NEWS BULLETIN

The Sanatorium Board of Manitoba

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In 70's Horror of TB Must Go

In the 1970's old misconceptions about the infectiousness of tuberculosis must go — and its prevention, diagnosis and treatment returned to the realm of general medicine.

At the annual meeting of the Canadian Tuberculosis and Respiratory Disease Association in Toronto last month, Dr. Owen Clarke, medical director of Sir Adam Beck Chest Disease Unit in London, Ontario, told delegates that education of the medical profession, the general public and employers will be an important function of voluntary associations in the years ahead. "For too long have we allowed the old stigma, and the horror and fear of consumption to persist into the present era of active treatment and successful control," he said.

"Tuberculosis patients have the same responsibilities and hopes and needs as other people . . . and if properly handled, the economic and social consequences of getting tuberculosis can be reduced to an absolute minimum."

A primary target of the 1970's, Dr. Clarke said, is to accept the idea that tuberculosis is a treatable and curable disease. When treatment fails, Dr. Clarke does not blame the patient. "Usually," he said, "failure to cure is due to the failure of the doctor to apply the best techniques of treatment," or to the failure of those who supervise the patient's treatment.

In his address, Dr. Clarke touched on important developments in the treatment and prevention of tuberculosis. Primary drug treatment with INH, Rifampin and Ethambutol will probably replace the present standard regimes (e.g. INH, Streptomycin and PAS), he said.

Rifampin, the newest drug, has especially exciting possibilities. Discovered several years ago in Italy and recently introduced in Canada under specialist supervision, this drug could make the same contribution to the treatment of tuberculosis as the "wonder drug" INH did two decades ago, he predicted.

Rifampin has the great advantage in that it is given by mouth in one dose daily, and is almost non-toxic. It acts directly on the tubercle bacilli and kills them, rather than exerting only a bacteriostatic effect, such as the old drug PAS.

Its great disadvantage, however, is the cost. One dose of Rifampin costs $1.60 — while the cost of one year's treatment with INH is less than $5.00.

Regarding the place of treatment, Dr. Clarke noted that tuberculosis will be increasingly treated in the

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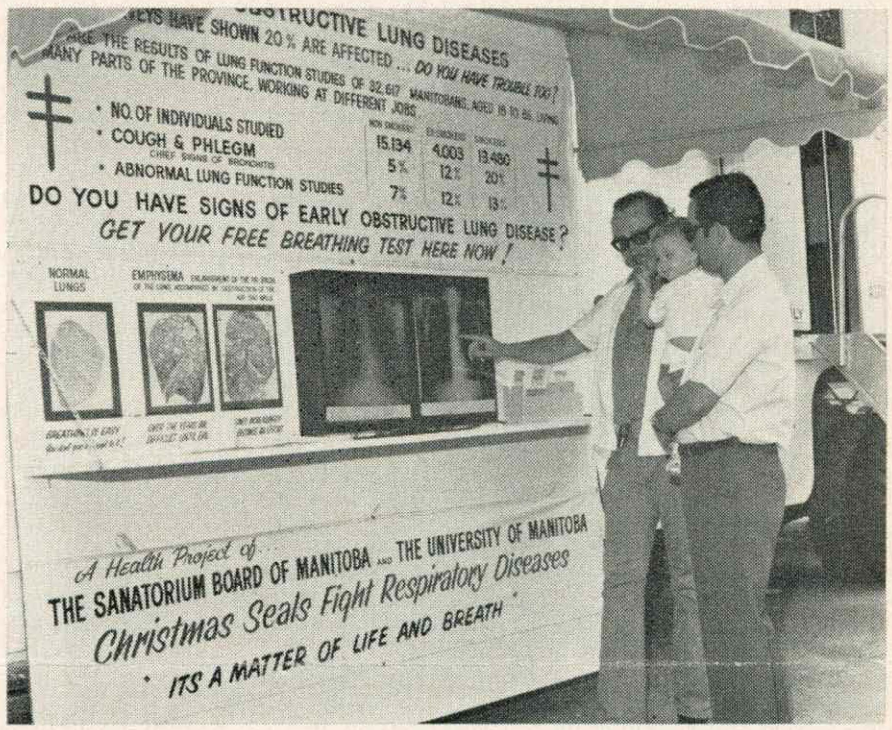
A.C.T. "LUCKY STAR" PROJECT — A major attraction at the Manisphere Exhibition in Winnipeg, June 25 to July 3, was a lottery on this 24 foot Triple-E. Motor Home, offered by the Associated Canadian Travellers, Winnipeg Club, in aid of the Sanatorium Board of Manitoba. Through their "Lucky Star" projects over the past 10 years, the Winnipeg A.C.T. has contributed over $80,000 towards a $100,000 pledge to provide needed treatment equipment and special services for patients at the Manitoba Rehabilitation Hospital. The winner of ths year's prize, valued at $15,000, is Mrs. Michael Bartinski of Sprague, Manitoba, who is shown receiving the key to her new motor home from A.C.T. Secretary-Treasurer Wilf Bardsley, while John Bruhart, a director of the Winnipeg A.C.T. looks on. Looking out from the trailer is Mr. Bartinski and their two children, Susan and Robert. —Photo by David Portigal

