NEWS BULLETIN

The Sanatorium Board of Manitoba

VOL. 11, NO. 8 PUBLISHED BY THE SANATORIUM BOARD OF MANITOBA, WINNIPEG OCTOBER - NOVEMBER, 1970

CHRISTMAS SEAL TARGET

Bronchitis - Fastest Growing Cause of Disability

Chronic obstructive lung diseases — chiefly bronchitis and emphysema — are the fastest growing cause of death and disability in Canada today.

This is the warning that goes out across the country this month as provincial tuberculosis and respiratory disease associations launch the 1970 Christmas Seal Campaign against this tremendous health problem.

In Manitoba — even with its relatively pollution-free air — special surveys are turning up evidence of bronchitis in epidemic proportions.

Over the past two years these surveys — conducted jointly by the University of Manitoba and the Christmas Seal Service of the Sanatorium Board of Manitoba — have studied ventilatory function and respiratory symptoms in 35,000 Manitobans, who live in many different parts of the province and range in age from 18 to 85.

Symptoms of bronchitis (chronic cough and sputum) were reported by 10 to 15 percent of the group. Other symptoms — wheezing and varying degrees of breathlessness — were reported by about 25 percent.

Once again cigarette smoking was implicated as the chief influencing factor.

Approximately one-half of the 35,000 people studied were smokers or ex-smokers. The prevalence of cough, phlegm, breathlessness and wheezing was highest in the cigarette smokers — and for a given severity of these symptoms, the disturbance in breathing was worse in smokers and ex-smokers than in people who had never smoked.

When compared to current smokers, ex-smokers showed a fewer number of symptoms (cough, sputum, etc.) . . . but at the same time it was discovered that the *ex-smoker's ability to get air in and out of his lungs was affected almost as much as it was in current smokers.*

The amount of disturbance seems to be related to the amount of tobacco consumed, said Dr. R. M. Cherniack, medical director of the SBM Tuber-

Nurses Learn About Respiratory Disease Care

"Bronchitis used to be a dirty word in medicine," a Winnipeg chest physician told nurses attending a Postgraduate Course in Respiratory Disease Care at the Manitoba Rehabilitation Hospital - D. A. Stewart Centre

last month.

Not so long ago, he explained, bronchitis was considered unimportant. Very little was known about it (it was not linked with cigarette smoking), and so medical students were "not allowed to mention it".

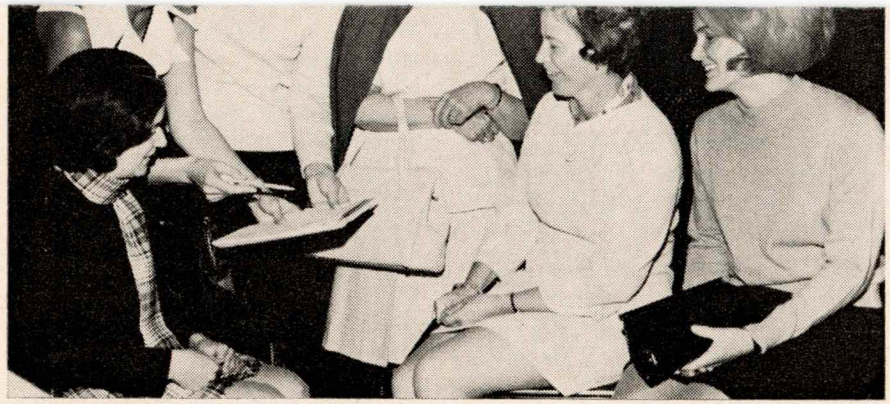
Today, however, with the recognition of bronchitis as a major and increasing health problem, the understanding of this disease, its prevention and treatment, has become tremendously important.

Nursing has especially asked for more information on bronchitis and other obstructive airway disease — and as one step towards meeting its request, this intensive two-week course —from September 28 to October 9— was organized by the Sanatorium Board of Manitoba for the Canadian Tuberculosis and Respiratory Disease Association.

