

News Bulletin

SANATORIUM *The* **BOARD OF MANITOBA**

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TB Increasing in Canada Executive Secretary Warns

For the first time in 13 years there has been an increase of tuberculosis in Canada.

Speaking at the annual meeting of the Canadian Tuberculosis Association in Montreal last June, Dr. C. W. L. Jeanes, CTA

executive secretary, told delegates that a total of 6,284 new active cases of tuberculosis were reported in this country in 1962 — nearly a six per cent increase over the number reported the previous year.

"We are simply deceiving ourselves if we do not face the fact that this is a setback and that we are not controlling

"People are so confident that the wonder drugs have banished the danger that many fail to avail themselves of the opportunities offered by mass tuberculin and x-ray surveys. The inevitable result of this has been that undiagnosed cases have infected others".

There is a 20% hard core of people who do not attend



A GOLDEN CUP AWARD for making good coffee was presented July 26 to the Manitoba Rehabilitation Hospital by the Coffee Brewing Institute of New York. Pictured standing around the urns after the presentation are left to right: Mrs. Margaret Johnston, Mrs. Louise Moe, Mrs. Isabella Stewart, E. L. Hibbert, sales manager for H. L. MacKinnon Company, Howard L. MacKinnon, Robert Thomas, of the Coffee Brewing Institute, Mrs. Dorothy McDermott, cafeteria supervisor, and Miss Mary Chetyrbok. (Photo by David Portigal).

Rehabilitation Hospital Wins Coffee Award

July was a proud month for our Manitoba Rehabilitation Hospital. During this time it not only received a "stamp of approval" from the Canadian Council on Hospital Accreditation and the Royal College of Physicians and Surgeons¹, but it was also presented with a Golden Cup award for brewing a tasty cup of coffee.

At a little ceremony on July 26, Hospital Manager A. H. Atkins, accepted the golden plaque from Robert Thomas, representative of the non-profit Coffee Brewing Institute of New York City. Proud witnesses were Mrs. Dorothy McDermott, cafeteria supervisor, Miss Nan T. Chapman, director of dietary services for the Sanatorium Board, and all the cafeteria staff.

Good Cup of Coffee

During his visit to Winnipeg Mr. Thomas gave an expert's opinion on how to make good coffee. For those who are interested in improving their brew, here are some of his tips:

The two things that affect the taste of coffee, according to Mr. Thomas, are water and time.

Water should be cold, fresh, not chemically softened. It should be brought to the boil before coffee is added.

The time coffee is exposed to the water depends on the grind. For a percolator a regular grind is used, and the water should be allowed to infuse the coffee grains for six to eight minutes. In a drip pot a drip grind is used and the water allowed to infuse the coffee for no more than four to six minutes.

Infusion time should be counted from the time the coffee is added until it is taken out. The coffee will become bitter if the grains are left in too long.

If you let coffee stand, it should be kept at a temperature between 185 and 190 degrees. It should not be left standing for more than one hour, nor should it be allowed to cool and then re-heated.

And for best results, advised Mr. Thomas, make sure your equipment is kept clean.

1. See Bulletin Board.

New CTA Officers

Dr. Hugh E. Burke of Montreal was elected president of the Canadian Tuberculosis Association at the annual meeting in Montreal in June. He succeeds Dr. G. R. Davison of Edmonton.

Other officers are: President-elect, Dr. E. M. Found, Prince Edward Island; honorary treasurer, T. A. Saul, Ontario; assistant honorary treasurer, Paul DesRochers, Quebec.

Members of the management committee are: Dr. Burke, president, Dr. Found, Dr. Davison, Dr. Roland Guy (Quebec), Dr. S. A. Holling (Ontario), A. C. Milner, Q.C. (Nova Scotia), Kenneth More, M.P. (Saskatchewan), Dr. G. E. Maddison (New Brunswick).

increase is fairly uniform across the country in every province except Alberta, Ontario and British Columbia."