S.B.M. Goes to the Fair



Salesman Dave Sokolan of Winnipeg and his young daughter Kathy Lynn stopped for a moment to examine a Sanatorium Board exhibit on chronic obstructive lung disease and the effects of cigarette smoking at Manisphere in July. At left is SBM x-ray technician James Murrie.

— Photo by Portigal.

Bronchitis is a serious and growing health problem in Manitoba, which may affect (in varying degrees) about 20 percent of the cigarette smoking population.

This was the message of a special exhibit set up by the Sanatorium Board of Manitoba at Manisphere in Winnipeg from June 25 to July 3 and at the Provincial Exhibition in Brandon, July 5 to 10.

Chest x-ray examinations and lung function studies (offered jointly by the Sanatorium Board and the University of Manitoba) were provided for fair-goers in the Christmas Seal mobile unit, and over 1,000 people took advantage of the free examinations.

The Associated Canadian Travellers of Winnipeg and Brandon joined with the Board in promoting this free health service at the fairs, and in the coming weeks the lung function studies will be carried right into the communities in the municipalities of Hanover, La Broquerie, Miniota, Hamiota, Blanchard, South Cypress, Argyle, Strathcona and Winchester.

Some 2,500 residents have already been tested in Dufferin and Morris municipalities.

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Physiotherapists Work For Better Care

It is a fact that professionals busily involved in the care of sick or injured people sometimes overlook, or perhaps fail to see, the total needs of each individual and the full effects of treatment programs, well intentioned though they may be.

As one means of providing the best possible care at the Manitoba Rehabilitation Hospital - D. A. Stewart Centre, of stimulating the interest of both patients and staff in treatment, and of improving communication between the major hospital departments, Miss Martha Treichel, assistant chief physiotherapist, has been conducting during the past 18 months a series of formal and informal studies and evaluations of the department's programs and aims.

The project — carried out in conjunction with doctors and other professionals in the hospital — involves the follow-up of hemiplegic patients who have returned to the community, the supervision and follow-up of patients with chronic obstructive lung disease who are on home care and exercise programs, the evaluation of special exercises for patients with back conditions, the management of people (mainly athletes and workmen) who have undergone surgical removal of cartilage in the knee, an in-depth examination of resistance exercises for patients with various leg disabilities, and finally, a study of the efficiency and effectiveness of the physiotherapy department as a whole.

Hemiplegia Follow-up: "We've felt that we have a good program for hemiplegic patients," Miss Treichel says. "Yet we don't really know how they fare after they are discharged from the hospital. The objective, therefore, is to evaluate the total hemiplegia program by bringing discharged patients back to the hospital to re-assess initial discharge arrangements and determine if they need further assistance or support for themselves or their families." Physicians, occupational therapists and social service workers, as well as physiotherapists, are especially involved in this project, which extends to hemiplegic patients discharged from the Manitoba Rehabilitation Hospital since December, 1970.

