NEWS BULLETIN

The Sanatorium Board of Manitoba

VOL. II, NO. 7 PUBLISHED BY THE SANATORIUM BOARD OF MANITOBA, WINNIPEG SEPTEMBER, 1970

Miss Peacock Concludes Outstanding Nursing Career

Miss Vera R. Peacock quietly concluded 36 years of nursing service on August 28 when she retired as assistant director of nursing at the Manitoba Rehabilitation Hospital - D.A. Stewart Centre.

At an informal reception in the hospital lounge, staff members of every department extended fond wishes to this capable, warm-hearted woman, who has served on our senior staff for the past eight years, and throughout her career has made many fine contributions to nursing education and health care.

Miss Peacock — who was born at Dauphin, Manitoba, and raised in Craigmyle, Alberta — was a school teacher in rural Alberta before she turned to nursing in the 1930's. She graduated (with a gold medal) from the St. Boniface Hospital School of Nursing in 1934, worked for two years as head nurse and nursing instructor at the St. Boniface Sanatorium, then in 1936 joined the newly organized Indian Health Services as a school and reserve nurse at the remote outpost of Lac la

decision to change to a less hazardous job.

In the early 1940's, Miss Peacock returned to St. Boniface Sanatorium to establish a training program for practical nurses. Soon after, she moved with this licensing program into separate quarters in St. Boniface; then in 1949 she joined the Department of Health and Public Welfare as an instructor at the Central School for Practical Nurses in Winnipeg. In 1951 she took a post-graduate course in teaching and supervision at the University of Manitoba, and two years later she was appointed science instructor at the St. Boniface Hospital School of Nursing.

Miss Peacock became day supervisor at the Manitoba Rehabilitation Hospital in August, 1962. She moved up to assistant director of nursing a few years later, and from 1967

New TB Cases Up This Year

A total of 164 new active cases of tuberculosis was reported in Manitoba during the first eight months of the year.

The number, according to the Central Tuberculosis Registry, is up a few cases from the previous year.

The recent discovery of tuberculous meningitis in two children from Ebb and Flow has resulted in the intensive anti-tuberculosis efforts in this area.

The Dauphin Health Unit and the medical services staff of the Department of Indian Affairs are conducting tuberculin skin tests of all age groups, administering BCG vaccine to those who have not yet been in contact with the tubercle bacillus, and providing intensive follow-up of

radio to summon outside assistance, she worked a 16-hour day, attending as best she could to the assorted health problems of old and young, travelling thousands of miles by canoe, plane and dog sled, always having to accept the most primitive conditions. The inevitable result — four years later — was a breakdown of her own health and the necessary

MISS V. R. PEACOCK

served as acting director of nursing.

Miss Peacock has always been popular with both patients and staff — well known and respected for her high nursing ideals. She will be missed by everyone.

Staff Members Prepare For A Busy Fall

With the first brisk winds of September and the first snows about a month (we hope not less) away, the Sanatorium Board staff is fairly bursting with new vigour and big plans in the areas of treatment and education. Volunteers, patients and former patients are also busy — drawing up a social and recreational program that has some of the aspects of a community club calendar.

Two major events in the very near future are a *Seminar on Respiratory Disease Nursing*, which the Sanatorium Board is arranging for the Canadian Tuberculosis and Respiratory Disease Association, and the *Centennial Symposium on Orthopaedic Disabilities and Rehabilitation*, to be held October 1, 2 and 3 at the Winnipeg General Hospital Nurses' Residence.

The nursing seminar at the Manitoba Rehabilitation Hospital - D. A. Stewart Centre is the first to be offered by the SBM and CTRDA, and the sessions from 8:30 a.m. to 4 p.m. will cover all aspects of the nurse's role in the treatment and prevention of acute and chronic respiratory disease. Some 35 registered nurses are attending the course, about 15 of whom are from other parts of Canada. The entire group includes public health nurses, nursing co-ordinators, instructors, supervisors, directors of nursing and nurses in charge of intensive care units from such centres as Montreal, Hamilton, Ottawa, Calgary, Edmonton, Thunder Bay, Sioux Lookout, St. John's in Newfoundland, Manitowaning, Ontario, Sept-Iles on the coast of Quebec, and, of course, Winnipeg.

