NEWS BULLETIN — The Sanatorium Board of Manitoba

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Nurses Face New Challenges in Respiratory Health Field

"If there is one word that would describe this 17th Annual Nurses' Institute, then that word must be *change*," said Dr. Floris King at the closing session in Winnipeg on April 9th.

Dr. King, who is field program and nursing consultant for the Canadian Tuberculosis Association, voiced the thoughts of many people who took part in the two-day Institute on Respiratory Diseases. Nearly the entire program emphasized change — not only in the scope of our interests, which now embrace many chronic respiratory diseases in addition to tuberculosis, but also in our thinking, which more than ever seems to be directed toward the prevention of sickness and disability.

Over 300 nurses from Manitoba and six other provinces attended the CTA Nurses' Institute, and 12 speakers (all but one of whom are involved in respiratory programs in Manitoba) took part in the teaching sessions, which were arranged this year by the Sanatorium Board of Manitoba, under the chairmanship of Miss E. L. M. Thorpe, and co-chairmanship of Miss Janet Smith.

Following addresses of welcome by provincial Health Minister C. H. Witney, Dr. King and executive staff of the Sanatorium Board, Dr. Reuben Cherniack stepped up to deliver the keynote address on "Current Concepts of Chronic Respiratory Diseases," (with particular reference to bronchitis and emphysema).

Stresses Positive Approach

Dr. Cherniack, who is medical director of the Sanatorium Board Tuberculosis and Respiratory Disease Service, painstakingly defined disturbances in respiratory function and outlined the principles of treatment and prevention. He also took a lively poke at cigarette smoking and at some of his "well-intentioned colleagues."

"Too often, many patients with chronic respiratory conditions have been advised to give up their jobs and to take it easy by well-intentioned physicians," he said. "Or (because they have a chronic disease that may be incurable), they become a drag on their busy attending physician, and he tends to slough them off.

"For these reasons the concentrated type of management is rarely practised beyond the hospital."

Dr. Cherniack stressed a positive treatment approach that would discourage invalidism. "It must be emphasized that these patients, like patients with diabetes or heart failure, are suffering from a chronic condition which may be incurable — but nevertheless progression of the disease can be prevented to a large extent, the symptoms relieved and function improved."

To achieve "even a modicum of success," it is imperative that the patient and his family understand the nature of the disease and the alterations in function that are present, he said.

Other principles of treatment include (a) removal of irritants (e.g. avoidance of dusty working conditions or environmental pollution and, in particular, the discontinuation of cigarette smoking); (b) improved elimination of secretions, through the elimination of infection or other irritants, and adequate drainage; (c) opening of bronchial tubes, by means of broncho-dilating drugs, adequate humidity in the home, physiotherapy and breathing aids in severe cases; (d) weight reduction, if indicated, to reduce the work of breathing; (e) gradually increasing programs of exercise (which lead to more efficient use of available oxygen and improve the patient's mental outlook considerably).

Dr. Cherniack defined *chronic bronchitis* as a condition in which there is chronic or recurrent cough with expectoration of excessive mucous secretion from the bronchial tree.

Emphysema, he said, is a condition in which there is enlargement of the air spaces of the lung, with destruction of the alveolar walls.

The cause of bronchitis and emphysema is not yet known, but factors such as sex (i.e. males), age (i.e. older), urban residence, occupation (i.e. unskilled workers) and atmospheric pollution seem to be important.

Cigarette smoking, in particular, has been implicated in the development of the disease. A study has shown that 75 per cent of heavy cigarette smokers had bronchitis.

Dr. Cherniack's address was followed by other talks on the medical and nursing care of patients with acute respiratory problems, the domiciliary care of respiratory patients, the role of physiotherapy in the treatment of pulmonary disease and the administration of aerosols.

Tuberculosis Control

The second day of the Institute was devoted primarily to tuberculosis and to the role of the public health nurse in control programs. At the closing session, Dr. E. Snell, director of Preventive Medical Services, Manitoba Department of Health, defined occupational lung diseases and the methods of prevention.

Dr. E. S. Hershfield, associate medical director of the Tuberculosis and Respiratory Disease Service, delivered the first address of the day.

"There has been a subtle and silent change in our thinking about tuberculosis," he said. "Isolation of the patient away from the community is becoming a thing of the past; and throughout the continent there is a growing trend toward treating patients (under the supervision of specialists in all chest disease) in long-term institutions in the general hospital area."