Respiratory Follow-up — For patients with chronic obstructive lung disease — such as bronchitis and emphysema — a new on-going program has been established to reinforce home exercises and to periodically re-assess their level of exercise tolerance and breathing patterns. While insufficient time has elapsed to draw conclusions, it is hoped that with continued supervision and support, preventive measures can be reinstituted early and hospital re-admissions kept to a minimum.

Back Program — This program — set up in the form of a questionnaire — is designed to evaluate special exercises for post-surgical patients and patients with acute back injuries.

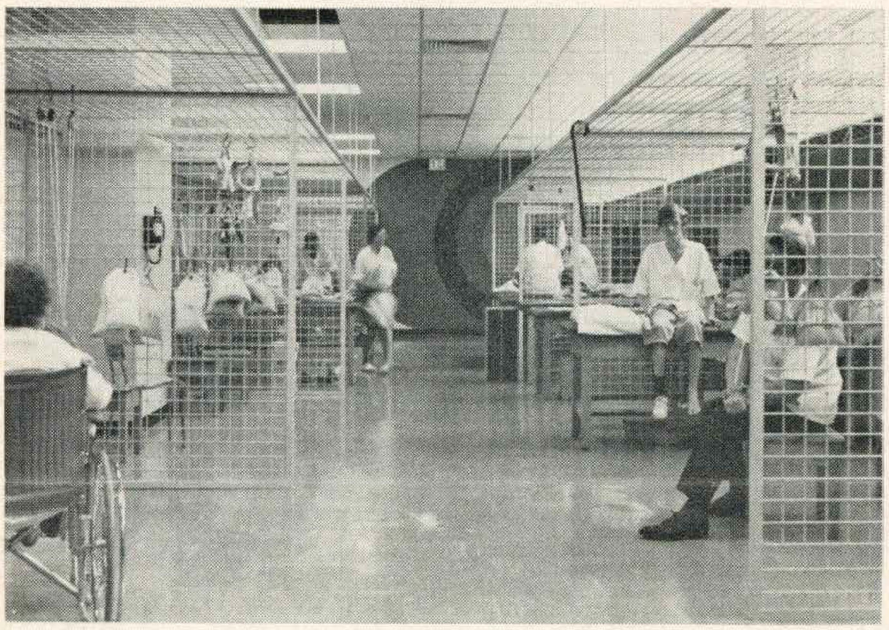
Menisectomy Study — In cooperation with other general hospitals in Winnipeg, the department hopes to bring to light any factors that may be contributing to poor knee function following physical therapy for patients who have had cartilage removed from their knees. "By working together on this problem, we may be able to restore much better function," Miss Treichel feels, adding that information now being gathered will be evaluated on a pilot project basis this summer.

Comparative Resistance Exercise Trials — Patients with leg injuries and surgery to the leg do exercises against resistance, which involves more and more work as function improves. The exercises are repeated over and over to achieve the fullest possible tolerance, endurance and strength — and "because of the repetitions it's easy for the therapist to lose interest in this treatment, and equally easy for the patient to become bored," Miss Treichel says. The project's aim, therefore, is to stimulate the patient's interest by inspiring him to "compete with himself" to achieve a higher level of function, and to promote the therapist's awareness of the importance of this program.

Within the Physiotherapy Department itself, Miss Treichel and her colleagues are taking a long look at the overall efficiency of treatment in terms of the utilization of time and space and discovering those factors that may be preventing or holding back patients from reaching realistic goals of physical rehabilitation in "an acceptable period of time".

It is most important, she points out, that we continually examine ourselves, keep new staff informed about the aims of the hospital, and strive for a treatment program that can be adjusted to each patient, as an individual.

