

My Days as a Student Nurse 1951 – 1954
at the Nova Scotia Hospital
by
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In 1951 I entered nurses training at the Nova Scotia Hospital, in Dartmouth, N.S. It was a journey of three years which I treasure to this day. The only items we were responsible for were our books, which cost \$50. Our uniforms were provided at no cost.

I remember our first “real” full day of orientation when we met the Medical Superintendent. His message was very clear. We were “never to discuss religion or politics, under any circumstances.” This proved a good rule to follow, when with patients or visitors. Our Director of Nursing was very fair to all of us. I personally learned a great deal from her during those three years. We also had a Housemother who kept a watchful eye on us and our instructress (an unmarried nurse from Boston) was very much a lady. Each time a doctor entered a room, we stood out of respect. Late leave was designated as 11: p.m. permitted once a month for “mental health.” Otherwise 9: p.m. was the time we were expected to be in our rooms. On a day off we were free to go and do whatever we chose. There were some beautiful beaches nearby we frequented, one in particular being Land’s End. We started as eighteen students, with fifteen graduating (one male) at the end of the three years. We were up daily at 6: a.m. and breakfast soon followed, then we were off to the designated units. We were all required to do night

shifts as well.

Accommodations were very good, with each of us having our own room and our laundry was done at the hospital facilities. It was a very well run and organized department and continues still to provide laundry services to various hospitals locally. Meals were excellent! The result of a huge farm near the property, owned and operated by the hospital. It was located on the site of the present-day Dartmouth General Hospital. We were able to take the patients out for walks there, or to play a ball game. A great asset for all concerned, there were cows, pigs, lambs, chickens, fruit and vegetables. It was deemed very therapeutic, for male patients to work at the farm and a great help for those overseeing the daily operation of this important asset. It supplied food for all four hundred patients, and staff.

One of the greatest outcomes from our time together as students was the camaraderie among us, that has lasted a lifetime! Everyone got along and enjoyed each other's company.

Dorothea Dix and Dr. DeWolfe were instrumental in purchasing the property on which to build the hospital. A beautiful treed site overlooking Halifax Harbour with a panoramic view of the city. It consisted of one main building, the North Unit, and one other, the South Unit, (used from the early 1900's) and connected by a very long and well constructed tunnel. I will always remember the beautiful mahogany staircase, leading from the front hall of the North Unit to all wards, including the Nursing School office. After I had graduated and was on staff (1958) one of the best social workers ever, suffered a heart attack running up those stairs. He collapsed and died at the top of the steps. (Long before CPR) Nurses attended his funeral and carried

the flowers out of the church to accompany his body for burial.

On the premises, we were fortunate to have a Lab., Autoclave Room, X-ray Dept. (These were read by female Dr. Hopgood, Medical Superintendent) and an Autopsy Room. We were also proud of our very own Canteen (operated by CNIB Canadian Institute for the Blind) and Library. Our Nurses Residence was in the South Unit.

During that period various staff members resided on site. Mr. Slayter, who was in charge of finances, and his family lived in an apartment. His sons Bruce, Bob, and David grew up surrounded by staff and patients. In later years, David was interviewed by a Nursing History member and commented he always felt he “couldn’t get away with anything” as he was always being observed by someone on the premises! Housing was also provided for the Medical Director, the Director of Nursing, as well as the Nurses’ Residence which housed both students and staff.

The first few months consisted of classroom instruction by female instructors, followed by lectures from doctors, social workers, psychologists, and heads of various departments within the hospital. Gradually we were permitted to go on the wards, under the supervision of our teachers. It was a very anxious time for me, not knowing what I would be facing! I’m quite sure my classmates felt the same.

Before I continue, I want to mention the importance of keys! We were given a set of keys which opened every door on the wards. We were responsible for the security of these at all times, and they were never to be given to a patient. Only two wards were “open” all others were locked for the safety of patients and to prevent “elopement.” (The term used for those attempting to leave.)

After a six-month probationary period, our big day arrived when we received our caps and pins. Capping was a lovely ceremony with families present.

Time spent in the classroom was combined with actual learning and applying “the art” of bed making, bed baths, irrigations, enemas, catheterizations, and all aspects of “hands on” procedures.

