

Commodity	Lbs.	SCALE C.			Calories
		Protein grms.	Fat grms.	Carbo-Hydr- grms.	
Meat ...	45.00	2,673.00	5,083.36	—	57,510
Fish ...	18.75	851.25	84.37	—	4,275
Bacon ...	12.50	537.50	3,402.50	—	33,850
Bread ...	75.00	2,664.40	160.80	18,540.00	88,436
Sugar ...	9.50	—	—	4,222.70	17,309
Margarine ...	4.18	—	1,584.22	—	14,734
Other Fats ...	3.62	—	—	—	—
Potatoes ...	70.00	555.80	32.20	6,668.20	29,890
Free Vegetables ...	35.00	120.75	23.80	633.50	3,325
Milk (pnts) ...	130.00	2,386.80	2,631.20	3,484.00	48,750
Syrup ...	1.00	10.88	—	314.34	1,330
Jam ...	4.00	5.60	—	1,253.60	5,160
Cheese ...	3.00	340.20	408.00	33.90	5,331
Cereals ...	30.00	1,518.00	261.00	10,089.00	50,010
Tea and Coffee ...	2.00	—	—	—	—
Cocoa ...	1.00	90.66	117.86	192.80	2,253
Eggs (number) ...	50.00	255.00	202.50	—	2,925
Total ...	—	12,009.84	13,996.81	45,432.04	365,093
Daily average per patient ...	—	120.09	139.96	454.32	3,650

As already mentioned, these scales became effective at the beginning of July when complaints of deficiency in the allowances ceased.

RETURNS OF ACTUAL CONSUMPTION.

A system of weekly returns of actual consumption in all hospitals was then instituted, and while a few commodities were at first found to be issued in excess of the scale, it was noted that the tendency in all hospitals was to under-issue the maximum quantity allowed. Representative hospitals operating under each scale of diet were kept under close observation, and it was found at the end of August that the average of actual issues showed considerable reduction in hospitals subsisted on Scale "A" and Scale "C," while hospitals engaged in physical training under Scale "B" closely approximated the maximum allowance.

A comparison of authorized and actual consumption during the period of observation per patient per diem is as follows:—

TABLE V.

AVERAGE CONSUMPTION PER PATIENT PER DIEM.

	SCALE A.			
	Protein Grms.	Fat Grms.	Carbo- Hydrates Grms.	Calories
Maximum allowance	213.52	256.16	666.52	5,983
Actual consumption	168.35	210.86	609.23	5,142
	SCALE B.			
	Protein Grms.	Fat Grms.	Carbo- Hydrates Grms.	Calories
Maximum allowance	125.59	146.05	471.13	3,799
Actual consumption	118.68	148.64	450.77	3,710
	SCALE C.			
	Protein Grms.	Fat Grms.	Carbo- Hydrates Grms.	Calories
Maximum allowance	120.09	139.96	454.32	3,650
Actual consumption	106.98	138.57	408.87	3,398

It was considered that Scales "A" and "B" afforded ample allowances for the purpose intended. The dieting of patients in active treatment hospitals, however, was believed to merit special attention. It was noted that in the actual carrying out of the dieting of patients under Scale "C" an under-issue of protein and carbohydrates had resulted in the loss of approximately two hundred and fifty calories per patient per diem.

After Scale "C" diet had been in operation for nearly two months, the question of arriving at an optimum diet for patients in Canadian active treatment hospitals was discussed with the Royal Army Medical authorities. Based on the metabolic requirements of patients subsisted in our primary hospitals on war-time food-stuffs, as calculated in the laboratories of the Royal Army Medical College, it was considered that the dieting needs of the average patient of this class were being met. The maximum daily requirements suggested by the dietetic adviser to the British Medical Service had been very closely approximated in Canadian hospitals subsisting patients under Scale "C" diet. The comparison computed at the daily requirements per patient is as follows:—

TABLE VI.

COMPARISON OF ACTIVE TREATMENT DIET.				
	Protein Grms.	Fat Grms.	Carbo- Hydrates Grms.	Calories
British ...	108.75	139.46	414.23	3,443
Canadian ...	106.98	138.57	408.87	3,398

SERVING AND SERVERIES.

In providing for the efficient feeding of hospital patients many contributing factors have been considered. It is, of course, essential that food should be thoroughly cooked, attractive in appearance, and served quickly at a proper temperature. Steps were taken to standardize the work of the serveries. In some instances, where large numbers dine together in a common hall, difficulty was experienced in placing hot food on the patient's plate.

The solution of this problem was found in the use of a specially designed self-serving tray. Patients were seated at small tables in groups of six or eight, and practically the entire meal for each group was served in one large water-jacketed container, divided into five compartments, holding soup, meat, potatoes, a second vegetable, and pudding. This tray was supplied with a lid and the necessary serving utensils. It was found that hot food could be kept at a proper temperature for one hour from the time that each tray was filled and the lid fixed in position, thus making it possible to place hot food on each group table before the patients were admitted to the dining hall. As soon as they were seated, one of the patients in each group would serve the soup and the other courses in succession, each article of the diet being placed on the patient's plate at practically the same temperature at which it had left the servery thirty minutes before.

An effort was made to increase the general attractiveness of dining halls. It was suggested that use should be made of decorative plants and flowers, and that the introduction of water-jugs and glasses would prove a welcome innovation, particularly at the midday meal, when no hot beverage is served. The changes effected resulted in a very noticeable improvement in the feeding of patients. The dining rooms were made bright and cheery; confusion in the seating and serving of patients was eliminated; food was placed on the tables in an attractive and appetizing manner, and the patients ate well.

Both the constitution of diets and the control of diet distribution have a direct bearing upon an important aspect of the food question not previously mentioned—that is, the question of eliminating wasteful practices.

Economy in the consumption of hospital food supplies is governed chiefly by the dietetic requirements of the patients fed. There is another consideration, however, which must not be overlooked, and that is the proper supervision of feeding cost. Under the system of centralized buying now in force, it may be assumed that hospitals are receiving food-stuffs at the lowest price compatible with good quality and availability of supply. Economy in the cost of accumulating food-stuffs need not then concern the Medical Service. There is, however, an opportunity for the introduction of many economies in the administration of food-stuffs after delivery to the hospital.

To make this possible there must be close co-operation between the administrators and the distributors in each institution. The administrators are the Officer Commanding, registrar, adjutant, quartermaster, and matron. The distributors are the medical officers and nursing sisters. The administrators lay down certain rules and regulations for the guidance of the distributors. When these regulations are carried out to the letter economies do take place; when they are ignored economies are impossible.

The attitude of the distributors, particularly towards the Quartermaster or the Messing Officer, has too often made the economical and efficient administration of food supplies a very uncertain business. From experience it is found that frequently medical officers leave the prescription of diets very largely to the nursing sisters, and, in turn, the nursing sisters refer the matter for final decision to the patient himself. It has been most difficult in some cases to persuade a medical officer that the prescription of a diet is as much his responsibility and as essentially a part of the treatment of the case as the prescription of medicine or massage.