Some 30 directors of nursing, nursing supervisors and public health nurses attended the sessions — and members of the University of Manitoba Faculty of Medicine presented most of the lectures, which covered nearly all aspects of respiratory disease care, including the principles behind treatment.

Special out-of-town speakers were Miss Ruth Barstow, noted clinical nurse specialist in respiratory diseases at the Veterans' Administration Hospital, Livermore, California, and Miss Lorette Morel, health education and nursing consultant for the Canadian Tuberculosis and Respiratory Disease Association in Ottawa.

Miss Barstow devoted nearly two full days to lectures on the nursing care of acute and chronic respiratory disease, and on the rehabilitation of the patient with obstructive airway disease. Although chronic bronchitis and emphysema cannot be cured, a great deal can be done to relieve symptoms, prevent progression, and help the patient live more comfortably with his disease, she emphasized.



Nurses exchange views during a break between sessions of the Postgraduate Course in Respiratory Disease Care, held in Winnipeg September 28 to October 9. From left to right are: Miss Lorette Morel, newly appointed health education and nursing consultant for the Canadian Tuberculosis and Respiratory Disease Association, Ottawa; Mrs. Marjorie Wright, assistant director of nursing, Aberhart Memorial Sanatorium, Edmonton; Miss Emma Nemetz, medical-surgical supervisor, Charles Camsell Hospital, Edmonton; Mrs. Ida Casper, nursing instructor, Baker Memorial Sanatorium, Edmonton; Mrs. Christina Mikoski, teacher, Lakehead Regional Hospital School of Nursing, Thunder Bay; and Miss Marie Bryndzak, charge nurse, pulmonary unit, University of Alberta Hospital, Edmonton. *(Photo by David Portigal)*

In general, symptoms are relieved by removing such irritants as cigarette smoking, reducing the production of secretions through the elimination of infection or other irritants and adequate drainage, opening the airway passages by such means as broncho-dilating drugs, physiotherapy and breathing aids, and improving the patient's exercise tolerance and physical condition.

Teaching the patient to control difficult breathing is an important part of treatment, Miss Barstow said — and the nurse, in order to teach,

(Continued on Page 4)

culosis and Respiratory Disease Service. "It has been suggested that once obvious bronchitis is present, it is irreversible.

"However, it is not known whether even minimal tobacco consumption causes some irreversible damage . . . or a certain amount must be consumed before damage occurs.

"It is also not known whether the duration of smoking is a critical factor."

The important fact is that bronchitis is a very common, very serious and very expensive disease. Deaths from both bronchitis and emphysema have been doubling every five years — rising to about 2,500 in Canada in 1968 and probably over 3,000 last year. The cost of hospital treatment days for these diseases was estimated to be at least $45 million in 1968. And on a broader scale, in terms of economic and social hardship, bronchitis alone accounts for a loss of at least 100 million productive hours in North America each year.

To do something about the problem is indeed an ambitious project for Christmas Seals.

Address all communications to:
THE EDITOR, SBM NEWS BULLETIN
800 Sherbrook Street, Winnipeg 2, Manitoba
Second Class Mail Registration Number 0324.

The Work of Christmas Seals

USE CHRISTMAS SEALS . . . and help the Sanatorium Board of Manitoba fight tuberculosis, bronchitis and other crippling respiratory disease.

This message is fairly familiar to most Manitobans at campaign time. But — although we try very hard to explain in the same breath the general work of Christmas Seals — we are nevertheless often asked: *How do Christmas Seals fight respiratory disease?*

So here, briefly, are the various programs that your Christmas Seal contribution supports. All are related in some way to the prevention or minimization of disease.

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EARLY DETECTION AND PREVENTION — In a society that puts great stress on the preservation of health — but at the same time allots only about 2½ percent of the total health budget for primary prevention — Christmas Seals are taking on a big job indeed in trying to cope with the prevention and control of a very large health problem. The task becomes even more difficult when the funds raised by Christmas Seals remain about the same each year — while costs of administering the programs spiral upwards.

