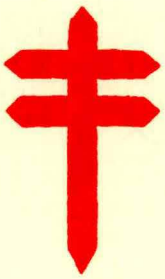
ANNUAL REPORT 1959



SANATORIUM BOARD OF MANITOBA

Issued May, 1960

SANATORIUM BOARD *of* MANITOBA

A Voluntary, Non-Profit Corporation

+

Operating

X-RAY AND TUBERCULIN SURVEYS
TRAVELLING TUBERCULOSIS CLINICS
CENTRAL TUBERCULOSIS CLINIC—WINNIPEG
MANITOBA SANATORIUM—NINETTE
ASSINIBOINE HOSPITAL—BRANDON
CLEARWATER LAKE HOSPITAL—THE PAS
MANITOBA REHABILITATION HOSPITAL
(Under construction)—WINNIPEG

Associated with the Sanatorium Board

ST. BONIFACE SANATORIUM—ST. VITAL

Co-operating with

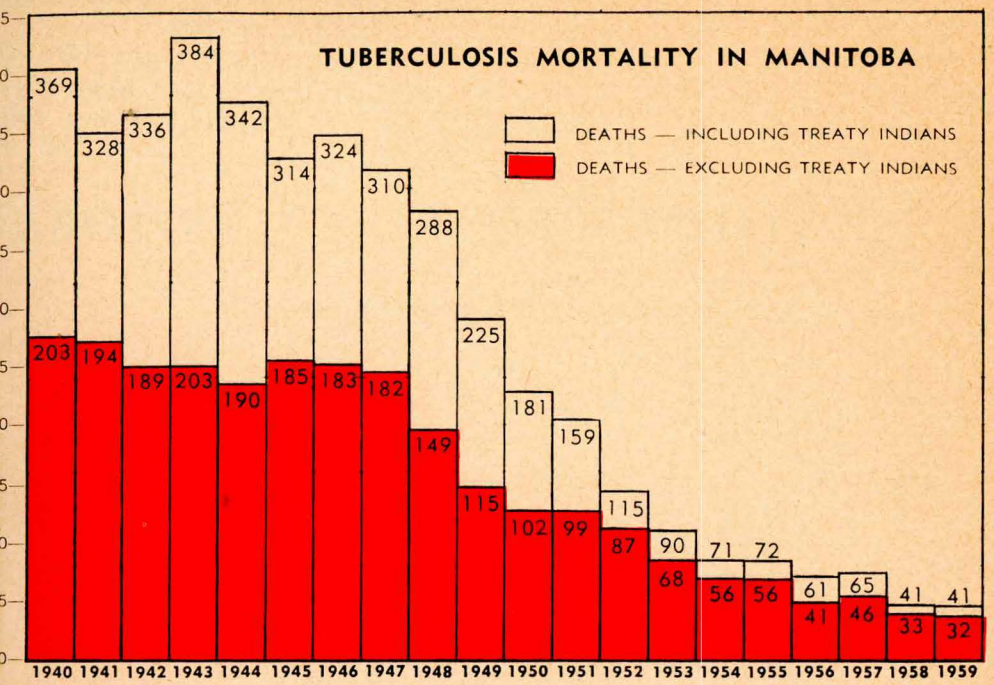
OTHER HEALTH AND WELFARE AGENCIES
IN THE PROVINCE

+

REPORT FOR THE YEAR 1959

WINNIPEG, MANITOBA

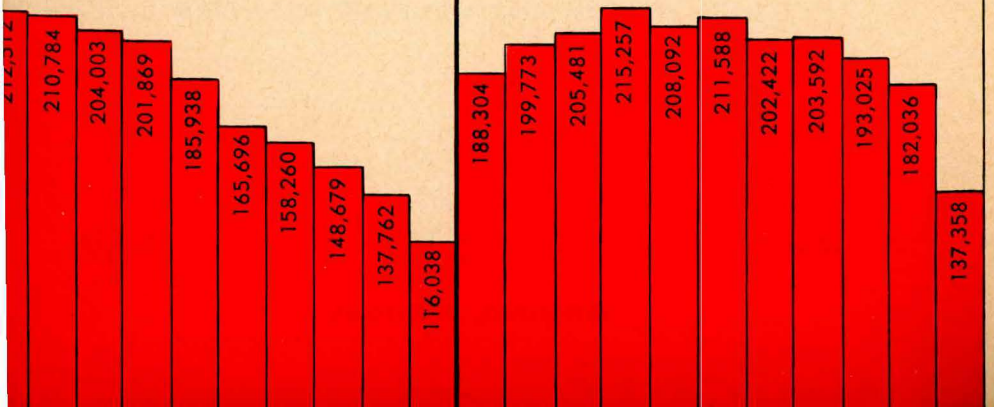
TUBERCULOSIS MORTALITY IN MANITOBA



	1949	1959
CASES under supervision in Manitoba	5,730	4,144
EXAMINATIONS	243,268	159,299
NEW CASES diagnosed Active	834	258
Inactive	347	107
DEATHS	225	41

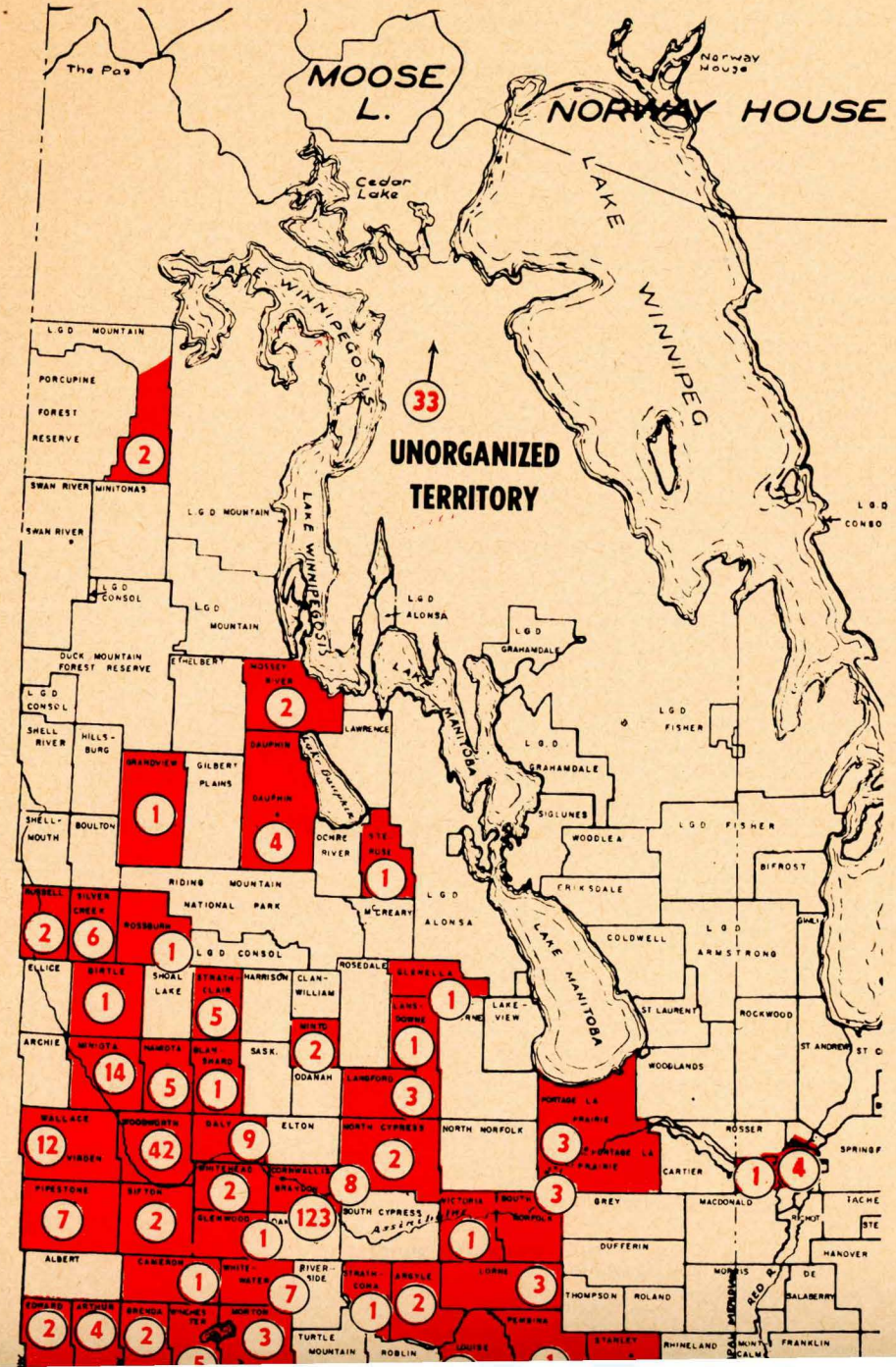
TUBERCULOSIS TREATMENT DAYS — COMPARATIVE STATEMENT 1949-1959

TREATMENT OF PATIENTS WHO ARE THE RESPONSIBILITY OF



SOURCE OF ADMISSIONS — 1959

To the Extended Treatment Section, Assiniboine Hospital



CONTENTS

SANATORIUM BOARD *of* MANITOBA

EXECUTIVE

Chairman	Mr. J. W. Speirs
Vice-Chairman and Chairman, Assiniboine Hospital Committee	Mr. J. N. Connacher
Chairman, Administration and Finance Committee	Mr. F. Boothroyd
Chairman, Clearwater Lake Hospital Committee	Mr. R. H. G. Bonnycastle
Chairman, Manitoba Rehabilitation Hospital Committee	Mr. S. Price Rattray
Honorary Solicitor	Mr. E. B. Pitblado, Q.C.

HONORARY LIFE MEMBERS

Mr. C. E. Drewry
Mr. I. Pitblado, Q.C., LL.D.
Mr. Wm. Whyte
Mr. A. E. Longstaffe

STATUTORY MEMBERS

Representing the Provincial Department of Health and Public Welfare	Hon. George Johnson, M.D. Dr. R. M. Creighton Mr. G. L. Pickering Mr. George Iliffe, C.A. Hon. Sterling Lyon
As Municipal Commissioner	Hon. Maurice Ridley
Representing the Union of Manitoba Municipalities	Mr. J. J. Pynoo Mr. A. Bedard Mr. D. F. Rose Mr. A. T. Hainsworth
Representing St. Boniface Sanatorium	Dr. A. C. Sinclair
Representing the City of Winnipeg	Mr. J. R. McInnes

ELECTED MEMBERS

Dr. J. D. Adamson	Mr. George Collins	Dr. Ross Mitchell
Mr. R. L. Bailey	Mr. J. N. Connacher	Mr. T. A. Moore
Mr. John F. Baldner	Mr. H. T. Decatur	Mr. E. B. Pitblado, Q.C.
Dr. L. G. Bell	Dr. J. E. Hudson	Mr. S. Price Rattray
Mr. R. H. G. Bonnycastle	Mr. G. E. Mayne	Mr. J. W. Speirs
Mr. Frank Boothroyd	Mr. J. R. McMillan	Mr. Howard T. Spohn

EXECUTIVE DIRECTOR AND SECRETARY-TREASURER

T. A. J. Cunnings

AUDITORS

Riddell, Stead, Graham and Hutchinson

ST. BONIFACE SANATORIUM

ADVISORY BOARD

Chairman	Mr. Justice A. Monnin
Secretary	Rev. Sr. M. Roy

Mr. E. G. Cass
Mr. C. Jessop
Mr. N. Vadeboncoeur
Mr. E. Bole
Mr. G. E. Sharpe
Dr. A. C. Sinclair

MEDICAL STAFF

EDWARD LACHLAN ROSS, M.D.
Medical Director

D. L. SCOTT, M.D.
Assistant Medical Director

SANATORIUM BOARD OF MANITOBA

Medical Advisory Committee

Chairman, DR. J. D. ADAMSON

DR. L. G. BELL
DR. R. G. CADHAM
DR. M. H. CAMPBELL
DR. S. L. CAREY
DR. R. M. CHERNIAK
DR. ROSS CREIGHTON
DR. M. R. ELLIOTT
DR. COLIN FERGUSON
DR. J. E. HUDSON
DR. J. M. LEDERMAN
DR. R. A. MACPHERSON
DR. ROSS MITCHELL
DR. A. L. PAINE
DR. A. H. POVAH
DR. E. L. ROSS
DR. D. L. SCOTT
DR. A. C. SINCLAIR
DR. W. J. WOOD

Consultants (All Board Hospitals)

Broncho-Esophagology: C. B. SCHOEMPERLEN, M.D., L.M.C.C., Cert. Int. Med. F.C.C.P., F.A.C.P.
Pathology: A. P. LAPKO, M.D., L.M.C.C.
Pediatrics: HARRY MEDOVY, M.D., L.M.C.C., Cert. Paed.
Psychiatry: T. A. PINCOCK, M.D., L.M.C.C., R.C.P. & S., Cert. Psy.
Radiology: R. A. MACPHERSON, M.D., C.M., L.M.C.C., F.A.C.R., Cert. D. & T. Rad.
Urology: C. B. STEWART, M.D., L.M.C.C., F.R.C.S. (Edin. and Can.), Cert. Urol.
H. D. MORSE, M.D., C.M., L.M.C.C., F.R.C.S. (Can.), Cert. Urol.

CENTRAL TUBERCULOSIS CLINIC

Resident Medical Staff

DR. D. L. SCOTT
DR. P. P. MARI

MANITOBA SANATORIUM

Resident Medical Staff

DR. A. L. PAINE
DR. S. M. MURPHY
DR. T. NICOLAIDES
DR. JOHN SIMON

Consultants

Eye, Ear, Nose and Throat: R. O. MCDIARMID, M.D., L.M.C.C., Cert. Ophth. Otol.
General Surgery: H. S. EVANS, M.D., L.M.C.C., F.R.C.S. (Edin. and Can.), F.A.C.S., Cert. Gen. Surg.
Orthopedics: W. B. MACKINNON, M.D., L.M.C.C., Ch.M. (Man.), F.R.C.S. (Can.), Cert. Orth. Surg.
Dentistry: J. P. HURTON, D.D.S.

ASSINIBOINE HOSPITAL

Resident Medical Staff

DR. A. H. POVAH
DR. WILLIAM SHAHARIW
DR. D. G. COGHLIN

Active Medical Staff

Brandon

DR. M. E. BRISTOW
DR. R. P. CROMARTY
DR. A. J. ELLIOTT
DR. H. S. EVANS
DR. J. A. FINDLAY
DP. F. FJELDSTED
DR. JAMES HENDRY
DR. W. P. HIRSCH
DR. DOREEN O. JOUBERT
DR. NOEL Y. JOUBERT
DR. A. C. KLASSEN
DR. J. M. MATHESON
DR. R. F. M. MYERS
DR. F. J. E. PURDIE
DR. L. C. ROSE
DR. J. E. ROWLANDS
DR. H. S. SHARPE
DR. V. J. H. SHARPE
DR. E. J. SKAFEL
DR. R. H. D. SYKES

Carberry

DR. G. T. MCNEILL

Oak Lake

DR. MARK SCHERZ

Courtesy Medical Staff

DR. A. M. GRANT, Souris
DR. J. E. HUDSON, Hamiota
DR. W. NAKIELNY, Rivers
DR. B. D. SUTTER, Souris

Consultants

Eye, Ear, Nose and Throat: R. O. MCDIARMID, M.D., L.M.C.C., Cert Ophth. Otol.
General Surgery: H. S. EVANS, M.D., L.M.C.C., F.R.C.S. (Edin. and Can.), F.A.C.S., Cert. Gen. Surg.
Internal Medicine: V. J. H. SHARPE, M.D., L.M.C.C., R.C.P. & S., Cert, Int. Med.
Orthopedics: F. R. TUCKER, M.D., L.M.C.C., M.Ch. (Orth.), F.R.C.S. (Edin. and Can.), Cert. Orth. Surg.
Radiology: R. H. D. SYKES, M.D., M.R.C.S. (Eng.), L.R.C.P. (Lond.), L.M.C.C., R.C.P. & S. (Eng. and Can.), Cert. Diag. Rad.
Urology: R. P. CROMARTY, M.B., L.M.C.C., F.R.C.S. (Can.), Cert. Gen. Surg.
Dentistry: B. CLAMAN, D.D.S.

