, 1942-1945. Purchasing Agent, Good Samaritan Hospital, 1945, and Assistant Superintendent, 1945-

Bertha R. Evans, 1928

Lt. Commander, U. S. Navy. Prisoner of War, Japanese theatre, World War II.

Lillie L. Tracey, 1923

Former Assistant Director of Nurses, 1942-1948.

Laura Lenhart, 1911

Superintendent of Training School, St. Elizabeth's Hospital, Shanghai, China

Isabel Leslie, 1929

Mission nursing, Waun H. Honen, China

Mrs. Jean Mundal (Jean McIrvin), 1940

Former Director Nursing Education, Good Samaritan
Hospital.
As student nurse: Oregon State League of Nursing Education Award: Biennial Nurses' Convention, 1940

Other forms of professional contributions:

Mrs. Annabelle Carlson (Annabelle Mickle), 1921
Violet Kirschmer, 1922

Recipients of awards given by American Red Cross, Portland Chapter, volunteer service during World War II.

Mrs. Florence Shelton (Florence Toon), 1910

Invention of re-breathing paper bag, in current use at Good Samaritan Hospital.

Mrs. Nola Sheldon (Nola Smith), 1936

Professional publication, "Fastening the Miller-Abbott Tube at the Nostrils."

Transfer of attention to specific phases of general developments of nursing as applied to the specific hospital call to mind a major area of change, i.e. the change in composition of the nursing staff.

Until the depression of the 1930's, students performed most of the activities of nursing; administrative and menial tasks alike fell to them. In 1911 Miss Jolly reported, "From the senior class are selected our Head Nurses, a position for which other hospitals of this size graduate nurses are employed." (13, p. 34) The bed capacity was then about 250, and the general situation remained unchanged for another twenty years.

An early use of student nursing was for "specializing."

Miss Loveridge has said that the students were rarely assigned
to nurse home cases, but it seems not to have been uncommon in the hospital. Miss Jolly reported in 1910:

At the present time there are ninety pupils in the school. With our present number of nurses it is impossible to give our own pupils the work of the nursing of special cases, thus causing monetary loss to the hospital, but also depriving the pupils of much valuable experience. (12, p. 45)

The period of the depression, then, serves to mark a point where the graduate nurse achieved a place of importance in the hospital scheme. The need of greater proficiency and maturity in professional practice was being realized by the medical profession, and the depression accelerated an already growing movement.

Not until the World War II period, with its shortage of graduate nurses, however, was a general need of non-professional workers detected, despite earlier recommendations to that effect by nursing and hospital authorities. Their advent and the close proximity in time of improved salaries and other personnel policies for nurses has given the Union an unwarranted sense of accomplishment for nurses.

The union contract between the hospital and Local 49, American Federation of Labor, stipulated certain policies as increased salaries, fixed vacation allowance, sick time, etc. Salaries of all employees necessarily had to be comparable to those of the untrained helpers, which resulted in an immediate rise in hospital costs of operating.

Added to the problems of finance, accentuated by the attendant and orderly group, arose an imperative need for an
on-the-job training program inaugurated in 1946.

The shortage of nursing personnel which was abated neither with the war's end nor in the post-war period, was the direct cause of a new category of nurses: practical (or attendant) nurses. A training program for practical nurses was begun under the Portland Public School System, and in 1949 a state law was promulgated requiring licensure of all practical nurses.

In contrast to the nursing staff of fifty years ago, the strata of nursing personnel include, then, the following:

1. graduate nurses
2. student nurses
3. trained and licensed practical nurses
4. untrained and licensed practical nurses (waiver)
5. untrained and unlicensed practical nurses (attendants)

<table>
<thead>
<tr>
<th>Hospital Nursing Staff - 1950</th>
</tr>
</thead>
<tbody>
<tr>
<td>Graduate nurses (in all positions)</td>
</tr>
<tr>
<td>Student nurses</td>
</tr>
<tr>
<td>Attendants (untrained; experienced and inexperienced)</td>
</tr>
<tr>
<td>Orderlies</td>
</tr>
</tbody>
</table>

The ratio, close to 50:50, demands ample and highly capable supervision to ensure the safety and quality care for the patients. Recognition of the right of every patient to have sufficient nursing care for his needs was given by the Board in 1948 when it went on record of approval of an average 3:5 hours of nursing care per patient, in line with certain findings of national research into hospital and care problems. (95, p. 60)
As no breakdown of ratio of professional:non-professional hours of care was made in accordance with the findings of the study, nor with relation to individual and specific group needs, the action was more important as a gesture of intent than as a means of ensuring high quality of care to each patient.

In concluding this phase of the hospital history of development, three main points may be permitted:

1. Those caring for the sick are no longer imbued solely with religious desire to devote their lives to that end, but are interested in pursuance of a profession which offers personal satisfaction, reasonable financial security, and a normal life. Such prerequisites as hours off duty, vacations, holidays are expected by the modern nurse, in contrast to the early nurse who expected (and received) little consideration.

2. Activities performed by graduate nurses have continuously grown in number and complexity, in line with medicine and science. These have resulted in a more thorough academic preparation and broadened experience in the clinical educative process.

3. The seed of using less skilled supplementary workers for routine nursing activities has flowered into the trained practical nurse, who resembles the trained nurse of 50 to 60 years ago. However necessary, the employment of non-trained nursing personnel for patient care, their indiscriminate use is not for the best interests of the patient. Therefore supervision and competent on-the-job training is imperative for the safety of the patients.
CHAPTER VI
CURRENT PROBLEMS AND CHANGING SOCIAL CONCEPTS

In a general discussion of contemporary hospital problems and new or changing attitudes, the hospital strike (January 2, 1951 - December 6, 1951) is charged with implications for the future.

The ostensible reason for the walk-out of more than one hundred non-professional employees was failure to obtain the Board's consent to a Union shop. Earlier grievances, during the preceding six months, had included wages; the goal was $1.00 an hour for untrained workers at a time when the professional nurses were paid $1.21 per hour. The decision to strike appears to have been fairly arrived at by the membership (Building Service Employees, Local 49, American Federation of Labor). Twice votes were cast; once by the organization as a whole; the second by hospital employees only. It is reasonable to believe that the decision was accelerated by failure to obtain concessions for a union contract from the Emanuel Hospital.

The attitude of the public toward the strikers was unsympathetic as expressed by local newspapers.

After the initial onslaught of the attack, bravely met by professional employees, volunteers and new employees, the strike settled down to its twelve months' stalemate. Its
ultimate dissolution brought no new solutions or concessions; the settlement terms were, in effect, those which had prevailed prior to the walk-out. (159, pp. 1, 12)

Of the larger place of unions in the United States, Local 49 is a small unit. Its activities must be related to others, and it appears unlikely that the present interlude of peace will continue long.

Because a strike against a hospital has especial meaning, certain fundamental questions occur.