Nevertheless, province-wide preventive programs continue to be conducted by the Sanatorium Board, and the *greatest percentage of your contribution* is spent on: Community and industrial surveys to discover chest disease at the earliest possible stage . . . tuberculin skin tests, BCG vaccinations and drug prophylaxis, as well as chest x-ray surveys, to control tuberculosis.

With respect to tuberculosis control, Christmas Seal-financed surveys used to cover the entire province every five years. This is no longer financially possible, or practical. Most of the surveys today are provided in those areas where tuberculosis is a significant problem . . . or where continuing measures are necessary for the protection of other people.

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RESEARCH — Research is an important arm of prevention. For example, a Winnipeg physician said recently, "Bronchitis is so common — yet we know

Warning Signals of Bronchitis

Are you bothered by a persistent morning cough for as much as three months during the year?

Do you usually bring up phlegm from your chest first thing on awakening . . . and perhaps at other times during the day?

Does cold or humid air . . . or smoking . . . induce you to cough?

People with these symptoms may presume they are in good health, chest physicians at the D. A. Stewart Centre in Winnipeg say. But the fact is that chronic cough and sputum production, and even the "cigarette cough" are warning signals that may indicate impending respiratory disability.

The greatest tragedy with diseases like bronchitis is that the symptoms are undramatic and insidious in the early stage. People tend to shrug them off as "only a cigarette cough" or as an irritating shortness of breath . . . due to inadequate exercise.

Too often, by the time they are aware of a serious problem, they are already respiratory cripples. It is said that almost one-third of all cases of chronic bronchitis are not diagnosed until the patient becomes sick enough to enter hospital.

The D. A. Stewart Centre doctors list the following warning signals that people, who presume they are in good health, should heed:

1. Coughing induced by the inhalation of tobacco smoke.

2. Coughing induced by being in a dusty atmosphere, which does not affect other individuals.

3. Coughing induced by either cold, frosty or humid air.

4. A persistent, or recurring, morning cough with sputum production for a total period of three or more months in one year, which may, or may not, be associated with wheezing.

5. Frequent episodes of acute lower respiratory infections during the year.

6. The development of breathlessness while carrying out a type of activity which the individual had previously been able to perform with ease . . . and a tendency to avoid this activity.

7. The presence of breathlessness and wheezing during an episode of an acute respiratory infection.

New National President

"If more money could be spent on research to learn more about the natural history of bronchitis, all the factors that influence the disease could be discovered. Then by early detection and removal of these factors, the rapidly rising incidence would undoubtedly be brought under control."

Each year each provincial tuberculosis and respiratory disease association allocates a percentage of Christmas Seal funds for research and scholarship grants. Most of this money is sent to the Canadian Tuberculosis and Respiratory Disease Association for distribution on a nation-wide basis.

In 1970 the total grants made by the CTRDA and its constituents to the research and fellowship program will amount to $325,000. Of this amount, $23,000 is being spent in Manitoba on basic research in the respiratory field.

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EDUCATION — As part of prevention, special programs are needed to educate both the general public and the professions about tuberculosis and the need for everyone to take a hand in control. Education is also important in the field of other chronic respiratory disease — particularly with respect to the dangers of smoking and air pollution. Throughout the year there is a steady flow of information from the Sanatorium Board to school children, teachers, doctors, nurses, patients and the public in general. The pamphlets, booklets and posters that we distribute are paid for by Christmas Seal funds.

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NATIONAL AND INTERNATIONAL ASSISTANCE — Whether you look at it from a humanitarian point of view — or in these days of stepped up travel, from the safety angle — tuberculosis is a communicable disease which must be fought on a world-wide basis. And we believe that it is the duty of nations that lead the way in tuberculosis control to share their experience and, to some extent, their money to help those countries where tuberculosis is still a leading killer. A small portion of Christmas Seal funds raised in Manitoba helps our national association to fulfill its commitments to the International Union Against Tuberculosis. Several projects in such countries as Malaysia and West Africa have been sponsored by the CTRDA through the IUAT. In other countries, such as VietNam, the CTRDA helps out by providing medical direction and advice.