The greatest problem facing tuberculosis workers today is public complacency, Dr. Jeanes told delegates. "The fact that the previously high mortality rate has been cut to a fraction has taken all the terror out of this disease. Modern treatment with drugs has changed the outlook dramatically, but tuberculosis is still the most common chronic infectious disease, producing an enormous amount of social, domestic and financial upheaval.

There is a widespread idea that the discovery of tuberculosis drugs has solved the whole problem, Dr. Jeanes said.

from various studies that it is in this group that the high incidence of tuberculosis and other respiratory diseases lie."

"If case finding were more diligent among the groups where it has been demonstrated that tuberculosis rates are above average, it would immediately cut down the incidence of fresh disease.

"Tuberculosis can only be controlled and eradicated by finding and treating every active case and providing adequate supervision for all old cases," he said.

"We have excellent tools for the diagnosis and treatment of tuberculosis . . . but all these tools are no good if they are not used."

Address all communications to:

THE EDITOR, SBM NEWS BULLETIN,
800 Sherbrooke Street, Winnipeg 2, Manitoba
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Puvaluttuq

By P. E. Moore, M.D., D.P.H.

Tuberculosis used to be known as "Captain of the hosts of death" and the "white plague", and it was well named.

The Eskimo may not know it by these names but his concept of its deadly power is much the same. Even though it killed

only six of his people in 1962, to him it is still the disease that breaks up the family circle, steals away the breadwinner or the mother or several of the children. The harshness of his northern environment and the dangers of his way of life make him somewhat fatalistic, but he is not complacent about tuberculosis. To him it is still Public and Private Enemy Number One.

There is an urgent lesson for the rest of us in the Eskimo's tragic experience with this disease. As the tuberculosis death rate amongst us has declined and our sanatoria have emptied and even closed, some of us have breathed a sigh of relief — much too early in my opinion.

For those of us who work for the health of Eskimos and Indians have had a recent vivid warning not to let down our guard for an instant against the disease. A tiny village of 329 Eskimos and 16 whites, on the western edge of Hudson Bay, 165 miles

gravel ridge, squeezed between the swampy muskeg of the tundra behind and the open sea in front.

During the height of the epidemic a public health doctor did a survey of the housing at Eskimo Point. His observations were as follows: 47 houses rated as "poor" or "very poor", only half of the 64 houses fitted with wooden floors and only 24 of them with dry floors. He reported leaking roofs, overcrowding, misery and filth.

Many Factors

But we shouldn't lay all of the blame for the epidemic on overcrowding. After all, many of the other Eskimos in the Canadian North are just as badly off. Why didn't *they* succumb to tuberculosis last winter?

I believe we have a situation that arose out of a combination of factors. One of these was poor housing and gross overcrowding, but another was the debilitating effect of

ed a positive result. There were much higher percentages of positives in the younger age groups than one would find in Southern Canada.

The films from the January x-ray survey were sent to Clearwater Lake Hospital at The Pas, where they were read by Dr. S. L. Carey, who has long been associated with Indian and Eskimo tuberculosis in Northern Manitoba and the Central Arctic.

Dr. Carey's findings were as follows: 54 new active cases or 22% of the population — 33 of them amongst children under the age of ten. Together with five reactivations, this made 59 patients who had to be evacuated by chartered aircraft to Clearwater Hospital during the next two months.

One might also be interested to know that the transportation costs alone averaged \$120 for each patient, and the average cost of treatment services is likely to reach \$5,700 per patient. The disease found on this survey alone will cost the taxpayers in excess of \$350,000 — and there was another

cently married, with no children of her own.

This woman was first hospitalized for suspected tuberculosis in 1958. The diagnosis at that time was "minimal arrested". She was x-rayed during the routine surveys of 1959 and 1961 and in each case the result was negative. In September, 1962, she came to the nurse at the newly built nursing station complaining of vague pain in the chest. She was advised to rest in bed and the pain went away. In December she was back, this time saying the pain was severe. In due course she was evacuated to Clearwater Lake Hospital. Meanwhile, two of her brothers had been hospitalized, suspected of having active tuberculosis. Now her husband is in hospital with moderately advanced disease.

