The Sanatorium Board of Manitoba News Bulletin

VOLUME 3—No. 8

PUBLISHED BY THE SANATORIUM BOARD OF MANITOBA
For Patients, Staff, and Friends of the Sanatorium Board

AUGUST, 1961

Among those who attended the opening of the new tunnel at the Manitoba Rehabilitation Hospital July

Opening of Tunnel Another Step In Developing Medical Centre

Another step towards the completion of the Manitoba Rehabilitation Hospital was the official opening on July 17 of the 320-foot tunnel connecting the rehabilitation hospital with the Winnipeg General and Children's Hospitals and the yet unconstructed Cancer Research and Treatment Institute.

The brief, ribbon-cutting ceremony was performed by Mrs. Lyman G. Van Vliet, president of the Board of the Children's Hospital, assisted by J. W. Speirs, chairman of the Sanatorium Board of Manitoba, and S. Price Rattray,

the older age group.

In Canada at the present time hospital care programs are primarily organized for the treatment of acutely ill patients, rather than for the long-term patient, Dr. Charron states. In almost every general hospital, some long term patients occupy beds.

J. E. Robinson, superintendent of the Children's Hospital; J. W. Speirs, chairman of the Sanatorium Board; Mrs. Lyman G. Van Vliet, president of the board, Children's Hospital; H. T. Spohn, member of the Sanatorium Board; S. Price Rattray, chairman of the Manitoba Rehabilitation Hospital Committee; A. H. Atkins, rehabilitation hospital manager; D. R. Wookey, of Moody, Moore and partners; and R. C. Clement, project engineer. (Photo by David Portigal)

Long-Term Care Presents Great Health Challenge Says Physician

"Chronic disease is responsible for some of the greatest and most complex problems facing health workers in Canada today."

This opinion is expressed by Dr. K. C. Charron, director of health services for the Department of National Health and Welfare, in the July 1961 issue of the Canadian Journal of Public Health.

The prevention of chronic disease and its successful treatment is a great challenge of the future, Dr. Charron points out in his article. To meet the challenge will require whole-hearted team effort on the part of every person in the present health field.

In the past, he says, chronic diseases have not received the attention they deserve. Although some progress has been made in the field, chronic diseases on the whole have not been amenable to prevention and treatment. "Heart disease, neoplasms (abnormal growths), disability following accidents, cerebrovascular conditions, arthritis and the like, all exact a heavy toll in human suffering, and place a substantial burden on our health resources."

Dr. Charron illustrates the magnitude of the chronic disease problem by quoting a number of statistics from the Canadian Sickness Survey of 1950-51. The population of the country at that time was 13,359,000.

According to the survey, the the average number of persons sick on any any day of the year were classified as follows:

Neoplasms. Approximately 36,000 persons were ill on any day from neoplastic diseases, and of these about 10,000 were unable to engage in usual activity or occupation. The average number of days of disabling illness from neoplasms is 55.4.

Vascular lesions, epilepsy, and other diseases of the brain and spinal cord resulted in 31,500 persons being ill on any one day. Over 20,000 of these suffered from disabling illness.

Diseases of the heart and hypertensive ..disease caused illness to 149,000 on a particular day and 36.5 thousand of these suffered from disabling illness.

Arthritis caused illness to 70,000 persons. This resulted in disability of over 16,000 of these individuals.

Accidents, poisoning and violence produced illness in over 104,000 people and 29,000 of these suffered disability.

The total number of year-long sicknesses[1], according to the survey, was estimated to be 684,000 for the survey year. This represented one year-long sickness for every 20 persons in the country, and included both major and minor illness.

The survey also showed that the age group of 65 or over accounted for nearly 25% of all these sicknesses. Yet this group represented only 7.8% of the total population.

The age group 45 to 64 showed 31.9% of year-long sicknesses for a group representing 17.9% of the total population.

As the population of the country increases, so will also the problem of chronic diseases. It is estimated that in 1961 the population of the country will exceed 18,400,000, and that in 1971 it will be about 23,480,000. Of the total population in 1961 there are 1,435,000 persons over 65 years of age. By 1971 it is estimated that this number will have increased to 1,845,000.

Although chronic disease affects all groups, the preponderance of cases suffering from long-term ilness are in have begun to develop special chronic and convalescent hospitals or special units attached to general hospitals. At the end of 1958 it was estimated that there were 14,267 beds for these long-term patients.