1. Did the strike by non-professional hospital employees, which included licensed practical nurses, reveal a lack of moral responsibility for the care of the sick, even to the extent that actual preservation of life may have been jeopardized?

2. Is the inherent difference between professional and practical nurses that of moral, ethical responsibility, educational qualifications aside?

3. Could not have dissatisfied hospital employees obtained work elsewhere?

4. Is it possible for a union to strengthen its position when it has demonstrated its potential, and real dangers by striking at the only large Portland hospital with which it had a contract?

5. A fundamental precept of our Christian, democratic society is that of the inherent value of the human life. Should, then, any hospital have a Union contract, since its ultimate weapon must be the strike? And a strike against a hospital is a strike against activities concerned with the saving of lives.

Attention is focused on another well-publicized problem— the national and local shortage of nurses. A survey conducted by the United States Public Health Service under
the auspices of the Oregon State Nurses Association revealed
the total number of active nurses in the State to be 6,037,
and of this number 3,478 were professional; the remainder,
non-professional. On the basis of accepted standards (not
budgets) of nursing care, the estimated number of nurses
needed was 7,651. (108A, pp. 26-29) This is in proportion
to the national need:

<table>
<thead>
<tr>
<th>Year</th>
<th>Estimated Active Nurses</th>
<th>Estimated Need of Active Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1949</td>
<td>300,533</td>
<td></td>
</tr>
<tr>
<td>1950</td>
<td>409,700</td>
<td></td>
</tr>
</tbody>
</table>

Given the facts of the nursing shortage and disregarding
causes, questions for consideration relate to the procure-
ment of more nurses, efficient use of those available, and
an understanding of the contemporary meaning of good nursing
care.

Because the Portland Council of Hospitals has mutual
agreements on salary scales in conjunction with the Oregon
State Nurses' Association, District #1, the employing and
retaining of nurses depends much on the job satisfaction for
the individual nurse. (An exception must here be inter-
polated; the Federal Government, through its Veterans' Hos-
pitals consistently pays salaries which in few areas of the
United States compare with those which can be offered by non-
tax supported hospitals.)

Preparatory to consideration of problems evolving about
advantageous use of nursing personnel available, is a deter-
mination of standards of nursing care and its meaning. The following definitive statements have been taken from a recent nursing publication:

The modern concept of adequate patient care interprets their care in terms of total patient needs, whether these be diagnostic, preventative or therapeutic; physical, psychological, spiritual or social. It recognizes the patient as a person, with an individual personality and with individual needs, who has come from a recognized place within the family and the community and must be helped to make his adjustment to his condition and his new environment. The ultimate objective of adequate patient care is to return the individual to his family and community restored to health and productive capacity. In some instances he must be prepared to adjust his living to his physical potentialities. (69, p. 1)

It has also been recognized that "the amount of nursing service, professional and non-professional, which an institution provides is a significant index of the quality of care that it gives." (69, p. 28)

Average number of general nursing hours needed per patient in every twenty-four hours in hospitals surveyed:

<table>
<thead>
<tr>
<th>In ward and semi-private accommodations</th>
<th>% Professional</th>
<th>% Non-professional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>3.4 hours</td>
<td>65</td>
</tr>
<tr>
<td>Surgical</td>
<td>3.5</td>
<td>70</td>
</tr>
<tr>
<td>Mixed (medical-surgical)</td>
<td>3.4</td>
<td>67</td>
</tr>
<tr>
<td>Obstetric</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Postpartum</td>
<td>3.0</td>
<td>65</td>
</tr>
<tr>
<td>Newborn</td>
<td>2.8</td>
<td>77</td>
</tr>
<tr>
<td>Pediatric - all ages</td>
<td>4.6</td>
<td>80</td>
</tr>
<tr>
<td>In private accommodations, medical and surgical</td>
<td>3.8</td>
<td>76</td>
</tr>
</tbody>
</table>

(Supplementary figures and findings include evaluation of student level of performance, ratio of supervisors to patients, etc.)
The mean average of nursing hours per patient indicates that the decision of the Good Samaritan Hospital Board---3.5 average hours per patient---is in line with the general findings of the study. However, certain problems exist with relation to the number and distribution of authorized paid personnel, and restrictions on student nursing service due to classes, and clinical experience requirements. The total number of nursing personnel as of August, 1950 was:

General Hospital: (including head nurses and supervisors)

Nurses 70
Practical nurses (attendants and orderlies) 80.5
Student nurses 100

Wilcox Memorial Hospital (1stetrical)

Nurses (not including delivery room, 10) 35
Practical nurses 20
Student nurses 7

By way of further pointing up the problems of ensuring adequate nursing care to all hospital patients, the comparison of two departments, comparable in size, is presented.

Obstetrical Department (completely specialized) 61 beds

Ratio Nursing care:
Professional 60%
Non-professional 40%

Men's orthopedic and surgical (4 West) - 61 beds

Nursing care:
Professional 35%
Non-professional 65%

For purposes of convenience, both departments were computed on a basis of 85% occupancy, a high average, for a single day
only, assuming all personnel are on duty for eight hours. For present purposes, it is irrelevant to give daily average care, according to the actual findings.

The foregoing leads to the question of means of welding the three single entities into a single instrument of nursing care.

A glance at the patients making up the hospital census accentuates the urgency of need of trained nurses to replace untrained workers. The longer life span of the general populace has, quite naturally, resulted in a preponderance of an older age group of hospital patients.

On a "typical" day in a medical ward (4 Center) of the 36 patients in the department, 22 were over 60 years of age, 11 were over 70 years of age, and two of the three younger patients were confined to "closed" rooms by reason of mental aberrations. In caring for older people, experience has taught the necessity of using bed rails to prevent the elderly confused patient from falling out. The need of special skin care is clearly evident to prevent abrasions and sores of the dry, old tissues. But these physical needs are not enough in themselves. An active, positive program of diversional and occupational therapy is the sine qua non of the care of the whole patient. The weakness in care of the mental wellbeing of the patient is further aggravated by such factors as: the high proportion of untrained (except on the job) for nursing care, the insistent pressure of overwork ex-
experienced by the professional nurses which allows no time for the supplying of "narcissistic needs" of the patient. Even more devastating is her unawareness of such patient needs occasioned by her excessive awareness of the physical needs of the sick, and the multitudinous tasks assigned which may or may not bear a resemblance to nursing, in its common connotation.

Unless some method is devised which permits the professional nurse to obtain satisfaction from her work, a high percentage of turnover among the staff cannot be reduced. The impossibility of increasing the number of nurses in the immediate future does not absolve the hospital from responsibility in seeking methods for minimizing non-essential, non-nursing duties for the nurses, and allocating them elsewhere.

In looking toward the future nursing of these older patients, the high percentage of early school leaves casts a real cloud on the horizon. While student enrollment has been slightly lower than the war and pre-war years, the incidence of student loss is much more disastrous.