Among other things, Dr. Hershfield discussed current thinking about the infectiousness of tuberculosis (It is the patient, not the doctor or nurse, who should wear the mask); drug treatment (It should be continued for two years, regardless of the type or severity of the disease); home treatment (The idea is to reduce hospital costs and hardship on the patient and his family); and exercise, which is now being stressed instead of bed rest, as a means of getting the patient back into "good physical shape."

TB in the North

Dr. J. D. Galbraith, chronic disease consultant to the Northern Region Medical Services, Department of National Health and Welfare, gave an illustrated talk on tuberculosis control in the Northwest Territories and the Yukon.

The incidence of tuberculosis in the north, he said, is at least 10 times higher than the incidence in the rest of Canada — and it is higher among Eskimos than among Indians.

The Eskimos, who comprise only 25 percent of the population in the north, accounted for 73 percent of the 137 new active cases in the Yukon and Northwest Territories in 1966, while the Indians, who make up 21 percent of the population, accounted for only 17.6 percent.

In one big effort to bring tuberculosis under control, the Department of National Health and Welfare, in co-operation with voluntary tuberculosis organizations in the south, has embarked on an intensive program that includes complete tuberculin surveys, sputum surveys and chest X-ray surveys of the north, BCG vaccination for those with a negative tuberculin test, widespread chemoprophylaxis for those who are infected with tuberculosis, and supervised home chemotherapy for patients released from sanatorium.

This program was begun last year, with attention being directed first to the Keewatin District and, in particular, to Eskimo Point, which was the scene of a big outbreak of tuberculosis in 1963.

"The object now is to bring tuberculosis back into the mainstream of medicine." (Dr. E. S. Hershfield)

* * *

"A gradually increasing exercise program is important in the treatment of patients with chronic bronchitis and emphysema . . . In our hospital patients who are unable to climb one flight of stairs on admission can frequently conquer seven flights within 10 days."

* * *

"Anyone who has the so-called cigarette cough should know that he has bronchitis." (Dr. R. M. Cherniack)

* * *

"The TB germ hasn't changed a bit. It is as tough and treacherous as ever, and about 20 percent of our population are harboring it. Three to five percent of this group will develop demonstrable disease in their lifetime." (J. J. Zayshley, SBM Surveys Officer)

Address all communications to:

THE EDITOR, SBM NEWS BULLETIN,
800 Sherbrook Street, Winnipeg 2, Manitoba

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A Chest Physician Talks About Respiratory Disease

Q. Dr. Cherniack. In what respects has the tuberculosis program in Manitoba changed?

A. It is now recognized that tuberculosis is primarily a respiratory disease and that the problems that arise in people with tuberculosis are similar to those encountered in patients with other respiratory diseases. Thus it is felt that tuberculosis patients should be brought back into the mainstream of medicine where they can be looked after by specialists in all chest diseases, and by specialists in surgery and medicine as well.

The other change in the tuberculosis program concerns the inclusion of other chronic respiratory diseases in our treatment and preventive services. Across Canada, for example, there has been an increased awareness of the rising incidence of chronic bronchitis and emphysema. Reported deaths have risen fourfold over the past 10 years and these are now rated as the fastest growing crippler diseases today. We hope do to something about this tremendous public health problem.

Q. Does this rise in bronchitis and emphysema also apply to our native populations?

A. There have been some preliminary studies of pulmonary function among Eskimos, which suggest that the Eskimo has a very high incidence of chronic bronchial disease. The reasons are unknown, although the fact that they live in close quarters where there may be a heavy density of pollution may have a bearing on the high incidence, as well as the fact that they use a certain type of oil in their diets. As far as the Indians are concerned, no studies have been made yet.

Q. Do you plan to do some studies?

A. This year we plan to start a survey of the population of Manitoba. This survey will include measurements of ventilatory function and a questionnaire that is built around one used in England by the Medical Research Council. The pulmonary function tests will tell us the incidence of chronic bronchial disease in the community and through our questionnaire we will be able to correlate the findings with age groups, race, smoking, environment, social strata, etc. And, of course, those who are discovered to have a disturbance in function will be advised about treatment and preventive measures.