But, based on the 1961 population, the bed requirement for long-term patient care in Canada is about 33,000 beds.

"The effective utilization of hospital beds for long-term care is a matter of the greatest concern in the present and future development of a hospital program in Canada," says Dr. Charron.

Although there are some excellent programs providing long-term care, the development on the whole has been "spotty", he says.

(Cont. on page 3.)

Hospital Committee.

Located at the northwest corner of the rehabilitation hospital, the tunnel was built by the Sanatorium Board, with the co-operation of the other hospitals concerned, to provide easy access for hospital personnel, doctors and patients from one hospital to another.

It is also a big step forward in the development of the Manitoba Medical Centre as it will make possible the joint use of hospital services and facilities and provide a connecting link with the Manitoba Medical College.

Actual completion of the six-story, 222-bed rehabilitation hospital is scheduled for early next year. The construction of

(Cont. on page 2.)

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The News Bulletin
SANATORIUM BOARD OF MANITOBA

Profiles

MISS JANET SMITH

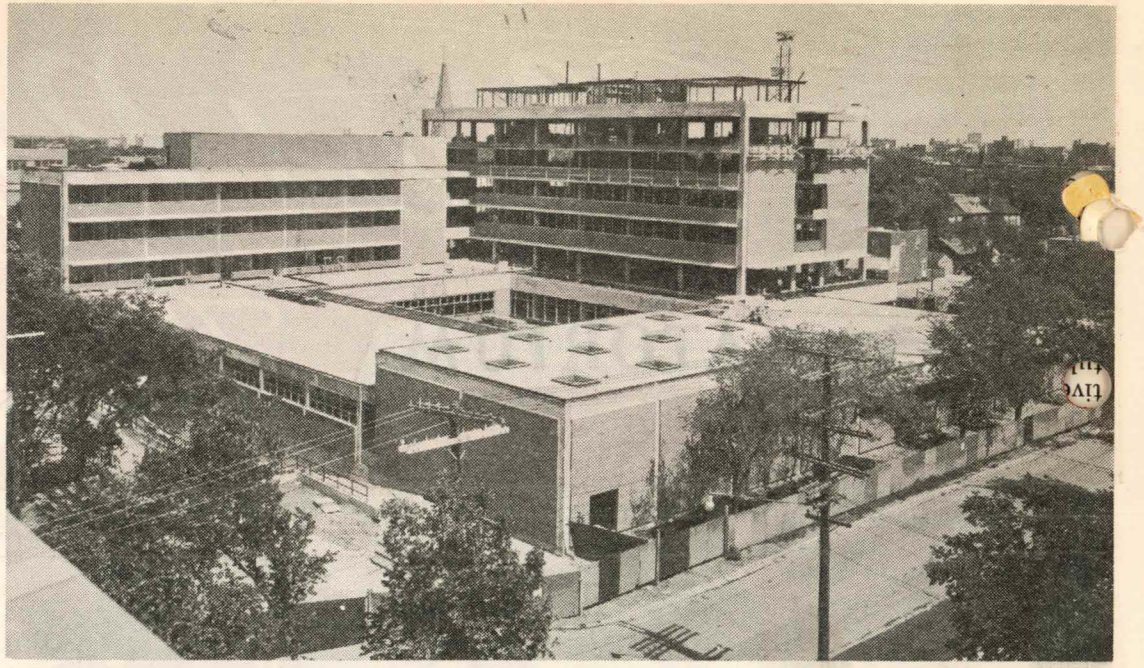
For nearly a quarter of a century the Central Tuberculosis Registry has worked hand in hand with the Sanatorium Board of Manitoba for the control of tuberculosis in this province. Established in 1937 by the Provincial Department of Health and Public Welfare, the registry has its headquarters at the Sanatorium Board's head offices and is the agency to which the Board (or any other health organization) constantly turns for accurate information on all phases of tuberculosis work in Manitoba.

The director of this efficient organization for the past five years is Miss Janet Smith, a public health nurse and a consultant in tuberculosis nursing with the provincial health department. A slight, good-natured, and extremely energetic woman, Miss Smith has the dual task of supervising the record-keeping and helping to plan and carry out the overall tuberculosis control program. She acts as the liaison between the patients and the sanatoria, the family doctor, health department and community, and guides other public health nurses in the tuberculosis field. She also helps the TB patient to accept his diagnosis and to follow through the medical recommendations.