Students enrolled in 1947 - Graduated in 1950

<table>
<thead>
<tr>
<th>National</th>
<th>Oregon</th>
<th>Good Samaritan Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>34.1%</td>
<td>48.2%</td>
<td>57%</td>
</tr>
</tbody>
</table>

Percent of Early School Leaves - 5 Years

<table>
<thead>
<tr>
<th>Year Graduated</th>
<th>Good Samaritan Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>1945</td>
<td>25</td>
</tr>
<tr>
<td>1946</td>
<td>40</td>
</tr>
<tr>
<td>1947</td>
<td>57</td>
</tr>
<tr>
<td>1948</td>
<td>44</td>
</tr>
<tr>
<td>1949</td>
<td>64</td>
</tr>
</tbody>
</table>

(author's findings)
These figures induce concern on at least five counts:

1. Reduction of number of future graduate nurses
2. Student nurse recruitment program affected
3. Source of poor hospital-public relations
4. Financial loss to students and to hospital
5. Psychological trauma to student

The costs of nursing education have long been problematical. In contrast to the estimated one-half billion dollars spent on medical education following the publishing of the Flexner report (70, p. 385) through private philanthropy, endowments for nursing schools have been minimal if not almost non-existent.

Student nurses have, through nursing service, paid for a higher percentage of their costs of education than has been found true in comparable professional education programs. In representative schools 88% of the cost was via nursing service, 11% student fees and 1% hospital funds. (37, pp.165-167)

Notwithstanding the fact that a break-down of costs of student education at the Good Samaritan Hospital is not available, it may be properly considered a fair representative of the three year hospital nursing schools. A conundrum exists then: when student nursing service is reduced to provide a more equitable educational experience, the differential cost must be borne by the hospital. The hospital has two sources of income: charitable gifts and patient fees. The propriety of using either income for student education is open to question. The precarious position of the country, and Oregon, specifically, with relation to its future nurses
makes advisable the inauguration of a student tuition which might proximate the actual cost of education.

A possible solution appears to exist in the use of public funds for nursing education—as has been practiced in other fields. The general public is sufficiently concerned to make possible Federal appropriations, whether administered according to the precedent set by the Cadet Nurses Corps or some other device.

Another problem which the hospital has faced is the tendency of the public to misconstrue or misunderstand the meaning of its charitable role. This seems to prevail as commonly among medical personnel as non-medical, and may be accredited to specific causes: (1) the fact that large numbers of persons have contributed to the construction of new buildings, (2) the average individual has paid his hospital bill, regardless of the personal sacrifice entailed, and (3) ignorance of actual costs of operating and existing deficits of a hospital—individual hospital charges seem excessive. These lead to casual assumptions that the hospital is avaricious and wealthy. A look at the records proves the contrary, but first a definition of charity may be appropriately inserted at this point.

Charity may be defined in another sense.

Charity in its legal sense extends to the poor as well as the rich; a person who is sick, injured or afflicted, or is in a helpless condition, is a proper object to be included in the purpose of public charity, whether he is poor or not. (32, p. 511)
The essence of meaning is that the Good Samaritan Hospital, with or without its precedent of free care, is a veritable charitable organization and is so incorporated under the laws of Oregon pertaining to charitable and eleemosynary institutions.

Hospital Days of Care, Good Samaritan Hospital
(selected years)

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Patients Cared For</th>
<th>Full Payment</th>
<th>Part Payment</th>
<th>Free</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1920</td>
<td>8,572</td>
<td>69,180</td>
<td>18,820</td>
<td>6,810</td>
<td>94,810</td>
</tr>
<tr>
<td>1925</td>
<td>8,483</td>
<td>65,930</td>
<td>15,181</td>
<td>15,034</td>
<td>96,245</td>
</tr>
<tr>
<td>1930</td>
<td>8,357</td>
<td>58,942</td>
<td>14,171</td>
<td>8,267</td>
<td>81,380</td>
</tr>
<tr>
<td>1935</td>
<td>8,496</td>
<td>57,758</td>
<td>2,566</td>
<td></td>
<td>62,834</td>
</tr>
<tr>
<td>1940</td>
<td>9,524</td>
<td>81,432</td>
<td>205</td>
<td>3,150</td>
<td>84,432</td>
</tr>
</tbody>
</table>

*Percentage of payment of hospital bills not known.

Sources - Annual Reports of Board of Hospital Trustees

Estimated Financial Value of Free Care Given Good Samaritan Hospital

<table>
<thead>
<tr>
<th>Year</th>
<th>Total &quot;Free&quot; Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>1932</td>
<td>$82,397.10</td>
</tr>
<tr>
<td>1933</td>
<td>68,349.03</td>
</tr>
<tr>
<td>1934</td>
<td>112,157.79</td>
</tr>
<tr>
<td>1950</td>
<td>106,848.00 (approximate; 5% of total income)</td>
</tr>
</tbody>
</table>

(55)
The above table demonstrates unequivocally that large amounts of free care are given. The records do not show:

1. Percentage of free care given with charitable intent

2. Percentage of free care given because of gaps between actual costs of care and hospital rates. For example - so-called "city" cases, periods between Blue Cross increases and higher hospital costs.

3. Bad debts.

In light of the magnitude of the sums of money involved, it would appear that two avenues of approach would make a more effective and fairer way of administering "free" care.

1. Instead of emphasizing the down payment at time of admission of the patient, check his credit rating. Most patients book rooms some time in advance.

2. Institute a social service department that free care may be given as it is most needed, in relation to available charity funds.

A misconception of the meaning of the hospital's charitable status, together with the fact that it does make a profit during some periods, has led to another type of difficulty; that is, the proposition that if a profit is made, tax laws should be enacted to reverse their non-taxable status. Such suggestions seem to be promulgated by politicians during periods of a depleted public treasury, and ignore a basic principle of the non-profit making hospitals. Any profits must revert to the institutions for improvements, equipment and other needs. No salaries are paid Board members, nor do they receive financial benefits from the hospital.
A general interest in the problem of hospitals and their tax status may be assumed from Portland newspaper editorials. (103, Sec. 2, p. 2) The City Club Report on Portland hospitals stated:

A determined effort is being made at the present time to place the Portland hospitals on the Multnomah county tax rolls on the grounds that they are making substantial profits and are non-charitable in character. This effort has been unsuccessful to date, however, it having been held by the Circuit Court January 17, 1948 that Portland Osteopathic Hospital is exempt from taxation as a charitable institution. (58, p. 114)

Both of the Journal editorials corroborated arguments generally propounded in justification of the tax-exempt status: the result must be increased hospital costs, a hardship on the sick; the hospital is the servant of the public and the medical professions; and that, in any event, the ultimate answer must rest with the courts and the voters. (Historically, the hospital was taxed in 1896.)