CLEARWATER LAKE HOSPITAL

Resident Medical Staff

DR. S. L. CAREY
DR. I. H. RIDDELL
DR. A. P. CHORNOMORETZ

Active Medical Staff

The Pas

DR. M. W. BLACK
DR. H. N. COLBURN
DR. D. L. GEMMILL
DR. JOSEPH LEICESTER
DR. P. G. LOMMERSE
DR. J. LOPEZ
DR. R. SEIFER

Consultants

Cardiology: L. R. COKE, M.D., L.M.C.C., F.A.C.C.P., F.A.C.P., R.C.P. & S., Cert. Int. Med.
General Surgery: JOSEPH LEICESTER, M.D., L.M.C.C.
Ophthalmology: C. H. LING, M.D., L.M.C.C., P.U.M.C. (Peking), Cert. Otol. Ophth.
Orthopedics: F. R. TUCKER, M.D., L.M.C.C., M.Ch. (Orth.), F.R.C.S. (Edin. and Can.), Cert. Orth. Surg.
Dentistry: B. CLAMAN, D.D.S.

MANITOBA REHABILITATION HOSPITAL ADVISORY PLANNING COMMITTEE

Chairman, DR. F. HARTLEY SMITH

DR. FLETCHER BARAGER
DR. L. G. BELL
W. N. BOYD
DR. M. R. ELLIOTT
DR. J. F. S. HUGHES
DR. C. D. LEES
S. PRICE RATTRAY
DR. E. L. ROSS
DR. L. H. TRUELOVE
DR. F. R. TUCKER

ST. BONIFACE SANATORIUM

Medical Staff

Medical Director and Thoracic Surgeon.....DR. A. C. SINCLAIR
Assistant Medical Director.....DR. V. J. HAGEN
Senior Physician.....DR. F. KOZIN
Resident.....DR. L. TOTH

Consultants

Anaesthesiology: MARJORIE BENNETT, M.D., L.M.C.C., R.C.P. & S. (Can.), Cert Anaes.
Bronchoscopy: D. S. MCEWEN, M.D., L.M.C.C., Cert. Int. Med.
Cardiology: L. R. COKE, M.D., L.M.C.C., F.A.C.C.P., F.A.C.P., R.C.P. & S., Cert. Int. Med.
J. H. MARTIN, M.D., L.M.C.C., Cert. Int. Med.
Dermatology: W. G. BROCK, M.D., L.M.C.C., M.S. (Derm.), Cert. Derm. Syph.
Medicine: J. D. ADAMSON, M.D., M.R.C.P. (Edin.), F.R.C.P. (Can.)
Obstetrics: H. GUYOT, M.D., L.M.C.C.
Ophthalmology: R. M. RAMSAY, M.D., L.M.C.C., Cert. Ophth., M.Sc. (Ophth.)
Orthopedics: W. B. MACKINNON, M.D., L.M.C.C., Ch.M. (Man.), F.R.C.S. (Can.), Cert. Orth. Surg.
Pathology: F. H. BURGOYNE, M.D., L.M.C.C., Cert. Path.
Proctology: J. J. BOURGOUIN, M.D., L.M.C.C., Cert. Urol., Cert. Amer. Bd. Urol.
Psychiatry: T. A. PINCOCK, M.D., L.M.C.C., Cert. Psy.
Surgery: T. O. BURRELL, M.D., L.M.C.C., Ch.M. (Man.), F.R.C.S. (Edin. and Can.), Cert. Gen. Surg.
C. E. CORRIGAN, M.D., L.M.C.C., L.R.C.P. (Lond.), M.R.C.S. (Eng.), F.R.C.S. (Eng. and Can.)
Urology: A. C. ABBOTT, M.D., C.M. (Man.), L.M.C.C., F.R.C.S. (Edin. and Can.), Cert. Urol., Cert. Gen. Surg., F.A.C.S., F.I.C.S.
X-ray: A. W. MCCULLOCH, M.D., L.M.C.C., Cert. Diag. Rad.
Dentistry: T. J. COOKE, D.D.S.
J. M. BENSON, D.D.S.

NON-MEDICAL SENIOR STAFF

	SUPERINTENDENTS OF NURSES	ADMINISTRATION	CHIEF ENGINEERS
ORIUM BOARD MANITOBA	Miss B. Hejlsted, R.N..... (*Director of Nursing Services*)	Edward Dubinsky..... (*Administrative Asst.*) R. F. Marks, C.A. (*Comptroller*) G. B. Hurley (*Accountant*)	.....
AL TUBERCULOSIS IC	Mrs. P. Torgerson, R.N.....	.....	.....
OBA SANATORIUM	Miss D. Ellis, R.N.....	N. Kilburg..... (*Business Manager*) W. Bradford (*Accountant*) W. B. Stewart (*Purchasing Agent*)	G. Stinson
BOINE HOSPITAL	Mrs. I. A. Cruikshank, R.N.....	C. C. Christianson..... (*Business Manager*) T. K. Yorke (*Accountant*)	R. N. Newman
WATER LAKE PITAL	Miss M. M. Quinn, R.N.....	R. B. McIvor..... (*Business Manager*) J. E. Durwael (*Accountant*)	F. F. Smith

ST. BONIFACE SANATORIUM

SUPERIOR.....	Rev. Sr. A. Ell, R.N.	
1ST ASSISTANT.....	Rev. Sr. M. Roy	
2ND ASSISTANT.....	Rev. Sr. A. Boisvert, R.N.	
CHAPLAIN.....	Rev. Fr. Florent Labonté	
Rev. Sr. E. Hamon, R.N..... (*Director of Nursing*)	Rev. Sr. M. Roy..... (*Sec. Treasurer*)	L. Beaupre
Rev. Sr. A. Sicotte, R.N..... (*Night Supervisor*)	Rev. Sr. M. Tougas (*Purchaser*)	

LLING TUBERCULOSIS ICS AND SURVEYS	J. J. Zayshley, R.T. (*Surveys Officer*)
ILITATION	Miss M. Busch..... (*Director of Rehabilitation*)..... E. Locke (*Indian Rehabilitation Officer*)
AL TUBERCULOSIS ISTRY	Miss Janet Smith, R.N. (*Supervisor*)

RADIOGRAPHERS	LABORATORY TECHNICIANS	TEACHERS	OTHERS
W. J. Anderson, R.T.....	.....	.....	Mrs. P. McFarlane (*Sec. to Exec. Dir.*) Miss Nan T. Chapman, M.Sc. (*Dir. Dietary Services*) C.G. Bonney, B.Sc.(Phar.) (*Dir. Pharm. Services*) Mrs. P. B. Holting, B.A. (*Health Educator and Informational Writer*)
E. W. Ackroyd, R.T.....	H. Daneleyko, R.T.....	.....	Miss E. L. McGarrol (*Sec. to Med. Supt.*)
Wm. C. Amos, R.T.....	J. M. Scott, R.T.....	Miss G. Manchester.. Miss G. Motheral..... Mrs. V. Hastings..... Miss M. Newmark.... (*Occup'l Therapist*)	Miss G. M. Wheatley (*Sec. to Med. Supt.*) Mrs. F. Wardrop (*Food Supervisor*) F. J. Rodwell (*Laundry Foreman*)
F. H. Gibson, R.T.....	Miss L. E. Delamater, R.T.	Mrs. A. Clarke..... T. Daigle..... Mrs. V. Davidson..... (*Occup'l Therapist*)	Miss A. Maher (*Sec. to Med. Supt.*) J. P. Prendiville (*Physiotherapist*) Mrs. E. J. Wankling (*Food Supervisor*)
L. Joyal, R.T.....	Miss A. Morley.....	Miss W. Bromley..... J. Zurbec..... Mrs. A. D. Wong..... (*Occup'l Therapist*)	Mrs. L. Hoksbergen (*Sec. to Med. Supt.*) R. B. Lock (*Laundry Foreman*)

Rev. Sr. Y. Thibert..... (*Lab. and X-ray Supervisor*)	Mrs. H. Krol, B.Sc. (Phar.) (*Pharmacist*)	Miss I. Kujansuu..... Mrs. G. E. Horvath.. Mrs. M. A. Guillow... (*School Teachers*) Miss A. Hargreaves.... (*Occup'l Therapist*) Alex Vermette (*Crafts Instructor*)	Miss A. Eyres (*Medical Secretary*) Rev. Sr. A. Dupuis (*Main Kit. Super.*)
Alex Roh, R.T..... (*Supervising Radiographer*) O. D. Buhler, R.T..... A. Schmecko, R.T. E. Zemianski, R.T.	.....	.....	Miss G. Bowman (*Secretary*)
.....	.....	Miss Ruth Snuggs..... (*Rehab. Unit Supervisor*) Mrs. P. E. Watt (*Teacher*)	.....
.....	.....	.....	Miss Gladys McGarrol (*Senior Statistical Clerk*)

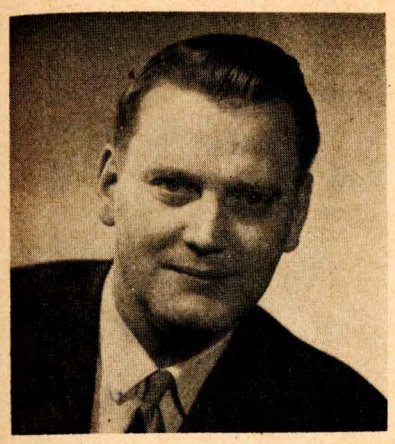
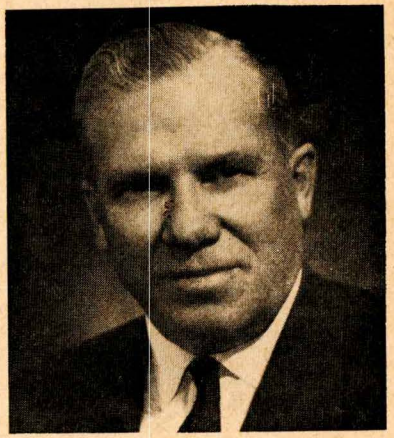


PHOTO BY ASHLEY & CRIPPEN

HON. GEORGE JOHNSON, M.D.
Minister of Health and Public Welfare
Manitoba



M. R. ELLIOTT, M.D., D.P.H.
Deputy Minister

The Annual Reports of the Sanatorium Board of Manitoba over the past ten years tell a story of achievement in public health that is truly remarkable. Almost without exception each year has shown continuous progress in all phases of the Tuberculosis Control program, culminating in the very encouraging results detailed in this report. This situation has been made possible only by the persistent and conscientious efforts of the Board, so ably supported for the past fifty years by the public of our province and carried on by a skilled and devoted staff. To reach our goal of complete eradication of this disease our combined efforts must be continued and the search even intensified in some areas so as to reach cases at the earliest possible stage of infection before disabling disease has developed.

I am happy to acknowledge the continued co-operation of the Board in the development of their expanding responsibilities in the field of extended care facilities for non-tuberculosis cases. The 200 sanatorium beds released during the past year for the care of other long-term illnesses has materially assisted the hospital needs of our province. As agent for the Government in the development of rehabilitation facilities the Board has again demonstrated the effectiveness of such a voluntary body working in the most cordial relationship with the Government department. We can look forward with confidence to continued progress in all these endeavours.

GEORGE JOHNSON, M.D.,
Minister of Health and
Public Welfare

Chairman's Report

Gentlemen: I have pleasure in welcoming you to the 49th Annual Meeting of the Sanatorium Board of Manitoba. This year, which closes a half-century of service to the people of this province, has marked continued progress in reducing the toll of tuberculosis and has brought about a significant change in the responsibilities of the Board. At the request of the Government, and under authority provided through the amendments to the Tuberculosis Control Act, the Board is now caring for non-tuberculosis patients requiring long periods of hospital treatment, and has undertaken the construction and operation of the Manitoba Rehabilitation Hospital in Winnipeg. These developments have been brought about by the continued reduction in the incidence of tuberculosis, making a number of sanatorium beds available for other purposes. Concurrently, there has developed a consciousness of the need for special facilities for the treatment of patients requiring extended periods of hospital care. The Board has had long experience in treating long-term illness and at the request of the Government, and with the concurrence of representative committees of the Manitoba Medical Association, this experience will be put at the service of the people of Manitoba in the larger sphere.

THE BOARD

The Board consists of three honorary life members and 28 active members, of whom 16 are elected and 12 are statutory members. All contribute their services on a voluntary basis.

On December 15, 1959, members were saddened to hear of the death of Major George W. Northwood, a former chairman and long time executive member of the Board. Major Northwood was first elected a member of the Sanatorium Board in 1922, and in 1925 became a member of the Executive Committee. He served as chairman from 1943 to 1948 during a period of major change and expansion of the Board's services through the establishment of Clearwater Lake Hospital at The Pas in 1945 and Assiniboine Hospital at Brandon in 1947. He was made an honorary member in 1949.

I also regret to report that Mr. A. E. Longstaffe, who has been a valued member of the Board since 1955, has advised that owing to ill health he cannot continue as an active member of the Board. Mr. Longstaffe acted as chairman of the Dynevor Indian Hospital Committee for a number of years and after the closing of that hospital has continued as a member of the Executive Committee and vice-chairman of the Administration and Finance Committee. I would be glad to entertain a motion to appoint Mr. Longstaffe an honorary member of the Board.

During 1959 there were 36 meetings of the Board or its committees. I would like to pay tribute to the busy and responsible professional and business men who have been elected to membership on the Sanatorium Board of Manitoba, and who faithfully attend the frequent

James W. Speirs has served on the Sanatorium Board since 1943, and became Chairman of the Board in 1958. A prominent Winnipeg businessman, he is President and General Manager of Modern Dairies Ltd.

committee meetings in conduct of the Board's affairs. I am grateful indeed for the support these gentlemen have accorded me as chairman of the Board, and for their careful consideration of the affairs of the Board brought to them for examination and decision during the past year.

GENERAL

The trend towards the reduced demand for tuberculosis treatment beds continued throughout 1959. Number Four Pavilion at Manitoba Sanatorium containing 28 beds has been temporarily closed; 30 beds have been closed at Clearwater Lake Hospital; and 39 beds have been released at St. Boniface Sanatorium for the accommodation of mentally impaired children. The Board has received a request from the Minister of Health and Public Welfare for release of an additional 50 beds at St. Boniface Sanatorium for the care of the chronically ill. This matter has been considered by the Board's Medical Advisory Committee and they recommend that release of these beds be given further consideration in May or June, when the pattern of discharges and admissions for the current year is more clearly established.

The planning of the Manitoba Rehabilitation Hospital has proceeded steadily and tenders have been called by our architects, Messrs. Moody, Moore and Associates to close on May 18, 1960.

FINANCE

The Executive Director, Mr. Cunnings, will report in detail the Board's financial position. In general, however, it can be said that this year has been one of considerable difficulty due to the declining occupancy of tuberculosis patients on the one hand, and the establishment of new relations with the Manitoba Hospital Services Plan on the other. The extensive capital financing for the new occupational therapy and physiotherapy unit at Assiniboine Hospital, and the Manitoba Rehabilitation Hospital in Winnipeg, has created additional problems.

I would like at this time to thank especially the Associated Canadian Travellers for their support. The Brandon Club has assumed special responsibilities with respect to financing the construction of the physiotherapy unit at Assiniboine Hospital, over and above the hospital construction grants. Also, the Winnipeg Club has undertaken to raise $100,000 towards the cost of special equipment for the Manitoba Rehabilitation Hospital. I cannot express too strongly the indebtedness of the Board and the people of Manitoba to these men who give so generously and unselfishly of their time and effort for the public good.

From time to time we receive bequests and special gifts from interested persons to provide for assistance to patients, the purchase of hospital equipment, and other services for which no provision is otherwise made. All such donations over $500 are listed on a permanent memorial page in the published annual report. We are grateful indeed for this interest and support.