Her job, in all, is a complicated and busy one.

Although Miss Smith is not a native Westerner, she has spent the better part of her life on the prairies. The oldest of a family of three girls and one boy, she was born in Tavistock, Ontario, and at the age of four moved west to Neudorf, Saskatchewan, where her father, the late W. H. Smith, operated a general store. After completing public school in Neudorf, she came to Winnipeg to attend Kelvin High School and later to study nursing at the Winnipeg General Hospital.

After graduating with her R.N., Miss Smith did private duty nursing for a year, then entered the public health nursing



Pictured here is the latest "construction" picture of the beautiful new Manitoba Rehabilitation Hospital. Located at Bannatyne and Sherbrook street, the hospital will provide physical and psychological rehabilitation for disabled persons in Manitoba. It will also be the headquarters of the Sanatorium Board of Manitoba and the site of the Central TB Clinic (left background). This picture was taken from the roof of the Nurses' Residence on Olivia and McDermot streets. In the foreground left to right are the occupational therapy wing, the gymnasium and hydrotherapy and heavy resistance areas. (Photo by David Portigal.)

Noted BCG Pioneer Dies

Not long ago the newspapers carried a little item on the death of Dr. Camille Guerin, the veterinarian who, with Dr. Albert Calmette, developed BCG, the tuberculosis vaccine which the World Health Organization has used for more than 100 million human

cause they were in a zone occupied by the Germans. Just in time they managed to get their plea through to German veterinarians.

Then, one morning late in 1914 Dr. Calmette was arrested. The Germans had found his laboratory pigeons and

more than 13 years.

BCG is not as sure fire in its effects as the vaccine used against smallpox, but it gives a measure of protection to those who have not been infected already. It is not given to persons who have a positive response to the tuberculin test. It is used only on those negative reactors who are likely to be exposed to infec-

year later with her certificate in public health nursing, she worked for over six years with the St. Thomas (Ontario) Board of Health.

In 1938, Miss Smith returned to Winnipeg to take a position with the provincial department of health. She served first as a sort of wandering public health nurse in the municipalities of St. Francis, Brooklands, Rosser, Brenda, Edward and Arthur, then became senior nurse at the health units at Flin Flon, Brandon, Steinbach and Portage la Prairie. In 1954 she attended the University of Minnesota for further study, two years later was appointed in charge of the Central Tuberculosis Registry.

Miss Smith lives in a cosy apartment on Arlington street. She is interested in needlework, reading and music, and spends most of her vacation time visiting her mother who now lives in Galt, Ontario.

Considering her busy professional life (she is also a member of the Manitoba Association of Registered Nurses and the Manitoba Public Health Association), she could easily leave her sparetime activities to that . . . but she doesn't. She also loves outdoor life and all kinds of sports, is an ardent rooter for the Winnipeg Blue Bombers and a staunch hockey fan. And, when she has the time, she likes to play the occasional game of golf.

Over 10,000 TB Patients

The latest count of tuberculosis patients in Canadian institutions shows that at the end of 1959 there were 10,200, including 1,755 patients in psychiatric hospitals who were being treated for tuberculosis.

Of those not in psychiatric hospitals, just over 61 per cent were men. The median age for men was 46 years and for women 32, slightly higher than in the previous year.

Pulmonary tuberculosis was diagnosed for almost 83 per cent of the patients, slightly smaller than in the previous year. Tuberculosis in other forms, mainly bones and joints, was proportionately greater.

However, the most vunerable target of tuberculosis is still the teen-agers. Although the infection rate has decreased in Canada to the point where at least nine out of ten of our teen-agers have never encountered the TB germ, a teen-ager who suddenly changes from negative to positive to the tuberculin test is particularly vulnerable, especially if the teen-ager is a girl.

Dr. Guerin was 88 years old at the time of his death. For some years he lived at the Pasteur Institute in Paris.

Because of his great contribution to the fight against tuberculosis, we present a story on him and Dr. Calmette which was released by the Canadian Tuberculosis Association over a year ago.