This year for the first time our property has been taxed by the State. Through proper effort, exemption was secured for the block upon which the hospital stands, and it may be possible to exempt the half block upon which the barn, chicken house, etc. stand. (The chicken house was located on the plot on which the Student Nurses' Home now stands.) (133, p. 67)

The legality of non-taxation of hospitals has been upheld by many courts. Emanuel Hoyt, in his chapter, "The Legal Basis of Tax Exemption," wrote that the belief is erroneous which holds that tax exemption is based solely on the charity which the hospital gives, for other factors are involved. "It has been said that to tax a non-profit hospital
is to place a direct tax on the sick and injured." (32, p. 510) Excerpts from other decisions and opinions follow:

In a sense, tax exemption is a subsidy from the government to agencies which render services affecting the health and welfare of the community. (p. 510)

Organizations founded by religious, charitable, scientific, literary or educational purposes, whose income does not inure to the benefit of any private shareholder or individual, have generally been relieved from the tax on corporations. (p. 511)

Hospitals are entitled to charge at least cost for their services. (p. 514)

A public charity cannot be evaluated by the amount of money it loses in its operations, but by the extent of the good it does for the public in the gain of the community it serves. (p. 514)

Hospitals discharge, at least in part, a function which ordinarily devolves upon the government. (p. 581)

Adequate payments from governmental units for the care of the indigent patients increase the capacity of the hospital to fulfill its functions as an agency for the care of the sick, education of personnel, research and preventive medicine. (p. 517)

As long as the voluntary hospitals unselfishly serve the health of our citizens, there is little likelihood that the people or their representatives will revoke the traditional privilege of tax immunity now enjoyed by public charities throughout the country. (p. 517)

It has been observed, that the place and function of the contemporary hospital does not correlate with its primary stated purposes and objectives. The hospital is expected to charge for its services and the patient is expected to pay for them.

In place of the homely hospital administered by the church as part of its religious and missionary program,
designed primarily for the poor sick, has come the modern hospital, a scientific instrument for use of all who are ill. During the intervening period occurred social and health changes which could not have been practical without the twentieth century hospital. Among these were the Workmen's Compensation Law of 1913 (effective 1914) which defined hazardous occupations and specified methods of financing care of the injured employee. Later safety regulations were incorporated in the State laws. (75) As many as 260,000 workmen are covered by the provisions of the Act and benefits have been paid in excess of $114,321,488. (97, p. 42)

The time has long passed when the worker in the "Iron Mines of Oswego" is dependent upon charity should he become injured on the job, by virtue of the principle that the cost of production must include the cost of worker protection.

Ramifications of the Act are many. For the Good Samaritan Hospital it meant that the injured workman had the unquestioned right to hospital care; the hospital had a right to expect reimbursement.

The 1910 Hospital Report shows that this practice had been adopted by some industries prior to the promulgation of the law. A separate listing of "Company" patients was made, as differentiated from paying, non-paying, part-paying. Evidently regular rates were not charged, which may possibly be the source of the statement, "Certain commercial interests took advantage of the situation and purchased hospital services
at these charity rates, thereby making a profit for themselves." (104, p. 2)

Federal legislation ensuring the rights of individual categories to care include the Crippled Children's Division, the Social Security Act, and Aid to Dependent Children. The use of public funds reduces the need of private philanthropy.

Many privately sponsored agencies fill gaps between available public funds and those of individual institutions. The National Infantile Paralysis Foundation is a specific example of large charity which could not possibly be approached by a single hospital.

These selected examples of existing provisions show the variety of ways evolved for financing hospital bills, by law, by business, or by general subscription.

For the middle-class income group, and its hospital expenses, has been evolved prepaid medical and hospital plans, the non-profit making (Blue Cross, Oregon Physicians' Service) and commercial insurance plans.

The Blue Cross Plan Northwest Hospital Service, as an example, has been in operation since 1942, has a total of 83,286 members, and in the decade has paid a total of $5,754,249.61 in hospital fees for its subscribers, according to figures obtained from the Portland Blue Cross office in July, 1951.

Of the total income received from patients by the Good Samaritan Hospital in 1950, 25% was a "third party" type of
payment (which includes insurance claims, commercial health insurance, etc.) Some 5-6% was payment from State Industrial Accident settlements. This appears to be relatively low in comparison with the industrialized Eastern states, where the percentage may be more nearly 90% in certain areas. (55)

Four factors have contributed to the popularity of the non-profit group hospital prepaid plan:

1. It is a convenient and practical method of providing for unexpected and expensive illness.

2. Prepaid medical plans have the support of the medical profession.

3. Hospitals cooperate in the plans, from methods of self-interest, willingly.

4. Cooperative commercial insurance plans are much more expensive. (63, pp. 163-167)

Despite the seemingly large number of the Blue Cross membership, the number benefited is small, as was noted in the percentage of hospital income derived from other than direct patient payment. A study of the prevalence of the plan of the national scale confirms the Oregon situation, that for a variety of reasons, voluntary health insurance comprises but a small estimated total of the United States' costs of illness.

The mounting spiral of hospital costs is a source of concern to all. The fact that much more is purchased with the money is commonly overlooked when the hospital bill is faced. From the days when the hospital estimated that it could care for the city's sick for fifty cents to a dollar a
day, with paying patients' rates ranging from five to ten dollars a week, costs have mounted enormously.

In the City Club Report of 1948, a comparison of the charge for ward beds was made, in Portland hospitals.

<table>
<thead>
<tr>
<th>Year</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>1941</td>
<td>$5.00</td>
</tr>
<tr>
<td>1945</td>
<td>7.00</td>
</tr>
<tr>
<td>1946</td>
<td>8.00</td>
</tr>
<tr>
<td>1948</td>
<td>9.00</td>
</tr>
</tbody>
</table>

Since 1948, there have been periodic increases. Currently (1951) they were for the Good Samaritan Hospital (and a check with the other non-profit making hospitals showed a similarity, except for luxurious private rooms), according to mutual agreement among members of the Portland Hospital Council:

- Wards: $11.50
- Two-bed rooms: $13.00
- Private rooms: $14.50, and up

Why the major increase in the hospital rates? Salaries and equipment, as is shown in the table below, play a strong part in hospital operating costs. The general duty nurse, for example, who during the depression years was paid $40.00 per month and living expenses, earned around $110 per month in 1941, and in 1950 had a beginning salary of $220 per month for a forty hour week. Salaries of other employees are commensurate.
Good Samaritan Hospital - Expenditures
(according to reports submitted to A.H.A.)

<table>
<thead>
<tr>
<th>Expenses 1945</th>
<th>Expenses 1949</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payroll</td>
<td>$772,639</td>
</tr>
<tr>
<td>Equipment</td>
<td>15,939</td>
</tr>
<tr>
<td>Supplies</td>
<td>291,919</td>
</tr>
</tbody>
</table>

Good Samaritan Hospital

- Daily estimated cost of patient care (includes care cost, maintenance, improvements, replacements, etc.)
  - $18.65
- Blue Cross patient payments (cost of operation only)
  - $16.80
- City paid patients
  - $9.50 (up to $11.50 for medical expenses)

Multnomah County Hospital

- $9.50 (to be raised to $13.25 in 1952)

The rise in the county rates is included as evidence that the other hospitals are not "fudging" in their cost estimate! Evidence of the concern of the public with the problems dealing with hospitals, their management and finances is contained in the widely distributed reprint (43), which was the outcome of a fact-finding survey of hospitals in general. If statistics relate to the facts, one in ten of all the United States population may expect to be hospitalized annually. The financial implications are profound.