During the calendar year 1959 the sale of Christmas Seals amounted to $182,647, which exceeded the amount realized in any previous year. In addition the Associated Canadian Travellers Brandon Club contributed $14,500 which will be used as part of the capital cost of the Physiotherapy Unit at Assiniboine Hospital.

Our thanks are extended to the people who so generously supported both the Christmas Seal Sale and the work of the Associated Canadian Travellers. We gratefully acknowledge as well the assistance of hundreds of volunteer workers throughout the province who assisted us with our X-ray and tuberculin surveys, our rehabilitation services, and in scores of other ways. We acknowledge with deep appreciation the support and co-operation of officials of both the Provincial and Federal Governments and the Manitoba Hospital Services Plan, who have worked with officers of the Board in such a cordial and co-operative way in meeting the special problems that have been dealt with during the past year.

J. W. SPEIRS,
Chairman.

Executive Director's Report

This report on the administration of the Board's hospitals and services is intended to present to you those aspects of our operations not dealt with in other reports.

At Assiniboine Hospital 129 beds have now been set aside for non-tuberculous care and the total transfer of this hospital to the new service will be completed in 1960. At Clearwater Lake Hospital 58 beds are used solely for treatment of non-tuberculous patients. These units are designed primarily for extended treatment care—that is, for the treatment of patients requiring 30 days or more hospitalization and who in the main are transferred from general hospitals. However, in actual fact a considerable number of patients were admitted to both hospitals with acute respiratory disease, for non-tuberculous chest surgery and other conditions.

Our responsibilities in the field of physical medicine facilities have been marked by the planning and construction of a Physiotherapy-Occupational Therapy Unit at Assiniboine Hospital to act as a centre for this type of treatment in Western Manitoba; and the planning and development of the Manitoba Rehabilitation Hospital in Winnipeg which will provide for rehabilitation treatment facilities on an entirely new scale in this province. The establishment of these new facilities and the revision of our organizational plan which they involved have made it necessary to develop our administrative organization. During the year we have added to our executive office staff a Comptroller, a Director of Nursing Services, and a Director of Pharmacy Services.

A Chief of Staff, Dr. L. H. Truelove, who is a specialist in physical medicine, has been appointed for the Manitoba Rehabilitation Hospital. He will take up his new duties at the end of April, 1960. His initial concern will be the organization of the School of Physiotherapy and Occupational Therapy which will be operated by the University of Manitoba, under the Faculty of Medicine, in the Rehabilitation Hospital. Pending construction of the hospital, the school will commence in the fall of 1960 in temporary quarters in the Children's Hospital.

At the request of the Manitoba Hospital Survey Board a comprehensive study of the services and planned developments of the Sanatorium Board of Manitoba was prepared and our experience and studies with respect to the needs of long-stay patients and related matters have been given to the Survey Board in some detail.

ASSETS AND LIABILITIES

At December 31, 1959, assets held by the Board, including special funds but not including buildings and equipment at Brandon and Clearwater Lake owned by the Government of Canada and not carried as fixed assets in our books of account, totalled $2,312,207. This is a reduction of $27,492 as compared with the previous year. Liabilities of $321,425 are down $22,208 from the previous year.

T. A. J. Cunnings joined the Sanatorium Board executive staff in 1942. As Director of the Rehabilitation Division, he established the first successful rehabilitation programme for TB patients in Canada. In 1945 he was appointed Secretary-Treasurer of the Board, and in 1947 he assumed his present position as Executive Director and Secretary-Treasurer.

At the year end bank loans totalled $90,593, an increase of $64,155 as compared with 1959. The following statement of our accounts receivable for treatment account only indicates the reason for our dependence on bank loans.

TREATMENT ACCOUNTS RECEIVABLE AS AT DECEMBER 31, 1959

	M.H.S.P.	Province	D.N.H.W.
Manitoba Sanatorium	.....	$13,103	$58,041
Central Tuberculosis Clinic	.....	3,679	3,453
Assiniboine Hospital	$54,675	.....	45,297
Clearwater Lake Hospital	19,952	.....	38,561
	$74,627	$16,782	$145,352

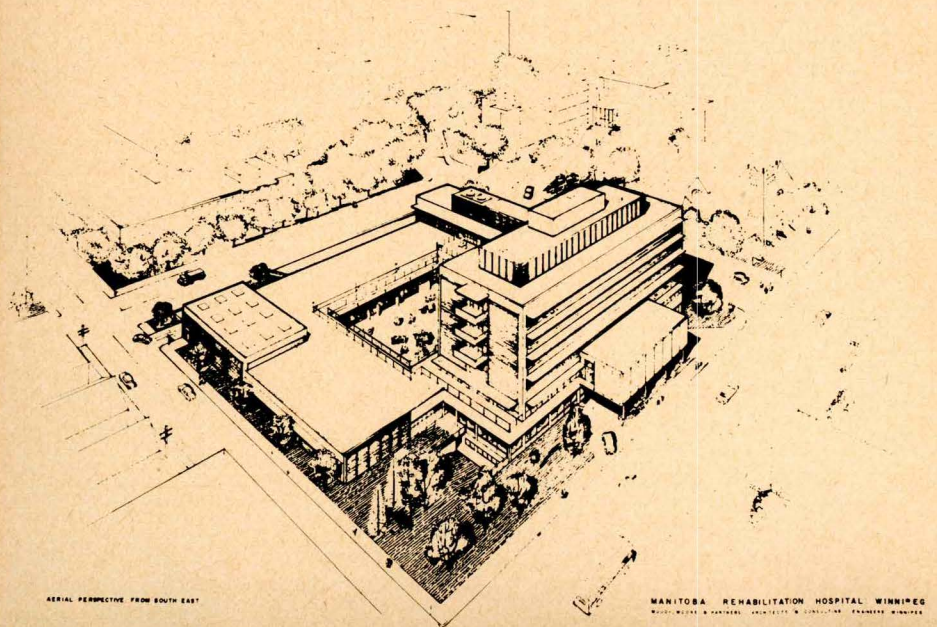
Recapitulation

Manitoba Hospital Services Plan	$74,627
Province of Manitoba	16,782
Department of National Health and Welfare	145,352
	$236,761

It is of interest to note that treatment accounts receivable had increased to $278,858 as at March 31, 1960. Working capital at Manitoba Sanatorium and Central Tuberculosis Clinic decreased $8,149 during the year.

DEVELOPMENT AND IMPROVEMENT OF FACILITIES

The largest undertaking in the area of planning and development of services in 1959 was the planning, design, organization and financing of the Manitoba Rehabilitation Hospital. Our architects, Messrs. Moody, Moore and Associates, have pressed forward the preparation of plans, and tenders will be called on April 18, to close on May 18. A contract was let in December for demolition of the houses in the block bounded by Sherbrook, Bannatyne, Olivia and McDermot. Services were transferred from the old Central Tuberculosis Building in January and February and demolition of that building has now been completed. Ward C-3 at the Winnipeg General Hospital was leased by the Board to accommodate the in-patient and out-patient services of the Central Tuberculosis Clinic. The property at 1654 Portage Avenue has been leased for the Executive Offices, Survey Offices, Central Registry, Rehabilitation Services and related central office functions during the construction period.



Artist's sketch of the Manitoba Rehabilitation Hospital. Architects are Moody, Moore and Associates.

Estimated gross cost of the Manitoba Rehabilitation Hospital, including construction, architect's fees, equipment, clearing of site, and contingencies is $4,370,000. This will be financed as follows:

Hospital Construction Grants (Federal and Provincial)	$1,449,511
Special provincial grant to cover balance of cost of School of Physiotherapy and Occupational Therapy	105,489
	$1,555,000
Contribution of Associated Canadian Travellers towards cost of special equipment	100,000
	$1,655,000
Bond issue of Sanatorium Board of Manitoba guaranteed as to principal and interest by Province of Manitoba	$2,715,000
TOTAL	$4,370,000

These figures are, of course, estimates, subject to such change as may be necessary as firm, figures become available. To cover preliminary costs, the Province has made the special grant of $105,489 towards the cost of the School of Physiotherapy and Occupational Therapy, and has advanced on a loan basis the sum of $112,511.

At Assiniboine Hospital there has been an urgent need for adequate physiotherapy-occupational therapy facilities. A thoroughly modern unit to house these services was designed during 1959 and is now under construction with the prospect that it will be completed in June 1960. Under agreement with Indian and Northern Health Services, this new unit is being financed by the Sanatorium Board of Manitoba and will be the property of the Board. Total contract cost of the unit, which is designed to fit ultimately into a new Extended Treatment Hospital, is $210,704.

At Clearwater Lake Hospital there has been urgent need for a staff building that would provide some opportunity for the staff to get out of the hospital buildings for relaxation and recreation. About 10 years ago we built a curling rink which has proved to be popular, but something more than this is necessary. The old army building that was formerly used for this purpose has been beyond repair for some time. Consequently, with the approval of the Directors of Indian and Northern Health Services we have constructed a staff building which will provide for canteen services, a sitting room, game room and a larger room which can be used for larger staff entertainment functions, meetings, and other events. The authorities at Ottawa have kindly approved naming this building "Northwood Hall", in memory of the late Major G. W. Northwood. It will be formally opened early in May.

At Manitoba Sanatorium Number One Pavilion has been remodelled by closing in the open balconies to increase the capacity of this unit from 24 to 52 beds. This makes it possible to provide 24-hour supervision for semi-ambulant patients on a reasonably economical basis. It is anticipated that a renovation grant will be forthcoming to assist in financing this improvement.

FINANCE

This has been a particularly difficult year with respect to financing normal operations. It was almost impossible to forecast accurately what the cost of caring for the non-tuberculous patients would be since there was no clear indication of the type of patient that would actually be admitted. Consequently, we made an agreement with the Manitoba Hospital Services Plan to establish an interim rate that would be subject to retroactive adjustment based on actual experience. The distribution of costs, as between the tuberculosis sections of the hospitals at Clearwater Lake Hospital and Assiniboine Hospital, is particularly difficult and subject to mutual agreement with hospital plan officials. Audited statements, supporting a request for retroactive adjustment of about $13,000 at Assiniboine Hospital and $26,000 at Clearwater Lake Hospital, have now been sent forward.

With respect to tuberculosis, treatment days for patients who are the responsibility of the Province of Manitoba dropped 21,724 to a total of 116,038 days in 1959; and tuberculosis treatment days for Indians, Eskimo and others dropped 44,678 to a total of 137,358 days in 1959. The corresponding drop in hospital income has complicated financial administration.

PREVENTIVE AND REHABILITATION SERVICES

By careful consideration of the best method of operating the preventive services, and modification in the light of circumstances, we were able to reduce expenditures in this department by about $9,000 in 1959 as compared with the previous year, without impairing the effectiveness of the programme and indeed perhaps improving it. We also took over full responsibility for the operation of the chest X-ray unit at the City Hall, with the City providing only space for the unit.

PREVENTIVE SERVICES

X-ray Field Services	$ 9,063	
Indian Clinics	3,944	
Travelling Clinics	6,717	
Industrial Surveys	3,476	
Survey Services	52,703	
City Hall	3,077	
		$ 78,980
Hospital Admission Chest X-ray		65,822
Tuberculin Surveys		16,706
Health Education		6,988
BCG Vaccinations		1,690
		$170,186

Expenditures on rehabilitation services in 1959 amount to $62,039 as follows:

Counselling and instruction services and travel	$ 26,097
Fees for courses and allowances to rehabilitants	7,978
Indian Rehabilitation Services	28,096
	$ 62,171
Less fees recovered from rehabilitants	132
	$ 62,039

INVENTORIES

As at December 31, 1959, supplies on hand, including commissary stores, engineering and maintenance supplies, fuel, diesel fuel oil, drugs and miscellaneous supplies, totalled $127,780, an increase of $5,399 as compared with the previous year. All inventories are valued at cost and all materials are in current demand.

NATIONAL HEALTH GRANTS

The appropriation available for the fiscal year 1959-60 under the National Health Grants to assist tuberculosis control in Manitoba was $227,706. Expenditures are subject to approval of acceptable projects. Expenditures in the fiscal year ended March 31, 1960, were:

Streptomycin and other antibiotics	$ 18,012
Assistance to Rehabilitation Division	17,732
X-raying of admissions to general hospitals	65,822
Assistance to Sanatorium Board of Manitoba	22,674
Extension of industrial and other chest X-ray surveys	5,184
Assistance to St. Boniface Sanatorium	8,560
Extension of Manitoba Travelling Clinic Services	33,079
Assistance to Manitoba Sanatorium	42,096
Extension of BCG vaccination program	1,680
Tuberculin Surveys	17,157
	$202,296

INSURANCE

Fire insurance with cover for supplementary perils was continued in force on buildings and equipment at Ninette and Central Tuberculosis Clinic in the amount of $1,295,000. In accordance with government policy no fire insurance is carried on buildings and equipment at Assiniboine Hospital or Clearwater Lake Hospital.

Motor vehicle insurance covers public liability and passenger hazard to a limit of $100,000, collision on the basis of $100 deductible and the usual fire and theft. No fire, theft and collision cover is placed on vehicles at Assiniboine Hospital or Clearwater Lake Hospital. Boiler insurance, comprehensive theft and dishonesty cover and all risks cover on the survey's field equipment are also carried.

PERSONNEL

At December 31, 1959, the staff of the Sanatorium Board numbered 520, an increase of 20 as compared with a year earlier. Some increase in nursing department staff was required to maintain an adequate standard of care in the extended treatment hospitals. The chronic shortage of nursing personnel, which we have experienced for many years, has recently shown a marked improvement, largely as the result of the appointment of the Director of Nursing Services.

At the end of 1959 there were 430 employees participating in our Group Insurance Plan, an increase of 21 as compared with a year previously. These members of the staff are insured for $1,424,500 of life insurance, and $10,360 weekly accident and sickness indemnity. Cover is included for surgical expense up to $250 for any one operation and payment of anaesthetic fees is insured. There are 156 members who also have surgical coverage on their dependents. Claims for weekly indemnity and surgical benefits were down about $4,500 for 1959 as compared with 1958, totalling $10,416. Life insurance claims at $8,000 were higher than they were in any year so far, and compare with $3,000 in 1958. Funds on deposit in the Board's Retirement Annuity Plan totalled $235,160 as at July 31, 1959, the anniversary of the contract This is an increase of $15,795 during the year.

T. A. J. CUNNINGS,
Executive Director and
Secretary-Treasurer.

STATEMENT OF TREATMENT DAYS—1959

Province of Manitoba—Cities, Municipalities and Unorganized Territory	City of Brandon	City of Portage la Prairie	City of St. Boniface	City of Winnipeg	Other Organized Municipalities	Unorganized Territory	Total
Assiniboine Hospital	33	—	—	109	138	893	1,173
Central Tuberculosis Clinic	34	184	441	3,936	2,788	1,178	8,561
Clearwater Lake Hospital	—	—	—	—	599	4,464	5,063
Manitoba Sanatorium	1,815	1,141	93	6,129	14,125	9,011	32,314
St. Boniface Sanatorium	—	1,001	2,341	27,015	24,816	13,754	68,927
	1,182	2,326	2,875	37,189	42,466	29,300	116,038

Government of Canada, Other Provinces and Manitoba Hospital Services Plan	Dept. of Veterans Affairs	Dept. of National Health & Welfare		Dept. of National Defence	Reciprocal Agreements with other Provinces	Manitoba Hospital Services Plan	Other	Total
		Tuberculosis	General					
Assiniboine Hospital	—	46,080	6,077	—	60	19,371	103	71,691
Central Tuberculosis Clinic	412	1,194	—	193	407	—	—	2,206
Clearwater Lake Hospital	42	32,731	2,704	—	—	8,153	340	43,970
Manitoba Sanatorium	3,503	35,813	360	16	269	—	365	40,326
St. Boniface Sanatorium	2,000	128,528	—	209	5,212	—	—	14,830
	6,047	127,346	9,141	209	5,948	27,524	808	173,023

TOTAL TREATMENT DAYS—1959

Province of Manitoba, Cities, Municipalities and Unorganized Territory	116,038
Government of Canada, Other Provinces and Manitoba Hospital Services Plan	174,023
	290,061

Medical Director's Report

Throughout this book I shall report on the progress in tuberculosis control as indicated by new cases and deaths, various aspects of case finding, and preventive and rehabilitation programmes. On page 27 I shall refer to tuberculosis treatment at Manitoba Sanatorium, the Central Tuberculosis Clinic, Assiniboine Hospital and Clearwater Lake Hospital. On page 42 I shall present a summary of the non-TB Extended Treatment Sections which have been opened recently at our Clearwater Lake and Assiniboine Hospitals.

