NEWS BULLETIN

The Sanatorium Board of Manitoba

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Farewell to a Faithful Servant

MOBILE UNIT NO. 2

— Photo by David Portigal

A valiant old war horse in the province-wide fight against tuberculosis has been retired from the field this month after nearly 24 years of service.

Mobile Unit No. 1, which was especially designed for mass survey work by Picker X-ray Engineering Ltd. of Winnipeg, was donated to the Sanatorium Board in 1946 by the Brandon Club of the Associated Canadian Travellers (with considerable assistance from CKX Radio Station in Brandon who sponsored the A.C.T.'s fund-raising *Search for Talent* broadcasts).

"I don't know of any other mobile x-ray unit that has lasted as long or performed so admirably in the field," says Sanatorium Board Surveys Officer Jim Zayshley, who would dearly love to see this huge thing enshrined as a tribute to the people's crusade against the greatest killer of all time.

"This old girl has criss-crossed the province countless times and has provided three and one-half million chest x-ray examinations to the population.

"The x-ray unit she carried was designed for work both inside the van and in buildings. It has travelled from Churchill to Emerson, from Virden to Rennie, and has been set up and dismantled over 12,000 times."

Mobile Unit No. 1, fully equipped and costing around $25,000, was officially presented to the Sanatorium Board at a ceremony at the Brandon Fair on July 5th, 1946. In accepting the gift, Chairman of the Board G. W. Northwood thanked the A.C.T. for their "splendid work, not only in fund raising, but also in educating Manitoba citizens to cooperate in active measures against tuberculosis". And SBM Medical Director said: "You are providing us with the tools to make the most effective use of our knowledge of how to prevent this disease and reduce its toll to the lowest possible figure."

Unit No. 1 was indeed a useful tool in whittling down the tuberculosis problem in Manitoba — from 1,187 new active cases in the year she went into operation to 225 last year.

When the van first went out into the field, she handled over 1,000 chest plates a day, remembers radiographer Alec Roh. The most x-rays she ever provided in one day was 1,740 chest plates, up in the Swan River area in the summer of 1947. (Alec remembers this very well, as he took every one of them.)

In the beginning, the van was designed for taking both miniature and large x-rays and it contained a permanent dark room, a dressing room and a unit for processing film right in the field. Later, when mass surveys switched over completely to miniature film, the van was somewhat modified to handle the public as speedily as possible.

But the generator, the shell of the van and the x-ray unit have remained essentially the same since 1946. Only the tractor part was completely replaced in 1956.

Now the bulk of Christmas Seal preventive work in Manitoba will be

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1969 Surveys Concentrate On Special Problem Areas

Christmas Seal funds from the 1968-69 Campaign are already going to work as the Sanatorium Board Surveys Department launches another 12 months of tuberculosis prevention and other early detection projects.

This month, after completing surveys of several industries and the School of Practical Nursing in Winnipeg, SBM technicians — accompanied by a portable x-ray unit and on occasion diabetes blood testing equipment — are screening 31 nursing homes in Winnipeg.

Nine nursing homes in Brandon will be completed (by portable unit) next month, and towards the end of March the weather should be fair enough for the mobile unit to come out of winter hibernation and begin its part of the rounds.

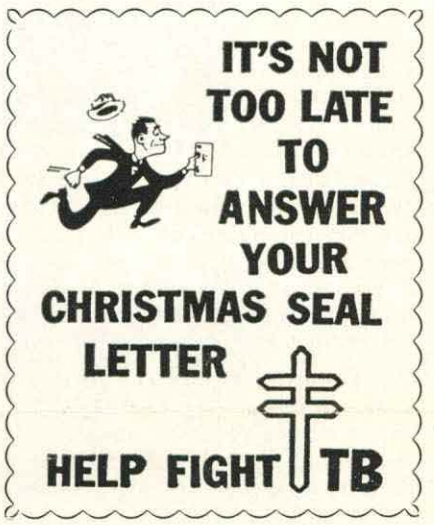
Free chest examinations are tentatively planned for some 2,000 employees of the Canadian Pacific Railway Company in March. After that the big x-ray van will head out in April for Indian Reserves in southern Manitoba to begin the surveys provided jointly by the Sanatorium Board and the Medical Services branch of the Department of National Health and Welfare. Then, beginning in June, portable x-ray equipment will be flown into the reserves and settlements in the northern part of the province.