Among the problems which are concurrent with rising hospital costs are:

1. Non-profit, as well as commercial, insurance programs must increase their rates, or reduce the benefits.
2. Blue Cross and Oregon Physicians' Service are necessarily tardy in equalizing their dues with increased hospital costs. This slack is taken up, in the interim, by the hospital, and so may be considered as constituting a form of charity.

3. Innovations which may be deemed desirable must be restricted to those essential for the welfare of the patient, in the light of hospital expenses, in many instances. This may well result in a less effective hospital-patient program. (Example: social service; occupational therapy.)

4. The percentage or number of hospital personnel employed has been a variable among the different hospitals, although the hospital rates are uniform, in the non-profit making voluntary hospitals. Facets needing study are:

a. Inequality of patient care.
b. More employees than are needed, indicating extravagance.
c. Fewer employees than are needed, indicating penuriousness.
d. Differential for hospitals where all employees are on a salary basis, as against those where a backlog exists of unsalaried religious personnel.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Total Bed Capacity</th>
<th>Personnel (student nurses 1/2 employee)</th>
<th>Ratio Patient-Employee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emanuel</td>
<td>330</td>
<td>547</td>
<td>1:1.6</td>
</tr>
<tr>
<td>Good Samaritan</td>
<td>427</td>
<td>478</td>
<td>1:1.1</td>
</tr>
<tr>
<td>Portland Sanitarium</td>
<td>151</td>
<td>230</td>
<td>1:1.5</td>
</tr>
<tr>
<td>Providence</td>
<td>237</td>
<td>255</td>
<td>1:1.1</td>
</tr>
<tr>
<td>St. Vincent's</td>
<td>356</td>
<td>439</td>
<td>1:1.3</td>
</tr>
<tr>
<td>U. of Oregon Hospitals</td>
<td>418</td>
<td>557</td>
<td>1:1.8</td>
</tr>
<tr>
<td>Oregon Average</td>
<td></td>
<td></td>
<td>1:1.4 Media</td>
</tr>
<tr>
<td>Pacific states</td>
<td></td>
<td></td>
<td>1:1.69</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1:2</td>
</tr>
</tbody>
</table>

(2, pp.115, 118)
Hospital management has a deep responsibility to ensure that the hospital rates are valid, since the prospective patient neither may nor can compare prices in buying his hospital care. His opportunity to exercise a free choice is further restricted by his doctor, since he must patronize the hospital where his physician is on staff.

A rather distinct change in attitude toward a larger social responsibility is evident in the passage of the Hospital Survey and Construction Act in 1946, with its provision for massive sums of money to build badly needed hospitals throughout the country ($75,000,000 for government and other hospitals, for five successive years). (45, p. 536) For the Good Samaritan Hospital, the bill had direct and immediate results, since a substantial portion of its building funds were derived from it. The acceptance of these funds had at least a double implication; on the one hand, the act was concrete evidence of national concern over the marked shortage of hospital beds in the country, a threat to national health; on the other, the hospital weakened its stand perceptibly as a voluntary, private hospital, in accepting public money.

The remaining discussion is concerned with hospital employees. A major change in policy occurred in 1950 when the hospital joined the Social Security program. Contrary to business practice, the hospital had previously made no provisions for retirement plans for its workers. (An exception may be cited; Miss Loveridge was retired on full pay.) In
view of the consistently lower salaries received by hospital employees, in comparison with other forms of industry, the benefits of Social Security should counteract these and possibly reduce the high incidence of turnover among personnel.

In the health supervision of its employees, the hospital does not set an example for other businesses. Although medical care to the sick or injured employee is administered readily, the weakness of omitting routine physical examinations and health follow-up is obvious, both from the patient's and the worker's standpoint. Because tuberculosis has been classified as a form of occupational disease among hospital workers, the source of which is undiagnosed tubercular patients (96, pp. 40, 49) chest X-rays should be routine for all patients, as they are by law for all hospital employees.

In closing this phase of the progress of the hospital, emphasis must be made on the highly selective nature of the topics discussed. The problems of greater or lesser importance in selection must rest with the selector.
CHAPTER VII
SUMMARY AND CONCLUSIONS

A general summary of the Good Samaritan Hospital history has shown that its place historically is more specifically related to the general history of the national hospital movement than to the history of Portland and Oregon. Its value as a topic for study has been in the understanding and insight gained about the growth of hospitals and medical and social trends rather than the learning of rather specific details about the Good Samaritan Hospital alone. That is to say, the hospital is a single example from among the many private, voluntary, non-profit-making general hospitals, and knowledge about the one makes for understanding more about all.

This definition is in no sense to be interpreted that the Good Samaritan Hospital and the Episcopal Church have not made substantial and rather unique contributions to the health and welfare of the city, but their accomplishments are representative of other hospitals in other cities.

Correlation between the youth of the city, and the hospital in 1875 is not as clear cut as was earlier conceived by the author; i.e., much older cities were starting hospitals at the same time, for it was the beginning of the hospital movement in general, resulting in hospitals everywhere
throughout the country, north, south, east and west.

The fact that the hospital continues to exist bespeaks the quality of its accomplishments and the confidence of the public in its administration and church sponsorship. This is borne out by citing the 193 hospitals established in the United States between 1871 and 1880, only 66 of them still functioning in 1945—the remaining 127 no longer exist. It is one of three hospitals started in Oregon during the same period which survives.

The success of the Portland hospital may have a close connection between it and the success of other Episcopal hospitals. In 1875 there were four only in the country; three in the East and one in Utah (St. Mark's). In 1950, the Good Samaritan of Portland was one of 72 hospitals and sanatoria managed by the Episcopal Church, and one of 36 general hospitals in the United States and its territories.

In the years immediately after the start of the Good Samaritan Hospital, seven others were begun in the far West (Arizona, Colorado, Idaho, Iowa, Minnesota, Montana, Oklahoma).

The association of the Good Samaritan Hospital and the Episcopal Church is largely a coincidence, for church management of hospitals was common. It happened only that the aggressive Bishop Morris came to Oregon at the right time, and familiar with other eastern Episcopal hospitals, especially the one in Philadelphia, it was to be expected that
he would wish to follow the precedent. His driving force overcame the obstacles of the small parish, lack of money and support. It has been seen that his interest in creating a hospital was that it be Protestant Episcopal, rather than a Catholic hospital, as a means of extending the mission work of his church. Because of the timing of the venture, Bishop Morris was fortunate in enlisting the sympathy of Protestant community leaders. (Dr. Josephi personified three desirable qualifications: Episcopalianism, medicine, community leadership).