NEW ACTIVE CASES

An indication of the effectiveness of tuberculosis control is the annual number of new cases. Identifying, isolating and treating sources of infection control the spread of tuberculosis, and benefits of a comprehensive case-finding programme are compounded year by year and generation by generation. Complacency and slackening of the preventive programme could cause a setback.

Year	Whites Active TB	Indians Active TB	Total
1945	438	134	572
1950	364	239	603
1955	231	101	332
1956	268	108	376
1957	239	118	357
1958	239	92	331
1959	196	62	258

Between 1955 and 1958 there was virtually no reduction in the number of new cases. In 1959 figures are much more encouraging, showing a total decrease from 331 to 258, or 22%. For non-Indians the reduction from 1958 was 18%; for Indians it was 32.6%. Although the 1959 reduction is gratifying and a stimulation to even more intensive effort, too much reliance should not be placed on any one year for, in contrast to other infectious diseases, the interval between tuberculosis infection and manifest disease may be months or even years.

In spite of educational efforts and tuberculin and X-ray surveys, 25% of the new cases have far advanced disease when first reported. This means a less hopeful prognosis and often the spreading of infection to countless others. The recovery rate is good in non-Indians between the ages of 20 and 40. Thirty-six percent of the new cases were in this age group, but only 6% of the deaths.

The distribution of new cases in Manitoba has a bearing on the intensity and location of preventive activities. Manitoba has 142 municipalities, of which 87, or 61%, had no new active cases in 1959. Only one case, or 19%, was reported in 27 other municipalities. The City of Winnipeg, which comprises 29% of the population in Manitoba, accounted for 42% of the new active cases. Of these 22% resided in Ward 1, 46% in Ward 2 and 32% in Ward 3. Seventy-eight percent of all tuberculosis in Winnipeg came from the area bounded by the Red River, Portage Avenue, Arlington and Redwood. Twelve percent of the new cases were New Canadians who had emigrated from Central Europe since 1950. This is a relatively high incidence.

Dr. E. L. Ross has been associated with the Sanatorium Board of Manitoba for 35 years. A Certified Specialist in Internal Medicine (Tuberculosis) he has directed the medical affairs of the Board's institutions, travelling chest clinics and X-ray and tuberculin surveys since 1937.

Besides the new active cases there are the known "inactive" cases which have become active. This is characteristic of tuberculosis and it is significant because recurrence of activity usually also means recurrence of infectivity. During 1959, 106 patients at home (13 less than in 1958), whose disease had been classified as inactive, developed active disease. This constitutes 29% of all active cases. It is evident that "inactive" disease requires close follow-up for a number of years. One-third were originally found by routine X-rays and considered not to need treatment. Twenty-five percent of the reactivated cases had sanatorium treatment since 1955 and 6%, pulmonary resectional surgery. A special study is being made of these treatment failures, having in mind the type of disease, the duration of treatment and chemotherapy. We concentrate case finding upon high incidence groups. The highest yielding groups are elderly people, those with a low economic status, those who are known to have had contact with a tuberculous person, and those known at one time to have had a lesion.

During 1959, 107 inactive cases were reported for the first time, compared to 151 in 1958. The 1959 case rate (active and inactive) is 41 per 100,000 population. In 1958 the rate was 55 per 100,000.

TUBERCULOSIS DEATHS

Year	Whites and Indians Combined		Whites		Indians	
	Rate per 100,000	Total Deaths	Rate per 100,000	Total Deaths	Rate per 100,000	Total Deaths
1935	60.8	432	38.6	269	1,258	163
1940	50.3	369	27.7	203	1,140	166
1945	42.7	314	25.1	185	793	129
1950	22.8	181	12.8	102	438	79
1955	8.5	72	6.8	56	80	16
1956	7.2	61	4.9	41	100	20
1957	7.5	65	5.4	46	90.4	19
1958	4.8	42	3.9	34	38.1	8
1959	4.6	41	3.7	32	39.0	9

(The figures for 1959 are tentative and based on the estimated population for Manitoba of 885,000, which includes 23,000 Indians.)

The decline in tuberculosis deaths during the last 15 years has been remarkable. The rate of 4.6 per 100,000 population is the lowest ever recorded in Manitoba. Nevertheless, it should still be a matter of concern that 41 people lost their lives to this one disease because most could have been saved if treatment had been started earlier.

Of the 32 non-Indians who died from tuberculosis 17 were 70 years of age or older. Only three deaths occurred under the age of 40 years and none under 10. The preponderence of elderly males dying of tuberculosis (except for Indians) is the same all across Canada and is without convincing explanation. Thirty-four of the 41 died of pulmonary disease; four of non-pulmonary disease (kidney and spine). Two Indian children died of meningitis and another, of generalized tuberculosis. Twenty-nine deaths occurred in sanatorium, 10 in general hospitals, one in a mental hospital and one at home. No Indians died at home—a rather big improvement over 20 years ago when most of the 166 Indian deaths occurred in crowded, unhygenic homes on the reserve.

Perhaps one wonders why 10 people died of tuberculosis in general hospitals. The reason is that, except for three Indians with acute and terminal meningeal or cerebral tuberculosis, all were elderly people and most had pneumonic illnesses of short duration which were not proven tuberculous until after death.

E. L. ROSS, M.D.,
Medical Director.

SUMMARY

1. Manitoba has a low death rate from tuberculosis—4.6 per 100,000 population, a slight decrease from 1958 and one-fifth the rate of 10 years ago.

2. Particularly encouraging is a decrease of 22% in the new active cases reported for 1959, in comparison with 1958.

3. Tuberculosis is noted for its recurring tendency and, in spite of treatment advances, it is significant that 29% of the active cases reported were reactivations. The immediate dramatic effect of drug therapy can be a pitfall to the patient and the physician. Tuberculosis is still a serious disease to the person and to the public.

4. Treatment days for tuberculosis continue to decrease, being down 18.8% in 1959. The average drop for the few years previously was 5%.

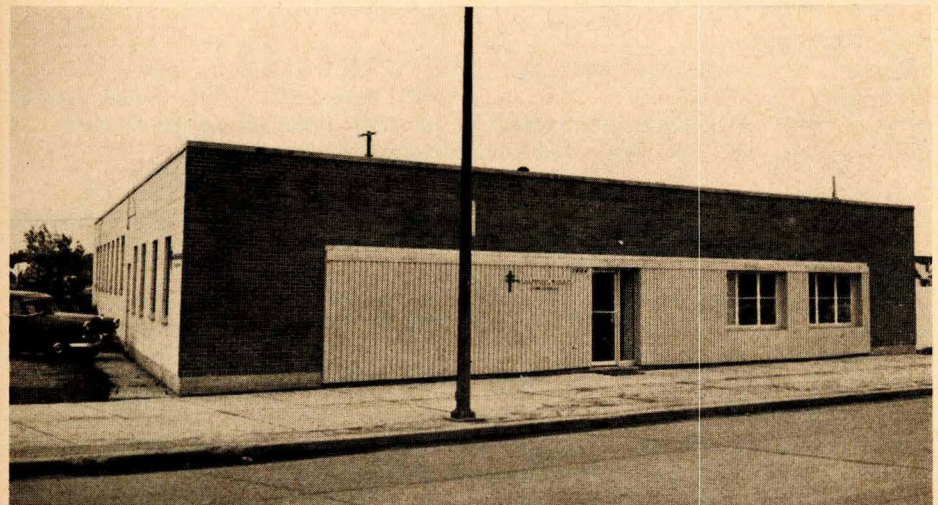
5. The number of tuberculous patients on treatment in sanatoria on December 31, 1959, was 625, compared with 740 in 1958 and 940 in 1947.

6. More beds became available for non-tuberculous extended treatment patients. There were 103 extended treatment beds in Assiniboine Hospital and 58 in Clearwater Lake Hospital at December 31, 1959.

7. A major change in case finding has been the inclusion of tuberculin testing in our survey programme. Fewer X-rays are necessary. Apart from current advantages, valuable information is obtained regarding infection rates for comparison with the past and also the future. The present low infection rate augurs well for the rising generation.

8. Aggressive and intensive preventive and treatment programmes are still necessary for continued success and for the ultimate eradication of tuberculosis.

PHOTO BY DAVID PORTIGAL & CO.



The Sanatorium Board's head offices were moved from 668 Bannatyne Avenue into new, temporary quarters at 1654 Portage Avenue early in 1960. The move paves the way for the construction of the Manitoba Rehabilitation Hospital which will be operated by the Board for the provincial government.

TB PREVENTION

Why are fewer people developing tuberculosis? Why are there only about half as many needing sanatorium treatment, compared with 10 years ago? Why is infection as shown by the tuberculin test becoming less and less? The answer simply is that the spread of the tubercle bacillus is being controlled. There is less opportunity for infection. Early discovery means prompt treatment and saving others from infection. The anti-tuberculosis drugs soon make the patient non-infectious and deaden the germ's power of reproduction. The year in and year out combing of the province by X-ray and tuberculin surveys may seem tedious—indeed, with diminishing returns, costly—but in the long run it is paying off in health, life and dollars saved.

This year Manitoba Sanatorium and the Sanatorium Board mark a half century of service to the people of Manitoba in lessening the menace of a deadly and tragic disease. Fifty years ago tuberculosis was a scourge from which few families escaped. Infection was everywhere. At that time emphasis was placed on building up body resistance, but before many years, as beds for isolation and treatment increased, it became evident that people could be spared infection and subsequent illness. We finally realized that to control the spread of tuberculosis we must reach out beyond the sanatorium walls. Tuberculosis has to be sought, not waited for. So, in 1926 the travelling clinics began and 20 years later, the mass X-ray surveys, which now incorporate tuberculin testing. Interest is being focused on infection, the prerequisite to disease.

EXAMINATIONS BY CLINICS, HOSPITALS AND SURVEYS

Year	Stationary Clinics	Travelling Clinics	Hospital Admission X-rays	X-ray Surveys	Total
1949	10,636	4,515	12,722	222,919	250,792
1950	10,440	5,205	47,774	170,402	233,821
1951	10,353	4,055	64,181	240,110	318,699
1952	11,325	5,566	72,872	223,086	312,849
1953	10,137	4,703	83,259	214,916	313,015
1954	9,554	3,375	85,513	239,850	338,292
1955	8,830	5,894	93,812	215,806	324,342
1956	9,339	5,093	99,232	212,060	325,724
1957	9,559	3,690	103,485	190,753	307,487
1958	8,392	1,874	86,714	137,456	234,436
1959	8,483	1,416	70,355	79,045	159,299
	107,048	45,386	919,919	2,146,403	3,118,756

CHEST X-RAY SURVEYS

For many years most of the province was covered every two years by X-ray surveys. But when the finding of active tuberculosis diminished to one case in 6,000 X-rayed, we began to concentrate on areas with a higher prevalence of disease. In 1959 half the number of residents were X-rayed as compared with 1958. This decrease was compensated for by tuberculin testing.

All new cases for the past three years are charted by municipalities. This serves as a guide in determining where travelling clinics and surveys are most needed. It is almost surprising, but certainly gratifying, to observe just what can be accomplished by intensive effort. Five years ago Camperville and Duck Bay districts were our worst areas of infection with as many as 10 cases developing in a year. We have held two or three clinics there annually since then including the vaccination of a number of residents with BCG, and in 1959 there were no new cases.

Out of 63,184 non-Indians X-rayed by surveys only 15 were found with active disease, about one in 4,200. When the 26 with inactive lesions are included the "catch" is one in 1,500. Out of 14,983 Indians X-rayed, only three had new active disease.

TUBERCULIN TESTING

Most people infected with the tubercle bacillus do not develop manifest disease. Because the tuberculin test, as far as infection goes, distinguishes the "haves" from the "have nots", the latter are screened out and only the former need chest X-rays. Over the age of 40, however, all people are X-rayed because of the higher prevalence of non-tuberculous conditions.

The tuberculin test is not new: it has been in use for over 60 years. What is new is its application on a mass scale. When infection rates are low it is of increased importance in the differential diagnosis of respiratory diseases. Applied to large population groups its value is also epidemiological, as it is the most accurate measurement of the infection rate.

During 1959 the total number tuberculin tested on surveys was 81,749. A total of 7,679, or 9.3%, did not return for a reading of their test.

The largest group surveyed consisted of 24 municipalities, in which 61,371 tests were read. Few children today are infected up to the age of 10; only a fraction of one percent have a positive test. From 15 to 19 years of age the percentage is 6.25; from 20 to 24, 14.6. At the age of 50 there is a steady rise to about 50%. From 65 to 69 the tuberculin positive rate is 68.3% but this can be expected since most of these people in their younger years had a greater chance of becoming infected. It is of interest that over the age of 70 the rate decreases slightly. This may indicate a loss of sensitivity to tuberculin and may have a bearing on the increased incidence of disease among the elderly.

The overall average of positive tests for the 61,371 tested is 21.4%. Most of the tuberculosis in the next 25 years will come from this percentage, so they will require closer following. A tuberculin registry is kept on these reactors.

Of the 4,915 tuberculin tested at the University of Manitoba those in the 15 to 19 age group had a positive rate of 5.1%, compared with 6.25% in community surveys outside of Winnipeg and 8.58% among the 6,590 Winnipeg high school students. Infection rates are a little higher in Winnipeg than in the rural or suburban municipalities.

I mentioned before that tuberculin testing is not new. In 1939 we tuberculin tested 3,000 rural and suburban school children and a comparison of the infection rate then and now is interesting. In 1939, 18% of the students had a positive test (i.e. were infected) compared with 3% in 1959. Although last year's group included more children in the five to 19 age group, it does show that, up to the age of 19, 97% of our young people outside of Winnipeg today have never encountered the TB germ.

For 50 years we have concentrated on disease, its early discovery and treatment, and this accounts for the progress attained. But now you can see that we are finally getting down to the root of the problem: infection before disease develops.

TRAVELLING CHEST CLINICS

Travelling Chest Clinics provide a more concentrated service than X-ray and tuberculin surveys. A doctor is in attendance and examinations are confined to suspects referred by local doctors, those who are known to have had contact with TB, and to follow-up reviews of ex-sanatorium patients and known cases. Due to the greater use of community X-ray facilities (i.e. local hospitals) the number attending these clinics has gradually decreased to 1,416 in 1959, compared with 1,874 in 1958. Just one active and four inactive cases were found. Ex-patients examined numbered 251 and contacts, 992. In 1959, 45 clinics were held at 27 centres, but due to the lack of findings, light attendance and other factors even fewer travelling clinics are planned for 1960.

STATIONARY CLINICS

These clinics are the out-patient clinics of each sanatorium and the Central Tuberculosis Clinic. They are responsible for finalizing the diagnosis in about half of all the new active cases in the province. Most of these cases are referred by private physicians whose role in case finding is of major importance. During 1959 out-patient clinics made 8,483 examinations. Of these 3,250 were patients with known, old tuberculosis and 3,064 were contacts. This is a slight increase over 1958.

THE CENTRAL TUBERCULOSIS CLINIC

The Central Tuberculosis Clinic is a centre for the diagnosis of tuberculosis and other chest diseases and for the periodic examination of known tuberculosis cases, ex-sanatorium patients and contacts. Of the 51 beds available the average occupancy during 1959 was 29. A total of 379 were admitted to the wards for an average of 28 days, and 4,780 were referred as out-patients for diagnosis and advice. Out-patients for chemotherapy numbered 321, compared with 260 the year before.