Ten Manitoba municipalities, plus two unorganized districts, will be screened for tuberculosis, other respiratory diseases and for diabetes this summer and fall. They include Dauphin (municipality and town), Lawrence, Lakeview, L.G.D. North Mountain, L.G.D. South Mountain, Swan River, Minitonas, Russell, Shoal Lake, North Norfolk, Portage la Prairie and St. Boniface.

These are the southern areas of the province where tuberculosis currently presents the biggest problem. In the past three years, 67 new active cases have been discovered in these parts.

The pulmonary function tests and questionnaires, which will be included in part of this year's survey work, are largely research studies designed to learn more about the incidence and nature of such chronic respiratory ailments as bronchitis and emphysema. They are provided by the Joint Respiratory Program of the Sanatorium Board and the University of Manitoba Faculty of Medicine.

The diabetes screening programs— carried out in the form of blood tests and research questionnaires — are the joint effort of the Sanatorium Board and the University of Manitoba Metabolic Laboratory, and are assisted by a grant from the Canadian Diabetic Association.



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The Story of the Sanatorium Board of Manitoba

By Patricia A. Holting

The plastics industry has been developing by leaps and bounds during the war, and it will probably offer considerable opportunity for employment in the post-war period. The Rehabilitation Division is prepared to offer courses of instruction in plastics engineering . . .

More and more is being accomplished through the vocational training courses being taken by patients in sanatorium and sanatorium graduates who are continuing their studies at home. Not counting Canadian Legion or academic courses, 595 examinations were submitted for correction during the first four months of the year. . . .

Scientific agriculture offers an especially attractive profession to those with the interest and educational background. We were talking a few weeks ago with a man now engaged in this work, who pointed out the opportunities in this field . . . .

Congratulations to the following who have completed courses in recent months: Peter Bass, Introductory Mathematics; Laverne Baxter, Unit II Typing; Allan Drummond, Unit II Bookkeeping; Garth Johnston, Electrical Appliances, Batteries and Meters; Rosaline Watkins, Unit I Interior Decorating; Joseph Welsh, How to Estimate for the Building Trades; Fred Whittaker, Unit II Radio; Claude Ground, Photography. . . .

— From Rehabilitation Notes, Messenger of Health, 1944.

PART SIX

Tuberculosis has always been a great leveller of man — but especially so in the years before the welfare cheque and other forms of assistance to the sick. Cut off from his source of income and isolated in a barrack-type existence for a year or two, perhaps three or more, even top professionals found they had much in common with the ordinary working man. Aside from the disease itself, most patients were deeply troubled by financial and family problems and by doubts of their own ability to re-establish themselves in the outside world. Loss of security and sometimes self-esteem worked against healing, and as one day dragged on to another and yet another the physical and mental suffering of patients often became more profound.

Dr. D. A. Stewart, seeking to "neutralize inertia" and "prevent deterioration and the sense of inferiority", continually urged patients to keep themselves usefully busy through study or the pursuit of some hobby. In 1925 he secured two full-time teachers for the sanatorium and instituted 'round-the-clock instruction in the elementary and high school grades. For those who completed basic education he suggested self-imposed study to increase their general knowledge. "Hospital days," he maintained, "can be among the best days of life. People who have been hurried and worried, who have worn the shackles of exacting duties, can sometimes find in hospitals time to think, to come to themselves, to relax . . . to read what they have not had time to read, to write what they have not had time to write, to rest and invite their souls."

But the doctor's approach was fitted more for the ivory tower than for the tough work-a-day world which in the 1930's offered few jobs, set a high premium on skilled labor, and very often discriminated against the ex-TB patient. Where possible, of course, patients were encouraged to improve job skills or study a new vocation, but for many years the sanatorium offered no practical, organized program for enabling them to do so. As one former patient, recalling sanatorium life in the 1930's, remembers: "We spent our time reading, resting or knitting . . . more or less devising our own entertainment. A few correspondence courses in business subjects were available at a low cost through the Department of Education. But they might as well have cost a million dollars for many of us had no money. And since we had already completed high school, there was nothing to do but brush up on subjects we had already taken."