Every rotation of six weeks, on the different wards, was surely a learning experience in itself! The admission procedure was a very involved process. During training years 1951 – 1954, there was no specific designated “admission” unit. Each patient was brought by family or sometimes police to the front entrance where they were walked up the stairs sometimes restrained. The hospital was trying hard to reduce the use of manual restraints, but some still required wrist or ankle restraints, or lesser forms of restraint. However, I still saw police bring patients in on a stretcher in strait jackets! Often these were difficult situations, but I would ask that the strait jacket be removed as they were escorted by staff and a student (there was no elevator at that time). There was no male staff on female units and no buzzers. If you needed help you screamed.

Later on, specific units were established and named F5 & M5 (F designating “female”, M “male”) During training years female students were not assigned a rotation to the male wards. Upon arrival at the unit, the patient was usually met by the Head Nurse in charge, then students assisted with giving the patient a tub bath and shampoo. This provided opportunity to check for scars or bruises, head and body lice.

Each item of clothing and personal effects was documented, the patient was then dressed in a johnny shirt and slippers, while their clothing was sent to

the sewing room, for labelling. The new patient was monitored in the “sick room” containing six beds. This was always staffed by a registered nurse and used for patients who required twenty-four-hour observation. Including those receiving intensive treatments such as “wet packs,” coma & sub-coma insulin, and (E.C.T.) electro-convulsive therapy. On night duty, with always two R.N.’s in charge of the building, two students were always assigned to help with applying “cold packs” and to make rounds on the “back wards.” Every new admission received a complete physical exam, by the hospital’s medical doctor, which included having blood work, urinalysis and chest x-ray done. Each was seen and interviewed by a psychiatrist assigned to their care. Social workers also played a significant role in patient and family care. No visitors were permitted during the first month of admission. Every item of cutlery (objects that could potentially be used as a lethal weapon) was counted before and after each meal and kept locked. Large spoons were the only utensil permitted for eating. If any were unaccounted for at the end of a shift, you had to stay on duty until found!

In seclusion meals went in through a slot in the door and all plates and utensils were made of paper. Medications were crushed and put in soft food. Three wards were referred to as “back wards” and housed those who were very disturbed and unpredictable. You were never to enter the rooms alone! The doors were always locked except during doctor’s rounds, and for “guard room bathing.” This procedure required at least three staff, and almost always an R.N. The patient would be taken out, given a tub bath and shampoo, and immediately returned to their room. This isolated space had a commode

(secured to the floor) a window with bars, and a slot in the door, for meals to be passed through. Only a wool blanket and paper plates and spoons were permitted. There were some patients up and about the ward who were not considered a danger.

At night was a very scary time, as we had to let certain patients out of a locked room (there were usually six to eight patients in one room at a time) and change and toilet each one. There were many nights I wished I was elsewhere. I still remember it as if it were yesterday! This sounds very barbaric but it was still late forties, very early fifties, and tranquilizers had not yet been developed.

I remember one day while working on a "back ward" I had to take a group of patients to the "Airing Court" by myself! This was a very large outdoor fenced and secured area, where patients went for fresh air. They seemed to really enjoy these outings, but I was very anxious being in charge of them. We usually stayed an hour, always dependent on weather. One particular day I left them with an attendant and went back inside to help with the noon meal. When I returned to bring them back into the ward I was to count each patient to make sure they were all accounted for.

Imbedded in memory from that outing is that of a patient missing on return to the unit. I frantically rushed back outside to look for her, and there she was lying on her back under a big tree enjoying some solitude. "What are you doing out here?" I asked. Very relaxed with her head resting in her folded hands, she quietly replied: "Oh Miss Langille, I was just looking up at the sky." To which I responded: "We've got to go back Alice" and without protest she took my hand and we returned to the unit together. Much to my

relief!