In the past 10 years, over one quarter of a million dollars has been donated by national and provincial associations to the international program.

Finally, a percentage of Christmas Seal money goes to the support of the Canadian Tuberculosis and Respiratory Disease Association, which brings national direction to the Christmas Seal fight against tuberculosis and other respiratory disease.

Department of Communication Disorders at the Manitoba Rehabilitation Hospital, stepped up to the presidency of the Canadian Speech and Hearing Association at the 1970 joint convention of the CSHA and the Speech and Hearing Association of Alberta.

The meeting, held at the Chateau Lacombe in Edmonton October 22 to 24, was attended by about 120 delegates from nine Canadian provinces.

Mr. Person, who holds a Master's Degree in speech pathology and clinical audiology, has been a member of the CSHA from the time he moved to Winnipeg from the University of Indiana in 1967. He was elected vice-president of the association one year ago.

The major work of the association in the year ahead, says Mr. Person, will be to strengthen its internal organization and maintain a close link with members across Canada.

The association and its constituents will also continue to push for adequate Canadian training programs in speech pathology and audiology.

So far, McGill University has the only long-standing training programs. Fledgling programs are now being developed in British Columbia, Ontario and Alberta — but these (especially in Alberta) are hardly able to cope with enrollments from their own provinces.

In Manitoba a committee for a training program was formed eight years ago, but according to Mr. Person, "we've not made one step forward".

For some years, he predicts, Manitoba will likely look to Britain and

J. B. PERSON

south of the border both for training and staff recruitment.

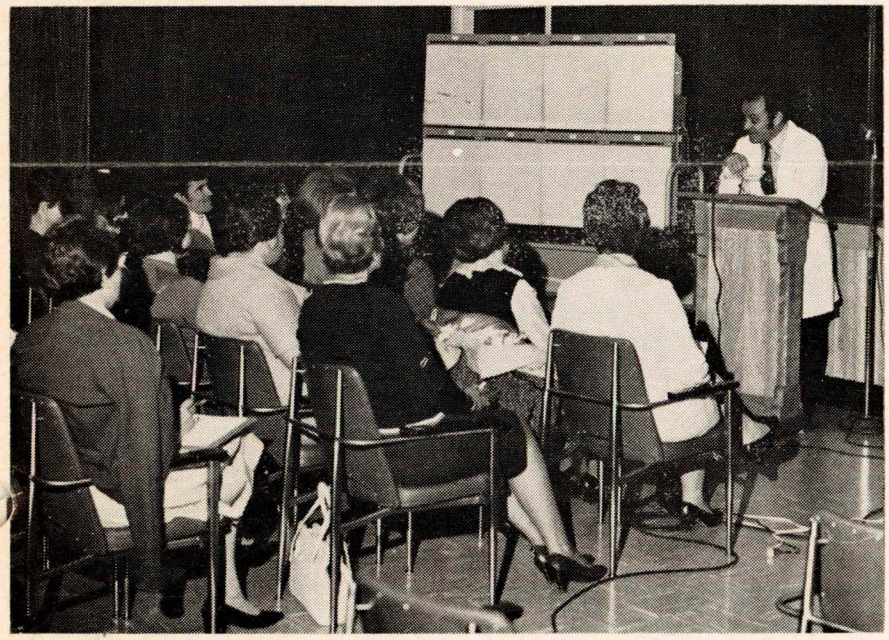
Other members of the 1971 CSHA executive are: John Dudley, McGill, past-president; Gordon Zard, Edmonton, vice-president; Miss Germaine Huot, Sherbrooke, secretary; Mrs. Elizabeth McGill, Dartmouth, treasurer.