Towards the end of that decade many troubled patients were drawn to the bedside of a young, bright-eyed bank accountant who seemed to have a deep and compassionate understanding of his fellows' problems and basic needs. T. A. J. (Jack) Cunnings was himself hard hit by tuberculosis. Born on a farm at Rosthern, Saskatchewan, and educated at Regina, he had embarked on a career with the Imperial Bank of Canada in 1925, only to fall ill with tuberculosis of the spine six years later. He spent 16 months in a shell cast in a hospital in Alberta, recovered and returned to the bank and was transferred to Winnipeg in late 1932. Then in 1937 he again became ill, this time with rampant miliary tuberculosis, from which no patient at that time had much hope of recovery.

For five years Jack Cunnings battled disease and prognosis and as bit by bit he regained strength he became increasingly interested in the wider problems of tuberculosis. Eventually his room became a counselling chamber for patients and the site of much dialogue between himself and the sanatorium doctors. He possessed a quick and inquiring mind and an insatiable curiosity about the psychology of human behavior. "The sanatorium," he once remarked, "is a great laboratory for the study of people — for here, where everyone is stripped of the marks of social and financial distinction, it is easier to contemplate real values and the real man."

The acceptable solution to the tuberculosis patient's problems, he felt, should go far beyond treatment and a philosophy for the sick, and place more emphasis from the beginning on ability rather than disability. "It is generally recognized," he wrote, "that the patient's psychological, social and economic relationships play a vital part in his response to treatment and subsequent control of his disease. A diagnosis of tuberculosis brings with it difficult problems of adjustment, not the least of which is the patient's anxiety over his future means of livelihood. Neglected, this natural distress militates against his progress on the cure. In the post sanatorium period this hard-won health may be jeopardized by throwing him suddenly on his own resources in a world that too often fails to understand his efforts to regain a place in the economic scheme." In other words, what the patient needed most was a practical answer to the uppermost questions in his mind: What will I be able to do when I leave hospital? Will I be able to support myself and my family? Will I be accepted?

As a first step toward creating a better understanding of tuberculosis and all its inherent problems, Mr. Cunnings edited from his bedside a monthly magazine called *The Messenger of Health.* This publication, which first appeared in March 1938, was aimed primarily at patients' families and friends, its purpose being to gain wider attention for the anti-tuberculosis campaign and to educate the public about tuberculosis through the presentation of news and features about sanatorium life and scientific articles by the sanatorium doctors. Also, as part of the effort to advance the patient's rehabilitation, the editor noted in 1941, "the Messenger has actively encouraged and assisted patients, who might profitably do so, to undertake vocational training by correspondence under special arrangements with the Department of Education".

Thus the concept of a tuberculosis rehabilitation program was formulated abed; then brought into action on May 1, 1942, when following his discharge from hospital Mr. Cunnings was appointed first director of the Rehabilitation Division of the Sanatorium Board of Manitoba. Working out of an office at the Central Tuberculosis Clinic in Winnipeg, he established a comprehensive service of vocational counselling and training, employment guidance and assistance — a scheme which was put into effect for each patient ① almost as soon as he entered hospital, and which continued until he was successfully re-established in the community.

To be successful, vocational rehabilitation counselling of the sick or disabled must be based on a clear indication from the doctor with respect to the patient's physical condition. To convey this information with clarity and precision, a coded Work Tolerance Prognosis was evolved by the Rehabilitation Director, which called for a specific classification of the patient's disease right after his admission to sanatorium, plus an estimate of his recovery chances and probable work capacity. This classification system was simple and speedy, yet provided the counsellor with precise medical guidance on which to base rehabilitation advice and direction. It appeared on admission cards as follows:

WTP 0	Unlikely to recover
WTP 1	Unlikely to be able to work
WTP 2	Unlikely to be able to do more than part-time or very light work
WTP 3	Expected to be able to do full-time light work
WTP 4	Expected to be able to do full-time normal work

Along with the Work Tolerance Prognosis, the physician also checked off a work prescription for each patient:

R1 to R4	Restricted work — i.e. study in the sanatorium from one to four hours per day, as indicated
L4	Half-time light work
L8	Full-time light work
N8	Full-time normal work
D1 to D6	Deferred — i.e. In sanatorium, not permitted to study; outside sanatorium, not permitted to work — from one to six months, as indicated.