The rehabilitation symposium, which hopefully will attract a good turn-out of physicians and paramedical personnel, is being sponsored by four agencies (including the SBM) and will deal with surgery of the hand. Distinguished speakers from Glasgow, New York, California and Michigan will lecture on such topics as burns of the hand, mutilating injuries, amputations, wounds, arthroplasties of the hand, and peripheral nerve injuries.

★ ★ ★

The weekly *Chest Conferences*, which continued throughout most of the summer, are back into full swing with a new list of topics and a large attendance. About 75 chest physicians, residents, students, nurses and therapists are now attending these sessions in the Manitoba Rehabilitation Hospital - D. A. Stewart Centre each Wednesday noon. The program, arranged by Dr. E. S. Hershfield, presents such intriguing problem cases as pulmonary complication of acute pancreatitis, histoplasmosis, mushroom worker's disease, farmer's lung, pigeon breeder's disease, and aspergillosis.

The D. A. Stewart Centre also holds less formal chest conferences in the second floor conference room at 3:15 p.m. Fridays.

★ ★ ★

The 15th *Postgraduate Course in Rehabilitation Nursing* gets under way at the Manitoba Rehabilitation Hospital on October 19. The day-long sessions, continuing until November 9, includes lectures by physicians and senior personnel involved in the rehabilitation of the physically disabled, plus classroom demonstrations and observation in the treatment departments.

(Continued on Page 4)

The Preventive Health Services of the Sanatorium Board will also join the screening program next month by providing chest x-ray examinations of all residents. Between October 8 and 20, the Christmas Seal mobile unit will visit reserves at Ebb and Flow, Crane River, Skownan and Valley River.

As part of the year's normal survey operations, x-ray examinations will be provided to residents of Birdtail Sioux, Oak Lake and Oak River Reserves during the early part of October.

Also next month, the Board's surveys team will begin the annual round of Manitoba's college campuses. On September 21, chest x-ray examinations were offered to students and staff at the Red River Community College.

After that, the surveys teams will provide tuberculin skin tests and chest x-rays to students and faculty of Brandon University, University of Manitoba, University of Winnipeg and St. Boniface College.

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

Club Will Help Laryngectomees

It's 90 percent "your own battle" to adjust to surgical removal of the voice box, a Winnipeg railway foreman told a meeting of 50 health workers and laryngectomy patients at the Manitoba Rehabilitation Hospital on September 16.

But laryngectomees banded together as a Lost Cord Club, he felt, could be helpful to others facing this ordeal by offering practical advice and encouragement and demonstrating that there are a number of excellent ways to speak again.

Stanley Luby, who had his larynx removed a year ago, was one of several guest speakers at the organizational meeting of the Lost Cord Club of Winnipeg. He used esophageal speech to tell the audience about his adjustment to the operation.

As demonstrated by Mr. Luby and others at the meeting, esophageal speech provides a fluent, easy to understand means of communication. It is accomplished by swallowing air into the upper esophagus, and immediately forcing it back. As the air passes the narrow throat muscles, it is made to pulsate, producing a sound similar to that of a vowel. Then in normal fashion, the tongue, teeth and lips are used to shape the sound into words.

Mr. Steve Kurceba, another guest speaker, said he threw away his note pads when he began instruction in esophageal speech six years ago some way to *speak* — because, from his observations, they are gregarious people who love to talk.

Ten laryngectomy patients, accompanied by their families, attended this first meeting of the Lost Cord Club, and it is hoped that many of the several score other laryngectomees in the province will attend the next meeting at the Manitoba Rehabilitation Hospital at 8:30 p.m. on September 30.

Lost Cord Clubs now flourish in many other parts of North America and Europe, and together they form the International Association of Laryngectomees.

Until the Winnipeg club is formally established, Mr. Luby is serving as acting president, and Miss Winnifred Dickinson, of the MRH Department of Communication Disorders, is acting secretary. Advisors are speech clinician Mrs. Marijke Vogel, speech pathologist and audiologist Stephen Foster, and J. B. Person, director of the Department of Communication Disorders, who also chaired this first meeting.