The Central Clinic is the headquarters of the preventive programme, travelling clinics and X-ray surveys. Here all films (including admission films from 57 rural hospitals) are processed, interpreted and reported upon. Last year these totalled 96,089. It is also a teaching centre for medical students and nurses and provides a consultation service to the Winnipeg General and other hospitals.

GENERAL HOSPITAL X-RAY PROGRAM

	1958	1959
Number of Hospitals 71		
Number of Admissions X-rayed	67,984	53,356
Number of Out-patients X-rayed	10,559	9,770
Number of Hospital Staff X-rayed	8,171	7,229
	86,714	70,355

A program to routinely chest X-ray patients admitted to general hospitals was initiated 10 years ago because this large segment of our population was known to have a much higher prevalence of active tuberculosis. In 1956 five times as much tuberculosis was found in general hospitals than in community surveys. This ratio has decreased and in 1959 was only twice as much. Of the 127,081 patients admitted to general hospitals, 53,356 (42%) had chest films. In 1957, 68% were X-rayed and in 1958, 51%. There are several reasons for this decrease. Due to the low infection rate, paucity of positive findings and the avoidance of radiation, children under the age of 15 are excluded. Many coming into general hospitals are readmissions and chest X-rays are not repeated within the year. Besides this, reorganization of X-ray departments in two large hospitals accounted for a decrease of over 10,000 X-rays, compared with 1958.

X-RAY FINDINGS

It is understood that these X-ray films are a method of screening out abnormalities which have to be assessed by further investigation.

1. Of the 53,356 admissions X-rayed, 26, or *one in 2,052*, had apparently active tuberculosis.
2. 459, or *one in 116*, had tuberculosis that was considered inactive.
3. 67, or *one in 796*, had tuberculosis of doubtful activity.
4. 213, or *one in 250*, were considered tuberculosis suspects.
5. Taking into account all the above, 764, or *one in 70*, had evidence of present, past or suspected tuberculosis.
6. Of the 9,770 out-patients, nine, or *one in 1,085*, had apparently active tuberculosis.
7. Among 7,229 hospital staff X-rayed, one had apparently active tuberculosis.
8. The value of this program and, indeed, of all our surveys is not confined to discovering tuberculosis. Many other abnormalities are drawn to attention and referred to the private physician. This is evident by the fact that among 53,356 patients X-rayed on admission, 3,510 (*one in 15*) had non-tuberculous chest conditions, and 3,252 (*one in 16*) had suggested cardiac abnormalities.

All case-finding methods need to be kept under constant review and I consider that the general hospital admission X-ray program contributes to the control of tuberculosis. The programme creates and maintains the interest of physicians and hospitals in tuberculosis and provides a liaison with the official tuberculosis control body. This is important because, with falling infection rates, fewer people needing treatment and fewer dying of the disease, professional and public concern is tending to wane.

B.C.G. VACCINATIONS

Tuberculosis Contacts	194	
Medical Students	3	
Student Nurses (General Hospital)	338	
Student Nurses (Mental Hospital)	23	
Student Nurses (Practical)	78	
Nurses' Assistants	42	
Sanatorium Staff	50	
Laboratory Technicians	21	
Others	68	817
By Indian and Northern Health Services		508
Total		1,325

The table shows the extent of our B.C.G. vaccination programme. This is much the same as in previous years except for a marked reduction in vaccinations by Indian Health Services due to a change in policy. B.C.G. is a vaccine that stimulates defensive forces within the body against tuberculosis. It provides some degree of protection if a previously uninfected person is infected with the tubercle bacillus. A mass vaccination program would not be warranted with our low infection rate. We therefore confine vaccination to those who may not be able to avoid infection. The fact that the tuberculin test is of increasing diagnostic and epidemiologic significance is a deterrant to a more comprehensive B.C.G. programme, as the vaccine artificially produces a reaction to tuberculin.

CENTRAL TUBERCULOSIS REGISTRY

The Central Tuberculosis Registry is the medical accountancy department. It records and analyses medical and social data pertaining to all phases of the prevention and treatment of tuberculosis. The whole system is practical and economical to operate and is essential for appraisal and direction of the Board's medical programme.

Information about 4,144 tuberculous patients was on file in the Registry on December 31, 1959. This includes 1,203 Indians and 415 Eskimos. Records on all sanatorium patients and their contacts are readily available as well as data on all known cases regardless of whether or not they have had treatment. Details are also recorded about X-ray and tuberculin surveys, new cases and deaths. The Registry follows up all medical recommendations.

—From the report of the Medical Director.

During 1959 a total of 81,749 Manitobans received free tuberculin skin tests. These tests are not only an important aid in the discovery of new cases of TB, but are also helpful in determining the extent of the tuberculosis problem in a community.

City of Winnipeg

Continued progress in the control of tuberculosis in Winnipeg is reflected in the following report of the Tuberculosis Division of the City Health Department.

Death Rate—There were 18 deaths in Winnipeg due to tuberculosis. This corresponds to a death rate of seven per 100,000. There is no significant change over the past seven years.

Year	Number of Deaths	Rate per 100,000 Population
1940	52	23.0
1950	21	8.8
1954	17	7.0
1955	17	7.0
1956	12	4.7
1957	22	8.7
1958	16	6.3
1959	18	7.0

Hospitalization—A monthly average of 126 patients were hospitalized in the various sanatoria during 1959. This is slightly less than figures for 1958 (148), 1956 (147) and 1957 (139), but is well below figures for 1954 (191) and 1955 (166).

Ninette	31
St. Boniface Sanatorium	79
Central Tuberculosis Clinic	15
Assiniboine Hospital	1
Total	126

X-ray Surveys—The City Hall unit did surveys of 1,790 Civic Employees and of 1,035 in the Needle Trade as well as numerous pre-employment medicals.

INDUSTRIAL SURVEYS

Employees of 386 business and industrial concerns were given the opportunity to have chest X-rays at one of 22 sites. Eighty-two percent attended.

MOBILE UNITS

Number of operational sites	22	
Number of industries X-rayed	386	
Average attendance	82%	
Number of industrial X-rays taken	17,464	
Number of X-rays taken at schools and colleges	913	
Total 70 mm. X-rays		18,377

UNIT AT CITY HALL

Number of survey, contact and patients X-rayed	5,935	
Number of pre-employment X-rays	3,248	
Total 4 x 5 X-rays		9,183
TOTAL X-RAYS TAKEN DURING 1959		27,560

Three new cases of pulmonary tuberculosis were discovered during the year. This is 3.8% of the total number of new active pulmonary cases discovered by private physicians, sanatoria, hospitals, private and public clinics.

ACTIVE CASES OF PULMONARY TUBERCULOSIS

Year	By All Means	By City Health Surveys	% of Total Found by City Health Surveys
1953	74	26	35.1%
1954	67	17	25.4%
1955	48	11	22.9%
1956	49	9	18.3%
1957	61	8	13.1%
1958	58	7	12.7%
1959	79	3	3.8%

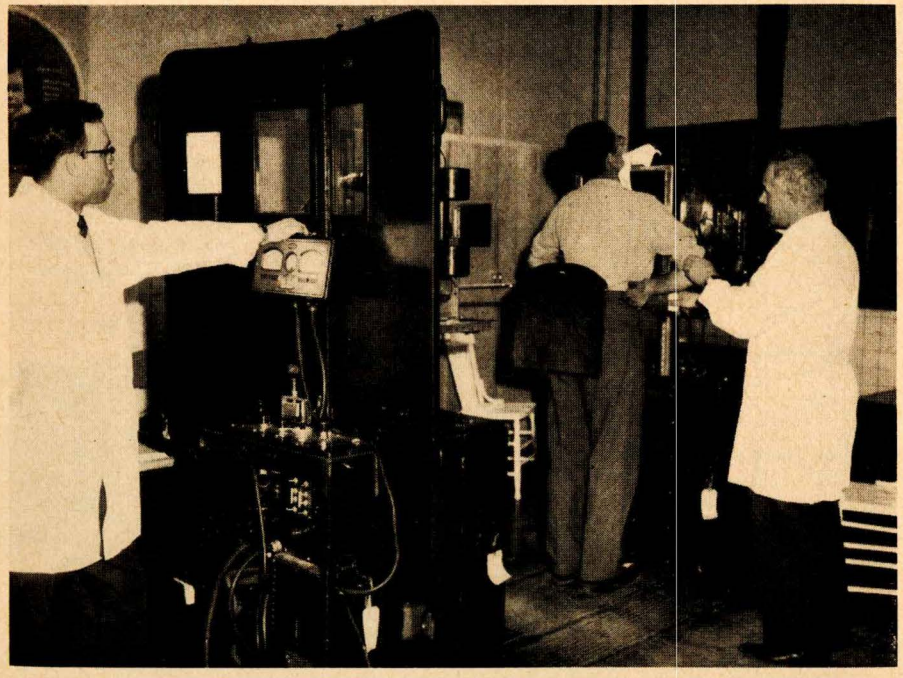
Routine chest X-rays are becoming a less efficient method of case finding, and more emphasis is placed on X-raying only tuberculin sensitive individuals, contacts, and certain exposed groups. Pre-employment X-rays are done only if no recent X-ray has been taken. Two of the three cases discovered in the survey were clinically ill and had far advanced tuberculosis. Only one was discovered by routine film, or a ratio of one in 9,187, or a little over 1% of total cases discovered. No new case was found in X-rays of 556 contacts of tuberculin positive persons.

ACTIVE CASES DISCOVERED BY SURVEYS

Year	Number of X-rays	Total Active Cases	Active Case Rate per 1,000 X-rays
1952	52,466	25	.5 or 1 every 2,088 X-rays
1953	72,259	26	.4 or 1 every 2,779 X-rays
1954	83,883	17	.2 or 1 every 4,934 X-rays
1955	49,150	11	.2 or 1 every 4,468 X-rays
1956	58,422	9	.1 or 1 every 6,491 X-rays
1957	61,064	8	.1 or 1 every 7,633 X-rays
1958	32,387	7	.2 or 1 every 4,627 X-rays
1959	27,560	3	.1 or 1 every 9,187 X-rays

In addition to these new unsuspected cases of tuberculosis some individuals were found to have other significant pathology of the lung, heart or great vessels. They were advised to consult their own physicians for further advice or treatment as required. It should be noted that there were 625 individuals referred to the City Hall by private physicians for chest X-rays and that two new active cases were discovered among this group.

J. B. MORISON, M.D., D.P.H.,
Deputy Medical Health Officer.



Although tuberculin tests are most effective as a preliminary screening of all age groups, the chest X-ray remains the most valuable tool in the diagnosis of pulmonary tuberculosis. The chest X-rays are given to those who show a positive reaction to the skin test and to persons over 40 years of age, since many chest abnormalities other than tuberculosis are often found in this age group.

TUBERCULOSIS TREATMENT

On December 31, 1959, there were 614 tuberculosis beds occupied in Manitoba and approximately 138 were vacant. However, with more beds being allocated for non-tuberculous patients and with the Central Tuberculosis Clinic losing 24 beds, there were only 69 vacant beds on February 29, 1960.

The decrease of 18.8% patient days in 1959 is greater than the yearly decrease for 1958 and 1957. This is because fewer people need treatment and treatment in hospital is of shorter duration. In attempting to forecast tuberculosis bed requirements during the next few years I cannot anticipate any radical treatment or epidemiological factor that would unfavorably alter the trend of the past five years. The peak year for Indian and Eskimo patients was in 1954, and since then it will be noted that Government of Canada (mostly Indians and Eskimos) and other provinces' treatment days have decreased from 211,588 to 137,358. Past experience would indicate that the yearly decrease will continue, possibly 8% to 10%. On this basis patient days by 1962 should be about 200,000, and the number of beds required for tuberculosis, approximately 450.

TREATMENT FACILITIES

Tuberculosis

	Bed Capacity						Bed Occupancy					
	Dec. 31 1955	Dec. 31 1956	Dec. 31 1957	Dec. 31 1958	Dec. 31 1959	Feb. 29 1960	Dec. 31 1955	Dec. 31 1956	Dec. 31 1957	Dec. 31 1958	Dec. 31 1959	Feb. 29 1960
Manitoba Sanatorium	280	280	250	250	267	265	224	223	212	173	196	201
Central TB Clinic	50	50	53	46	46	18	45	48	38	29	27	18
St. Boniface Sanatorium	285	285	284	284	245	245	264	253	250	230	223	227
Dynevor Indian Hospital	55	55	—	—	—	—	53	52	—	—	—	—
Clearwater Lake Hospital	190	190	187	127	96	81	185	185	192	137	77	88
Assiniboine Hospital	260	256	227	167	98	80	243	238	248	230	91	86
	1120	1116	1001	874	752	689	1014	999	940	799	614	620

Extended Treatment Section

	Bed Capacity		Bed Occupancy	
	Dec. 31 1959	Feb. 29 1960	Dec. 31 1959	Feb. 29 1960
Clearwater Lake Hospital	58	73	47	56
Assiniboine Hospital	103	129	94	102
	161	202	141	158

It is planned during 1960 to transfer 100 tuberculosis patients from Assiniboine Hospital to Manitoba Sanatorium as soon as suitable accommodation becomes available in the latter institution and the demand for extended treatment beds increases at Assiniboine Hospital. Ultimately Assiniboine Hospital (200 beds) could be used solely as an extended treatment hospital.

It is proposed that the 450 beds required for tuberculosis be provided by Manitoba Sanatorium, Ninette, and St. Boniface Sanatorium, St. Vital. Clearwater Lake Hospital in Northern Manitoba can reduce the tuberculosis section to 50 beds, but this number should be retained, leaving 100 beds for extended treatment, non-tuberculous patients. The Central Tuberculosis Clinic will have 20 beds, primarily for diagnosis and assessment.

ADMISSIONS AND DISCHARGES

In Manitoba in 1959, 23% fewer tuberculous patients were admitted to sanatoria than in 1958, the respective numbers being 600 and 788. All but 8% of the 258 new active cases

reported were admitted. Those not admitted were non-pulmonary or non-infectious and could manage at home. Our first knowledge of 11 was notification of their deaths. They died of acute disease, mostly meningeal or pneumonic, in general hospitals.

Although fewer people are breaking down with tuberculosis, there has been no real improvement for a number of years in the stage of disease on admission for treatment. Of the first admissions, 21% were far advanced and another 33%, moderately advanced. For the readmissions the respective figures are 25% and 42%. Most of these could spread infection.

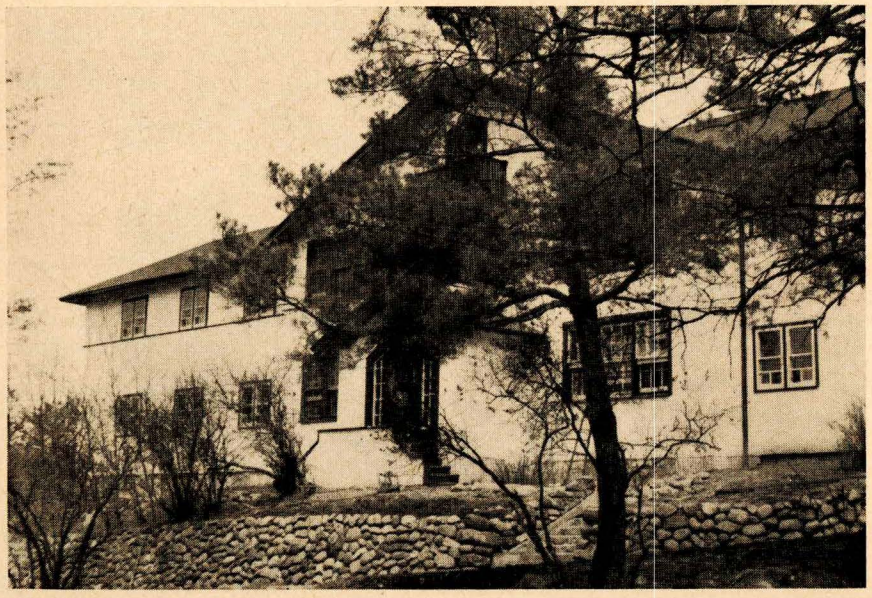
There were 712 tuberculosis patients discharged from sanatorium. In 66% disease was classified as inactive. Deaths accounted for 4.7% of the sanatorium discharges. Of the 712 discharges 9% were against medical advice. This is lower than the average for Canada and much lower than that for the United States.