The services of the Rehabilitation Division were available to every patient at the Manitoba Sanatorium and at St. Boniface Sanatorium and the King Edward Hospital in Winnipeg. In explaining the program, the Director had this to say in the June 1942 issue of The Messenger of Health:

> **Keynote of the whole rehabilitation program is training, which will be considered an integral part of the patient's treatment, and will be begun as soon after entering sanatorium as the doctor considers proper . . . Every new patient admitted to sanatorium will be interviewed (by the Director of Rehabilitation) within a reasonable time after admission to decide on his vocational program. Training in sanatorium or after discharge will be arranged as indicated. Then, when the patient is ready for work, the rehabilitation office, with complete data on every patient's physical and educational qualifications, and his work experience, will act as a point of reference between the patient's former, new or prospective employer.**
>
> **Treatment of tuberculosis must be admitted to be an unfinished business until the individual concerned has been established in an occupation that is commensurate with his physical and other qualifications. For after all, we have passed beyond the stage when it is considered enough if treatment but maintains life. It must give useful life, life allowing the joys and satisfactions, the stimulation and security of work well done.**

The rehabilitation program set up for tuberculosis patients in Manitoba in 1942 may seem rather commonplace and unoriginal to people today, but it should be remembered that at that time it incorporated a principle that had never before been demonstrated on a large scale in Canada. It was, in fact, a unique approach to tuberculosis treatment and control — a highly successful, simple scheme that made use of existing employment, training and social welfare resources. And, unlike previous experiments, such as the Papworth Settlement plan in England, which provided medically supervised,

Thirty years ago, according to T. A. J. Cunnings, the Canadian attitude toward vocational rehabilitation was much the same as one's feelings about motherhood. Everyone agreed it was a good thing . . . and that's as far as it went.

segregated employment for the chronically ill, it brought the patient into a normal place in business and industry where his health would not be jeopardized and yet he could compete fairly with others. The benefits of the Manitoba plan are perhaps best illustrated in the stories of two men — one of whom was discharged from sanatorium before the Rehabilitation Division was set up, the other afterwards:

> **The first patient was well qualified for a number of jobs. Prior to his admission to sanatorium in 1934 he had completed two years at university, had taken teacher training for one year at the Winnipeg Normal School, had studied bookkeeping and typing, and had been employed for four years in a large financial institution. Yet in the three years from the time of his discharge in 1939 until he finally secured help from the Rehabilitation Division, he was able to obtain only occasional employment. The problems of this man, who had gone through five years of gruelling treatment and had left sanatorium unsure of himself, were obviously too big for him to tackle alone. How much easier it was for the second patient who before becoming ill in 1942 drove for a cross-country trucking firm. This man had very little education so after his admission he was launched on a few courses which included practical mathematics. Since his work prescription on discharge advised lighter work, he was enrolled in a War Emergency Training Program for practical training in machine shop work, thence in a sheet metal course at the Manitoba Technical Institute. Afterwards, without trouble, he found a job as a lead hand in a pontoon assembly plant.**

In due course the business community cooperated with the new project. But, of course, it had to be sold to them first, and in order to do this the Rehabilitation Director joined the Young Men's Section of the Board of Trade, got himself appointed to the Advisory Council of the Servicemen's Re-establishment Committee, enlisted the cooperation of the provincial Department of Education and of social and welfare agencies, gave numerous speeches and made personal appearances in the offices of presidents and personnel managers of the various industries. Perhaps it should also be mentioned that he had almost daily discussions with landlords and landladies, for 25 years ago there was a pronounced prejudice towards tuberculosis — a fact demonstrated time and again when ex-patients, letting slip where they had been for the previous year or so, suddenly found themselves out of lodging and sometimes work. Education perforce was an on-going program that had to penetrate all levels of the community.