OUR GIFT SHOP

The Gift Shop at the Manitoba Rehabilitation Hospital-D. A. Stewart Centre will soon be bulging with a delightful variety of cards and gift

SOCIAL SERVICES: Sup

She believed in me. After a while I began to believe her . . . and life seemed worth living again.

In these simple words, a retired businessman explained how he triumphed over alcoholism and stroke. The many deep-rooted problems of John X are not exactly representative of those of most patients admitted to the Manitoba Rehabilitation Hospital - D. A. Stewart Centre; nevertheless the story of his rehabilitation serves as a good illustration of the contributions of Social Service to total patient care.

"I wish people would stop thinking of the social worker as the person who hands over the money," said Director of Social Services Mrs. Mary Johnston in a recent interview. Primarily, she intimated, the social worker is a counsellor and arranger — perhaps a bit of the psychotherapist — who emphasizes the worth of the individual, helps him to come to terms with his disability, assists with his re-establishment in the community, and interprets his needs to others concerned with his welfare.

Money hardly entered the problems of John X. The biggest obstacles to his rehabilitation centred on his drinking and family alienation — and the social worker on the hemiplegic ward made a tremendous effort over a two-month period to persuade him to do something about his personal life and become a willing partner in treatment.

Mr. X, who not long ago had lost all interest in living, is now an enthusiastic member of Alcoholics Anonymous, sees his family again, and as he puts it, has "a feeling of worth and companionship I've not known for a very long time".

He won the battle himself, Mrs. Johnston stressed. But it was the responsibility of Social Services to give him a push.

★ ★ ★

Last year over 3,000 patients were given "a little push" by our Social Services Department — 1,347 were new patients, and some 2,000 others remained in the department's caseload from the previous year.

Most of the patients found it difficult to accept their situation, Mrs. Johnston recalled. A fairly large number were also concerned about future employment, income, and returning to their home and community responsibilities. In addition, these and others might have needed direction or assistance for obtaining artificial limbs, braces and self-help devices, or for providing help in the home, or — if they were outpatients — for arranging transportation to and from hospital. A sizeable

patients to demonstrate that the surgery isn't "all that bad".

Laryngectomy patient Dumas Payette said he learned esophageal speech in six weeks. He is now studying radio and TV repair at the Red River Community College, demonstrates his new voice to health sciences students, and according to his wife who came with him to the meeting, talks more now than he ever did.

Ear, nose and throat specialist Dr. D. M. Brodovsky and surgeon Dr. E. G. Karasewich also addressed the meeting.

Dr. Brodovsky, who explained esophageal speech, said that a Lost Cord Club could do much to allay the fears and depression of people who have just undergone — or are about to undergo — this form of surgery.

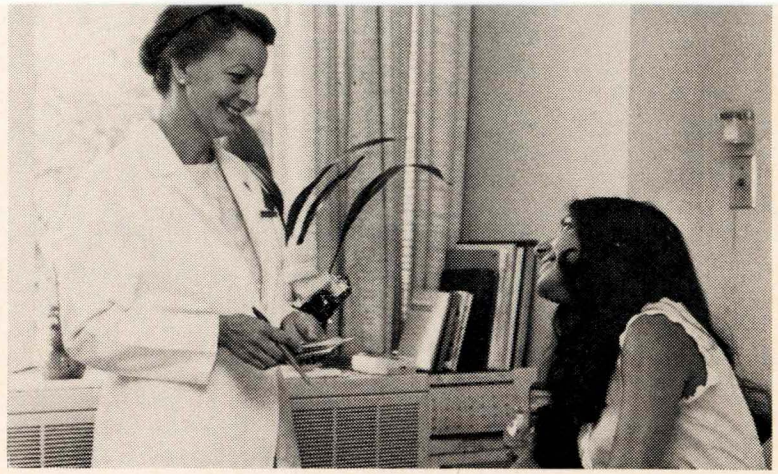
Dr. Karasewich stressed that even if an individual is unable to learn esophageal speech, there are excellent mechanical aids. Usually, he continued, laryngectomy patients find

Director of Volunteer Services, Mrs. W. B. Barnard, and her assistant, Mrs. Joe Miske, have spent many hours in sample show rooms this past summer, selecting merchandise that they hope will please our visitors and patients . . . and, of course, staff members.