Other churches were not so fortunate. The Methodist, a numerically large group, encountered a series of difficulties in its early hospital which caused it to fail. Among these was apparently an ill-advised selection or staff doctors, and unfortunate administrative problems.

Bishop Morris was not always successful in his projects as has been seen. He gauged the need of the city for an orphanage rather on its value as mission work than actual need of facilities for children. The boys' school, also (Bishop Scott Academy) had a short life span.

Because they afford a useful perspective, the following statistics are presented:

<table>
<thead>
<tr>
<th></th>
<th>Year</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Episcopal church communicants</td>
<td>1875</td>
<td>742</td>
</tr>
<tr>
<td></td>
<td>1950</td>
<td>13,932</td>
</tr>
<tr>
<td>Portland population</td>
<td>1870</td>
<td>13,000</td>
</tr>
</tbody>
</table>
|                         | 1950 | 373,628 | (cont.)
Oregon population

<table>
<thead>
<tr>
<th>Year</th>
<th>Census</th>
</tr>
</thead>
<tbody>
<tr>
<td>1870</td>
<td>90,922</td>
</tr>
<tr>
<td>1950</td>
<td>1,521,341</td>
</tr>
</tbody>
</table>

Good Samaritan Hospital
census

<table>
<thead>
<tr>
<th>Year</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1875</td>
<td>51</td>
</tr>
<tr>
<td>1950</td>
<td>12,737</td>
</tr>
</tbody>
</table>

Deliveries

2,263

Daily average number of
patients (1875)

322.4

1950: 250 times number of
patients in 1875

332.4

The foregoing figures, showing the increased hospital occupancy, also reveal the broad cross-section of the public which was staying in the hospital.

Departments of the Hospital Contributing
to Whole Care of Patient

- Administration
- Admitting
- Basal metabolism
- Blood bank: intravenous therapy
- Central supply
- Chaplain
- Clinical pathology
- Children's educational program
- Diet
- Electro-encephalogram
- Emergency surgery and out-patient
- Medical library and records
- Medical staff
- Nursing
- Pharmacy
- Physical therapy
- Women's Auxiliary
- X-ray
- Supporting departments:
  - Business offices
  - Housekeeping
  - Laundry
  - Maintenance and Engineering

The listing of all the hospital departments points up the multi-phased hospital of today.

In affecting the complex, functional hospital of today many of its earlier charms had necessarily to be forfeited; crowding of the city placed a premium on all land. Gone are
the lovely hospital grounds, with wide lawns for croquet or relaxation; gone is the "Bishop's Arch," its vine maple planted by Bishop Morris, and which for so long made a charming entrance to the hospital from Twenty-second and Lovejoy; the fine fir trees, the splendid magnolia, the trees planted by the Board and staff members commemorating the fiftieth anniversary of the hospital. They, too, had to be forfeited to the aggrandizement of the hospitals' buildings; no longer does "Loveridge's Island" provide a delightful oasis of color and of shade in the center of the bleak turn-about for hospital service truck deliveries. The hospital of 1950 is a city hospital, and in the entire block of hospital buildings there is little room left for gardens.

The hospital has become so much a part of twentieth century living, that hospital terminology is common parlance for the man-in-the-street (e.g., "i.v's, specials, Penicillin shots, C.B.C. etc."). Less than seventy-five years ago, hospitals were a novelty and the public had not yet learned its language. In 1877, for example, a note introducing a patient to the hospital was addressed: "To the Warden of the Good Samaritan Hospital. Receive and care for the sailmaker.... of the Ship Aluminia." And the patients were long called "inmates" by the Oregon Churchman.

There was ample opportunity for increased familiarity with the hospital during the three quarters of a century for some 377,242 patients have received hospital care in the
Good Samaritan Hospital, and 28,454 babies have been born since 1922.

Bearing these figures in mind, the statement is valid that the Good Samaritan Hospital, through its available services, has played an active role in the steady decline in infant and maternal mortality rates, as well as contributing to the increased longevity of life of Oregon residents.

Through the years intrinsic changes have been observed in the administration of the hospital, its purposes and functions. These have been evolved gradually, in accordance with the needs of the times, and in line with hospital advances in general. A first major change was exemplified in the act of incorporation in 1891 with control of all hospital funds and properties lodged with the Board of Hospital Trustees (later designated The Board of Hospital Trustees for the Diocese of Oregon).

It has been seen that the post World War I period marked a more general acceptance of the principle of the hospital as a community hospital rather than simply a church hospital. The rapid rate of the city and medical science growth meant that a larger hospital was mandatory, which was too large an undertaking for a single body to manage alone. The public then learned that the hospital was not purely church but was community. This philosophy was prevailing elsewhere, and the American College of Surgeons applied its principle by recommending a large and more representative hospital board. It
was also during this period that enactments of other professional and legal restrictions took place.

The following news item has been taken from The Oregonian of October 27, 1951.

Daveno Fire Burns Child

A 9-months-old girl, Brend Lou Banks... received second and third degree burns to her feet and both legs early Friday in a hotel fire...

The child was treated at Good Samaritan Hospital where her condition was described as fair Friday afternoon.

Because Doernbecher Memorial Hospital for Children would not have a bed available for the little girl for two or three days, the parents took her home to Hood River on the 8 P.M. bus, after she had an afternoon blood transfusion, which the doctors ordered. They had the doctor's permission for the trip. They couldn't afford to keep her at Good Samaritan, they said.

It is not known yet whether there will have to be any skin grafting or not on the child's legs, but she is expected to be brought back to Doernbecher later this week.

The Good Samaritan

A certain man went down from Jerusalem to Jericho, and fell among thieves, which stripped him of his raiment, and wounded him, and departed leaving him half dead.

And by chance there came down a certain priest that way, and when he saw him, he passed on the other side.

And likewise a Levite, when he was at the place, came and looked on him, and passed on the other side.

But a certain Samaritan, as he journeyed, came where he was! and when he saw him, he had compassion on him. And went to him, and bound up his wounds, pouring in oil and wine, and set him on his own beast, and brought him to an inn, and took care of him.
On the morrow when he departed, he took out two pence, and gave them to the host, and said unto him, Take care of him; and whatsoever thou spendest more, when I come again, I will repay thee.

Which now of these three, thinkest thou, was neighbor unto him that fell among the thieves? And he said, "He that shewed mercy on him." Then said Jesus, Go, and do thou likewise.

The juxtaposition in the foregoing news item of the words *afford* and *Good Samaritan* appears to be an incongruity. The original purpose of the hospital was to serve the Brendas, and the childrens' comfort cots were so endowed. Affirmations were made as late as 1925 by Bishop Sumner that a third of the hospital care was free, which justified the hospital's existence. Is it possible to present logical explanation for the "Brend Lou" incident? (Injection at this point of a statement that the child would not have been permitted to leave the hospital, were she to suffer untoward effects from the homeward trip is hardly necessary.)