Knowing the hospitable nature of the Eskimos, their love for children and their habit of visiting from house to house, is it not likely that she might be the "spreader" in this epidemic? It's hard to say. But in my view this is probably what happened.

... is the Eskimo word for tuberculosis, meaning literally "lung sickness". It is a term the Eskimo has reason to dread, says Dr. P. E. Moore, Director of Medical Services for the Department of National Health and Welfare, who in the following article* relates how "Puvaluttuq" affected one northern community not long ago.

age and three of these were reactivations of old cases.

Indeed, the way in which the older age groups escaped is interesting. Four old folks born in the 1880's had chest x-rays that were considered entirely free of active disease.

Administer BCG

We have given BCG vaccine to all the tuberculin negative people who have remained in the village. We are considering the possibilities of giving prophylactic INH to everybody...

Some have said that the giving of BCG at this time will only cloud the picture. Others think that we should have instituted a BCG program at this village long ago. There is still considerable disagreement on the subject.

We have relied in the past on an annual chest x-ray and medical survey, which usually obtains between 60% and 70% coverage of the population. Considering that the Eskimo is a free Canadian, we believe this represents good co-operation on his part and a reasonable check on the

north of Churchill, in the past six months has produced 80 cases of active tuberculosis, involving 55% of all the households, half the children under ten years of age and 24% of the whole population. The outbreak has already claimed two lives. In the households affected, there are as many as four cases in some and three cases in others.

Before treatment services have ended for these patients, \$500,000 of public funds will have been spent and the economic and social life of this village scarred for years to come.

I want to tell you about this outbreak in detail, because I hope you and I will never forget that it represents just a small but expensive sample of what could happen across the country if we do not keep up our defence against this ancient killer.

Remote Community

The place of the outbreak is Eskimo Point in the Northwest Territories. It is reached by boat in summer and by plane in summer and winter. It gets mail once a week. There is a nursing station, built last year, a school run by the Department of Northern Affairs, a detachment of the R.C.M.P., a Hudson's Bay Company store and three missions. The 82 Eskimo households are crowded into 64 wooden and snow houses scattered along 1,500 yards of

ease — measles and mumps in the spring of 1962 and German measles in January, 1963.

The Eskimos are still far more susceptible to these so-called "childhood diseases" than the rest of us. When measles hits an Eskimo community everybody gets it and frequently some of the infants and the elderly die. Tuberculosis found easy targets amongst the people of Eskimo Point last winter, because most of them were still sick or convalescing from these other illnesses.

In addition, the Eskimos had experienced tuberculosis before. Nine percent of them have histories of sanatorium care, but most of these are now over 10 years of age, showing that in recent years there has been reasonable control of the disease. However, there have been five cases of reactivation during this epidemic, or 17%.

TB Surveys

Between the epidemics of measles and mumps in the spring of 1962 and the end of the year, several cases of tuberculosis appeared, referred by the local nurses on the basis of symptoms. An x-ray party visited the settlement in January. At that time about half the population was sick with what was later labelled German measles.

During the survey 84% of the population were tuberculin tested and of these 80% show-

knew there were likely to be more new cases by then.

Eighty-nine percent of the remaining population of 270 were x-rayed in the April survey and 21 further cases of new active disease were found. Thus the score is now 80 cases out of the population of 329, or 24% of the community.

About half the children under the age of ten years had to be removed to hospital, and even in the adolescent and young adult age groups, from one quarter to one-fifth of the population were hospitalized. Only the older age groups, particularly those over 60 years of age, seemed to have escaped. This is an epidemic of the very young — the unprotected — the susceptibles.

The Source

Where did it start? Did it begin with one of the reactivation cases? Or did it begin with one of the cases found in the summer and fall of 1962 — one of the handful of cases we always seem to get from these northern communities every year, in spite of everything we do to find and isolate the active cases and follow up the old ones?