They have stocked Christmas cards of all kinds, in many price ranges, and there is a good selection of handsome gift wrap. For those who prefer personal greeting cards, there are many designs to browse through in the Volunteer Office (R206).

It's a very good idea to start Christmas shopping early — and it's an even better idea to part with your dollars at the hospital gift shop. With every item you buy, you assist the Special Equipment Fund of the Manitoba Rehabilitation Hospital - D. A. Stewart Centre.

And, as a way of saying thank-you for this support, the Volunteer Services are selling Christmas cards and giftwrap at 15 percent off!



All in-patients at the D. A. Stewart Centre are seen by social worker Mrs. Margaret Masterman. In recent times, she says, increasing numbers of out-patients are also benefiting from social services.

Mrs. Merle Wilson spends a good part of her day counselling hemiplegia patients about the nature of their disability and the impact it may have on family life. Families, too, are advised about the needs and abilities of the patient.

(Photographs by David Portigal)

CENTENNIAL SYMPOSIUM ON ORTHOPAEDIC DISABILITIES AND REHABILITATION

SURGERY OF THE HAND

Auditorium, Nurses' Residence
October 1, 2 and 3, 1970

Speakers:

Dr. A. E. Flatt, Iowa City, Iowa
Prof. J. I. P. James, Edinburgh, Scotland
Dr. J. W. Littler, New York City
Dr. R. M. McCormack, Rochester, N.Y.
Dr. A. B. Swanson, Grand Rapids, Mich.

pport for The Patient with "A Little Push"

group had drinking and family problems. Too many were just plain lonely.

★ ★ ★

From 50 to 75 percent of the social worker's time is devoted to counselling about adjustment to disability, finances, discharge and welfare — the amount of time and the subject varying according to the disability and, of course, to the individual.

Paraplegic patients and amputees, for example, usually require a lot of counselling about post-hospital accommodation, vocational training and job placement. Arthritis patients may need counselling about these things, too. But they also need considerably more counselling about their disease, for unlike paraplegics and amputees, who are suddenly presented with a set situation which they cannot hope to change very much, arthritis patients must make continuous adjustments to disability if disease progresses.

Many patients, regardless of their disability, find it difficult to accept financial help, because they feel it is one more step towards full dependence. In contrast, respiratory disease patients (particularly tuberculosis patients) in the D. A. Stewart Centre require 50 percent of the counsellor's time for advice about finances, and an additional 24 per-

er's office is brought closer to the patients on the wards.

★ ★ ★

The families of patients may also benefit from counselling. The 10-year-old daughter of a partially paralyzed, aphasic woman was brought to the department for guidance her parent seemed no longer able to give. The child had not only ceased to respect her mother, but at this tender age, had also taken over much of the responsibility of managing the home.

She needed help to have fun again, the director said. And the child's father, who had been partly responsible for the mix-up by overprotecting his wife, needed some instruction about hemiplegia and what his wife could and could not do in the home. "I wish I had been treated along with my wife," the father remarked later. "It would have saved a lot of grief had I understood from the beginning."

★ ★ ★

Social Services usually provides *follow-up* for discharged in-patients who are to become out-patients. (There is generally no follow-up of people who receive a simple discharge.[1]) Prior to the patient's departure from hospital, the department does a lot of the preparatory work by letter or telephone, relying heavily on such agencies as the Society for

The Social Services Department holds many conferences within their own group, as well as with other members of the hospital treatment staff and outside agencies. The small group that makes up our Social Services are, left to right, Mrs. Margaret Masterman, Mrs. Merle Wilson, Mrs. Mary Johnston, Mrs. Kay Lawson and Mrs. Judy Vielgut.