The scientific sessions at the meeting included two short courses: the social psychology of stuttering, presented by Dr. Joseph Sheehan, professor of psychology at the University of California at Los Angeles, and recent developments in the calibration of bone conduction oscillators, presented by Dr. G. Studebaker, associate professor, University of Oklahoma Medical Centre, and chaired by Mr. Person.

How Infectious Is Tuberculosis?

Tuberculosis is an infectious disease . . . but it is not very contagious, Dr. E. S. Hershfield told nurses attending a Postgraduate Course on Respiratory Disease Care at the Manitoba Rehabilitation Hospital - D. A. Stewart Centre last month.

Dr. Hershfield, who is associate medical director of the D. A. Stewart Centre, explained that tuberculosis is not considered particularly contagious because in the first place, it requires long exposure to a massive number of tubercle bacilli to contract disease; and secondly, contagiousness in bacillary cases drops off rapidly after two weeks of drug treatment.



Dr. E. S. Hershfield, associate medical director of the Tuberculosis and Respiratory Disease Service of the Sanatorium Board, talks about modern treatment of tuberculosis to 28 nurses from different parts of Canada. *(Photo by David Portigal)*

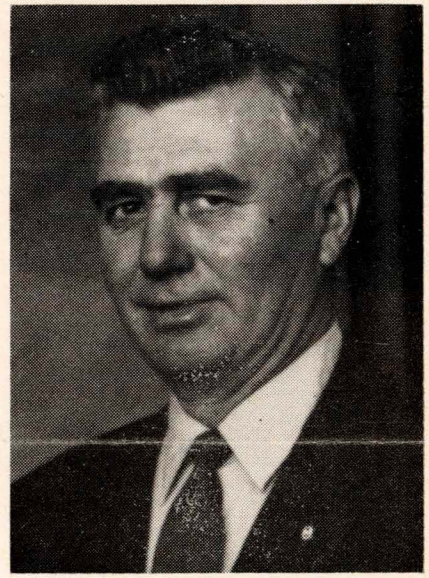
TB is "not a bad disease", he said. It is not spread by pencils, books, clothing and the like. It is picked up by breathing the germs into the lungs in tiny drops of moisture (droplet nuclei), which are sneezed or coughed into the air by someone with active, bacillary disease.

Even then, only those particles that are less than five microns in size are able to penetrate into the lungs. Larger particles are trapped in the nasal and upper respiratory passages.

Tubercle bacilli outside the human body are readily killed by heat, drying, sunshine and ultraviolet light. In the patient who receives adequate chemotherapy, the excretion of bacilli is usually halted within a few weeks. Prior to this, transmission of infection is effectively broken when patients take the precaution to cover the nose and mouth when sneezing, coughing, raising sputum, laughing, etc.

This knowledge about the infectiousness of tuberculosis has greatly influenced the modern treatment of tuberculosis. Isolation is no longer considered important. Once the acute phase of illness has passed, patients can benefit from the same rehabilitation programs as any other patients with a chest disease; and they can receive this treatment in a general hospital setting where the most modern facilities and techniques are available.

Board Member



J. N. (JACK) COOK

The Sanatorium Board of Manitoba welcomed a new Board member this month.

He is J. N. "Jack" Cook, who succeeds William Paton as the Associated Canadian Travellers (Brandon Club) representative on our Board.

Mr. Cook has been a member of the Brandon A.C.T. since 1954, and as a director, vice-president and president, he has been deeply involved in this organization's support of Sanatorium Board health services in Southwestern Manitoba. For the past three years, he has also served as parade marshal for the Travellers'

Rehabilitation Begins With Diagnosis

Exercise strengthens; inactivity wastes.

This Hippocratic message to Greek physicians 2,000 years ago survives today as a basic precept of medicine — and according to Dr. Frederick K. Kottke, head of the University of Minnesota Department of Physical Medicine and Rehabilitation, it especially holds true in the management of stroke.