Investigation showed that the greatest concentration of cases occurred in the eastern of the village. Many of them were clustered around the home of a particularly open, far advanced case — a young Eskimo housewife of 20, re-

What part did the epidemics of virus disease play in this explosion of tuberculosis? There were 44 cases associated with one or more of the virus diseases and 36 cases not associated with any of them. It is noteworthy that two deaths occurred in patients in the 20-29 age group who had all three of the virus diseases between May 1962 and February 1963.

As one might expect from the age distribution of the cases, 61% of the 80 patients were considered to be in the primary active category. Further laboratory studies may reduce this number but I should not be surprised if the final results show that at least 90% really have active disease requiring hospitalization for as long as 12 months.

The number of youngsters under five years of age who were infected is shocking — 23 cases, or over a third of the youngsters in this age group.

Twenty-five percent of all the cases and six percent of the total population had "reinfection tuberculosis" (i.e. the type that develops in a person who has already had primary infection).

Out of the 80 cases, there were 69 with pulmonary tuberculosis and 11 with extrapulmonary. Forty-five of them were under the age of 10 years and another 30 were under the age of 30. Only five cases were over 30 years of

community. Nevertheless, here is an example where the disease got away on us.

Warning to Others

This brings me to my final point. In Southern Canada, where chest x-ray survey coverage is usually not as good as we can achieve in some of the isolated northern communities, and where people seem to have become complacent about tuberculosis, I believe the kind of explosion you have seen demonstrated today could happen. It could happen suddenly — from a single spreader such as the young housewife I told you about.

My guess is that most of our youngsters under 20 years of age are tuberculin negative, having had neither an encounter with the disease nor BCG vaccination. They are sitting targets for the acid-fast bacillus with its high fat content, its sensitizing protein, its changing resistance to the best drugs we have and its long history of repeated victories over the human race. In my view we must continue and even increase our vigilance against this enemy, if we not want him once again become known as "Captain of the hosts of death".

**Condensed from a paper presented by Dr. Moore to the annual meeting of the Canadian Tuberculosis Association, held in Montreal in June, 1963.*

By P. E. Moore, M.D., D.P.H.L.

*Biomechanics Laboratory***Director Outlines Aims of New Program**

This month we are happy to welcome James Foort, who joined in Winnipeg on August 1 to assume his post as technical director of the Biomechanics Laboratory at the Manitoba Rehabilitation Hospital.

Since many of us know very little about biomechanics or the relationship of this field to the total rehabilitation scheme, we hastily arranged an interview with the engaging new director in hopes of satisfying our curiosity.

In the first place, we learned that Mr. Foort is one of the continent's few prosthetics research engineers. Moreover, although he has spent a great deal of time in the United States, we were delighted to find that he is also a Canadian — born and raised on one of the small gulf islands (Quadra Island) just off Campbell River, B.C. He has a degree in chemical engineering from the University of Toronto and has spent the past 12 years as a research engineer, first at Sunnybrook Hospital in Toronto, and, for the last 10 years, with the Biomechanics Laboratory at the University of California. He is married, has a young, newlywed daughter in Victoria, and a 12-year-old son.

Mr. Foort's new laboratory at the rehabilitation hospital is



JAMES FOORT

of patients, and by arranging an educational program for people handling patients and a study program aimed at improving techniques and appliances.

The treatment part of the program will mean providing orthotic and prosthetic appliances to the patients, adjusting and maintaining them, training patients to use them, and taking care of any medical problems associated with wearing them.

Information would also be provided on a broader scale to other people interested in the problems of rehabilitation.

Research

Under the research program, appliances, procedures and techniques will be developed to meet the special problems of the patients.

The exchange of information between the various professions in the hospital will be of great importance to research, said Mr. Foort. "Where special information is needed for the development of some new device or technique, I hope people outside will contribute their knowledge to the problem, either through special studies or advice."

The dermatologist, for example, could assist with any problems related to the skin. The surgeon could perhaps modify stump surgery. With recent improvements in prosthetic care, Mr. Foort suggested that it is now possible to amputate the leg at a lower level and make it easier to rehabilitate the patient.