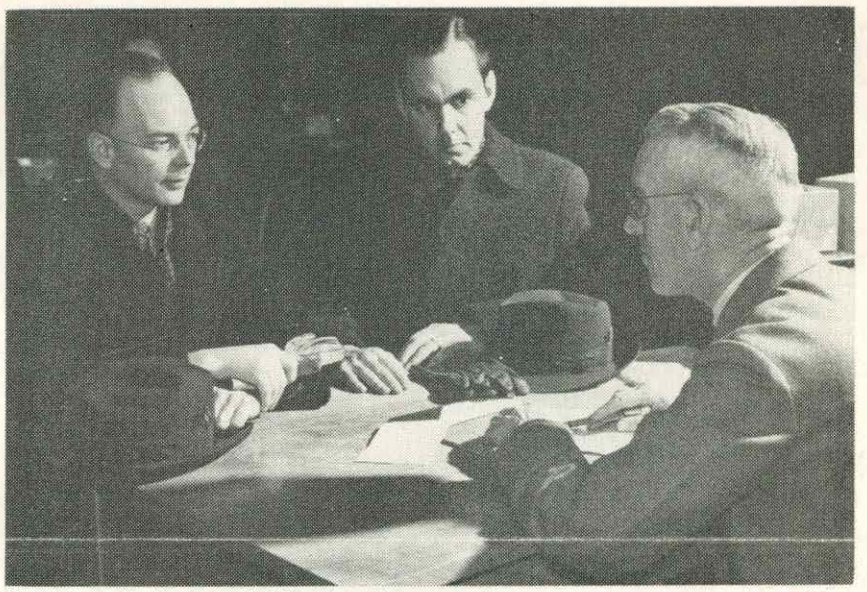
The new services also had a tremendous effect on patient morale. Almost overnight the atmosphere of the sanatorium was transformed, as patients, from the day of their admission, were now presented with new hope and a goal. With the enthusiastic cooperation of R. J. Johns, director of Technical Training for the Department of Education, some 150 short unit vocational courses were made available by correspondence for a low fee.[2] Academic instruction was continued and extended to the university level. Eight months after the plan went into effect, some 150 patients were on courses of study and over 800 interviews had been conducted among 388 patients. One year later Mr. Cunnings was able to report to the Sanatorium Board that "not a single patient known to us, who is medically fit, qualified for work and keen to work, is without employment".

In the years following, the Manitoba program became a model for rehabilitation programs in other provinces and countries. In 1945, when the Rehabilitation Director stepped up to the post of secretary-treasurer of the Sanatorium Board, thence to Executive Director, the work was carried on by Stephen C. Sparling (who later became Executive Director of the Society for Crippled Children and Adults in Manitoba), then by E. G. Metcalfe and finally by Miss Margaret Busch. Eventually, in 1964, the major part of this service was incorporated into the over-all rehabilitation program of the Manitoba government.

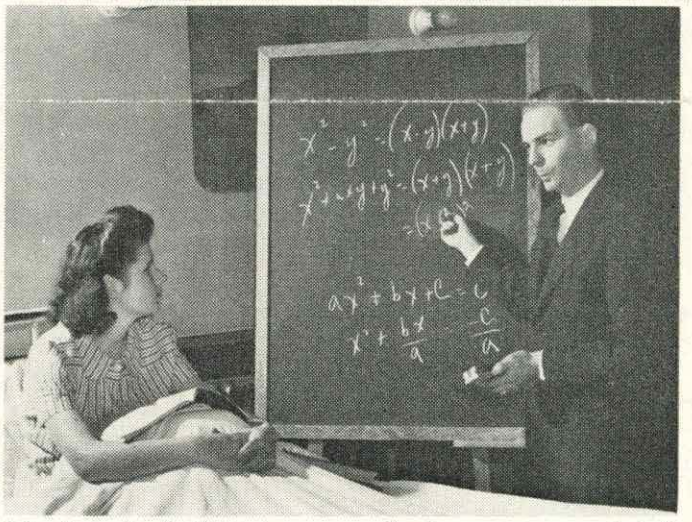
In 1956 the Rehabilitation Division was modified to include a separate service for Indians and Eskimos with tuberculosis; then this, too, was extended a few years later to other people with other types of disabilities (social and vocational, as well as physical). This section of the program — begun first with an in-sanatorium program and post-sanatorium scheme in two Winnipeg boarding houses, and later transferred to a unit at Assiniboine Hospital in Brandon and finally to Pembina House at Ninette — was also a pioneering effort which has proved more successful than most other plans of its kind. It places emphasis first on the social reorientation of citizens from isolated sectors of our society, then on assessment of job aptitudes and capabilities. Only when these initial problems are resolved are the men and women directed into job training and placement.