(Photographs by David Portigal)

Bureau and other specialized organizations aid people with other social, emotional and financial difficulties. When referrals are made to welfare authorities, a letter and medical report is sent to them, and an appointment made for the patient. This is usually followed by a telephone call to the welfare agency and a report back from the patient.[2]

Our social workers depend on mature young volunteers to make the home visits that they themselves usually have no time for. The young

and it wonders about the auxiliaries of health and service organizations, which are often more interested in raising money than in helping people who are already disabled by the diseases they hope to help conquer. "I am thinking of a victim of multiple sclerosis who sits alone every day, with no useful purpose," Mrs. Johnston said. "There must be thousands like her who would benefit now and then from companionship and encouragement."

★ ★ ★

Even so, Mrs. Johnston feels that these percentages do not reflect the true needs of respiratory patients who, like Mr. X, are confronted with a long-term, chronic illness. Hopefully, she said, the situation will change in the Stewart Centre when staff members learn that more than financial assistance is involved in Social Services, and when the work-

Canadian Paraplegic Association, Victorian Order of Nurses and Canadian Arthritis and Rheumatism Society to help with vocational and home assessment, job placement or training, and the provision of wheelchairs, braces or other assistive devices. Alcoholics Anonymous willingly offer assistance to patients with an alcohol problem; the Family

ents, according to Mrs. Johnston, — mostly because they have a lively interest in others. Students from the Mennonite Bible College, for example, are so anxious to make their home visiting project useful that they come to the hospital to study treatment programs.

The department feels strongly about the lonely patient at home,

ues as long as it takes the patient to achieve his utmost capacity for life and work. Yet in so many instances, post-hospital programs fall short of this philosophy. *Time* is probably a chief reason for the breakdown. Health organizations, which are so often understaffed,

(Continued on Page 4)

In 1969 the Social Services at the Manitoba Rehabilitation Hospital — D. A. Stewart Centre conducted 2,804 in-patient interviews and 580 out-patient interviews. Some patients were seen only once, others were seen many times, depending upon readmissions and the problems involved. The average number of interviews was three per patient.

The following lists some of the special problems of various groups of disabled patients, and the amount of time spent on counselling, ward rounds, conferences and referrals.

OUT-PATIENTS: 25% of the worker's time is spent on counselling about attitude and adjustment to disability; 30% on counselling about finances, 13% on welfare referrals, 12% on referrals to the Society for Crippled Children and Adults (primarily for help in paying for prostheses and, to some extent, for work assessment and training); and 20% on clinics and conferences. Few out-patients are financially prepared for sickness or disability. Many are referred for such simple items as transportation, payment for splints, clothing. Others are referred for a re-evaluation of their financial status in relation to their physical situation.

D. A. STEWART CENTRE: The sudden admission of a tuberculosis patient for long-term care creates an emergency family problem, particularly with respect to housing and financing. The worker spends 10% of her time counselling patients about their disease, 50% on counselling about finances, 24% on welfare referrals, 4% on referrals to the SCCA, and 12% on ward rounds and conferences.

ARTHRITIS WARD (R-6): The social worker on this ward devotes 35% of her time to counselling about attitude and adjustment to disease; 19% to counselling about finances; 21% to counselling about patients' discharge; 8% to welfare referrals, and 17% to ward rounds and conferences. Because the worker's office is located on the wards, the worker has daily contact with the patients, and thus many problems are anticipated and worked out early. Arthritis patients require a lot of counselling about their disease — and, particularly if they are among the many who look for a miracle cure, they need help to strike a reasonable balance between acceptance and hope. There is also a good deal of counselling about physical changes in the home and the patient's changed role in the household. Referrals to other agencies involve letters, medical reports, meeting and *call-backs* to ensure that the patient is looked after.