Q. How will these studies be carried out?

A. The pulmonary function tests will be conducted in conjunction with the Christmas Seal tuberculosis surveys. But even the TB surveys are changing in character. We are reverting to mass chest x-raying of people beyond school age to find, in addition to tuberculosis, other respiratory and cardiac conditions. At the same time we are stepping up the tuberculosis testing program among children up to the age of about 16.

Q. Then this does not mean that there will be less emphasis on tuberculosis control?

A. With over 200 new active cases of tuberculosis reported in the province each year, we cannot afford to lose interest in tuberculosis. What we are trying to do is improve our preventive measures by introducing a much more intensive survey of the child entering school and the child leaving school. It is interesting that a child entering school has a very low tuberculin positive rate, but when he leaves school it is much higher. If we can pick up the positive reactors and give them prophylactic treatment, we may be able to prevent the development of disease in later life. Also, through investigation of the child's contacts, we should be able to find and treat the source of infection.

Dr. R. M. Cherniack

Per Holting interviews Dr. R. M. Cherniack, Associate Dean and Professor of Medicine, University of Manitoba, and Medical Director of the Tuberculosis and Respiratory Disease Service, Sanatorium Board of Manitoba.

Q. Lately we have heard a great deal about a critical shortage of physicians in the tuberculosis field. Has this situation changed?

A. There is no longer any attraction in being a specialist in tuberculosis only, but that's because tuberculosis is just another respiratory disease . . . although it does have its own epidemiological problems, more perhaps than bronchitis and emphysema.

However, we are attracting a good many people to the respiratory field, and what we are trying to do is to make sure that these physicians have an active interest in and knowledge of tuberculosis and all its problems.

The University of Manitoba and the Sanatorium Board of Manitoba have set up a three-year program which will train respiratory disease specialists who will either go out into practice or teach or do research. As a result of the initial steps in establishing this training program, we will soon have two full time residents and eight other rotating residents in the tuberculosis and respiratory disease service, plus six Fellows in research.

Q. How does Canada's respiratory program compare with programs in other countries?

A. I think there are two or three outstanding respiratory centres in Canada that can hold their own with any other centre in the world. Manitoba has one of them.

Q. How do the present methods of treating chronic obstructive pulmonary disease differ from those used in the past?

A. Stress is now put on continued active preventive measures as well as on rehabilitating the patient so that he can live a normal life. Among other things, we encourage the patient to increase his physical activity up to capacity . . . to go for walks, climb stairs, exercise daily on a bicycle and so forth.

Another important aspect of treatment is the home management of the patient with chronic bronchitis and emphysema. We see the patient well treated in hospital, but very often after he goes home, he is not looked after adequately . . . either because the busy physician doesn't have time to cope with a patient who has a continuous respiratory problem, or because the physician becomes frustrated over the fact that this is a chronic disease that cannot be cured . . . and so he tends to slough him off.

To remedy this situation we have set up a home care service in which we take patients who have repeated hospital admissions and put them on a program at home. This includes the provision of mechanical aids to breathing, frequent visits from the VON nurse and physiotherapist, installation of humidifiers if indicated, and hiring a housekeeper, if indicated.

Q. How costly is the Home Care Program?

A. Amazingly enough, you can carry out this program for about 75 cents per patient per day, as compared to about $45 per day per hospital bed. So it works out well for everyone: the patient is at home where he is happiest, the hospital gains the bed it badly needs for the acutely ill, and the whole community saves money.

Even more illuminating is the fact that the Home Care Program is conducted primarily by para-medical personnel. We are learning . . . as everyone will have to learn . . . that the use of the entire health team is extremely important in the care of patients and that the doctors are only really necessary to supervise the program and be at hand in case of emergency.

Q. I was rather surprised to hear you say that you yourself would rather have lung cancer than chronic bronchitis or emphysema.

A. There has been considerable publicity about cigarette smoking as a possible cause of lung cancer. This is a legitimate amount of publicity, but I think there isn't enough said about the fact that the majority of patients who have bronchitis are smokers, or that a good number of smokers develop bronchitis.

Bronchitis is an incapacitating disease which increases in severity. It leads to severe shortness of breath, to such an extent that an individual who has chronic bronchitis and/or emphysema is frequently unable to carry on his normal daily activities. The disease hits you at a young age . . . usually at about the age of 40 . . . and you may have it for 25 to 30 years.