Dr. Guerin and Dr. Calmette, a bacteriologist, began their work in the tuberculosis field in 1903. They had a firm conviction that with time and patience they could develop a tuberculosis germ which would be too weak to cause disease, but strong enough to stimulate the body's resistance.

To do this they had to find, first of all, a substance on which the tubercle bacillus would grow, but not with its usual strength. Not until 1908 did they establish that on ox bile the tubercle bacillus while growing and multiplying would also become attenuated.

Once they found this out it meant great care, constant testing, patient waiting for each new culture to grow. Every three weeks a new generation of tubercle bacilli was reaped and tested and started on another culture of ox bile.

World War I nearly ruined everything. The first thing that happened was that they almost ran out of ox bile It was touch and go whether they would get ox bile in time, before pigeons and that he was sending messages to the allies Guerin's assurance that they were harmless laboratory test birds did not impress the Germans. They demanded an autopsy in front of army doctors. Fortunately the tuberculous lesions were apparent to the doctors and they released Dr. Calmette.

How many generations of tubercle bacilli did they need to feed on ox bile before they produced a germ so weak that it would not cause disease? It took 230. At three weeks each, that is 690 weeks —

and nurses in training. It is also used in a household

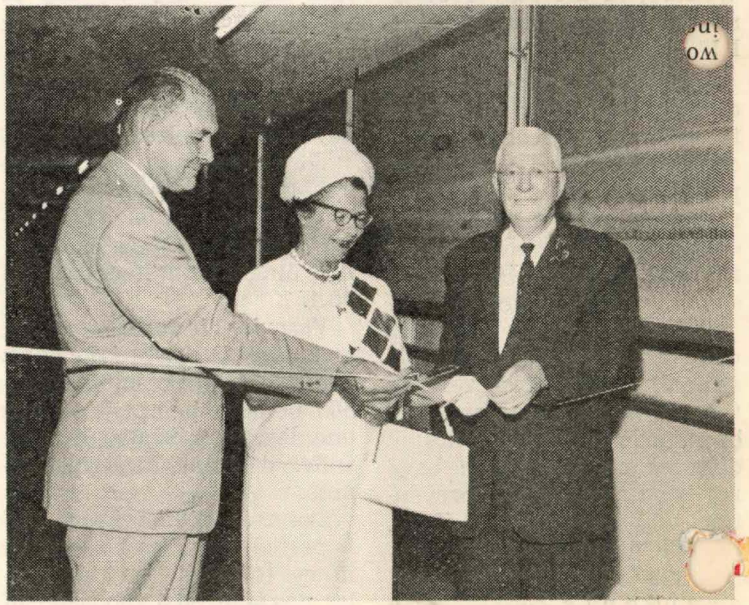
(Cont. on page 3.)

Tunnel

(Cont. from page 1.)

the hospital is proceeding rapidly and, among other things, workmen are now completing the concrete partitions and doing the plastering on the inside of the building, and installing the brick work and the attractive granite and ceramic panels on the exteri

It is expected that the laying of the cornerstone will take place within the next month.



Mrs. Lyman Van Vliet, president of the board of the Children's Hospital, cuts a ribbon to officially open the 320 foot tunnels connecting the Manitoba Rehabilitation Hospital with the Winnipeg General and Children's Hospitals and the soon-to-be-constructed Cancer Treatment and Research Institute. With her, left and right, are S. Price Rattray, chairman of the Manitoba Rehabilitation Hospital Committee, and J. W. Speirs, Chairman of the Sanatorium Board. (Photo by David Portigal.)

The Tuberculin Test: How It Works

For over 50 years the tuberculin skin test has been an important aid in discovering tuberculosis infection in countless numbers of people who do not realize that they have this silent illness. In Manitoba it has been applied on a mass scale for the last several years as both a case-finding tool and as a means of determining the prevalence of tuberculosis infection in the community.

Because the public is not particularly well acquainted with this simple skin test, many misconceptions have arisen about its value in TB prevention. Some people, for instance, believe that the test actually diagnoses active disease. Worse still, others are under the impression that it works as a vaccine by preventing tuberculosis.

Neither of these, of course, is true. Simply speaking, the tuberculin test is a simple, painless skin test which determines whether or not there are tuberculosis germs in the body. Unfortunately it does not reveal the location of infection in the body, its extent, its activity, nor when it might become a threat to health.