Aim Is Simplicity

In developing any new mechanical device the aim is

in treating amputees who have lost their foot or leg.

Other work at Sunnybrook led to a wider application of plastics to the problems of prosthesis fabrication. A molded rubber foot now used almost universally originated at Sunnybrook Hospital, and was further developed in the Biomechanics Laboratory at the University of California.

While he was with the University of California, Mr. Foort was part of the team who developed a new prosthesis for people amputated through the shank. With this simple prosthesis (if it is correctly fitted and aligned), it is not possible for the casual observer to tell that the wearer is an amputee.

Among other recent developments in which our director has been involved is

the brim fitting technique which will soon be introduced in Winnipeg. This technique takes much of the guesswork out of fitting artificial limbs to thigh amputees.

"However, it is important that people understand that we are not only interested in artificial legs, but in all engineering possibilities in the field," Mr. Foort said. Two areas which he feels could do with more research are brace-making and the production of artificial arms.

But all of this must be developed gradually. "Our main concern now is to get the department into operation," he said.

The laboratory, he felt, should be in full swing early next year. Its involvement in treatment and education, of course, need not wait.

Hospital Administrators' College Honors Our Executive Director

Our executive director T. A. J. Cummings will be admitted as a Nominee to the American College of Hospital Administrators at its 29th annual Convocation Ceremony to be held Sunday afternoon, August 25, in the Imperial Ballroom of the Americana Hotel

the Board and two years later assumed his present position. Today he administers a Board whose responsibilities have been extended greatly to include not only the control of tuberculosis in Manitoba, but also the care of certain long-term and disabled patients. Five institutions in various

others are in Toronto and Montreal) which are being established by the federal and provincial governments to assess, develop and research prosthetic (artificial limbs) and orthotic (braces) devices and techniques. It will serve as a training and educational centre for all of Western Canada and will be a most important arm of the rehabilitation hospital's total treatment program.

The laboratory will occupy a large space in the hospital basement, and will comprise the following areas: (1) Treatment Section, including plaster room, fitting rooms, light workshop, training area and waiting area; (2) Research Area composed of workshop, office and drafting room.

The department's staff will number about six persons and, in addition to the technical director, will include a medical director, technician, technician's helper and perhaps in time a second engineer. The department will also require the services of a prosthetist-orthotist and, of course, the close co-operation of the orthopedic surgeon and other medical personnel.

Treatment

"The goal of the Biomechanics Laboratory is to provide and improve services to patients," Mr. Foort said. "This can be accomplished by involving the laboratory personnel directly in the treatment

According to Mr. Foort, the introduction of this sort of program into the hospital marks a major step forward in the rehabilitation of the disabled.

Until recently, he said, the amputee was sent (or found his own way) from the doctor's office with a prescription that might say, for example: "Give this man a new leg." This often meant that the prosthetics manufacturer not only had to make the appliance, but also had to assume the responsibility for aligning and fitting it, perhaps attending to the patient's psychological problems and guessing at any medical complications.

"There should be a trend toward the separation of patient handling and the manufacture of appliances," Mr. Foort said. "The hospital should share the load with the manufacturer by letting him concentrate more on the production and maintenance of appliances, while it assumes the responsibility for many of the other services."

Education

The aims of the educational program will be to teach medical personnel (including doctors, therapists and technicians) about prosthetics and orthotics. The steps will include familiarizing the staff with techniques and devices through lecture-demonstrations, teaching them how appliances are used and demonstrating them clinically on selected patients.

ment which will be simple, but at the same time replace as much lost function as possible.

Mr. Foort, who has just completed a study tour of major prosthetic centres in England, Germany and Denmark, disclosed that throughout his career much of his interest has centred on the problem of how to make a simple, comfortable link between the prosthesis and the body.

New materials from industry, such as plastics, foams and rubbers, have greatly helped the engineer toward this goal, he said.

Indeed, according to Mr. Foort, there are many exciting facets to biomechanics. "It is wide open to research," he said, "and I think that a centre like this hospital offers the right climate, facilities and personnel for new ideas to find expression."