Open New Treatment Area



The Sanatorium Board of Manitoba is pleased to announce the opening of a new addition to the Physiotherapy Department at the Manitoba Rehabilitation Hospital-D. A. Stewart Centre.

The group treatment area — which extends 20 feet into the hospital's interior courtyard and comprises 1,500 square feet of space — is designed for carrying out heavy resistance exercises by means of overhead mesh and pulleys.

According to Miss Joan Edwards, chief physiotherapist, the new facility gives the department a better opportunity to provide postural drainage and breathing exercises for respiratory disease patients from the D. A. Stewart Centre; and it can accommodate larger groups of patients from the Manitoba Rehabilitation Hospital, who have many other physical disabilities.

About 20 patients can receive group or individual treatment at one time. There is sufficient space for 16 treatment plinths, plus open areas for those patients who carry out resistance exercises in their wheelchairs.

Lung Tests Could Prevent Disability

Simple lung function tests may be a valuable means of detecting obstructive airway disease at its earliest stage, according to Dr. P. T. Macklem of the Royal Victoria Hospital, Montreal.

Commenting on the problem of chronic respiratory disease in Canada today, Dr. Macklem explained that by the time most patients seek help from their doctors for cough, sputum and shortness of breath, the lung changes leading to chronic bronchitis are permanent.

Simple lung function tests, sensitive enough to pick up abnormalities in the breathing tubes while they are still reversible, could preclude this situation, he feels.

To illustrate his point he told about testing smokers attending a stop-smoking course at the Royal Edward Hospital in Montreal. Airway obstruction was found in all the smokers who ranged in age from the 20's to the 60's. Twelve who quit smoking were retested at two month intervals and all showed improvement.

Good Treatment Necessary For Early Detection

Deaths from cancer of the respiratory system in Canada today are almost equal to deaths from road accidents at age 45, and deaths from chronic, non-specific respiratory disease are now about the same as traffic fatalities at age 55, Dr. J. F. Paterson told the Canadian Tuberculosis and Respiratory Disease Association at the 71st annual meeting in Toronto, June 1.

On the other hand, tuberculosis mortality rates have diminished to such a degree that a man is as likely to be murdered as to die of this disease. (Nonetheless, the tuberculosis morbidity rate has diminished very little over the past five years, and here in Manitoba the rate equals about one new active case each working day of the year.)

Dr. Paterson, conference keynote speaker who is professor and head of the Department of Medicine at Toronto Sunnybrook Hospital, talked about the rapidly rising problem of chronic respiratory disease in Canada, and he suggested that health workers carefully evaluate the cost-benefit aspect of early detection programs.

"My belief is that the best anchor with the strongest rope is true prevention, and that claims for the early detection of certain lung diseases may lead to a trap," he said.

True prevention is when no disease develops — and it is possible to achieve this with tuberculosis, smallpox, typhoid and other infectious diseases.

But chest diseases like lung cancer and emphysema are not infectious, Dr. Paterson pointed out — and in the present state of our knowledge it is doubtful whether early discovery either prevents progression of disease or increases life expectancy to any great extent.

During the panel discussion following the keynote address, Dr. D. W. Chamberlain of the University of Toronto said that with present treatment methods, earlier detection of lung cancer does not always enable the patient to recover; it merely provides earlier diagnosis and very often it has a long, traumatic effect on the patient's pattern of living.

When better treatment is devised, he suggested, screening programs will undoubtedly be of immense value and the cost very worth-while.

Until then, probably the best prevention of lung cancer, and other diseases like chronic bronchitis and emphysema is to get people to stop smoking.

D. M. Rae of Stratford noted that the voluntary health agency has an important role to play in investigating new avenues of health care which would give good value for the money spent. It should be the government's role, he said, to carry on with established programs that are known to work well.

Group Therapy Aids Adjustment of the Aphasic Patient

The ..... drove down the road. The house? The car? The dog?