Discovery of Tuberculin

The substance known as tuberculin was first produced by the German microbiologist Robert Koch, who shortly after announced that he had found a cure for tuberculosis. The result is an inflamed lump which is interpreted as a *positive reaction.*

If, on the other hand, a person has never been in contact with the TB germ, there will be no TB antibodies to react to the protein part of the tuberculin. Thus nothing happens. The test is *negative.*

Positive Reactors

To have tuberculosis infection does not mean, however, that one has clinical disease. Many people who become infected with the tuberculosis germ never break down with active disease because the infection is permanently controlled by these natural body defenses. The germs lie dormant in the body surrounded by scar tissue or lime which deprives them of nutrition and causes them to more or less hibernate

If however, the general health of the body breaks down it is quite possible that these germs will break out of their prisons, start to multiply

Nine Rules

It is important that in a community TB survey, everyone must participate. The one child, the one teacher, truck driver or what have you who does not take part in the survey may well be the unknown TB case . . . a spreader of TB infection.

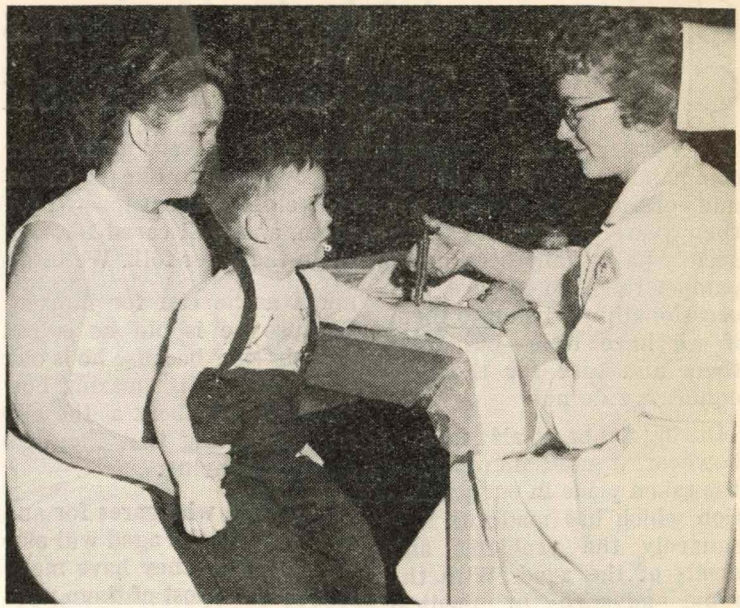
Dr. J. A. Myers, a well-known American authority on tuberculosis, once set forth these rules in advocating the tuberculin test:

•When TB strikes infants it is often quickly fatal That is why parents and baby sitters should be tuberculin tested.

•TB. picked up in childhood may go to work during adolescence. That is why high school students should be tuberculin tested.

•TB often disables for years. That is why those who have family responsibilities should be tuberculin tested.

•TB may remain inactive for a long time only to go on the warpath during old age. That is why the aging should be tuberculin tested.



The simple tuberculin test will show if this child has been infected with the tuberculosis germ. Even if he is infected, chances are he will not have clinical disease. And, if good health is maintained, he need never come down with active disease. TB surveys to find tuberculosis early are largely financed by the sale of Christmas Seals. (Photo by Tom Dobson, Flin Flon Daily Reminder.)

Technologists' Society Awards Licentiate Standing to J. Scott

The Sanatorium Board warmly congratulates J. M. Scott, senior laboratory technician at Manitoba Sanatorium, who was recently granted Licentiate standing from the Canadian Society of Laboratory Technologists.

Mr. Scott received his new

years experience in laboratory work and during this time has published many papers relating to his work. He has also compiled a manual on Laboratory Techniques inTuberculosis, taken a medical mycology course at Duke University, and undertaken the teaching

bacillus of TB germ in the late nineteenth century, turned his efforts to discovering a cure for the disease. He grew the tubercle bacilli in his laboratory for a few months, then by means of heat killed the germs. Next, the material was condensed and passed through a filter which removed the dead bacilli and left a clear broth.

Dr. Koch hoped that this fluid, which he named Old Tuberculin, would cure people of the disease by raising an allergy when injected into the body and thus causing the body to reinforce its defenses. As it turned out, tuberculin proved ineffective as a means of cure, but most valuable in detecting infection.