So, when I said that I would much rather have lung cancer than bronchitis, I meant that some cases of cancer can be cured, and if not, it would kill me five to seven years earlier than I would normally die. But I would have a full productive life until that time. On the other hand, with chronic bronchitis, I might be faced with 25 to 30 years of severe disability, which would be a tremendous hardship on me and the rest of my family.

Q. Since cigarette smoking, in particular, seems to be implicated in the development of respiratory disease, do you advise everyone to stop smoking?

A. I am not concerned about cigarette smokers who do not cough. Normal people do not cough, even when they smoke cigarettes. If you start to develop a cigarette cough, this is an indication that bronchial trouble is beginning, and this should be a signal to (a) see your doctor and (b) stop smoking.

Q. What about people who smoke cigars or pipes?

A. Cigarette smoking causes narrowing of the bronchi. The inhalation of smoke from even one cigarette causes resistance in the airways. So far it hasn't been shown that smoke inhaled from a pipe or cigar will do this.

Q. Is it all right to smoke cigarettes as long as you don't inhale?

A. No matter what he thinks he's doing, every cigarette smoker inhales smoke to some extent. So I repeat that if you smoke cigarettes and cough, give the cigarettes up.

Dr. S. W. Lee Nominated for Award

Dr. Siu Wah Lee, chief resident physician at the Manitoba Rehabilitation Hospital, has been nominated to receive an Honors Achievement Award for his recent contribution in the field of angiology.

The award, established by the Purdue Frederick Company in Collaboration with the Angiology Research Foundation, is being presented to Dr. Lee on May 3 in recognition of his paper — "Vascular Effects of Direct and Indirect Heating in the Hand" — which appears in Volume 4 of the Journal of Vascular Diseases.

The presentation will take place at the University of Illinois College of Medicine. The award will consist of a Citation Volume of the Journal of Vascular Diseases for the year in which Dr. Lee's article was published, plus an Honors Certificate commemorating the event.

The Manitoba Rehabilitation Hospital, which is very proud of Dr. Lee's achievement, will also receive a Citation Volume.

Our Executive Director Looks at Prevention of Illness

Many of you may remember the story of the community that faced a difficult problem in emergency care in their hospital. The highway near this city ran close to a cliff and for whatever reason, many automobile drivers slipped over the edge and were seriously injured. Owing to the inadequacy of the ambulance service, many arrived at the emergency department of the hospital in such serious condition that their lives could not be saved. Consequently, with great emotional fanfare a big fund raising drive was started to provide the very best and most efficient emergency service. Common sense came to the rescue when one rather diffident citizen wondered if the best solution to the problem was to build a fence along the edge of the road to prevent the cars from slipping over.

I was reminded of this story last week at a meeting in Edmonton when it was reported that in Canada we spend about two billion dollars a year on hospital and medical care. In Manitoba we will spend this year something in the order of $65 to $70 million on hospital care and $35 to $40 million on the other aspects of medical care, or say $100 to $110 million in all. This is an annual expenditure of about $450 for an average family of four persons.

At the same time we spend only about five percent of this amount on what might be termed "preventive services."

It is evident that the vast majority of our expenditure on health goes to pay for repair or salvage measures that are taken after the damage to individual health has occurred.

Perhaps there is now a duty to re-examine the structure of our health care system. Health seems to have moved from the area of being simply a "private good" to being what sociologists call a "public good." This is a measure of the acceptance of the premise that good health is a necessary foundation on which to build nearly all the other benefits which mankind can achieve; and in the search for social justice, society must give special attention to it.

Definition of Goals

In considering any problem, it is desirable first to define our goals. If our aim is to attain the highest possible level of health for our people, it seems obvious that we have to consider both the findings of medical science and of social science. For in the area of preventive health it is not a matter of just leading the horse to water; you have to make him thirsty.

Perhaps first we need to define "Health." On reflection, this proves to be more difficult than one would think. Indeed, it seems that all our statistical measures of health are in terms of mortality and morbidity. In other words, we seem to be reasonably clear about the concept of illness; and until the advent of heart transplants, we thought we were quite sure about the concept of death. On the other hand, health is defined somewhat vaguely in the dictionary as "being sound of body, mind and soul; especially freedom from physical disease or pain." The World Health Organization has adopted a broader view. Its manifesto states that "health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity."