Between the years 1875 and 1951 significant changes occurred. The Doernbecher Memorial Hospital, opened in 1931, was given for the purpose of caring for children, with payment according to family means. The Oregon Code of 1930, Chapter 15, 27-1501 provides that each county provide hospital care for its poor which was not available in the times of the early Good Samaritan Hospital. The State, then, had provided means for child care in the absence of alternatives.

Because a casual reading of similar news items has, on
occasion, been interpreted to mean that the hospital is not a charitable institution, the meaning of charity with relation to a hospital should be reviewed.

A dictionary definition of charity states: "good will to the poor and the suffering; liberality to the poor by benevolent institutions or to worthy causes...whatever is bestowed gratuitously on the needy or suffering for their relief...an institution founded by a gift and intended for the use of the public as a hospital," etc.

In comparing the earlier hospital with the mid-century institution, there can be no appraisal in terms of superiority or inferiority. The differences in purpose lie in the differences in need of the community. In contrast to the paucity of available medical resources of the city for the poor of the nineteenth and early twentieth century are the numerous ways and means of caring for, not only the indigent, but the medically indigent, of the mid-century. In contrast to the infrequency of hospitalization is the almost universal usage of hospitals by physicians in the care of the sick today. These are among the factors which have caused a change of underlying principles. No longer is the prime function of the hospital the care of the poor; rather, its principal reason for being lies in its availability to all.

As has been pointed out, the hospital, in itself, has no funds for charity care. It is the purveyor of other people's charity. Its free, or partially free care must be
determined by available funds for that purpose. Obviously beds endowed with sums ranging from $2,500 to $10,000 provide little income for care under the specific proviso of an endowment. Endowment income (see 1943 Annual Report of Good Samaritan Hospital for complete list of endowments and memorials) must now be pooled and administered as wisely as possible for the benefit of those patients who are unable to meet hospital costs.

Because the Church, in its own right, is not responsible for the financial underwriting of the hospital, and because the term "Good Samaritan" has a common connotation of unweighed or un-premeditated charity (i.e. empirical versus scientific) its aptness of nomenclature in present day society may be questioned. It is hoped that the spirit prompting the act of the Good Samaritan prevails and will prevail in the hospital. A conclusion must be, nonetheless, that the emotional association with the name gives rise to hasty, ill-advised, adverse criticism, which would not be occasioned by such a name as "The Portland Community Hospital," as tepid as its emotional appeal might be.

In further consideration of such mundane matters as hospital costs, history has shown as sharp a rise as with other commodities. However, a great deal has been purchased by the patient with the payment of his hospital bill. The shorter hospital stay (9-8-7 days in recent years) has become the distinctive hallmark of scientific medical care. Not
only does the brief hospital stay result in a shorter period of pain and discomfort, but it makes possible a more rapid return of the individual to productive capacity (to ignore entirely the advantages of a decidedly more favorable prognosis than was true fifty to seventy-five years ago).

However realistically hospital charges are calculated in relation to actual costs of care, they still do not provide funds for building and purchase of new equipment. This has again been proven in the case of the present new building. Large and small gifts continue (general building campaign, and some $600,000 from the Rosalie Willman estate), but Federal funds ($729,000, minimum guaranteed) have made the new wing a reality.

The acceptance of Federal Aid also demonstrates unequivocally public ownership and/or interest in the hospital.

A source of possible income which has received no mention in any literature perused (by the author) might be derived from the hospital staff physician. If patients are expected to pay for their care; if the public (to which group the patients belong) are expected, as good citizens, to contribute voluntarily to building funds, it would appear valid to presume that the practicing physicians had some financial obligations toward the hospital.

Reflection brings to light no other business which provides the utilities (including the physical plant, equipment and personnel) wherein a person engaged in private enterprise
can make his living without some form of financial assessment or compensation for their use. They were originally made possible by charity which makes the situation even more unreal. It is a truism that the hospital has no reason for existing, except as a servant to the physician in the care of the ill. It is a reasonable conclusion that the master should pay the servant. It would make an excellent source of income for the voluntary hospital.

In turning to discussion pertaining to the care of the hospital patient, the shortage of professional nurses with an increase in use of untrained or less highly trained personnel has been duly noted. Also has been noted the inefficiency in use of available nursing service because of:

1. The demands on nursing time in performing non-nursing duties.

2. The lack of continuity and effectiveness of student nursing time because of curriculum academic requirements.

3. Inequalities in distribution of nurses.

It is concluded, therefore, that a comprehensive, objective survey should be made to determine the amount and quality of nursing care needed, in terms of professional and non-professional service. A study should be made of such devices and means which could affect better and more equitable use of available nursing hours. This will be of monetary saving to the hospital, and give greater satisfaction to the patient.

It is also recommended that consideration be given the possibilities of the "Block System" method of clinical assign-
ment for student nurses in order to use their nursing service hours to better advantage, and also to provide better learning opportunities, clinically and academically, until such time as other means are found to pay for nursing education rather than nursing service.

Study of the nursing school has shown that it has not been consistently considered as an educational process. Evidence of administrative attitude is contained in the hospital report of 1919 when Miss Welch was promoted from the position of Superintendent of Nurses to the position of Assistant Superintendent of the Hospital and Chief Surgical Nurse. The implication was clear; the lesser importance of the school; the greater importance of nursing service. The premium placed on student nursing is also evident in the comparison on prolonged duty with a small number of class hours offered for many years.

The trend toward the goal of the professional school has been the result of forces outside the hospital, such as the national nursing organizations and attractions necessary for successful recruitment of students in a competitive world. Because lack of money has hampered nursing education in the past and the Cadet Nurse Corps demonstrated the gains possible with financial backing, hospitals should promote interest in Federal appropriations for nursing education; first, to improve the quality of nursing education, thereby ensuring better prepared and qualified nurses, and second, to provide
more graduate nurses for the future, in the interest of the nation's health.

The role of the private voluntary hospital in the positive health programs of the community must be circumscribed by money. Great moral responsibility is entailed in wise spending of hospital funds. Nonetheless, certain phases of preventative medicine appear justified, regardless of cost; (1) regular physical examinations with health follow-up programs for all employees (kitchen personnel do have physical examinations which are required by law); (2) routine chest x-rays of all patients admitted to the hospital.

The lowered incidence of severe illnesses and tuberculosis among the student nurses, after the installation of a health program, has proven its value. The merits of routine chest x-rays (required by law for all employees) has been proven so often, that their continued omission for hospital patients is contrary to basic modern health precepts.

Discussion of the hospital and its employees leads to the topic of a personnel department. The five hundred and more employees on the payroll, alone, justifies a recommendation that such a department be activated in the interests of improved hospital service. Here also it is fair to believe that there will be ultimate saving to the hospital, and hence the patient, by the same reasoning that business and industry find it worth while.
A specific recommendation of the City Club, in its report about hospitals in 1948, is as timely today as it was then; i.e. the matter of public relations and the lack of sources of hospital information.