The six-year-old, venturing for the first time into the world of written language, would master this workbook exercise with little difficulty. But for some adults, who have communication problems as a result of brain damage caused by stroke, trauma, etc., the ability to select the right word has been impaired.

The dog drove down the road? The patient may well know that it was *the car* but — because of damaged language areas in the brain — he very often cannot say or write what is on his mind.

People who suffer varying degrees of aphasia — i.e. are unable to express themselves through spoken or written language, or lose their verbal comprehension — will likely experience a profound sense of frustration, bewilderment and even terror when they try to communicate, says Stephen Foster, Speech Pathologist at the Manitoba Rehabilitation Hospital - D. A. Stewart Centre. In the lay mind, language and speech have become so closely associated with the concept of intelligence and personality that people with aphasia — whether it's temporary or permanent — live in fear of being misunderstood or thought mentally ill or retarded.

To help aphasic patients through these difficulties, Mr. Foster has organized twice weekly group therapy for some 25 patients, who may range in age from 20 to 70 years. The foremost aim, he explains, is to improve the individual's social and mental well-being by bringing him together with patients with similar problems.

A second, but nonetheless important objective, is to help the patient as much as possible to re-establish his powers of communication.

Mr. Foster, who holds an M.A. in Speech Pathology from the University of Utah, has divided the patients into two groups. The session for the first group — held each Monday afternoon — is geared for the "new aphasic" who is just beginning to tackle his communication problems; and the program largely comprises filling in the blanks (in writing and orally) in sentences written on a blackboard. The patient is given a choice of words for the missing part of the sentence; and nouns and verbs are particularly stressed.

At the more advanced group sessions on Tuesday afternoon, more emphasis is placed on reading aloud, on "filling in the blanks" from the patient's own memory, and on encouraging patients to help each other.

Members of the patients' families are invited to attend the sessions so that they may understand better the patient's problems and the means of offering assistance and support at home; and in addition, much use is made of volunteer workers (some of whom have graduated from aphasia therapy). Two volunteers — Mrs. Gwen Conquergood and Miss Vera Fryer, a retired school teacher — attend the Monday class to help set up the assignments. Mrs. Olive Smolak, who assists on Tuesdays, takes a hand in supervising the work.

About 95 percent of the patients attending aphasia group therapy are out-patients, and some suffered 'stroke' as long as five years ago, Mr. Foster states. Approximately one-half of the new aphasics also receive individual speech therapy in the Department of Communication Disorders; but only a few in the advanced Tuesday class are receiving additional assistance.

Mr. Foster prefers to leave his sessions "open-ended". In the beginning, he explains, the patient will find group therapy a challenge, but eventually, after he graduates to the advanced group, he usually reaches a point where the work becomes so repetitious that he will feel he can carry on alone. If, on the other hand, a patient feels the need for continued contact with the group, he is free to return to the sessions.

What is needed, Mr. Foster believes, is a greater understanding of aphasia in the community. There are patients who have residual damage in the language areas in the brain, who have gone as far as they can with out-patient hospital treatment, but who have a great need for useful activity and social intercourse in the community.