This seems to be a rational ultimate goal, for which the structure of our health services should be designed. But today we seem to be very pre-occupied with pathology. Perhaps as a society, we should avoid the fallacy of turning hospitals into the modern equivalents of the ancient temples, with their esoteric rights, and their miracles, performed by ranks of votaries dedicated to restoring physical function to the penitent deviants that seek their health.

T. A. J. Cunnings

An address delivered by T. A. J. Cunnings to the CTA Nurses' Institute on Respiratory Diseases, on Monday evening, April 8th. Mr. Cunnings is executive director and secretary-treasurer of the Sanatorium Board of Manitoba, and this month he celebrates his 26th year as an executive officer of the Sanatorium Board.

To be sure, we need the very best hospitals we can achieve to enable doctors and those in the para-medical professions to bring to the care of the ill and the injured all the marvellous achievements of modern medical science. But in North America, from reading the hospital literature, one gets the impression that the level of community health can only be evaluated in terms of the number of hospital beds or the multiplicity of hospital services. There is danger of committing the error so common when we want to improve something, of applying "more of the same."

As one writer puts it, if we established as one of our goals improving the health of children, some might say that our first priority is to train more pediatricians, to provide more and a higher standard of medical care; but on the other hand it might be argued that the greatest benefit would come from supplying free milk morning and afternoon for public school children, and thus improving their nutrition and contributing to a healthy mind in a healthy body.

Consider the current estimate that one person in 12 will require treatment for mental illness at some period in his life. Then equate this with the view of behavioral scientists that the most crucial period in the formation of the personality structure of the individual is in the age period from two to six years. As a preventive measure, what are we doing as a society to try to strengthen the processes of these formative years through improved methods of family health counselling for parents, to strengthen family stability and relieve damaging inter-personal stress through a wider organization of such things as day nurseries or nursery schools? Or could we improve child development in these times when in so many families both parents have jobs?

Examples of Preventive Services

In the field of tuberculosis we have focused our attention for many years on prevention as an essential part of the integrated program of control. That this comprehensive attack on a major health problem pays financial dividends is indicated by the fact that in Manitoba, despite the great rise in hospital treatment costs in the past 15 years, the per capita cost of tuberculosis treatment in current dollar dropped from $1.17 per capita in 1953 to 52 cents per capita in 1968. If we used 1968 dollars throughout, the drop would be even more impressive. The social and economic benefit to thousands of individuals who, without the preventive program, would have spent months or years on treatment represents an immense saving to the individual and to the community.

The early detection of unsuspected disease through the examination of apparently healthy people has been a basic premise of the tuberculosis control program for 25 to 30 years. It is widely agreed today that this preventive principle ought to be extended into other areas through *multiphasic screening*. This involves doing a wide variety of laboratory tests, using automated equipment, on individuals to detect possible areas of health concern.

In 1966 our Medical Advisory Committee recommended that we make an exploratory move towards taking a multi-phasic screening program into the community. This was approved in principle by the Manitoba Medical Association and the Department of Health. The program also had the approval and support of the Canadian Diabetic Association. Consequently, (using contributed funds) in conjunction with our tuberculin and x-ray surveys in the western part of the Province, we tested 18,000 adults for diabetes, kidney malfunction and anemia. The work was done under the medical direction of Dr. John A. Moorhouse and Dr. Barry Kaufman of the Metabolic Laboratory of the University of Manitoba. Minute samples of blood taken in the field were shipped daily to the laboratory in Winnipeg and processed through an auto-analyser. About five percent of the cases were screened out for further examination by the family physician or the health unit and subsequently one percent were found to have previously unknown diabetes. A small but significant number were found to have abnormal BUN's and

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Joy Huston Assumes New Post

Mrs. Joy Huston, chief occupational therapist at the Manitoba Rehabilitation Hospital for the past six years, is leaving her post this month to become consultant in occupational therapy to the Ontario Hospital Commission.

Mrs. Huston started work with the Sanatorium Board in January, 1962, when the Manitoba Rehabilitation Hospital was in the final stages of construction. Striking out with a set of blueprints, a stack of catalogues and her own experience as guide, she developed a treatment service that today leads all others in Canada, and indeed is internationally renowned.

For this alone, Mrs. Huston has made a lasting mark on the work of the Sanatorium Board and on health services in Manitoba. But even beyond this, she has done much to demonstrate the role of occupational therapy as an indispensable, dynamic force in the rehabilitation of the physically disabled.