If business, which is producing for profit, finds it necessary to spend large sums of money to educate the public about it and its goals, surely the hospital which asks for free will contributions has a deep obligation to keep the public fully informed of its aims, aspirations, problems and accomplishments. Not only has the public the right to this, but its neglect cannot be considered other than most unwise, in the light of the countless advantages to be gained from a community intelligent in hospital matters. The man-in-the-street, who has been to the hospital building campaign and who has paid his own hospital bill can hardly be condemned for failure to understand hospital problems, nor for a hostile attitude if he continues to be kept in ignorance.

A hospital educational and information program is, then, long overdue.

More attention should be paid by the Portland Hospitals to the desirability of keeping the public better informed as to the problems confronting management and the reasons for the high cost of hospital care in an effort to develop a more sympathetic public attitude. Exceedingly little has been done in this area and the hospitals subject themselves to the misunderstanding of individuals apparently quite willingly—and it appears rather surprising that there is so much good will. (58, p.15)

Evidence of the favorable inclination on the part of the public has been noted in the press. Not only feature writers,
as Ann Sullivan of The Oregonian and the late Marilyn Miller of the Journal, but routine news items are slanted favorably toward hospitals.

An example of the public's eagerness for education in hospital problems is clearly presented in the previously quoted reprint of Look Magazine's survey report.

If the public has not only the right to but a desire for information about the hospital, these recommendations are submitted as methods of approaching the objective.

1. Re-activate the Hospital Annual Report (last printed in 1943), with a generous breadth of distribution of copies.

2. Inaugurate a series of public lectures about Portland hospitals, or panel discussions, with ample opportunity for questions.

3. The Reports of the Diocesan conventions have, in past years, contained specific and generous information about the hospital and its progress. A resumption of the practice would provide the church membership with better understanding.

4. Hospital Day (May 12) and "open house" have received spurious support from the hospitals in recent years. It is recommended that the custom be re-inaugurated as a means of thoroughly acquainting the public with the hospital and its assets and disadvantages in time of health. The recently published booklet "Peace of Mind" (for hospital patients) is noteworthy; however, the mindset is late, especially in view of the forced admission of any patient to any hospital, by circumstances, selection of doctor.

An effort to anticipate the future of the hospital seems not too difficult as regards certain aspects. There is no reason to expect any marked change of course in the immediate future. The leveling effects of the country's taxation laws
have, by more approximate equalization of wealth, reduced
the incidence of many large legacies and bequests, and have
made the financial structure of the Good Samaritan Hospital
(and others) much more precarious. The acceptance of pub-
lic money for building points the way to further state and
federal subsidisation as time goes on. However, as a church
sponsored hospital it will continue to receive private gifts,
because of its unique appeal to members of the church or
those wishing to support a Protestant hospital, which might
not be applicable to other hospitals.

Public confidence in the administration of the hos-
pital by the Episcopal church is evident in its continuance
and its state of financial stability. Further evidence is
found in the fact that Corvallis Hospital came under the
church sponsorship three years ago, by request of members of
the community.

Other areas of the future are dimly seen. There can
be little doubt, however, that hospitals in general will
continue to play a vital role in the medical field; busy
doctors and small homes make them almost mandatory, for the
care of any acutely ill, regardless of the need of scientific
equipment.

Because tax funds are becoming more commonly appro-
priated for higher education, the various trainee groups
within the hospital will undoubtedly receive more benefits
in the future.
The ultimate demise of the hospital, as a private, voluntary, non-profit making institution, if or when it occurs, will be attributed, not to any want in the quality of its services, but to social changes. And if, or when, the Episcopal hospital ceases to sponsor the Good Samaritan hospital, its property will revert—not to the church—but to the City of Portland. This is based on a legal opinion given to the Board of Hospital Trustees on the principle that it is, in effect, community property under the guardianship of the Episcopal Church, Diocese of Oregon.

Certain conclusions have been drawn, as a result of this historical study:

1. The hospital is a charitable institution, and administers charity according to its means and funds given for that purpose.

2. Modern medicine science demands the modern hospital as a scientific instrument for the safe care of patients, as well as convenience for physicians and patients. Portland has a serious shortage of hospital beds, with the conclusion mandatory that the hospital is essential to the city's well-being.

3. Through its clinical facilities, the Good Samaritan Hospital, a general hospital, functions as a hospital in its category, i.e., in education, research and patient care. In at least one of its training programs, the dietary, its contribution is but one of two available in Oregon.

4. The commonly used descriptive term "Episcopal sponsored hospital" is technically correct. The hospital, in effect, belongs to the community. A natural corollary is the exhortation to the community to share this responsibility.
5. The history of the hospital has shown that it is representative of similar hospitals in weaknesses as well as strengths; its marked strengths outweigh its comparatively minor weaknesses.

To two persons especially may be attributed much of its early success and prominence: Bishop Morris and Miss Emily Loveridge.
## ORGANIZATION OF THE HOSPITAL

### GOVERNING BOARD

<table>
<thead>
<tr>
<th>Organized Medical Staff</th>
<th>DIRECTOR</th>
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<tr>
<td>Committees of the Board such as Committee on Finance Public Relations</td>
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<tr>
<th>Committee on Internes</th>
<th>ASSISTANT DIRECTOR</th>
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### Departments Concerned With the Professional Care of Patients

<table>
<thead>
<tr>
<th><strong>PRESIDENT OF STAFF</strong></th>
<th><strong>NURSING DIRECTOR</strong></th>
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<tbody>
<tr>
<td>Chiefs of Staff</td>
<td>Nursing Service</td>
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<tr>
<td>Active Staff</td>
<td>Nursing School</td>
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<tr>
<td>Consulting Staff</td>
<td>Ass't Director</td>
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<tr>
<td>Associate Staff</td>
<td>Supervisors</td>
</tr>
<tr>
<td>Courtesy Staff</td>
<td>Head Nurses</td>
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<td>Residents</td>
<td>Subsidiary Workers</td>
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<td>Ass't Residents</td>
<td>Attendants</td>
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<td>Internes</td>
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<tr>
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<tr>
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<td>Ass't Director</td>
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<tr>
<td>Special Therapists</td>
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<tr>
<td>(Radiologist)</td>
<td>Kitchen Staff</td>
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<td>Physiotherapist</td>
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<td>Occupational Therapist</td>
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<tr>
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<tr>
<td>Director of Admissions and Discharge</td>
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### Departments Concerned With Business Management

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<tr>
<td>Purchasing Staff</td>
<td>Porters</td>
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<tr>
<td>Storekeeper</td>
<td>Linen Room Staff</td>
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<tr>
<td>Chief Engineer</td>
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<td>Mechanics</td>
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<tr>
<td><strong>Laundry Staff</strong></td>
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<td>Assistant Administrator, Good Samaritan Hospital</td>
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<td>Hollenbeck, Alta</td>
<td>Assistant Administrator, Good Samaritan Hospital</td>
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<td>Richardson, Mary Alice</td>
<td>Director, Dietetic Department, Good Samaritan Hospital</td>
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