How It Works

In modern times, Koch's Old Tuberculin has been replaced by a purified protein derivative (P.P.D.) which is a stable tuberculin product of guaranteed strength. When inserted into the superficial layers of the skin it works this way:

If a person has at some time or other been infected with the tubercle bacillus, either naturally or through a BCG vaccination, the body produces antibodies to fight the invading germs. When tuberculin is introduced into the skin, the protein part of these same antibodies, which were produced previously to fight the TB bacteria, react against the protein part of the tuberculin.

disease.

The finding of a positive reaction is, therefore, just the first step in finding disease. The next step is the chest X-ray, since most tuberculosis is found in the lungs. In most cases, no disease will show in the x-rays because only a fraction of those people who become infected with the tubercle bacillus ever develop tuberculosis.

Nevertheless all positive reactors should have a chest X-ray just to make sure. He should also continue to have periodic chest x-rays so that any future TB breakdown can be discovered at the earliest possible stage.

Similarly, negative reactors should have the tuberculin test repeated periodically, since anyone can be infected at any time.

Finding a positive reactor, even though it is one without active disease, is also a valuable aid in discovering an unsuspected case of tuberculosis. If, for example, a child shows a positive reaction to the test, a check should be made of the members of his family and anyone else who might have been the cause of his infection. Many cases of active TB have been found in this way.

Finally, we might add that the tuberculin test is also of value in ruling out tuberculosis as the cause of other pulmonary diseases that may simulate TB in the X-ray.

foreign countries. That is why returning military personnel, travellers and immigrants should be tuberculin tested.

•When one member of a household is a reactor, all others in it should be tested because they may have been infected by the same source.

•X-ray films reveal the damage done by tuberculosis, but not infection. That is why even those who have a negative chest film should be tuberculin tested.

•TB can do extensive damage without causing any symptoms. That is why those in apparent good health should be tuberculin tested.

•TB can strike anyone. That is why *you* should be tuberculin tested.

CORRECTION

In the July issue of the Sanatorium Board's News Bulletin, the editor made a grievous error in her report on the retirement of Claude Pettitt, a member of the staff at Manitoba Sanatorium for more than 40 years. Mr. Pettitt was *not* associated with the sanatorium laundry. He was head carpenter. My sincere apologies, Mr. Pettitt. Ed.

whole new classification of titles was announced at the Society's national convention in Winnipeg, June 11 to15.

To obtain his Licentiate, the registered laboratory technician must have at least 10 years experience in the field and have written a thesis and examinations.

Mr. Scott actually has 30 nology students in his own laboratory.

Mr. Scott has been a member of the Canadian Society of Laboratory Technologists since its inception in 1937, and was president of that organization in 1951 and 1952. In 1957 he was made an honorary life member, the fourth to receive this honor.

BCG Pioneer

(Cont. from page 2.)

where there is a patient with TB, or in areas where there is a lot of tuberculosis infection.

It is this last use that gives it such great value in Asia where tens of thousands of children must live in households where some of the members have TB and where there is no hope of sanatorium treatment for the invalid.

Dr. Calmette died in 1933 before he could know the wide use to which the vaccine had been put. Dr. Guerin in the years since the end of the war saw the vaccine put to use on a scale of such great proportions that he must have felt it was well worth the devotion of a life time.

* * *

At least we sincerely hope so, for despite the wide use of BCG, neither he nor Dr. Calmette ever made a dollar out of it.

Long-Term Care

(Cont. from page 1.)

"The question might be asked as to whether we are getting the type and scale of leadership from the medical profession that this major problem deserves.

"Furthermore, with the emphasis on the participation of other professional disciplines, are these disciplines trained and motivated to participate effectively in the program?

"I believe that a careful look at the situation across Canada would lead one to conclude that a great deal more attention needs to be paid to the care and rehabilitation of long-term patients in our hospitals."

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1. Dr. Charron defines year-long sickness as either one year-long sickness or two or more overlapping or concurrent sicknesses, if these illnesses did not leave the affected person free of symptoms during the entire survey year.

Caring for Elderly Patients Can Be A Rewarding Task

As a general rule, elderly persons in our society have never commanded a position of much importance. Unlike in China and certain other cultures where the elderly are respected for their years, revered for their wisdom, and well cared for, our society has usually been indifferent to the older folk. We often pamper them, to be sure, and occasionally we listen to them if we have time—but treat them and care for them as equals, we do not!