As students in our second year, we were given a great deal of responsibility. One rotation I found especially difficult, was the “TB” (tuberculosis) Unit. Patients with mental illness and T.B. could not take care of themselves and could not be treated at a Sanitarium. The “unit” or ward, was at the far end of the admission ward, separated only by a wall with a door, and without a bathroom of its own. I mention this only to emphasize how difficult it was to carry out proper “Precaution Procedures.” Disposing of urine and feces was a very difficult task! Bed pans and all wash water was carried to the back hall, just off the wards, and put into large containers of lime and formaldehyde.

Two of the rooms were “locked.” One large room housed six patients, and another four. A gown and mask were worn at all times. No gloves were available for use! Before being taken to the main laundry, all soiled linens were bagged and clearly marked “contaminated.” Food came from the kitchen, all on paper plates and eaten with only a spoon. Oral medications used for T.B. (tuberculosis) were P.A.S. and I.N.H. Some patients, when needed, and ordered by the doctor, received streptomycin, which was given intramuscularly. It was a very trying time for all involved in the care of TB patients.

Treatments used during my training years are as follows: Electro – convulsive therapy, hydrotherapy, and Coma Insulin. Treatment most often used was ECT. Given for schizophrenia, catatonia, and severe depression, each patient was required to have a complete physical exam before approved for treatment. Although very much stigmatized in many circles, it can be a

very effective form of therapy that continues to be used in drug resistant illnesses.

Hydrotherapy was used for the very psychotic, disturbed and out of control patient, and varied from warm tub baths, to dry (not as effective) and wet (could also be very cold) packs, wrung out by hand. It acted as a sedation and was calming. Our duty was to assist the R.N. in applying these sheets in a very specific procedure (packs) wet or dry to the patient, and to restrain them, for periods of up to four hours. During this time we were responsible to ensure the patient was given thirty or more ounces of fluid, to prevent dehydration. This was done carefully to prevent aspiration by using a small pitcher with a spout, at different intervals of the treatment. After four hours, the patient was removed from the pack, toileted, given a tub bath, and returned to the "sick room" to start another four hours. This treatment was very useful in calming the patient, and they rested well. The psychiatrist determined how long the treatment would continue. It seemed barbaric but appeared to be very effective. People got better, were discharged and rarely needed re-admission.

Another form of treatment called Coma Insulin, and a less intense form called Sub Coma Insulin was also in use. Sub Coma patients were never to go into the stage of Deep Coma and required specially trained staff. The dose of insulin was much smaller and the duration of the treatment was less also. They were not as sick as Deep Coma patients, and it was used for catatonia as well as schizophrenia.

Coma Insulin required R.N's with special training in it's administration and

care, and was given on a special ward, away from any disturbances, always staffed by two R.N's and two students. It was given during eight hour days, five days a week. Each day, the psychiatrist determined the doses of insulin to be given. Only one type of insulin was in use at that time.

To prepare the patient before being taken to the special ward, they were given a tub bath, were toileted, and had nothing by mouth. Once there, they were put to bed, vitals signs were done by an R.N. and recorded; the ordered dose of insulin was given, then close monitoring began.

All we could do was wait and watch very carefully. As the stages of Deep Coma appeared, the patient was checked for corneal reflexes, or absence thereof. The absence occurs when stage four is entered. The big toe is checked using a tongue depressor. If the toe turns upward, after running the depressor over the outer aspect of the sole, and across the top to the large toe, you have a Babinski! Indicating the degree of coma the patient has reached. When it was determined the patient had reached the required time in Deep Coma, it was carefully documented and reviewed by the doctor to determine the next dose, or if any changes were needed in the next treatment. It could take days and weeks, before the stages of Coma were reached. I have seen up to 800 units of insulin used each day! A completed treatment consisted of a total of twenty hours of DEEP coma. This could take a few months to achieve.

The patient was taken out of Coma by being given a dose of Glucose, slowly, intravenously from a 100 cc syringe filled with Glucose and administered until the patient became responsive. We learned how to make this glucose in the kitchen. It was boiled, cooled and stored in apothecary jars. Then they

were given fluids orally and a meal before returning to their unit when alert, mobile and vitals were stable. There they were checked very often in case of Irreversible Coma, which was very rare. They usually had a full recovery, and eventually were discharged home. I enjoyed my time on Coma Insulin and learned a lot!