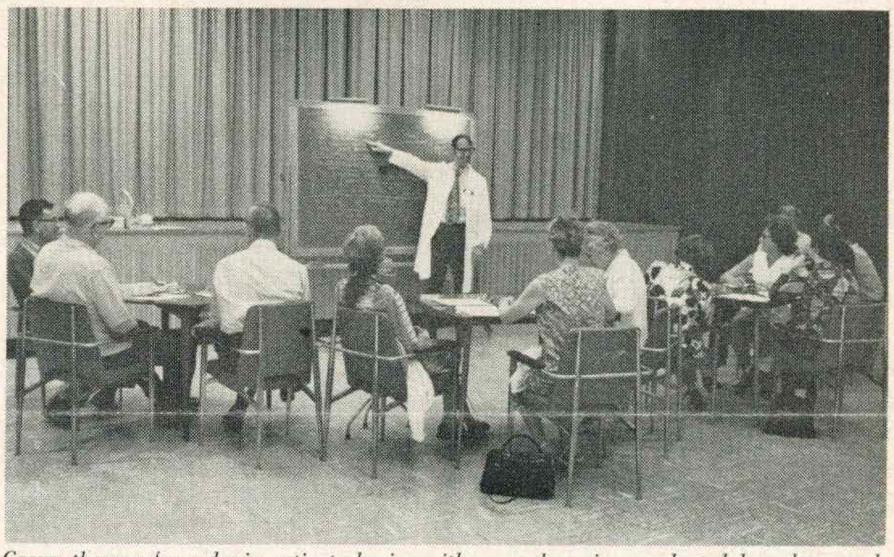
At the Manitoba Rehabilitation Hospital, 'stroke' (hemiplegia) patients constitute a significant section of the caseload. Only a few with right hemiplegia and other disabilities have persisting communication disorders. In many cases, loss of speech and the comprehension of language is transitory and near normal communication is regained in one to three months.

Nevertheless, people with longer lasting problems accumulate over the years, Mr. Foster points out. The Department of Communication Disorders assesses approximately 50 aphasic patients each year, but these probably constitute only a small percentage of the people who suffer total or partial aphasia in the province.

"Nonetheless the individual and group therapy we offer is at least a beginning toward providing a vital health service," Mr. Foster says. "Hopefully in years to come, all aphasics will benefit from professional help both in the hospital and the community, as soon as possible after the onset of illness.

"In our group therapy, there may be much to be desired in assisting the aphasic patient to regain the fullest possible power of communication," he concludes.

"But in almost every case, the patient leaves us with a more positive outlook on life . . . and the ability to accept, even laugh at, his problems because he understands them."



Group therapy for aphasic patients begins with an oral session conducted here by speech pathologist Stephen Foster.

Mrs. Olive Smolak, a volunteer worker, and Mr. Foster assist patients during the written part of group therapy. — *Photos by Portigal Photography.*

HOW THE FAMILY CAN HELP

Patients who suffer right hemiplegia as a result of stroke may have one or more problems, for short or long periods of time, in the area of communication. They may have difficulty expressing themselves even though they know what they want to say; they may have a problem comprehending what others say to them, and they may find it arduous, if not impossible, to read or write. Sometimes aphasic patients will have trouble learning new things, remembering events or what has been said, and often they will have a short concentration span.

If you are a relative or friend of an aphasic patient, you can help him in many ways to settle back into a comfortable life when he returns home. You should talk to him clearly and often, allowing longer pauses in your speech than you normally would and giving him extra time to respond. When the patient shows unexpected progress, be happy for him but do not show undue excitement and do not ask him to repeat what he has learned or done on demand. Spend frequent, short periods listening to his attempts to talk, and carry on natural conversation on familiar topics in his presence.

Do not raise your voice to the aphasic patient as if he were hard of hearing. Talk with him intelligently, not on a childish level. Do not talk about him as if he were not present; and above all, do not assume that because he has problems with communication he does not understand you.

BE PATIENT. Never ask too much of him at once.

The use of paper and pencil, gestures and pictures will be a helpful means of maintaining communication. A notebook containing utilitarian words, the names of friends and relatives, and pictures of familiar objects or people would be a useful reference.

DO TALK TO THE DOCTOR, THE SPEECH PATHOLOGIST, THE NURSE AND OTHERS INVOLVED IN THE PATIENT'S TREATMENT. THEY ARE ALL ANXIOUS TO HELP YOU TO UNDERSTAND HIS PROBLEMS.

AND PLEASE REMEMBER THAT THE MEMBER OF YOUR FAMILY WHO HAS APHASIA WILL NOT NECESSARILY HAVE *ALL* THE PROBLEMS MENTIONED IN THIS ARTICLE.