(To Be Continued)

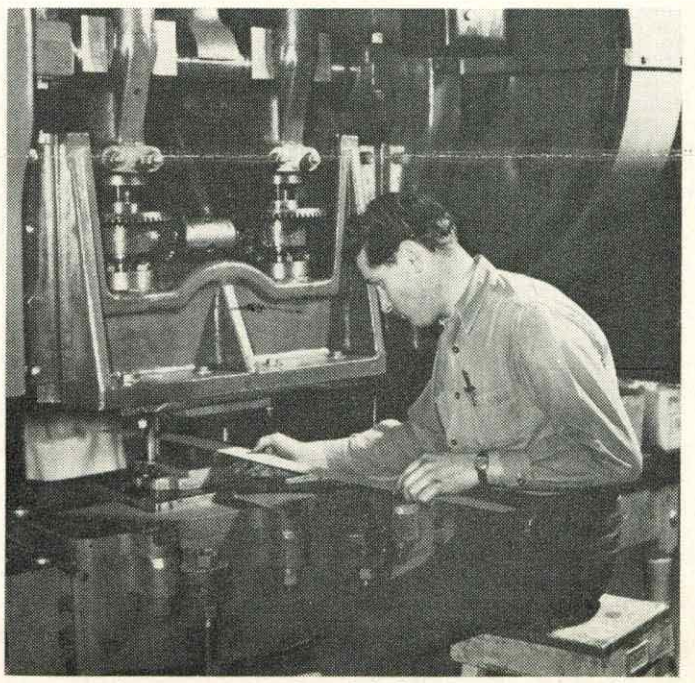
1. The services did not include patients who were unlikely to recover or were unfit for work, nor did they include patients over 60 years of age and children under 14. Housewives were not included in the beginning, but later on short courses in such subjects as food study and home management became available to them, too.
2. From the beginning it was felt inadvisable, from both the financial and psychological standpoints, to provide courses entirely without charge. Payment of even a small fee, said the Rehabilitation Director, engenders a greater feeling of independence and responsibility. The courses, however, were inexpensive, the fees ranging from 40 cents to a maximum of $4.50, with an average cost of $2.00 per unit study. In the few instances where patients could not pay even this, the fees were looked after by Christmas Seal or other contributed funds.



Back in early forties, rehabilitation director and ex-patient meet employment officer.



"We have the facilities to arrange almost any program of study that will be of vocational advantage to you, whether you wish to improve academic knowledge, or study in the technical and business field," Rehabilitation Director told patients.



"Being proficient at one's job, and finding in it a certain pleasure and satisfaction, are vital to happiness and health."

Home Care Cuts Costs to 53c Per Day

One outstanding example of cutting health costs, and at the same time maintaining adequate supervised patient management, is the Home Care Program operated out of the Winnipeg General Hospital for patients with severe chronic illness.

According to a report by chest specialist Dr. Reuben Cherniack and the program's medical director and nursing co-ordinator, Dr. R. G. Handford and Miss Edith Svanhill, the cost of providing concentrated home care in 1967 for 79 patients with chronic respiratory insufficiency amounted to only $15,262.69.