The average duration of treatment for all patients discharged (excluding those in for less than 30 days and those from the Central Clinic) was 435 days, compared with 490 for 1958.

TREATMENT

Sanatorium rest, regulation and education still have an important bearing on permanent cure Bed rest can be less intensive and less prolonged. We depend more than anything else on anti-tuberculosis drugs. Surgery has an important role but indications are becoming more limited. This is evident by a reduction of 39% in surgery on patients discharged in 1959 compared to 1958. Some of this decrease is due, of course, to fewer patients on treatment. Of the pulmonary cases discharged 22% had surgery, mostly resectional.

—From the report of the Medical Director.



Built as a military pavilion in 1917, Number One Pavilion at Manitoba Sanatorium was remodelled during 1959 into a 52-bed semi-infirmary unit. The out-moded balconies of the one-time convalescent building were closed in and the exterior walls were covered with white stucco. Inside, partitions erected provided a patient's cafeteria, common rooms and a classroom.

Central Tuberculosis Clinic

There were 7,627 visits to the Central Tuberculosis Clinic Out-patient Department during 1959—1,583 for first examination, 3,160 for repeat examinations, 2,847 for streptomycin injections, and a few miscellaneous visits. Examinations of people known to have had contact with tuberculosis totalled 2,397.

The 5,207 examinations in our out-patient department yielded 140 new cases of tuberculosis, an incidence of one case for every 37 examinations. This shows the importance of the private practitioner in our preventive programme because over half of our examinations are referrals from private physicians. Of the 140 new discoveries, 126 were found to be active and in need of treatment and 53 were openly bacillary. No doubt as a result of an aggressive case-finding programme there is gradually emerging a different pattern of new cases. In 1959 for the first time the far advanced cases were the least, being 22.53% as compared with 39.44% moderately advanced and 38% minimal.

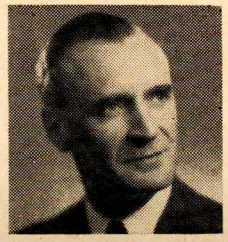
The incidence of disease by age groups is also of interest. The group from 30 to 39 yielded the most cases—19. The group aged 50 and over is of great importance. These people yielded 38 cases, 27 of which had pulmonary disease.

TREATMENT

There were 379 admissions to the ward for 10,003 patient days. A total of 221 patients were in hospital for the first time; the remainder were readmissions, transfers, reviews, etc. Of these admissions 271 had tuberculosis and 108 were proven to be non-tuberculous. Acute and subacute respiratory infections were most common but it is interesting to note that there were 10 cases of lung malignancy. Thirty-five of the 271 tuberculous patients had non-pulmonary tuberculosis, and 123, or almost half, of the tuberculosis admissions were found to be bacillary.

There were 381 discharges, 164 of which were transferred to sanatorium to continue treatment. There were nine deaths but only one was due to tuberculosis. Nine patients had irregular discharges, either for discipline or against advice. The average length of treatment was 28.3 days.

Streptomycin, PAS and INH continue to be the three standard drugs and on the ward 214 patients were treated with these. It is only an impression but it seems to me we did not have as much trouble last year with patients insisting on being treated at home. This, however, is still a problem.



Dr. D. L. Scott has been Medical Superintendent of the Central Tuberculosis Clinic since it was first opened in October, 1930. He has been Assistant Medical Director of the Sanatorium Board of Manitoba and Superintendent of Preventive Services since 1946.

MEDICAL DEPARTMENTS

Laboratory—Diagnostic tests are most numerous: 1,619 specimens of sputum, 9,207 tuberculin tests, 3,181 blood examinations. Vaccination of known contacts, nursing students and medical students was continued. The nursing staff of Winnipeg's three largest hospitals and St. Boniface Hospital are done each year. Altogether, a total of 16,438 tests were done, besides preparing tuberculin and mailing tuberculin and sputum containers to doctors and hospitals. The laboratory staff were required to assist in some of the tuberculin surveys and also fill in for duty at Clearwater Lake Hospital for a month.

X-ray Department—In the X-ray Department a total of 4,376 people were X-rayed, using 4,557 films for the various procedures.

PREVENTION

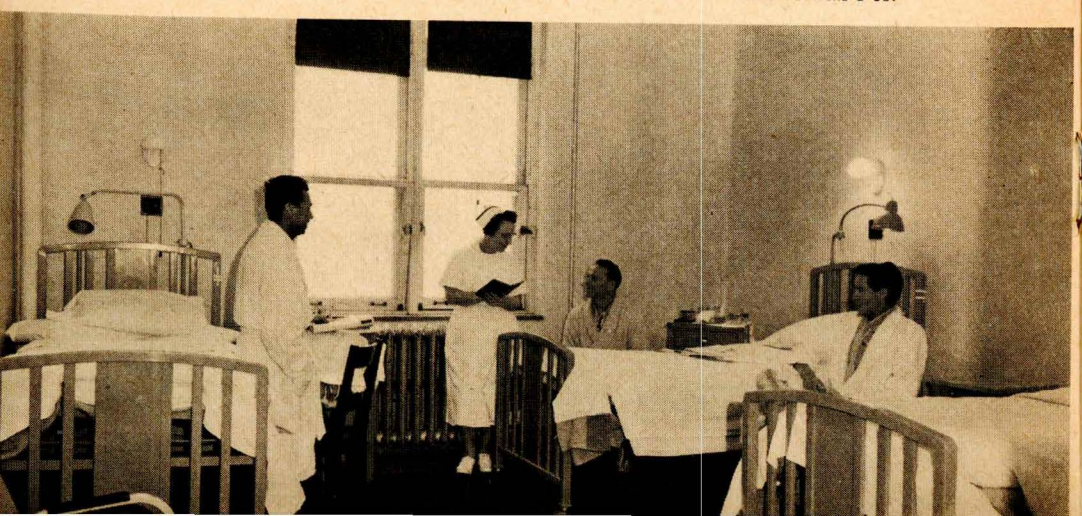
Travelling Clinics—Travelling clinics continue to be of some importance, especially in outlying districts. Forty-five clinics were held at 27 centres in the province. A total of 1,353 whites and 63 Indians were examined and five new cases of disease were found, only one of which was active. Of almost equal importance was the examination of 251 ex-sanatorium patients, and the examination of contacts with disease.

Surveys—Mass surveys as we knew them 10 years ago are not conducted now. First, because of economy, we restricted X-rays to certain age groups. Then, in 1959 we adopted a plan to tuberculin test all citizens in a mass way and X-ray only the positive reactors, except for those 40 years of age and over who were all X-rayed. Altogether 81,749 tuberculin tests were made in 22 municipalities and two larger towns. There were 79,045 people X-rayed at our surveys and 54 new cases were discovered, or one case in 1,463. Only 18 of the 54 new cases were found to be active and in need of treatment.

Hospital Admission X-ray Program—Fifty-seven hospitals in Manitoba sent X-ray films to us for reading. The 24,821 films yielded 19 cases of suspected tuberculosis.

D. L. SCOTT, M.D.,
Medical Superintendent,
Central Tuberculosis Clinic and
Preventive Services.

One of the attractive patients' rooms at the new quarters of the Central Tuberculosis Clinic. The Clinic was moved in January, 1960, to temporary quarters at Winnipeg General Hospital.
PHOTO BY DAVID PORTIGAL & CO.



Manitoba Sanatorium

There was no outstanding variation in treatment in 1959. The year was mainly remarkable for a sharp increase in patients of native blood, due to transfers from other institutions, and for some alteration in patient accommodation and routines in keeping with this change in population. On December 31 natives, plus Metis, accounted for 69% of the sanatorium population, as compared to 45% a year ago. The year's end census stood at 193. Of these 93 were Treaty Indians; 22, Eskimos; 17, Metis; and 61, Whites. Males outnumbered females two to one. Total patient days dropped from 79,006 in 1958 to 72,640.

The upkeep of the buildings continues to be good. The main work of the year was the closing in of No. 1 balconies and the redecoration of the building inside and out. In this way the pavilion was converted from a 27-bed observation ward to a 52-bed semi-infirmary unit with 24-hour nursing service.

During the year we also started two projects which take advantage of the increased physical activity of patients, made possible by drug treatment in sanatorium surroundings. The first of these is to reduce the number of patients who are served meals in bed. In No. 1 Pavilion patients now have their own cafeteria and in the infirmary quite a few of the patients are eating in common rooms close to the serveries. This makes possible hotter meals with less tray carrying service and fewer food complaints from the patients.

The second project is a programme of periodic social gatherings for combined staff and patients. The object is a supervised social outlet, and in native patients, particularly, the fostering of acceptable deportment and confidence in mingling with White groups.

ADMISSIONS AND DISCHARGES

Admissions to the sanatorium totalled 262. Of these 217 were tuberculous and 45 proved to have other chest conditions. Of the 217 tuberculous admissions 198 had pulmonary disease, which was far advanced in 42%, moderately advanced in 31% and minimal in 27%. Five patients had pleurisy with effusion and four, primary infection tuberculosis. Ten patients had non-pulmonary tuberculosis with sites as follows: Glands, 4; bone, 1; genito-urinary, 5.

The incidence of relapse in tuberculous admissions to Manitoba Sanatorium has not decreased in the last 10 years. Of the 1959 admissions 47, or 22%, have relapsed as compared with 34, or 19%, in 1949. The relapse rate in the 57 White admissions was slightly higher than in the 160 non-White (Indian, Metis and Eskimo). Because many non-White admissions had

Dr. A. L. Paine, a thoracic surgeon, started his medical career at Manitoba Sanatorium, Ninette, as a Medical Assistant. In 1936 he joined the Sanatorium Board's Travelling Clinics, and in 1947 was appointed Medical Superintendent. He is president of the College of Physicians and Surgeons of Manitoba.

started treatment in other hospitals their relapse rate was studied in relation to the date of first hospitalization, and the 1959 relapse rate also was found to be slightly higher than in previous years. Of the combined group of 47 White and non-White relapses, 18 had been treated with chemotherapy for two years or more; 20, for shorter periods (mainly one year or less); and nine had no drug treatment. Only 13 were treated with INH and only three had resection surgery.

There were 238 discharges. Of these 190 were from treatment of tuberculosis and 45 from investigation and diagnosis of a condition ultimately proven non-tuberculous. Of the total discharges 78% left on medical advice; 5% against medical advice; 1% were disciplinary; 12% were transferred and 4% died. None of the 12 irregular discharges had positive sputum. Seven have been re-admitted here or elsewhere; five have remained well to date at home. For the 34 patients discharged on medical advice chemotherapy is being continued at home.

There were 10 deaths with autopsies performed in eight. Four of the deaths were from tuberculosis and four from other causes in tuberculous patients. Two patients died from a condition which proved to be non-tuberculous.

OUTPATIENTS

The outpatient department made 1,101 examinations. Of these 447 were old patients back for review. There was one discovery of tuberculosis and 28 had non-tuberculous chest conditions.

TREATMENT

The principles of treatment have not varied significantly in the past year and are still based on prolonged rest in sanatorium. Despite outside influences most patients, even Whites, manage to put in the prescribed period of time. The average stay last year was 288 days, but many non-Whites were transfers with considerable previous treatment. Patients are allowed ward exercise sooner than previously and they retire later. Rest periods are strictly adhered to.

All patients receive anti-tuberculosis drugs and an increasing number are placed on triple drug therapy: Streptomycin, 1 gram twice weekly; INH, 300 daily; PAS to tolerance not exceeding 12 grams daily. Sick patients are placed on daily injections of streptohydrazide for the first two or three months of treatment. Some use is made of viomycin, streptomycin and pyrazinamide for patients with drug-resistant organisms. In the matter of general drug purchase and management a consultant pharmacist service has been set up.

Surgery was used less widely in the last year. Sixteen operations were considered either mandatory or of a salvage nature. Of these 11 of the patients were drug-resistant with positive sputum, four had empyema and one required pack removal. This group required 31 surgical procedures, including resection, plombage, standard and Schede thoracoplasty. Surgical indications were considered strong but not mandatory in 10 patients with negative sputum but extensive residual sepsis or cystic cavity formation. Five had resection; four, plombage; and one, thoracoplasty. Thirty patients, with varying degrees of residual disease following six months or more of chemotherapy and with indications for surgery in the main controversial, were treated with wedge or segmental resection.

Major chest operations for the year totalled 74, of which 42 were resection and 32 were chest wall procedures. There was one operative death following a surgical attempt at salvage.

MEDICAL DEPARTMENTS

X-Ray and Laboratory Departments—These departments have kept up their usual high standard of service. Work in the X-ray Department included 4,023 radiographic examinations and 77 electrocardiograms (including pre-operative electrocardiograms). Coloured slides were made of all operative specimens.

The Laboratory Department performed a total of 12,561 tests during the year. This is numerically less than in 1958 but represents a gain of 15.8% in standard work units. A new test for liver function was introduced. There is an increasing need for more culture work in sputum and gastric washings which will necessitate further equipment.

Physiotherapy Department—The Physiotherapy Department continues to fill a definite need. It is an important adjunct to chest surgery in avoiding post-operative complications and providing functional re-education. It is of great benefit to tuberculous patients with associated arthritic conditions and in the management of orthopedic problems.

Education and Study—The growing number of Indian and Eskimo patients has increased the need for primary education. This is well supplied by the Rehabilitation Department and by vocational training and occupational therapy instruction. Study in itself affords much needed psychotherapy by keeping patients adjusted to their long stay in hospital.

The affiliate course in infectious disease nursing for the Brandon General Hospital School of Nursing has continued. Members of the nursing, medical, laboratory and dietetic staff contribute to the lectures. A similar course for practical nurses is being prepared. Nurses assistants are also given lectures and ward training.

PAPERS

"Fifteen Consecutive Admissions" presented to the Pembine Therapy Conference in Pembine, Wisconsin, by A. L. Paine, M.D., September 11, 1959.

A. L. PAINE, M.D.,
Medical Superintendent.

An aerial view of Manitoba Sanatorium at Ninette.

Assiniboine Hospital

During 1959 patient days at Assiniboine Hospital totalled 72,864. Of these 47,313 were for tuberculous patients. The total patient days are down from the 1958 figure of 83,545 but this reduction is due largely to the change-over from tuberculous to general hospital sections. It was impossible to have tuberculous and general cases on the same ward and once a ward was designated a general hospital section, all tuberculous patients were transferred from that ward, leaving it for a time partially empty. Tuberculosis patients requiring admission during the year were, for the most part, directed to other sanatoria. At the same time 129 tuberculous patients resident in Assiniboine Hospital were transferred to other institutions.

ADMISSIONS

Eighty-seven tuberculous patients were admitted to Assiniboine Hospital in 1959. Most of them were children and patients with bone and joint tuberculosis. Forty-two were under 19 years of age. Very few were admitted for long term care: most were for investigation and initial treatment and were later transferred to Manitoba Sanatorium to make room for non-tuberculous cases.

Of the 87 admissions, only 60 had active disease, and one-half of these were bacillary. Sixty had respiratory disease, the majority being moderately advanced or minimal cases. Only 10 had far advanced disease. One had miliary tuberculosis and four had primary infection type. Of the 18 non-respiratory tuberculous cases, seven had adenitis, five osseous disease, one renal and one meningeal.

DISCHARGES

While only 87 tuberculosis patients were admitted during the year, 202 were discharged. The majority were transferred to other sanatoria to continue treatment. Four TB patients died, all of whom had respiratory disease. Two others left against medical advice. The average length of treatment of all tuberculous discharges was 322.87 days, as compared with 333.24 in 1958.