Achievements

Mr. Foort said that he felt fortunate to be one of the few research engineers who have made biomechanics their special interest and who have been able to contribute some solutions to the problems of the disabled.

Research at Sunnybrook, he noted, resulted in the development of the Canadian Symes Prosthesis and the Canadian Hip Disarticulation Prosthesis. These devices have become standard throughout the world

The College, a professional society now in its 30th year, was founded for the purpose of providing recognition to men and women who are doing outstanding work in their professional careers as hospital administrators.

The convocation ceremony is held annually preceding the yearly meeting of the College, held in conjunction with the convention of the American Hospital Association. Dr. Frank C. Sutton, director of Miami Valley Hospital, Toledo, and president of the College will preside at the convocation.

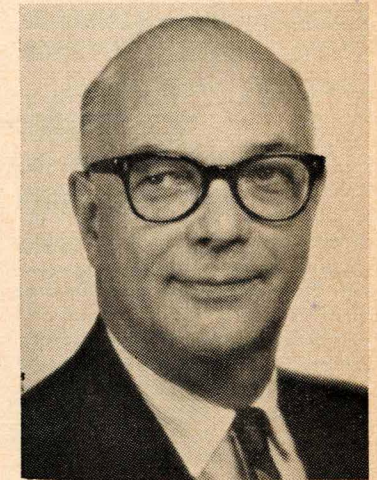
Long Association

Mr. Cunnings, who was born and raised on a Saskatchewan farm, has had a long and distinguished career with the Sanatorium Board. A former patient at our Manitoba Sanatorium, he published, while in hospital, the Sanatorium Board's first news magazine, "The Messenger of Health".

He joined the executive staff in 1942 and, as Director of Rehabilitation, established a comprehensive program for tuberculosis patients, which was soon after hailed as the first successful rehabilitation program of its type in Canada.

In 1945 Mr. Cunnings became secretary - treasurer of

parts of the province come directly under his management.



T. A. J. CUNNINGS

Despite his busy schedule, Mr. Cunnings has found time to take an active interest in community affairs. Among other things, he is a director of Neighborhood Services, a member of Winnipeg Rotary Club, and the Board of United College, and, until recently, secretary of the Manitoba Medical Centre. He also served for years on the executive council of the Canadian Tuberculosis Association.

The Sanatorium Board staff are proud to learn of this well deserved honor which has recently come to our executive director, and we all join in offering him our warmest congratulations.

Around Our Institutions

During the past two months we have seen many new faces around our various hospitals. Among those to whom we extend a most hearty welcome are the following:

Central TB Clinic

Marvin Thorgeirson has been appointed senior laboratory technologist for both the CTC and the Manitoba Rehabilitation Hospital. He is a registered technician, having received his training at the Ryerson Institute of Technology in Toronto, the Ontario Department of Health Central Laboratories, and the Toronto General Hospital.

His past experience has included posts in the tuberculosis department of the Central Laboratories, Sault Ste. Marie Department of Health, the chemistry department of Cottage Hospital in Pembroke and the Respiratory Laboratory of the Winnipeg General Hospital.

A native Winnipegger, Mr. Thorgeirson is married and has four children. His wife, Trudy, is also a registered technician at the Children's Hospital of Winnipeg.