During the past half century, however, a gradual transition has taken place in our population which has made us face squarely the problems and needs of the aged. With the rapid advance in medical science, more people are surviving the diseases of childhood and young adulthood and are living to a ripe old age. Nowhere is this felt more acutely than in our hospitals, for with the increase in our older population, there has been a corresponding increase in the number of elderly patients admitted for hospital treatment.

For this reason there is an urgent need for those in the hospital field to re-examine their attitude towards the aged. We must realize, for example, that the elderly sick should not, as they have in the

much as he can for himself. Because he is old he is not foolish—nor because he is old, is he deaf. It is amazing how many people shout at the elderly, assuming that they are hard of hearing.

A person who cares for and understands the aged will also discover that they have many worries . . . most of them well-founded. They are worried, for one thing, about being sick and losing their faculties and former agility. They are worried too, about losing their independence and being a burden on their families and on the hospital.

We can do a lot to allay these fears. We can, for example, be sympathetic, kindly, thoughtful, and friendly — for we know that many older people are very lonely.

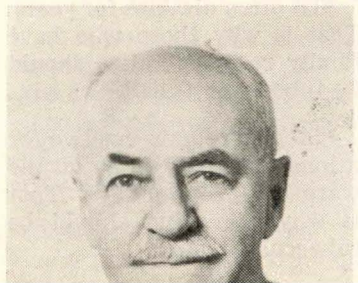
We can also listen to their problems and explain why certain things are being done for them. We can be patient and

Dr. W. J. Wood Retires

With regret the Sanatorium Board of Manitoba records the retirement of Dr. W. J. Wood, Regional Superintendent of Indian andNorthern Health Services. A long-time friend of the Sanatorium Board of Manitoba and a prominent figure in the whole field of health services in Central Canada, Dr. Wood has been regional superintendent since the office was first opened in Winnipeg under the Department of National Health and Welfare in 1946.

At that time his office covered Manitoba and Northwestern Ontario, but in 1953, under his jurisdiction, it was extended to include the Central Arctic.

Dr. Wood is a graduate of the University of Manitoba Medical School and holds a diploma in Public Health from the University of Toronto. He practised medicine for some years in Lac du Bonnet, Manitoba, and came to Winnipeg in 1939 where he assumed a position with the city health department.



A veteran of both world wars, Dr. Wood served with the Canadian Army, then for a year with UNRRA in China, prior to his appointment with Indian and Northern Health Services.

As regional superintendent, Dr. Wood has worked closely with the Saantorium Board in fighting tuberculosis among the Indian and Eskimo population. He was also a member of the former Dynevor Indian Hospital Committee and sat in on committee meetings of our Clearwater Lake and Assiniboine Hospitals.

On the occasion of his retirement last month, Dr. Wood was honored by some 115 friends and associates at a farewell dinner held at the Desert Sands Hotel.

Among those who attended the event were Dr. P. E. Moore, director of Indian and

Bulletin Board

Staff members at Assiniboine Hospital, Brandon, reluctantly b[id] farewell this month [to] Robert Newman who [is] retiring from his post as chief engineer. Mr. Newman, who has efficiently directed maintenance and the boiler plant at [the] hospital for the past 12 years, has been responsible for many major changes at the hospital over the years — including the conversion and centralizatoin of the heating system, the conversion of the hospital wards for extended treatment care, and the installation of new foundation[s] under the entire building.

As chief engineer Mr. Newman has done an exceedingly fine job, and all members of the Sanatorium Board staff join in wishing him much health and happiness in his retirement.

* * *

Representing the Sanatorium Board at the International Tuberculo[sis] Conference in Toronto, September 10 to 14. are R. L. Bailey, member of

past, be regarded as hopeless cases and forced into a death-in-life existence in inferior-type institutions. Rather, we must accept responsibility for the lives that the doctors and scientists have managed to prolong, make better provisions for the treatment and care of the aged, and do all in our power to make their last years as happy, comfortable and productive as possible.

Not many years ago a noted physician said that the successful doctor and nurse of the elderly are those who help their patients to "die with their boots on". To do this, he said, the doctor and the nurse must adopt the right attitude towards the elderly patient. In caring for their bodies, they must not lose respect for their minds and personalities. They must be able to bring them hope, to renew confidence in themselves, to make them feel useful and important again — better still, help all they can to make them useful and important again.