There were few medications in use at that time. For sedation, we used Barbitone 5 grains, (not grams), Chloral Hydrate 4 drams with a repeat as needed. Paraldehyde was used either orally or I/M. It had a very bad odour if taken by mouth, and could cause an abscess at the injection site, if not given correctly. Apomorphine was used in rare cases, for violent behaviour and given s/c which caused vomiting and made the patient very weak. Gardinal, used I/M was very effective and a safe sedative.

Tranquilizers did not come to the Nova Scotia Hospital until 1953 – '54, which took place while I was on affiliation in Halifax, and changed forever, the way we could provide care to the mentally ill. Largactil 25 mg. given with Morphine was used for terminally ill cancer patients, and to this day, Elavil is used for enhancing pain control. The greatest reward came from seeing patients recover and be discharged home.

My time at the Grace Maternity was quite an experience! Taking care of newborns and their mothers post-partum. Learning about making formulas and the proper feeding of babies was very interesting. Assisting the doctor in a delivery was very exciting! I remember as if it was yesterday the feeling of joy when the doctor passed me the baby I had just witnessed being born! All so rewarding.

The three months at The Children's Hospital, gave us great experience in dealing with very sick children. It was sad to see any child suffering but gave great comfort to us to hold them and care for them as best we could. Some days were very challenging, especially when we watched a child leave this world! I know I still think about some of these children.

Six months at the Victoria General in 1953 was a great test of will and courage. There I witnessed the first use of radiation in the form of seeds inserted into the patient's cervix. She had to be isolated for 24 – 48 hours. Also at the VGH I was able to assist a doctor administering an intravenous Nitrogen Mustard treatment to a male patient with lung cancer.

Being called out at night to assist in emergency surgeries in the operating room, proved to be a most stressful time for me. There were days and nights when I almost gave up my dream of becoming a nurse. If it had not been my last rotation, I'm not sure how it would have gone!

We learned Surgery, Medicine, Urology, O.R., Gynecology, finished training and returned to our own Hospital. The many days spent learning every aspect of nursing was needed to pass the State Board Exam. This was given after our three-year period, to earn the privilege of writing R.N. after our name, and becoming a Registered Nurse in the Province of Nova Scotia.

Although Mary has not included the following information in her memoir, it is recorded in the Nova Scotia Hospital Annual report for the year 1954 as follows: "Mary Langille was the winner of this years prestigious Dr. DeWolfe Medal." Given to a member of each graduating class for highest average marks over the three years.

Most memorable was Graduation Day, attended by my twin sister Martha my idol, my mother my greatest support and inspiration. I could not have succeeded without her. Also present was my future husband, Edgar Forsyth, all there to celebrate with me. That lovely day in September, 1954, fifteen students graduated during a wonderful ceremony. The Graduation Ball was held at the then Nova Scotian Hotel (now the Westin) Sept. 15, 1954. It was a day I was able to celebrate with my twin sister Martha who had Graduated from nursing one year ahead of me. During her last two years of training, and my first two years, our paths would periodically cross as we were assigned various wards.

We were identical twins, and this was very confusing to the patients and did not always bode well for us! If I happened to be on days and she on nights (on the same ward) we could often be mistaken for each other, and the outcome sometimes was not good. For example, once I was walking down the hall when I was suddenly hit with a wet towel across the back! The patient confused me with my sister and blamed me for something she thought my sister had done to her the previous night! It could be funny – depending on which one of us was on the receiving end!

In summary, it was our responsibility as students to learn from our teachers, work under the guidance of an R.N. and learn from them how to work with disturbed, depressed, catatonic, personality disorders, schizophrenics and sociopaths.

Looking back, I realize we received excellent training and were treated very well. Seventy years later as I reflect on those three years spent in nursing school to become a Registered Nurse, I am in awe of all that I learned, all that I witnessed and ALL that I remember. I was, and still am, very proud to say I

graduated from the Nova Scotia Hospital in Dartmouth. However, it is a very, very different place today.

For sure, many details have been left out, but I hope “my story” might help younger generations of nurses, understand what a psychiatric nursing student’s experience was like in 1951.

Mary (Langille) Forsyth

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