Assiniboine Hospital

Last month *Miss Margaret Adelaide Newton* arrived in

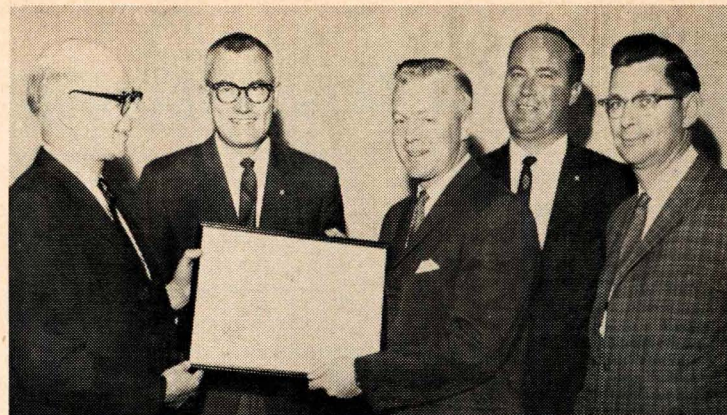
Teachers College (1952-53) and Covenant College in Toronto. For five years she worked for the Indian Affairs Department as a teacher at Berens River, then left her post to obtain her arts degree at United College in Winnipeg, graduating this past spring. During last summer she served as relief manager of the Indian and Metis Reception Lodge in Winnipeg.

Mrs. Margo Cameron Duncan has joined the hospital's physiotherapy department. She was born in Paisley, Scotland, and received her diploma from the Royal School of Physiotherapy. She worked for the Canadian Arthritis and Rheumatism Society before joining our Brandon staff.

New members of the hospital's nursing staff are *Mrs. Rita Pearl Hawkins*, general staff nurse, and licensed practical nurses *Mrs. Evelyn J. Doan* and *Miss Lillian Blackwell*. *Mrs. Hawkins* was born in England, trained at Hertford County Hospital, and has her certificate from the British Tuberculosis Association.

Manitoba Sanatorium

Recent additions to the nursing staff at Manitoba San-



A CERTIFICATE OF MERIT was recently presented to the Physiotherapy and Occupational Therapy Unit at Assiniboine Hospital by the Associated Canadian Travellers of Brandon. Taking part in the ceremony were, from left, Sanatorium Board Executive Director T. A. J. Cunnings, T. A. Moore, newly elected Dominion president of the ACT and a member of our Board, Neil Goodman, vice-president of the Brandon club, Ernie Forsyth, president, and Dr. A. H. Povah, chief of medical services at Assiniboine. Over the past few years the Brandon ACT, through such fund-raising projects as a raffle of major home appliances at the Brandon Fair last month, has raised nearly \$85,000 towards the cost of the therapy unit. (Photo by The Brandon Sun).

graduate course in Thoracic Nursing at Harefield Hospital, Middlesex. *Miss Peters*, who also has post-graduate training in thoracic nursing, worked at Royal National Hospital in Bournemouth before her departure for Canada. Both she and *Miss Waldron* have their certificates from the British Tuberculosis Association, and their certificates in midwifery.

Other new staff at Ninette include *Mrs. Twila Fern Oliver* and *Miss Lorna Gail Jefkins*, licensed practical nurses.

ist at the rehabilitation hospital; *Miss Constance Ham*, clerk-typist in the business office, *Miss Andrea Gudmundson*, weekend telephone operator, and *Mrs. Lois Hiebert*, general staff nurse. *Mrs. Hiebert*, who also arrived recently in Winnipeg, trained at Hamilton General Hospital.

Other new staff members include *Miss Heather Marshall*, keypunch operator in the Sanatorium Board's IBM Department, and *Mrs. Matilda Teran*, licensed practical nurse at the Central Tuberculosis Clinic.

Bulletin Board

The Sanatorium Board is proud to announce that the Manitoba Rehabilitation Hospital has received full accreditation from the Canadian Council on Hospital Accreditation, following a critical survey of the hospital's services by a council representative. The hospital is now the fourth Sanatorium Board institution to be awarded this certificate.

During the past month, our rehabilitation hospital has also been approved by the Royal College of Physicians and Surgeons of Canada as a training centre for post-graduate residents specializing in physical medicine.

* * *

The Sanatorium Board's nursing department is happy to announce the following nurses have successfully completed the Extension Course in Nursing Unit Administration, sponsored by the Canadian Hospital and Canadian Nurses' Association.

post as supervisor of the Rehabilitation Unit at Assiniboine Hospital.