This annual sum — which works out to $193.20 per patient, or 53 cents per patient per day — is insignificant when compared to the daily cost of a hospital bed, the authors note. In Winnipeg, for example, it would be adequate to maintain a patient for only four or five days in an acute hospital bed, for seven or eight days in a chronic hospital bed, or 12 to 20 days in a nursing home.

The Home Care Program was a small pioneering effort when it was started over 10 years ago for a handful of patients suffering chronic illness — principally respiratory, cardiac, neurological or malignant disease. With the enthusiastic support of health workers and the joint financial backing of Manitoba Hospital Commission payments and provincial government rehabilitation health grants, the services have been steadily extended over the years, and at present the daily census is around 175 patients, of whom 45 percent suffer from respiratory ailments (and some of these referred from our D. A. Stewart Centre).

Chronic respiratory insufficiency is punctuated with severe acute episides requiring repeated hospital admissions. The aim of Home Care in this field is to avoid costly hospital treatment by providing measures to prevent progression of the disease, relieve symptoms and improve lung function as much as possible.

The program depends heavily on the use of paramedical personnel and looks to the physician mainly for medical supervision and for aid in emergencies. Patients receive frequent visits from a V.O.N. nurse and they report regularly for reassessment (at two to six-month intervals) in the hospital outpatient clinic or in the office of their private physician. They are also provided with mechanical aids to breathing and the services of inhalation therapists, physiotherapists and, when indicated, a housekeeper.

On the whole the scheme works nicely, the authors feel. Patients seem to thrive just as well (if not better) on concentrated home care as in hospital. In fact, they appear to be more content to remain within the family circle, surrounded by the comforts that only the home can provide.

The death rate among patients admitted to the program is high, however — particularly among those suffering chronic obstructive pulmonary disease. But the high number of deaths (about 47 percent) is also understandable as the prerequisites for admission are stringent. Patients must have a record of repeated hospital admissions over the past few years, or persistent and very severe breathing difficulties.

In all, 148 patients with severe chronic respiratory disease spent 71,247 days on the home care program between 1958 and 1967. The average length of time on the program was 482 days.

Fifty-five percent of the patients required readmission to hospital — but the 4,078 days they spent in hospital represented only 5.7 percent of the time spent on the Home Care Program.

FAREWELL

Continued from Page 1

shouldered by the Sanatorium Board's last remaining Unit No. 2, donated two years ago by the Brandon A.C.T. for multiple screening purposes.

A third unit, purchased by the Associated Canadian Travellers of Winnipeg, preceded her sister into retirement in 1966, after she, too, had given many long years of fruitful service.

In Memoriam

Staff and patients of the Sanatorium Board of Manitoba were saddened by the deaths during the past month of two valued employees of the D.A. Stewart Centre.

Caroline Ruth Doern, R.T., who had given over 27 years of service to the Sanatorium Board, died unexpectedly on February 4. Miss Doern was born and educated in Morden, moving to Winnipeg in 1940. She became ill with tuberculosis a year later and on her recovery she joined the staff of the former Central Tuberculosis Clinic in August 1942 as an assistant radiographer. She remained with the C.T.C. x-ray department as a registered technician until the mid-1950's when she moved over to the Winnipeg City Hall to assist with the operation there of a Sanatorium Board x-ray service. In 1961 she was transferred to the Board's newly installed x-ray unit at the National Employment Service building and when this too was closed a year ago, she returned to the x-ray service in the out-patient department of the D. A. Stewart Centre. Caroline was a conscientious worker, a kind person, and very much devoted to the anti-tuberculosis cause. Our sympathy is extended to her parents, Mr. and Mrs. Philip Doern of Winnipeg, and to her five sisters and her brother.

Melville H. Pearce, school teacher for patients at the D.A. Stewart Centre for nearly five years, died at St. Boniface Hospital on January 29. Mr. Pearce was also born at Morden, Manitoba, and lived for a time at Englefeld, Saskatchewan, before returning to Winnipeg in 1920. He had a Bachelor of Arts degree from the University of Manitoba, attended Manitoba Teachers College for one year and taught school in suburban Winnipeg and rural Manitoba before taking a teaching position with the Sanatorium Board in January, 1962. In the summer of 1965 he left this post to teach at the Dauphin Collegiate, and then returned to the D.A. Stewart Centre in November, 1967. Mr. Pearce was highly respeced by both patients and staff and he will be missed very much. Our sympathy is expressed to his wife, Vera, his three daughters, brother, sister and grandchildren.