In an address to Manitoba Rehabilitation Hospital personnel and the Manitoba College of Family Physicians in the MRH auditorium October 15, Dr. Kottke urged physicians to begin rehabilitative measures — or at least plan them — as soon as the diagnosis is made.

Many disabilities in hemiplegic patients are secondary problems that arise out of delayed treatment, he said. With prolonged inactivity, patients not only suffer a rapid loss of mobility, muscle strength and endurance, but they also face such other problems as circulatory deterioration, metabolic imbalance, urinary tract dysfunction, respiratory complications, and intellectual and emotional disorientation.

On the other hand, when patients receive early intensive rehabilitation, about 95 percent become independent, and in most uncomplicated cases, they achieve self-sufficiency in four to seven weeks.

Between 90 and 95 percent will walk again, Dr. Kottke said. Around one-third will regain full use of the upper extremity, and another third will attain some improvement.

The physician must be prepared to deal with a multiplicity of problems in treating stroke, he stressed. The ability to walk again is no measure of recovery from hemiplegia. The goal is to return the patient to his previous status.

Dr. Kottke was named this year's visiting professor in physical medicine by the Canadian Association of Physical Medicine and Rehabilitation. He has been honored with the Distinguished Service Key from the American Congress for Physical Medicine and has a President's Citation for his work on the employment of the physically handicapped.

During his brief visit to Winnipeg, he also delivered a lecture on the *Clinical Evaluation and Management*

(Continued on Page 4)

most adult tuberculosis arises from an old infection, perhaps picked up by the individual many years ago. That is, the patient usually infects himself from within; he does not develop disease as a direct result of exposure to an active, bacillary case.

This "new" thinking about the way adult disease develops is having a subtle effect on preventive programs, he said. Health workers are more interested now in examining the contacts who may have picked up infection from a newly diagnosed adult patient, than in looking around for "the source" of infection.

the A.C.T. and the United Commercial Travellers.

Mr. Cook was born and educated in Miniota, Manitoba, and during the Second World War served with the Royal Canadian Navy. After the war he served for a short time with the Winnipeg Police Force, then joined a Winnipeg farm equipment firm as territory manager. In 1951 he was transferred to Brandon, and in 1956 he joined Modern Machines Limited, of which he is now a director and part owner.

Continued on Page 4

HONOR ROLL OF CONTRIBUTORS

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

Estate of the late Frank Deeley	$ 520.61
Estate of the late Duke Bryson (a further bequest)	144.44
Granada Investments Ltd.	1,000.00
Pharmaceuticals Division, Geigy (Canada) Ltd.	3,500.00
John Rickard Clements Memorial Fund (through The Winnipeg Foundation)	25.00
Grand Chapter of Manitoba, Order of the Eastern Star, *in memory of the late Mrs. Christine Piper, former Worthy Grand Matron, and the late John McClure, former Worthy Grand Patron*	50.00

The Sanatorium Board also expresses appreciation to the many people who have recently contributed to our Respiratory Disease Research and Education Fund and to the Manitoba Rehabilitation Hospital Research Fund. These contributions were made in honor of the late Jack A. George, the late Charles Rosner, the late Mrs. Cecil (Faith) Leckie, the late W. A. Graham, the late Isaac B. Griffiths, the late F. E. Umphrey, and the late Jack Chernick.

Teaches "System" to Scots

In mid-October James Foort completed a three-month visit to Scotland, and returned to his post as technical director of the Sanatorium Board's Prosthetics and Orthotics Research and Development Unit.

Mr. Foort, who led the team of engineers who developed the Winnipeg modular system of lower limb prostheses, primarily undertook this special visit to teach Scottish prosthetists limb-fitting techniques developed in Winnipeg. Scottish reaction, he reports, was favorable to both the modular system and the courses — and he adds, somewhat gleefully, that prosthetics researchers in Dundee, Glasgow, Edinburgh and Winnipeg will henceforth maintain a close link with each other's work.