PARAPLEGICS, AMPUTEES, ORTHOPAEDIC CONDITIONS (R-4); The patient is often faced with a job change and temporary loss of income. He needs counselling for this, and also for his disability which (particularly if he is a paraplegic or amputee) involves a big adjustment. Architectural changes in the home must often be arranged; for young paraplegics in particular, there is difficulty in finding suitable accommodation. The Canadian Paraplegic Association helps to meet the medical expenses of paraplegic patients, and provides excellent counselling, follow-up and a recreational program. The worker spends 35% of her time on counselling about attitude and adjustment, 19% on counselling about finances, 21% on counselling about discharge, 8% on welfare referrals, and 17% on ward rounds and conferences.

HEMIPLEGIA AND NEUROLOGICAL CONDITIONS (R-5): 13% of the worker's time is spent on counselling about attitudes and adjustments, 6% on referrals to Alcoholics Anonymous, 8% on finances, 31% on counselling about discharge, 10% on welfare referrals (financial), 14% on welfare and home care referrals (discharge), 18% on ward rounds and conferences. Because of organic and/or speech problems, the patient often finds it difficult to reflect his feelings. There tends to be more alcohol problems on this service. For some patients, there is no possibility of future employment. The worker encourages the family to find financial assistance on their own when possible (rather than making a direct referral to welfare), and she spends much time on family counselling.

BUSY FALL PROGRAM

Continued from Page 1

Another *Cardiac Program* — providing special, graded exercises for patients who have made a good recovery from heart attack — began in the M.R.H. gymnasium on September 15. Dr. Leon Michaels, consultant in cardiology, is in charge of these sessions, which are attended by some eight patients twice every week for a period of two months. Application forms for the next eight-week program are available from the nursing consultant and administrative assistant at the Manitoba Rehabilitation Hospital.

★ ★ ★

The *Aviva Chapter* of the B'nai B'rith will soon launch their seventh season of providing twice-monthly entertainment for patients. The program, under the chairmanship of Mrs. Sandra Nozick, will begin with a bingo game in the M.R.H.-D.A.S.C. auditorium at 8 p.m. on September 23. The next event, on the second Wednesday of the month, will be a variety concert.

★ ★ ★

The *Wheelchair Sports and Recreation Club* started off another season in the M.R.H. auditorium this month. The club holds a social and recreational program each Monday evening, and on September 28 members will hold their annual meeting and

★ ★ ★

The work isn't social. It is, in a way, educational. And it has nothing to do with treatment, but everything with prevention.

We're speaking of the preparations for the annual *Christmas Seal Campaign*, when several hundred volunteers start stuffing envelopes to raise money for the 1971 fight against tuberculosis and chronic respiratory disease.

Women members of the Granite Curling Club will start the ball rolling when they begin daytime "stuffing sessions" on September 28. The next evening the Professional Engineers' Wives come.

Other groups taking part in the campaign preparations are the Calvary Temple Mission Circle, the Ukrainian Catholic Women's League, West Winnipeg Rotary-Anns, South Winnipeg Kiwanis, Volunteer Services of the MRH - DASC, women of the Victoria Curling Club, Zonta International, and the Ladies Auxiliary to the Associated Canadian Travellers, Winnipeg Club.

Around 100 business women in Winnipeg will also take part in a special blitz night on October 13. Members of the 21st Boy Scout Troop (St. Vital) and of the 65th Venture Boy Scout Troop (East Kildonan) are also helping on this evening.

MANITOBA SOCIETY OF MEDICAL ASSISTANTS recently donated an ergometer for the use of cardiac patients attending the graded exercise classes at the Manitoba Rehabilitation Hospital Tuesday and Thursday evenings. Mrs. Donna Bjore, physiotherapist who directs the exercises, demonstrates the special bicycle for Miss Agnes Gray, president of the MSMA. The Society also meets at the rehabilitation hospital on the first Tuesday of every month. (Photo by Dave Portigal)

dent is Ted Misanchuk.

The Manitoba Civil Amputee Association had their first "together again" session in the small gym of the Manitoba Rehabilitation Hospital on September 16. Their program also involves social and recreational activities, plus special efforts to bring the problems of amputees to the attention of the public and the government.

At the annual meeting of the MCAA last spring, A. Seaford was elected president, John Weinburg was named vice-president, J. R. Ledwig, secretary, and Mrs. L. Thiesen, treasurer. In addition, there is an advisory committee consisting of MRH staff members Dr. R. R. P. Hayter, Mrs. K. Lawson, Mrs. Donna Bjore and Miss Jane Peacock.