OUTPATIENT DEPARTMENT

Out-patients examined totalled 1,425. The routine X-raying of school teachers, the Royal Canadian Mounted Police, employees of the Manitoba Power Commission, new admissions to the Old Folks' Home and inmates of the Brandon Jail was continued. A tuberculin survey of students at Brandon College was conducted and all reactors X-rayed. New employees with a negative tuberculin test at the Brandon General Hospital and Brandon Mental Hospital were given BCG. Of the 356 persons given Mantoux tests 8.7% were positive.

Dr. A. H. Povah has been a member of the Sanatorium Board medical staff for 13 years and Medical Superintendent of Assiniboine Hospital, Brandon, since 1951. He was formerly a resident physician at St. Boniface Sanatorium and Manitoba Sanatorium and came to Brandon as Sanatorium Surgeon in 1948.

Monthly visits were made to the Brandon Hospital for Mental Diseases where active tuberculosis cases, those needing close follow-up and suspects were reviewed. A consultation service for respiratory diseases was also provided. Also during the year a weekly medical clinic was held on the reserve at Griswold. This service had to be discontinued on December 31, 1959, but many of the patients who would have been seen in this clinic are now brought to our Out-Patient Department by the public health nurse.

TREATMENT

Drug therapy has been the same as other years, most patients receiving INH, PAS and streptomycin.

Seventy-seven thoracotomies were performed during the year. Thirty of these were on tuberculosis patients, two of whom had cavitary disease and two, tuberculomas. The remainder were done for destroyed lung as evidenced by tuberculous bronchiectasis and/or atelectasis. Of the 30 resections, four developed broncho pleural fistulae, three of which were successfully treated with intercostal tube suction. One required a thoracoplasty. There was one wound infection.

Other respiratory operating room procedures were: Thoracoplasty, 1; bronchograms, 141; bronchoscopies, 115. Forty-one of the bronchoscopies were on tuberculosis patients. There were 22 orthopedic operations, 10 of which were for tuberculous conditions.

DEPARTMENTS

X-ray—The X-ray Department performed 5,948 examinations during the year, as compared with 5,211 the previous year. Clinical photography was considerably reduced.

Laboratory—The laboratory had the busiest year in the history of the hospital, performing 15,395 tests, or 38,524 units of work. This compares with 35,986 units in 1958. There has been a decrease in bacteriology but a considerable increase in the amount of haematology and biochemistry.

COMMITTEES

On March 31, 1959, the physicians of Brandon and surrounding districts practicing in Assiniboine Hospital organized themselves in conformity with the by-laws and regulations adopted for the hospital, and have set up the necessary committees and held medical staff conferences as laid down in the constitution of the hospital. The following committees were formed: Credentials committee, Dr. A. H. Povah; medical records committee, Dr. G. Coghlin; tissue committee; Dr. A. Lapko; pharmacy committee, Dr. V. J. H. Sharpe.

Tissue Committee—Deaths and surgically removed tissues were reviewed by the committee. During the year there were 10 autopsies performed and 298 surgical specimens were grossly and microscopically examined. The examination and surgical specimens showed close correlation with the clinical diagnosis in all cases.

Medical Records Committee—At the two meetings held during the year, all medical records were reviewed and found to be satisfactory. Coding and cross-indexing of diseases and operation were continued throughout the year by the medical staff.
The committee recommended that all consultations between members of the resident staff be recorded on the prescribed form.

Executive Committee—Two meetings of the executive committee were held in 1959. Thirty-four applications for appointment to the courtesy medical staff, the active medical staff and the resident medical staff were reviewed and recommendations for appointments to the medical staff were made by the governing body. By-laws, rules and regulations of the medical staff were also reviewed.

ACCREDITATION

The Canadian Council on Hospital Accreditation awarded full accreditation to Assiniboine Hospital following a visit by Dr. D. D. Campbell, of Hamilton.

A. H. POVAH, M.D.,
Medical Superintendent.

St. Boniface Sanatorium

During 1959 a total of 84,757 treatment days were given at St. Boniface Sanatorium, as compared with 87,295 for the preceding year. Two hundred and eight individuals were admitted to the Sanatorium, and of this number three were for review and seven were newborn. Forty-five, or 21.5%, of the admissions were under 20 years of age, with the age group 25 to 29 having the highest incidence. One-third of the patients were over 50 years of age.

The majority of the patients required treatment for respiratory tuberculosis. The figures with their percentages follow. Pulmonary: minimal, 32 or 18%; moderately advanced, 79 or 44.4%; far advanced, 56 or 31.4%; pleurisy with effusion, 5 or 2.8%; miscellaneous group, 6 cases or 3.4%. This makes a total of 178 cases.

Almost all the patients on admission were in the active category. The majority (122) were proven bacillary. In 56 patients, tubercle bacilli were not found and, therefore, were probably not dangerous to their contacts. The non-respiratory group made up 22 cases. Of these five, or 22.6%, were genito-urinary and 11, or 50%, were admitted for tuberculosis of bone and joint.

DISCHARGES

A total of 215 persons were discharged from the Sanatorium. The type of separation is as follows: On medical advice, 35 or 16.3%; on medical advice to continue anti-microbial treatment, 95 or 44.2%; against medical advice, 34 or 15.0%; against medical advice to continue anti-microbial treatment, 8 or 3.7%; disciplinary, 6 or 2.7%; transferred to other institutions, 13 or 6.0%; deceased, 24 or 11.1%. The results of treatment were indicated by their discharge classification. Inactive: 69 or 37.5%. Active improved: Bacillary, 19 or 10.3%, non-bacillary, 71 or 38.6%. Active unimproved: Bacilliary, 2 or 1.1%; non-bacilliary, 2 or 1.1%. Deceased, 21 or 11.4%. The total: 184.

The average length of treatment for all discharged patients was 373 days; on medical advice, 455 days; deceased, 434 days.

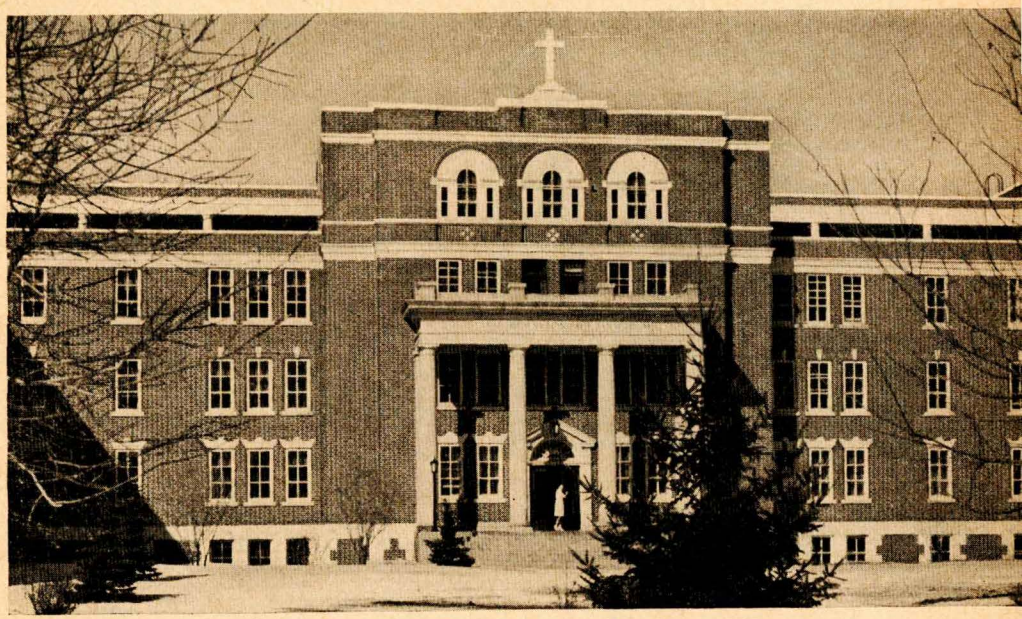
TREATMENT

The anti-tuberculosis chemicals still play an important part in treatment. To be most effective they must be applied early in the course of disease. They appear to render the human body an unsatisfactory host to the tubercle bacillus—"a fertilizer in reverse." A bird's-eye view of the chemotherapy may be obtained from the following:

	No. of In-patients	No. of Out-patients
Streptomycin	397	9
I.N.H.	402	125
P.A.S.	78	99
D. Cycloserine	5	3
Viomycin	4	0

Thoracic surgery in 1959 decreased in extent. It is felt that this is temporary and that in the future these procedures will be required in slightly greater frequency. There were 15 thoracoplasty procedures and 26 resections. The results were satisfactory. Unfortunately, we have to report two deaths in the early post-operative period. Post mortem examination revealed a satisfactory technical operation. Death was due to a massive pulmonary thrombosis in one instance and a ruptured oesophagus in the other. The rupture took place at a stricture caused by swallowing lye in childhood.

A. C. SINCLAIR, M.D.,
Medical Director.



St. Boniface Sanatorium, Main Entrance.

St. Boniface Sanatorium's Chapel.

Born near Collingwood, Ontario, Dr. A. C. Sinclair has been associated with the medical staff of St. Boniface Sanatorium since 1931 and has been Medical Director of that institution since 1939. He is a Certified Thoracic Surgeon.

Care of Indian Patients

Five hundred lives saved in the last 10 years! This hypothetical figure might not have been true if Indians had continued to die at the same time rate in 1959 as they had in 1950. In 1950, 79 Indians died from tuberculosis. In 1959 there were only nine deaths. Similarly, new active cases of tuberculosis have been whittled down from 239 in 1950 to 62 in 1959. If the new cases had continued at the same rate in 1959 as in 1950 there would have been 1,266 more cases than the actual 1,124. We would have had to operate Brandon and Clearwater Lake Sanatoria at full capacity, keep Dynevor Hospital open, fill Ninette, and possibly look for more beds.

However, the elimination of tuberculosis in our Indian population is far from reality. The death rate is still 10 times that of the white population; in fact it is similar in 1959 to that of the white population in 1935. Tuberculosis in Indians still takes its greatest toll among the youth. Whereas in whites the shift is to older age groups the majority of our new Indian cases are under 21 years of age.

X-ray surveys continue to be a fruitful means of finding new active cases. In 15,618 survey chest plates of Indians in Manitoba we found 26 new active cases, or one in 585. In X-ray surveys of Eskimos at Churchill and the Central Arctic we found one in 110 chest films.

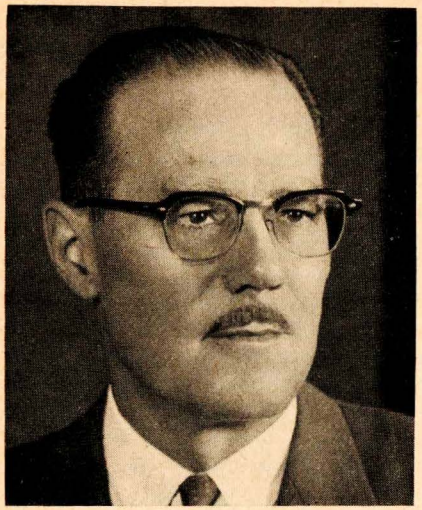
The factors that influence the high incidence of tuberculosis in Indians are those due to their environment: the low economic status caused by lack of employment, the low price and increasing scarcity of fur, poor housing and overcrowding, poor nutrition, which is the direct result of low income, and the lack of education, particularly in regard to health.

Our forces are too extended and too few in numbers to pursue the epidemiological work that should be done to track down the source of new cases. Due to the isolation of most Indian reserves our field staff must engage in treatment as well as in preventive medicine. We welcome the efforts of the Provincial Department of Health in Northern Manitoba in assuming some of the responsibilities that were formerly ours and hope that the future will see an extension of their interest and control.

In tuberculosis control, while we supplied some of the tools, it was the personnel of the Sanatorium Board of Manitoba that did most of the work—even to the extent of working in Northwest Ontario and the Central Arctic. For this you have our most sincere thanks.

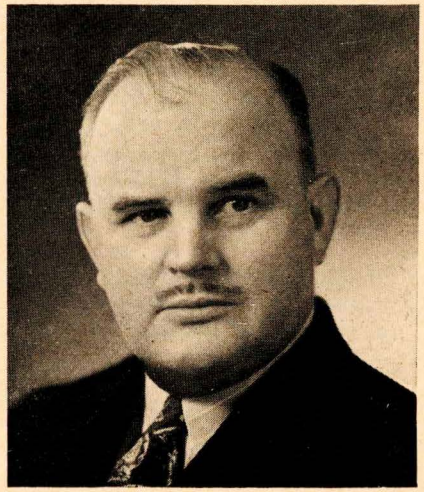
W. J. WOOD, M.D.,
Regional Superintendent,
Indian & Northern Health Services

Dr. W. J. Wood has been regional superintendent of Indian Health Services for the Department of National Health and Welfare since the office was first opened in Winnipeg in 1947. At that time the office covered Manitoba and Northwestern Ontario, but in 1953 was extended to include the Central Arctic. Prior to his appointment, Dr. Wood served three years with the Canadian Army and UNRRA.



HON. J. WALDO MONTEITH
Minister of National Health and Welfare

National Health and Welfare Photo.



P. E. MOORE, M.D., D.P.H.
Director, Indian Health Services
Department of National Health and Welfare

National Film Board Photo

Once again it is my pleasure to commend the Sanatorium Board of Manitoba on another year of outstanding achievement.

With the dramatic progress being made in reducing deaths from tuberculosis, it would be only too easy to become complacent, to let up on the campaign to wipe out the disease. As this Annual Report clearly shows, the Sanatorium Board of Manitoba has not taken such a course. It has recognized that a serious problem still exists and that continuing effort is necessary if we are to reduce the very large number of new cases of tuberculosis requiring hospitalization every year.

As far as my Department is concerned, we have long enjoyed the Board's wholehearted co-operation in the care and treatment of Indian and Eskimo patients. In the past year, evidence of this joint endeavour has been particularly notable in connection with the Department's hospital at Brandon. Facilities have been set up for the care of long-term patients and striking success achieved in its new Rehabilitation Unit. These advances are typical of the important benefits accruing from our close working relationship with the Sanatorium Board of Manitoba for whose assistance we are most grateful.

J. WALDO MONTEITH,
Minister of National
Health and Welfare.

EXTENDED TREATMENT

AND OTHER NON-TUBERCULOUS SERVICES

The year 1959 was the Sanatorium Board's first full year of operating Extended Treatment Sections for non-tuberculous long-stay patients at Assiniboine and Clearwater Lake Hospitals. These sections have an open medical staff organized in accordance with accepted general hospital practice. The hospitals are fully accredited by the Canadian Council on Hospitalization and are providing first-class service for long-stay patients. In doing so they are also helping to relieve an acute bed shortage in Manitoba's general hospitals.

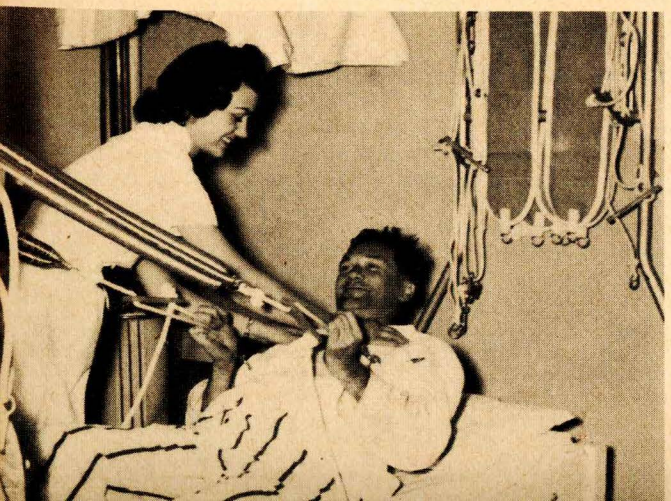
The extended treatment patients at Assiniboine Hospital, Brandon, are elderly and have a wide variety of degenerative conditions. The most common are arteriosclerosis with cardiac or cerebral complications, carcinoma, pneumonia and varying types of paralyses. Because of our special service and experience some non-tuberculous, respiratory cases are also referred to this hospital. The death rate seems high (13.8% of all discharges) but this can be expected when one considers the patients' ages and the nature of their illnesses. It is particularly significant, however, that 29% of these patients, many of whom had been bed-ridden or invalids for a long time, were cured and that another 48% improved. These gratifying results are due to active medical management and the excellent nursing care administered with an attitude of understanding, optimism and encouragement.