While Mr. Foort found some time to acquaint himself with national customs (see photo), his sojourn in Scotland mostly amounted to hard work.

The visit began on July 15 with a week or so of planning one-week teaching courses and special research for the times in between. Then the first course was held for eight prosthetists, plus "a couple of engineers and some doctors as observers", at the University of Strathclyde in Glasgow.

The next week, Mr. Foort repeated the course for six other prosthetists (and some engineers and doctors) at the Dundee Limb-fitting Centre.

After that there was another week fitting. Before returning to Winnipeg on October 13, he also conferred with London researchers and designers about the English modular system of lower limb prostheses.

JAMES FOORT

How does the English system compare with Winnipeg's? Mr. Foort is reluctant to say.

Nursing Course

Continued from Page 1

should know how to breathe that way herself.

Nursing care, she added, should be as simple as possible. The prime responsibility of the nurse is to teach the patient to care for himself, to retrain and rebuild. "Don't baby the patient," she advised. "Sit with him, teach him to be independent, get him inwardly motivated to live comfortably with his condition.

"The COLD fact is that patients with chronic obstructive airway disease need a tremendous amount of nursing and family support — simply because it is the nurse and the family who spend the most time with the patient."

* * *

Home care programs for COLD patients were discussed by Dr. R. M. Cherniack, professor of medicine at the University of Manitoba, and Miss Edith Svanhill, nursing coordinator of the Home Care Program at the Winnipeg General Hospital.

"We as physicians have failed over the past decade because we have not stressed intensive care in the home," said Dr. Cherniack.

"The future of intensive care is diligent intensive care at home. I'd like to see nurses look after the patients so that they don't ever get inside an intensive care unit in the

BULLETIN BOARD

The Sanatorium Board warmly welcomes Dr. Shirley E. Parker, Dr. Carl T. Zylak and Dr. Robert Martin to the medical organization of the Manitoba Rehabilitation Hospital - D. A. Stewart Centre.

In recent weeks Dr. Parker has assumed the position of assistant director of medical microbiology at the MRH - DASC; Dr. Zylak has succeeded Dr. M. K. Kiernan as chief radiologist; and Dr. Martin has been appointed chief psychologist.

The three also hold appointments with the University of Manitoba. Dr. Parker is associate professor, Clinical Microbiology; Dr. Zylak is assistant professor, Department of Radiology; and Dr. Martin is chief psychologist and associate professor, Department of Psychiatry.

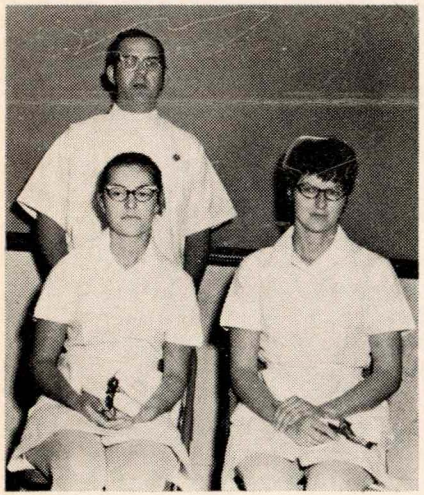
* * *

Recent additions to the active medical staff of the D. A. Stewart Centre are Dr. Donal McCarthy (respiratory diseases and immunology) and Dr. Kam S. Tse (allergy and immunology). Dr. McCarthy, who is Irish, is an assistant professor of medicine, University of Manitoba, and Dr. Tse is assistant professor of medicine

amputee locomotion; then on to the Princess Margaret Rose Hospital in Edinburgh for a third course on Winnipeg techniques. In Edinburgh Mr. Foort also took part in a teaching clinic for physicians, prosthetists and therapists, and "made orthopaedic rounds" in the hospital to demonstrate the Winnipeg system (on amputees) for residents.