Doctors Examine Costs of Smoking

A drop in the consumption of cigarettes would mean a drop in one of the government's largest sources of revenues, say tobacco growers and cigarette manufacturers. But with the recent publication of "Smoking and Health Now", the second report of the Royal College of Physicians and Surgeons of London, this argument has gone up in smoke.

In Britain it is estimated that tobacco sales bring in about £1,000 million annually in tax to the government treasury. The report points out, however, that the great financial loss to the country and to individuals from illness associated with cigarette smoking is seldom considered.

"There are costs of hospital and other treatments, and incapacity to work with loss of production and loss of earnings, partly compensated by sickness benefits. To this must be added lifetime loss of production of earnings from premature deaths due to cigarette smoking and the consequent widows' pensions.

"A recent estimate of these losses due to lung cancer, bronchitis and coronary disease attributable to cigarette smoking was £270 million per year."

In addition, reduction in cigarette smoking would prevent many fires, the British doctors claim. In 1964 it was estimated that some £10 million could be saved by the prevention of fires due to smoking.

(In Canada, the government collected nearly $300 million in excise tax on tobacco products produced in the country during the 1969-70 fiscal year — most of which came from cigarette taxes.

It has been estimated that at least $45 million was spent on hospital treatment days for bronchitis and emphysema in 1968. This does not include treatment for other diseases associated with smoking, such as cancer of the respiratory system and heart disease. Nor does it take into account costs in terms of economic and social hardship to the individual and the community, and the cost of other health care.)

"Savings from the reduction of these real costs to the country due to the decrease of cigarette smoking would offset the inconvenience of seeking other sources of revenue than tobacco," the report points out.

— From the CTRDA Bulletin

Ninette Staff Honors Physician

The staff of the Manitoba Sanatorium at Ninette held a special tea recently to honor and express their good wishes to Dr. and Mrs. Honesto M. Hernando.

Dr. Hernando, who has given eight years of service to the tuberculosis patients of the Sanatorium Board, has taken a new position with the Tuberculosis Prevention Service of the Ontario Department of Health in Toronto.

He was born and received his medical training in the Philippines, and soon after emigrating to Canada he took a post at our former Clearwater Lake Hospital at The Pas in 1962. Then, after a brief period as a general practitioner in Strathclair, Manitoba, he became a resident physician at the Manitoba Sanatorium in November, 1966.

At the tea in honor of Dr. and Mrs. Hernando on April 30, sanatorium medical superintendent Dr. A. L. Paine presented the couple with an engraved silver server. Pink tapers and carnations graced the tea table and Mrs. Gordon Stinton, Mrs. Terry O'Brien, Mrs. N. Kilburg and Miss Marion Hine were hostesses.

Dr. A. L. Paine, right, poses with Dr. Honesto Hernando, his wife Monika, holding baby Raoul, and children Simone and Lito.

HORROR OF TB

(Continued from Page 1)

general hospital setting by chest doctors, with only a minimum of isolation procedures.

But whenever possible, he continued, treatment will be given at home . . . on an ambulatory basis . . . so that the patient may not even have to give up his work.

In the 1970's, chemoprophylaxis will also be used increasingly to prevent the development of active disease. "When a person is infected with the tubercle bacillus," Dr. Clarke explained, "his body reacts to overcome that infection and in so doing, his tuberculin skin test becomes positive. At that stage — maybe for a year or so — the outcome of the battle is uncertain. The individual will either overcome the infection, or active disease will develop — depending to a large extent upon the virulence of the infecting organism and the total bacillary population of that infection.

At this early stage, Dr. Clarke said, INH preventive drug therapy can be used in these tuberculin converters to assist in the battle and ensure that disease does not develop.

Other groups for whom similar chemoprophylaxis is recommended include those who have had inadequate drug therapy in the past, and people who have no history of disease but abnormal chest x-rays.

NAME NEW PRESIDENT

F. M. Bradley, of Cornwall, Ontario, was installed as president of the Canadian Tuberculosis and Respiratory Disease Association for 1971-72 at the association's annual meeting in Toronto in June.