Within her own profession, she has been very active in the affairs of the Canadian Association of Occupational Therapists; she organized a national meeting here several years ago, and served for two terms as president of the Manitoba branch.

Mrs. Huston has been an occupational therapist for about 19 years.

Mrs. Joy Huston

The daughter of Irish missionary perents (she was born in Manchuria) she started her career in the mid-thirties with a diploma from the Edinburgh College of Domestic Science, then switched to occupational therapy following the war and the death of her husband (a Pilot Officer in the Bomber Command, killed in action). Following graduation in 1949 from Merton Rise School of Occupational Therapy (London), she stepped immediately into the position of head occupational therapist at the Royal Northern Hospital in London. A few

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Seal Contributions Are Highest Ever

With the official closing of the 1967-68 Christmas Seal Campaign, we would like to record our thanks to the many contributors.

The Campaign, which officially closed on February 29, was very successful — both in terms of contributions and health education. The total returns amounted to $189,750.29 — which is a 5.9 percent increase over the amount raised last year and, in fact, is the biggest amount ever raised by Christmas Seals in this province.

A total of 190,868 letters containing Christmas Seals went out to Manitobans last fall. The total contributions from these letters represent one of the highest percent returns per letter mailed out in Canada.

The Christmas Seal funds will be used to help finance province-wide programs to detect and prevent tuberculosis and other chronic respiratory diseases . . . through tuberculin and x-ray surveys, pulmonary function tests, BCG vaccinations, research and education.

Health education is a very important arm of Christmas Seal work. During campaign time, the familiar little stamps carry an educational message in themselves; throughout the year a percentage of the money the raise finances a busy service that channels health information to the public.

We are deeply grateful to the thousands of Manitobans who support our work through their donations, their interest and their participation in preventive surveys.

We also thank the radio and television stations, the Manitoba newspapers and other organizations who did so much to publicize the campaign and the problems of respiratory diseases.

And finally we thank our wonderful volunteers. A total of 378 volunteers were involved in the preparations. Together they contributed 1,770 hours of their time.

Mrs. Huston

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years later she was appointed to the additional post of chief (physical) examiner for the Association of Occupational Therapists, and when she left England to come to Canada, she was also examiner in administration and resettlement.

With this wide background of experience, Mrs. Huston will be a great asset to the Ontario Hospital Commission where, working out of Toronto, she will serve as an advisor to hospitals throughout the province, which wish to establish or improve occupational therapy services.

The people of Manitoba wish her well. But at the same time we shall miss her very much. She has been one of the liveliest additions to our hospital scene in many a year — in all, an outstanding, warm-hearted woman, wholly devoted to her profession and to the people she has served. We look forward to the day, about 10 years hence, when she will return.

Prevention of Illness

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hemoglobins, although Dr. Moorhouse and Dr. Kaufman felt that further research is required to establish adequate criteria for community screening tests of this type. Reports, of course, go to the patient's private physician, who has full responsibility for the treatment he considers indicated in any individual case. This program could be continued, but up to the present time financial support has not been forthcoming.

This year we hope to add to our preventive services a pulmonary function test to enable doctors to identify other respiratory conditions.

A much more elaborate screening program that provides a patient's doctor with a comprehensive profile of significant health information is now being operated through computerized multi-phasic testing centres in at least two cities in the United States. Some of our local physicians are keenly interested in the potentialities of this type of service. In the American centres, under the direction of a physician, but using largely nursing and technical staff, the persons coming to the centres for examination receive about 2½ hours of testing, including blood, heart, breathing, hearing and visual acuity tests, along with chest x-rays and a variety of other specialized procedures.

Services Among the Elderly

To avoid long periods of hospital and other institutional care, nowhere is the preservation of health more important than among people 65 and over, who now number about eight percent of the population. As the organism ages, it seems to be more and more subject to chronic disease. Preventive measures are especially difficult among the elderly. Many older people take for granted that they will have a few aches and pains and many are not too inclined to seek medical aid until pain or disability forces it upon them. Yet we know that continued full use of physical, mental and social capabilities is the best possible defence against the encroachment of apathy, declining function and disease.