By September, Mr. Foort was back in Glasgow doing further research on "amputee locomotion" and picking up information on 3-D shape sensing and processing for a special Winnipeg project, which, if completed, will eliminate the guesswork in prosthetics

Ninette Graduates



On October 26 Miss Caroline Peter, seated left, and Miss Jessie Myers successfully completed the Nurses' Assistants Training Program at Manitoba Sanatorium. The new graduates, who represent Class No. 27, are pictured here with the Director of Nursing, William Broadhead.

—Photo by Bill Amos.

[illegible] above-knee and below-knee units were shipped off to Scotland for research, education and evaluation programs.

WINS AWARD

Dr. Victor Chernick, consultant in pediatrics to the D. A. Stewart Centre, was the recipient of the Canadian Pediatric Society medal for a paper on "Interaction of Arterial Pco2 and Po2 in the Initiation of Respiration of Fetal Sheep". The award winning paper — entered in a cross-Canada competition — was written by Dr. Chernick, with Dr. R. Pagtakan and Dr. E. Faridy as co-authors.

REHABILITATION

(Continued from Page 3)

of Cervical Spondylosis to third and fourth year medical students at the University of Manitoba, and he toured the wards and treatment departments at the Manitoba Rehabilitation Hospital.

Following the tour, Dr. Kottke exchanged views with staff physicians and therapists on the care of paraplegic patients. Here again, it was agreed, rehabilitation should begin "on the first day."

New Board Member

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Mr. Cook is married, has two daughters and a son. He maintains an active interest in athletics, and in addition to his work with the A.C.T., he is a member of the Royal Canadian Legion and the Army, Navy and Air Force Veterans.

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Miss Svanhill outlined the home care measures provided by WGH and the roles of the medical and paramedical personnel involved. Over 200 people now receive this care daily, she said. Of these about 50 percent have chronic respiratory disease, and about 20 percent live in rural areas.

The home care program, begun in Winnipeg in 1958, is just the beginning of a whole new field of health care, which in time will be broadened to prevention, Miss Svanhill felt. Health workers have learned that "home is where most patients really want to be", that home care means "a return to the community as a functioning individunal".

In the past, she concluded, vast sums of money have been spent on acute hospital care. Home care programs, such as the intensive one operated out of WGH, reduces costs to about $1.50 per patient per day.

* * *

In all, 25 guest lecturers took part in the course. The subjects covered included the needs of the respiratory patient in an intensive care setting, the special needs of children, respiratory viruses, allergic and hypersensitivity lung diseases, occupational hazards and the social aspects of illness. There were also demonstrations on postural drainage, inhalation therapy, and physiotherapy for respiratory patients.

The course was the first to be presented by the Sanatorium Board and CTRDA. Hopefully, said the course chairman, Miss E. L. M. Thorpe, it is the beginning of a regular annual event.

* * *

Miss Jean Colburn, chief occupational therapist at the Manitoba Rehabilitation Hospital - D. A. Stewart Centre, and Mrs. Heather Birtles, assistant chief, attended the annual congress of the Canadian Association of Occupational Therapists in Kingston, October 26 to 30.

* * *

Graham Ball has received his M.Sc. on his project, "Determination of Sensory Conduction Velocities", which was funded by the Manitoba Rehabilitation Research Fund. He has been accepted as a Ph.D. candidate at McGill University and will be working at the Montreal Neurological Institute.

Dr. M. G. Saunders, MRH consultant in electrophysiology, was chairman of the Medical Sector of the Association for Computing Machinery meeting in New York in September. The meeting was called the "unconventional convention", since experts in 16 different areas discussed the impact of computers in their different fields of use.

Dr. Saunders was also chairman and a panelist at the Second Canadian Conference of Biological and Medical Engineering in Halifax.

* * *

A recent visitor to the MRH was Dr. John Weston, a talented radiologist from Wellington, New Zealand. His visit especially benefited those involved in our arthritis program, as Dr. Weston's primary interest lies in joint and muscle radiology in arthritis.