RECENT ADDITIONS TO OUR BOOKSHELVES

DORLAND'S ILLUSTRATED MEDICAL DICTIONARY (24th Edition)

HOME TREATMENT AND POSTURE — W. E. Tucker

MEDICAL INTERVIEWING (A Programmed Manual) — Robert E. Froelich, M.D., and F. Marion Bishop

MEDICAL RECORDS, MEDICAL EDUCATION AND PATIENT CARE — Lawrence L. Weed, M.D.

MY FIRST DICTIONARY — Laura Oftedal and Nina Jacob

ORTHOPAEDIC MEDICINE — TREATMENT BY MANIPULATION AND MASSAGE (Volume 2) — James Cyriax, M.D.

PRODUCT LITERATURE — Electronic Products, E. I. Dupont De Nemours and Co., Wilmington, Delaware

RATIONAL THERAPY AND CONTROL OF TUBERCULOSIS — Edited by Joseph E. Johnson III, M.D.

STROKE (The Condition and the Patient) — John E. Sarno, M.D., and Martha T. Sarno, M.A.

Arrangements for borrowing books must be made at the Sanatorium Board Executive Offices.

Our Social Services Department

(Continued from Page 3)

never seem to have sufficient time to do all the home visiting they would like to do, to consult each other about individual cases, and to determine where one's responsibility ends and another's begins.

Unfortunately, it's the patient who gets lost in the mix-up, Mrs. Johnston pointed out.

"I remember one instance where nine different agencies were involved in the care of a patient.

"I recall another patient — a woman with arthritis — who had to be readmitted to hospital, primarily to rebuild her self-confidence."

The arthritis patient apparently had been considered ready for home care; but the team in charge of her care had come separately to her home, with little prior consultation. The nurse came, gave her a bath, then left. The physiotherapist walked her up and down the hall, and left. The occupational therapist suggested some physical changes in the kitchen and bath. She too left.

Then the woman sat down and cried.

★ ★ ★

"I don't know how problems like these can be solved," Mrs. Johnston continued. "But I do wonder how far the hospital must extend itself to get patients successfully re-established in the community."

Most health organizations agree that all professions — including social workers[3] — need considerably more education about the treatment and problems of the disabled, she said. And they also feel that the community itself has some way to go before it fully appreciates the capabilities of its handicapped citizens.

For example, there is a tremendous need for more job opportunities. As an illustration, our director cited the case of a former outdoor worker who is undergoing a series of long and painful operations on his hands. Between bouts with the surgeon's knife, he is trying to supplement the family income by making ceramic-top tables in the basement of his home — a skill he learned, by the way, as part of his occupational therapy.

How much more profitable to society to use this man's talents in a special workshop, Mrs. Johnston suggested. A workshop that is more advanced than our present, "assessment-type" workshops — a sheltered, profit-making workshop offering employment to all kinds of disabled people who are able and wanting to work, but cannot meet the terms of highly competitive industries.

★ ★ ★

Finally, if Mrs. Johnston had one more wish, she would change the attitude of people to the sick and the disabled.

Every individual, whether he is sick or not, is entitled to dignity — to a life that is satisfying and creative, she feels.

But very often people who are sick will act in a "non-social way". Sometimes they also drink — perhaps as a release from their plight.

"But they are people. And they are adults."

"And they should be treated as such."

1. Occasionally an informal relationship develops between the social worker and the patient who receives a simple discharge. That is, the patient may return on his own for counsel . . . or perhaps to say: I'm doing fine!

2. It is popularly believed that patients referred to welfare continue to get counselling. Frequently, these patients will see the welfare worker about twice each year.

3. To help correct the situation within their own profession, the Social Service Department is providing in-hospital rehabilitation training for students in welfare and social service courses. During the past two years five students from welfare courses at technical schools in Brandon and Winnipeg have received three months of training in the department. Plans are afoot to provide similar internships for undergraduate social service students at the University of Manitoba.