I suggest that much illness requiring institutional care of the elderly might be deferred or avoided if in suitable centres there were established "well oldster" clinics, comparable to the very effective "well baby" clinics of the public health service. I think such clinics are best held away from hospitals, and in places convenient for the elderly to visit — perhaps at day care and recreation centres. Here the elderly would come for preventive health checks. Most of the screening examinations could be done under the direction of or by a nurse with suitable post-graduate preparation; and she would refer patients to the family physician when specific examination and investigation seemed to be needed.

Part Two of the story of the Sanatorium Board of Manitoba appears in the May issue.

Here blood samples could be taken and routine multi-phasic laboratory screening could be used to reveal significant changes that would determine the need for medical referral. Such a service would be most effective if it were combined with a visiting nurse service on a routine basis — perhaps a monthly visit to the home of all patients on the "well-oldster" clinic register. This would offer an opportunity to call in preventive social services, or to enlist the aid of other agencies designed to keep the elderly person comfortable and independent at home. Nutrition is a common problem among the elderly. This might be improved by an extension of the Meals-on-Wheels service.

The Role of the Nurse

Like everything else in the health field the structure of medical practice has been changing in recent years. Perhaps in the future the medical practitioners will have available to them district nurses who work in the home and the community to act as on the spot family health counsellors. One could envision a team of nurses consisting of the specialist in family health, assisted perhaps by practical nurses who could give direct care in the home when this is needed. This would put a whole new resource at the doctor's disposal for providing total care to his patients. The well qualified nurse would be able to perceive health problems in the family before they became a crisis; and could see that the patient saw his doctor before the stage of significant breakdown. Through this team, one would envision an extension and expansion of the splendid work of the Victorian Order of Nurses and the Home Care Programs that have proved so effective for discharged hospital patients. Indeed, one could envision home care programs in every community, provided through such a nursing team.

Health is related closely to the quality of the individual's personal interactions, to his self-discipline, to the principles of moderation, to judgment in meeting life's fortunes or misfortunes with equanimity, as well as to hygiene, nutrition and the practice of safety. It involves the freedom and the responsibility of the individual to select appropriate alternatives of behavior and acting upon them.

This preventive point of view is illustrated by an old Cornish test of insanity. The test situation comprised a sink, a tap of running water, a bucket and a ladle. The bucket was placed under the tap of running water and the subject was asked to bail the water out of the bucket with a ladle. If the subject continued to bail without paying some attention to reducing or preventing the flow of water out of the bucket, he was judged to be mentally incompetent. Similarly, any society that attempts to provide more and larger buckets to contain the problems of that society, without simultaneously attempting to reduce the flow, might be equally suspect.

BULLETIN BOARD

The annual meeting of the Sanatorium Board of Manitoba will take place at noon April 26 in the auditorium of the Manitoba Rehabilitation Hospital.

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The very first Manitoba Association of (Civil) Amputees was recently formed at a meeting at the Manitoba Rehabilitation Hospital.

The new association plans to organize social and recreational activities for all amputees in the district, distribute information of interest to amputees, as well as participate in research of prosthetics and orthotics.

Officers are Ralph Wanner, president; A. G. Seifert, vice-president; Alice Skowronek, secretary. An advisory board was also elected, consisting of Dr. R. R. P. Hayter (chairman), Mrs. L. Hylton, Mrs. C. Brown and Miss L. Humphreys, all of the Rehabilitation Hospital staff.

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The Board extends best wishes to Walter Boyd who on April 1 became Assistant Deputy Minister of the provincial Department of Welfare. Mr. Boyd, who formerly held the position of Director of Rehabilitation Services of the provincial Department of Health, has been actively associated with much of the Board's work for many years.

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Our congratulations to Rudy Trnka, mailing room supervisor, who was recently honored for his many fine contributions to the Scouting movement during the past 15 years. At a banquet at St. Mary Magdalene Church in St. Vital, Rudy was presented with a special plaque by the members of his 21st Scout Troop.

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The Planning Committee of the CTA Nurses' Institute on Respiratory Diseases wishes to thank the many individuals and groups who contributed to the success of the program. The committee is especially grateful to the Volunteer Services of the Manitoba Rehabilitation Hospital, to the various firms who set up interesting displays, to Mayor Stephen Juba and the City of Winnipeg who sponsored the Civic Luncheon on April 8, and to Hoffman-La Roche Ltd. and the Maryland Motor Hotel who sponsored a fine wine and cheese party on April 7th.

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