New Personnel

The Sanatorium Boards bids a warm welcome to *Mrs. Gwenyth Anne Morley*, who has assumed the position of Chief Medical Record Librarian at the Manitoba Rehabilitation Hospital. Mrs. Morley, who was born in Medicine Hat, is a 1966 graduate of the Edmonton General Hospital School for Medical Record Librarians and was previously employed at the Children's Hospital of Winnipeg. She succeeds *Mrs. Florence Landygo*, who served very capably in this post for over two years, and has now taken a new position with the Selkirk Hospital for Mental Diseases.

Other recent additions to our staff are *Miss Verlie E. Jordan*, practical nurse at Manitoba Sanatorium, Ninette; *Mrs. Ethel L. Selinger*, general staff nurse at the Manitoba Rehabilitation Hospital; and *Mrs. Eileen A. Victor*, general staff nurse (from Pakistan) at the D.A. Stewart Centre.

New RD Film

Through the Christmas Seal health education fund, the Sanatorium Board has purchased a new Canadian film on respiratory disease and is placing it for public use in the Health Education Services film library, 316 Norquay Building, Winnipeg 1.

Life and Breath (about 20 mintues long) deals mainly with emphysema, a fast-rising, severely incapacitating lung disease, which (although the actual cause is not known) seems to have some link with heavy cigarette smoking. Actor John Vernon narrates the story of a man struck down in the prime of life by emphysema, and a series of flashbacks show how it all happened.

The film — suitable for teenagers and general adult audiences — was produced by Crawley Films and is a Centennial project of the B.C. Tuberculosis - Christmas Seal Society.

BULLETIN BOARD

The 12th Post-graduate Course in Rehabilitation Nursing gets under way at the Manitoba Rehabilitation Hospital on April 14 and continues until May 2. The day-long sessions, which cover all aspects of the rehabilitation of the physically disabled, include lectures and demonstrations, plus observation on the wards and in the treatment departments. Applications and inquiries should be directed to Mrs. Doris Setter, Nursing Instructor, Manitoba Rehabilitation Hospital, Winnipeg 2.

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The Manitoba Rehabilitation Hospital received more distinguished visitors in the past month. On February 6 Jerome Marik, who is associated with the hospital consultant firm of Norman Brady and Associates, in Princeton, New Jersey, toured our hospital and discussed special problems with the executive staff. The Princeton firm is currently involved in the building of new rehabilitation centres in Halifax and Philadelphia.

Dr. Paul J. Corcoran, assistant professor of Rehabilitation Medicine at Columbia University, had a look at the programs and operations of the Sanatorium Board's Prosthetics and Orthotics Research and Development Unit on January 31. Dr. Corcoran, who had also toured a similar department in Seattle, was particularly interested in immediate post-operative fittings of artificial limbs and in the Winnipeg modular system of prosthetics.

On March 13 the M.R.H. and the staff will again spruce up to receive the hospital consultants and administrative chiefs who are concerned with the building of a rehabilitation facility for Mount Sinai Hospital in Detroit. The guests will spend the day in consultation with our executive and medical chiefs.

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At the end of last month the staff of the Manitoba Rehabilitation Hospital, D.A. Stewart Centre and Sanatorium Board Executive Office got together to bid farewell to remedial gymnast Bill Williamson, who has taken a new post at the G. F. Strong Rehabilitation Centre in Vancouver. Bill has been highly popular with both patients and staff, and he was also well known around the city for his interest in sports (e.g. he served as trainer for the U. of M. Bisons). He will be missed very much.

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Dr. R. M. Cherniack, medical director of our TB and Respiratory Disease Service, and Dr. C. B. Schoemperlen, associate medical director, flew to Banff, February 6 to attend the regional meeting of the American College of Physicians. Dr. Cherniack presented a paper on myocardial infarction.