Above all we should understand that an elderly person wants more than anything else to be treated as an equal human being — not as some have put it, as a "walking hospital". It is said that he will accept his physical disabilities, suffer them gladly, if he is respected for his mind.

He does not want to be treated as a child. He wants to be heard like the rest of us, to think for himself, and do as older people tend to be fixed in their ways and that just like younger patients they become crochety when they are sick.

Like the rest of us, the elderly patient does not like to feel helpless. We can do much to make him feel more independent by doing things *with him,* instead of *for him.*

Many younger people are also inclined to expect the elderly to move as quickly as themselves. What they do not always realize is that elderly people can do things just as well as the younger, but need a little longer to do it. We can help a great deal if we will give them this extra time to do things for themselves — like washing, eating, getting out of bed — without making them feel hurried or inadequate.

A cheerful, optimistic atmosphere is essential in caring for the elderly — indeed, for all people. Such a spirit arises from the attitude of the hospital staff, for good morale is very contagious and if the hospital staff feels genuinely happy and optimistic, so will the patients.

And after all, when it comes right down to it, why should not the hospital staff feel hopeful and happy? We are beginning to learn that sickness in old age is not irremediable. With the introduction of physical and psychological medicine, we have learned that although the illness itself

DR. W. J. WOOD

cannot be cured, the symptoms may be alleviated and the patient rehabilitated to a useful and more independent life. Indeed, it is amazing what elderly persons, with a courageous attitude, hard work and a sense of humour, can do for themselves if given the opportunity. All we need to do is provide them with the tools.

These are the lessons now being learned in hospitals and nursing institutions across the country. At the Sanatorium Board we are learning them in our extended treatment and TB hospitals, which are becoming more and more concerned with the care of the elderly sick.

We are discovering that helping to restore the aged to a useful life and to a place of dignity and honor and self-respect is one of the most rewarding tasks ever assigned to us.

We are learning, too, that we can do no better than to adopt a "do-unto-others" attitude towards our elderly patients. For in providing them with high quality care now, we are in a way providing for our own future welfare.

tawa; G. H. Cappell, regional administrator for Indian Health Services; A. G. Leslie regional superintendent for the Indian Affairs Branch, and Mrs. Wilma Raynor, matron of Fisher River Hospital, who acted as chairman.

Representing the Sanatorium Board were T. A. J. Cunnings, executive director; Dr. D. L. Scott, medical superintendent of the Central Tuberculosis Clinic; Dr. A. L. Paine, medical superintendent, Manitoba Sanatorium; Dr. A. H. Povah, chief of medical services, Assiniboine Hospital; and Edward Locke, supervisor of special rehabilitation services.

Dr. E. L. Ross, medical director of the Sanatorium Board, was unable to attend the dinner, but sent a message to Dr. Wood, part of which we quote here:

"(Dr. Wood's) knowledge, judgment, untiring energy and devotion has been in a great measure responsible for the remarkable accomplishments of the Indian and Northern Health Services in this area for the past 10 years.

"The Sanatorium Board is in a preferred position to appreciate just what Dr. Wood has done and we look back with nothing but pride and satisfaction on our association over the years."

E. L. Ross, medical director; T. A. J. Cunnings, executive director; and Miss Mary Gray, Christmas Seal Supervisor.

Miss Janet Smith, supervisor of the Central Tuberculosis Registry, will also attend the international meeting.

* * *

Prior to the international conference, Dr. E. L. Ross will attend the famous Tri-State (Minnesota Wisconsin and Michigan) Pembine Conference to be held in Pembine, Wisconsin, from September 7 to 9. Some 60 specialists in tuberculosis and chest diseases will take part in the discussions on methods of handling and treating cases.

* * *

Miss Nan Tupper Chapman, director of dietary services for the Sanatorum Board, returned to Winnipeg this month after holidaying in Portugal and London. During her stay in London Miss Chapman attended the Third International Congress of Dietetics. Delegates from 30 countries attended the sessions held from July 10 to

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Among the recent auditions to the Sanatorium Board staff is Miss Rita M. Rossier of Winnipeg, a licensed practical nurse who will work with the Surveys Department.