Miss Newton was born in Ottawa, attended Ottawa

Academy include Miss Jonathan Waldron and Miss Patricia May Peters, general staff nurses. Miss Waldron trained at Walton Hospital in Liverpool, England, and took a post-

MISS ARIENNE HOCKIN, who left the staff at Clearwater Lake Hospital some time ago to take a course in medical technology at St. Boniface Hospital in Winnipeg, has now returned to this hospital to become senior laboratory technician.

Miss Sara Friesen, from Morden, Manitoba, has joined our Clearwater Staff as a licensed practical nurse and operating room technician.

Rehabilitation Hospital

New appointments at our Winnipeg centre include Mrs. Shirley B. Bergen, who arrived recently (as a bride) from Saskatoon and has become a medical records typ-

ASSISTANTS Graduate

Following closely on the heels of a graduation ceremony held in June, was the third graduation of nurses' assistants and nursing orderlies at the Manitoba Rehabilitation Hospital on July 26.

Six graduates, all members of the M.R.H. nursing staff, were included in "Group Number Three". Receiving their diplomas from Sanatorium Board executive director T. A. J. Cummings, and their badges from Miss E. G. Coull, director of nursing, were: Miss Sylvia Baron, Mrs. Winnifred Belle, Miss Simone Breard, Mrs. Wilma Erbach, Mrs. Herta Roloff and Steve Kertai.

Association Requires

ASSISTANT TO THE NATIONAL DIRECTOR OF THE CHRISTMAS SEAL CAMPAIGN

Location: Canadian Tuberculosis Association, Ottawa.

Qualifications: University graduate with experience in community health organization and business training. A knowledge of French is necessary.

Duties: To work on all aspects of the Christmas Seal Campaign in Canada. Opportunity for early promotion.

Salary: \$4800 per annum to commence; pension plan.

Applications and inquiries to: Dr. C. W. L. Jeanes, Executive Secretary, Canadian Tuberculosis Association, 343 O'Connor Street, Ottawa 4, Ontario.



Recent graduates from the Nurses' Assistants Training Program at the Manitoba Rehabilitation Hospital, Winnipeg, and Clearwater Lake Hospital, The Pas, are pictured with their teachers. In the left photo are the M.R.H. nurses' assistants and orderlies who graduated on July 26: Back row, left to right—Miss V. Peacock, day supervisor, Miss Sylvia Baron, Steve Kertai, and Miss M. R. Pemberton-Smith, nursing instructor. Front row: Mrs. Winnifred Belle, Miss Simone Breard, Mrs. Wilma Erbach and Mrs. Herta Roloff. Clearwater



Lake Hospital graduates on June 11 were: Front row—Miss Mary Tomchuk, Miss Jacqueline Savoie, Mrs. Shirley Tingate and Mrs. Olga Mallock. Second row—Miss Elizabeth Motkaluk, Sidney Castel and Miss Leona Genaille. In the background are Director of Nursing Miss V. Appleby, Mrs. Wilma Raynor, day supervisor, and Miss E. L. M. Thorpe, nursing consultant for the Sanatorium Board.

Manitoba Sanatorium; Mrs. Vera M. Myers, Assiniboine Hospital; Mrs. Doris Smith and Mrs. Mary E. Swaffield, Manitoba Rehabilitation Hospital.

* * *

The Sanatorium Board extends warmest congratulations to Miss E. G. Coull, director of nursing at a rehabilitation hospital, who will receive her bachelor's degree in nursing (B.Sc.) at the fall convocation of the University of Ottawa.

Our heartiest congratulations also to Dr. and Mrs. S. L. Carey of Clearwater Lake Hospital, who on Sunday, July 28, announced the arrival of their fifth child, first daughter—Joanne.

* * *

Mr. R. L. Bailey and Mr. J. F. Baldner, members of the Sanatorium Board, accompanied our executive director T. A. J. Cummings, on a tour of inspection of Clearwater Lake Hospital, August 7.

* * *

With deep regret we report the death July 1 of William Edward Jones, former patient at Manitoba Sanatorium and a former member of the cafeteria staff at the Manitoba Rehabilitation Hospital. Mr. Jones died unexpectedly in Calgary after a brief illness.