Mr. Bradley, who succeeds Dr. A. L. Paine, medical superintendent of the Manitoba Sanatorium at Ninette, is secretary-treasurer and director of Courtaulds (Canada) Ltd.

His interest in tuberculosis work began in 1938 when he was admitted to a sanatorium in London, Ontario, for a period of two years. Since 1952 he has served as treasurer, then president, of the St. Lawrence Tuberculosis Association, as a member of the Board of the Ontario Tuberculosis and Respiratory Disease Association, and as treasurer and president of the OTRDA.

In 1969 he was named treasurer of the Canadian Tuberculosis and Respiratory Disease Association.

STAFF ACHIEVEMENTS

Hearty congratulations to Miss Anna-Marie Torgerson, SBM x-ray technician, who in her spare time successfully completed a new course for medical secretaries and receptionists at the Red River Community College. The establishment of this course — offered as an evening program — was promoted by the Manitoba Society of Medical Assistants.

Our congratulations, too, to MRH physiotherapist Mrs. Donna Bjore, who took part in the annual congress of the Canadian Physiotherapy Association in Saskatoon, May 30 to June 5. Before an audience of 400, which included doctors (particularly cardiologists), Miss Bjore presented a paper on "A Graduate Exercise Program for Post-Myocardial Infarction Patients".

HONOR ROLL OF CONTRIBUTORS

The Sanatorium Board is grateful to the individuals and organizations who have recently made donations to our various health services. According to the wishes of the donors, these contributions have been used to provide special services or equipment for patients, or to finance research into the means of preventing and treating disabling illness or injury.

N. J. Reoch, Smith's Parish, Bermuda	$1,000.00
Eta Chapter, Beta Sigma Phi Sorority, Winnipeg	$ 100.00

We also express our appreciation to the many people who have made donations to the Respiratory Disease Research and Education Fund in memory of the late *Mrs. Helen Ramsay* and the late *Herbert Brydges*.

BULLETIN BOARD

Dr. A. L. Paine, medical superintendent of the Manitoba Sanatorium, Ninette, and immediate past president of the Canadian Tuberculosis and Respiratory Disease Association, was one of several Canadians who participated in the 21st International Tuberculosis Conference in Moscow July 12 to 16. The scientific sessions covered many topics including problems in the application of BCG, community participation in TB control and the side-effects of tuberculosis chemotherapy. The inaugural session was held in the Kremlin in the Palace of Congresses and the Soviet Minister for Public Health discussed the organization of health services in the U.S.S.R.

★ ★ ★

A warm welcome is extended to Dr. Omsin Sriswat of Bangkok, Thailand, who arrived at the Manitoba Rehabilitation Hospital on July 1 to take a post as assistant resident in the physical medicine training program. Dr. Sriswat is studying under the Colombo Plan and will remain in Winnipeg for approximately one year.

★ ★ ★

Members of the Department of Communication Disorders have been these days welcoming a new speech pathologist, two interns and a special visitor, and attending a workshop in Edmonton.

The new speech pathologist is George Gasek, a native of New York City, who holds an M.A. in speech pathology from the University of Washington and has taken further post-graduate work at the Oklahoma Medical Centre at the University of Oklahoma.

John G. Dudley, lecturer in the school of Human Communication Disorders at McGill University, visited the department in May to gather information for his project on finding a more definitive means of assessing the aphasic patient.

Also, in recent times the department has been providing a program for clinical training in speech pathology and audiology. There are two interns this summer: Mrs. Marion Stark, who is working towards her M.Sc. in Speech Pathology at McGill University, and Miss Lynn Hoffman, who is studying for a Diploma in Speech Pathology and Audiology at the University of Toronto.

Stephen Foster, staff speech pathologist, attended a two-day workshop at Glenrose Hospital in Edmonton, July 8 and 9. The subject was the Porch Index Communicative Ability test for aphasic patients, and the guest lecturer was Dr. Bruce Porch, author of the test.