One third of the patients are cared for medically by their own private physicians and two thirds by the resident medical staff. Every effort is made to rehabilitate the patient, at least to the extent of home care or other care less elaborate and less costly than that provided by general hospitals.

Physiotherapy has an important role in re-establishing function and mobility. In December, 1959, construction began on a new physiotherapy and occupational therapy unit at Assiniboine Hospital which will provide a more comprehensive service of this nature.

The extended treatment service at Clearwater Lake Hospital, The Pas, is much the same as at Assiniboine Hospital except that more acute conditions are treated. This is due mainly to the proximity of Guy Indian Residential School and the referral of more Indians with respiratory diseases. Also, because of the distance from physicians at The Pas, practically all patients are treated by the resident medical staff.

—From the report of the Medical Director.



A paraplegic patient at Assiniboine Hospital in Brandon is given exercises under the direction of Mrs. Magda Thys, physiotherapy assistant.
PHOTO BY J. P. PRENDIVILLE

Assiniboine Hospital

On January 1, 1959, an agreement was completed with the Federal and Provincial Governments, the Manitoba Hospital Services Plan and the Sanatorium Board of Manitoba whereby our institution is gradually being converted from a sanatorium to a hospital for the treatment of extended treatment patients, certain respiratory and orthopedic cases and Indians and Eskimos with acute and chronic conditions. Five of the nine hospital wards or a total of 97 beds have so far been allocated for these new services.

ADMISSIONS

During the year 342 patients were admitted to the extended treatment section of the hospital and 281 were discharged, giving an average length of stay per patient of 59.21 days. This reflects the policy that as soon as a patient has obtained maximum benefit and can be managed outside of hospital, arrangements are made for his care either in his own home, a nursing home or an old folks' home. A social worker is required to assist with these placements.

Patients who are terminal or require continued hospital care for chronic conditions that are not likely to improve remain in hospital. The accumulation of such patients will gradually increase the average length of stay.

It is interesting to note the source of admissions of patients to the general hospital section. Naturally, the majority come from Brandon. Other municipalities or cities who have referred patients include: Baldur, Boissevain, Brookdale, Carberry, Chater, Crystal City, Deloraine, Elkhorn, Elva, Gladstone, Grandview, Hamiota, Hartney Melita, Minnedosa, Miniota, Minto, Morden, Neepawa, Portage la Prairie, Reston, Russell Rossburn, St. Boniface, St. Rose du Lac St. James, Shilo, Souris, Treherne, Virden and Winnipeg.

In the general hospital section approximately one-third of the patients are cared for by their family doctor. On the average, 150 patients, including the tuberculous, were constantly under the care of the resident staff.

The chronically ill patient is usually elderly, and usually has multiple disorders, all requiring treatment. Frequently those who are bedridden develop complications such as aspiration pneumonia, myocardial infarcts, strokes, bowel obstructions, etc. All of these require medical attention and investigation—on the whole, much more attention than tuberculosis patients. A general classification of patients who have been admitted would include those with orthopedic conditions such as delayed union of fractures, patients requiring rehabilitation by physiotherapy, those with fractures, osteomyelitis, osteoarthritis and rheumatoid arthritis. Other conditions are neuro-muscular disorders such as cerebro-vascular accidents, paraplegics, hemiplegics, disseminated sclerosis, parkinsonism, cerebral arteriosclerosis, progressive muscular dystrophy; also cardio-vascular disorders such as recurrent myocardial infarcts, congestive heart failure, peripheral vascular diseases; ulcerative colitis, terminal carcinoma, uncontrolled diabetes, pulmonary emphysema, pulmonary insufficiency, bronchiectasis, cor pulmonale.

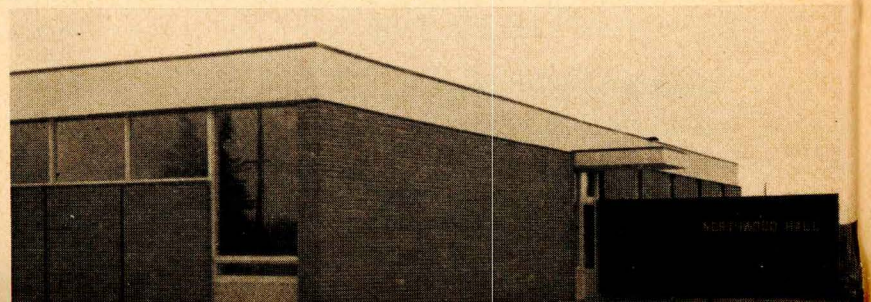
The laboratory in the respiratory disease section has facilities for PH and blood gas studies. There is an active bronchoscopic and surgical programme. The physiotherapist, in addition to providing breathing exercises and postural drainage, administers intermittent positive pressure breathing treatments. From June, 1959, to December 31, 1959, 1,250 I P.P.B. treatments were given.

Eye, Ear, Nose and Throat	22
	22
Respiratory	
Pneumonia (all types)	91
Pulmonary Sepsis	89
Bronchietasis	40
Lung Abscess	4
Carcinoma of Bronchus	2
	226
Cardiovascular	
Cardiovascular diseases (all types)	23
	23
Total	271

It should be mentioned that two rare cases were admitted, one with a nephrotic syndrome and another with disseminated lupus erythematosis. The nephrotic syndrome case was discharged home; the other case is still alive after one year of treatment.

—From the report of the Medical Superintendent.

Clearwater Lake Hospital, The Pas.



The new Northwood Recreation Hall.

NURSING SERVICES

We, as nurses, have one aim toward which we work: improved care to patients. To achieve this we have established certain changes in our department. The changing functions of the Sanatorium Board of Manitoba during 1959 have included admitting a different type of patient to our Assiniboine and Clearwater Lake Hospitals. It has been a great challenge to the nursing staff to meet the particular needs of these patients.

TUBERCULOSIS PATIENTS

There have been no major changes in the nursing care given to these patients. Shorter stay, drug therapy, surgery and rehabilitation continue to form the pattern of the care given. Indians and Eskimos constitute a major part of our patient population. The difficulties in communicating with these patients add to the challenge of giving good nursing care.

Tuberculosis patients still need the best of our skills and art in nursing.

EXTENDED TREATMENT PATIENTS

During 1959 we have admitted more and more extended treatment patients. We have gained considerable experience and some confidence in the nursing care required. To assist in the physical care of these patients different items of equipment have been purchased. We are now fairly well equipped with Hoyer lifts, side rails, wheel chairs, etc. The physical set-up of existing buildings has caused some difficulties. As far as it was possible facilities have been altered to suit the needs of extended treatment patients; but nursing service is still hampered by, among other things, inadequate bathroom facilities and lack of sitting room space for patients.

NURSING STAFF, ORGANIZATION AND QUOTA

In order to improve patient care we have changed somewhat the organization of the nursing staff. A Director of Nursing Services was appointed on February 1. In each institution a Superintendent of Nurses is responsible for the organization and administration of nursing service. To assist her in the numerous functions a day supervisor shares in the responsibility for nursing service and education. The evening and night supervisors carry these responsibilities during their particular working hours. We have set up units of wards, each unit under the management of a head nurse. General staff nurses, licensed practical nurses, nurses' assistants and nursing orderlies are directly responsible to the head nurse for the nursing care given. The titles of nursing positions were changed to bring us into line with the terminology used in other hospitals. Job descriptions have been done for each position on the nursing staff, and an organization chart for the nursing department was set up.

A graduate of Municipal Hospital in Copenhagen, Miss Bente Hejlsted came to Canada in 1955 and joined the nursing staff at Manitoba Sanatorium, Ninette. Following study at the University of Manitoba, she became Superintendent of Nurses at Clearwater Lake Hospital, The Pas, in 1957. In January, 1959, she was appointed Director of Nursing Services for the Sanatorium Board.

The nursing staff quota for each institution has been worked out on the basis of recommended hours as well as of actual nursing care hours given during 1959. It will be seen by the following figures that we have difficulty in obtaining the required quantity of nurses for our rural institutions. An active recruitment of nurses has been continued to help this shortage and pamphlets were prepared to introduce prospective nursing staff to the Sanatorium Board of Manitoba.

	Assiniboine Hospital	Central Tuberculosis Clinic	Clearwater Lake Hospital	Manitoba Sanatorium
Superintendent of Nurses	1 (1)	——	1 (1)	1 (1)
Supervisors	4 (4)	——	3 (2)	4 (4)
Head Nurses	4 (2)	1 (1)	3 (2)	2 (2)
General Staff Nurses	11 (9)	6 (6)	4 (0)	9 (4)
Licensed Practical Nurses	8 (9)	5 (5)	6 (5)	6 (4)
Nurses' Assistants	60 (55)	1 (1)	33 (37)	41 (46)
Nursing Orderlies	7 (6)	——	4 (0)	——

Figures in parenthesis indicate staff employed December 31, 1959.

NURSING CARE HOURS

Nursing care hours per patient per 24 hours were computed daily for each ward (or each category of wards) in our institutions. Only nursing staff rendering direct care to patients were included.

Professional hours include care given by registered nurses, graduate nurses and licensed practical nurses. Non-professional hours include care given by nurses' assistants and nursing orderlies. During periods of shortage of staff these hours fell below the recommended level.

NURSING EDUCATION

Nursing students from the School of Nursing, Brandon General Hospital, have affiliated at Manitoba Sanatorium for a four week course in tuberculosis nursing. There were a total of 21 students during 1959. Students from the Central School for Practical Nurses have taken a six week course in tuberculosis nursing at Assiniboine Hospital. A total of 58 students affiliated during 1959.

IN-SERVICE EDUCATION

The professional staff held monthly meetings where problems, procedures and changes were discussed. The non-professional staff were given on-the-job training, and the high standard of nursing care given by this group deserves special mention. At Manitoba Sanatorium class room instruction was given to nurses' assistants. The number of lectures to each group was 39. We are aware of the need for a formal In-Service Education Programme. The general scarcity of nurses with post-graduate preparation is partly responsible for the difficulties in carrying this out, but we hope to achieve an active programme for all categories of nursing staff during 1960. Such an education programme would ultimately improve our nursing care to patients and give greater job satisfaction to the staff.

TUBERCULIN SURVEYS

A licensed practical nurse has been a member of the tuberculin survey team during 1959.

BURSARIES

The Sanatorium Board of Manitoba offers bursaries to young women wishing to become Registered or Licensed Practical Nurses. During 1959 the following have taken advantage of this: Miss Elizabeth Harrison, Miss Joyce M. Brown, Miss Irmgard Fieguth. These three nursing students are taking their course at the Winnipeg General Hospital School of Nursing. Miss Bernice McDonald is a student at the Central School for Practical Nurses. Upon completion of their course these nurses will be employed in one of our institutions for one year.

MANITOBA REHABILITATION HOSPITAL

The Director of Nursing Services has taken an active part in the planning of nursing service areas for this new hospital.

Miss B. Hejlsted, R.N.,
Director of Nursing Services.

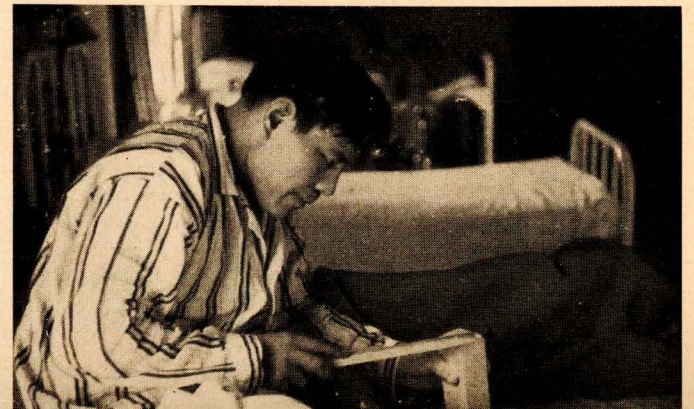
REHABILITATION

There have been many changes in the tuberculosis picture during recent years which have had an effect on the rehabilitation programme. The basic principles are the same but a changing of emphasis has been necessary to meet changing conditions. Treatment is now of shorter duration and recovery more ensured. More patients have a limited knowledge of basic subjects, so elementary teaching has wider application. Fewer patients have the educational background for vocational studies and technical training, and fewer prior to admission to sanatorium have any specific occupation. More patients are in the older age group and consequently are unemployable. Indeed, our rehabilitation programme in many respects is actually one of habilitation.

The acceptance and employment of Indian patients are as dependent upon their adjustment socially and their appreciation of occupational responsibility as upon their academic and technical training. Essentials in their rehabilitation are sound judging of character and aptitudes, teaching, encouragement, understanding, patience, job placement and follow-up. Of special interest is the continued development of the Rehabilitation Unit at Assiniboine Hospital, Brandon. This unit serves not only as a training centre but more particularly as a "buffer" zone for a gradual introduction from the reserve or the hospital to non-Indian society.

—From the report of the Medical Director.

Two patients at St. Boniface Sanatorium spend their time in hospital learning new secretarial skills.



An Eskimo patient at Assiniboine Hospital devotes his time to soapstone sculpture.

Tuberculosis Patients

The aim of the rehabilitation programme as visualized and initiated by the Sanatorium Board of Manitoba in 1942 is still to assist ex-patients as rapidly as health permits into a normal and satisfying place in the world. Every tuberculous man or woman is a potential rehabilitation problem, and all patients in a sanatorium can benefit psychologically, if not materially, from a rehabilitation service. Through our various services of counselling, education, vocational training, occupational therapy and good library service, we endeavour to bridge the gap between the sanatorium and the community, so that the transfer from hospital to home is a gradual one. The most important aspect of rehabilitation is the medical one, and it is absolutely essential as a guide in our rehabilitation vocational counselling, training, and job placement. We are fortunate in having medical staffs in our sanatoria who cooperate with us to the fullest extent. The most important person, however, is the rehabilitant himself, as without his cooperation and interest no success is possible.

IN-SANATORIUM REHABILITATION PROGRAM

This last year has brought a larger number of patients from a completely different cultural background. These people need an orientation period, coupled with instruction in the 3 R's, and occupational therapy as offered in our in-sanatorium rehabilitation division.

At Manitoba Sanatorium the addition of a classroom this past year, where 12 students can be given group instruction, has made daily instruction possible. A part-time teacher, Mrs. I. H. Wilson, has joined the teaching staff with Miss G. Motheral and Mrs. S. V. Hastings. Miss M. Newmark and a part-time assistant are in charge of the occupational therapy department. An excellent display of crafts was arranged at the annual Manitoba Wheat Pool Exhibition. Many prizes were won by patients at Brandon and Pelican Lake Fairs. Miss G. Manchester capably supervises the work done in both the academic and occupational therapy departments.

The rehabilitation staff at St. Boniface Sanatorium remained stable during 1959, with Miss I. Kujansuu and Mrs. G. Horvath sharing the teaching load. Most of the work here is bedside tuition. Miss A. Hargreaves, craft instructress, and Mr. A. Vermette, workshop instructor, report a successful year in their respective departments. Leather and plastic articles continue to be most popular.

From January 1, 1959, to December 31, 1959, enrolments in Manitoba Sanatorium and St. Boniface Sanatorium were as follows:

Miss Margaret C. Busch has directed the Sanatorium Board's Rehabilitation Department for the past four years. A graduate of Winnipeg Normal School, she was formerly principal of Shellmouth and Great Falls High Schools. In 1947 she was appointed institutional teacher for the Department of Education at Manitoba Sanatorium, Ninette.

	Manitoba San.	St. Boniface	Total
Pre-vocational	205	107	312
Vocational	35	21	46
Occupational Therapy	284	165	449
Shop Work	—	103	103

The cooperation of the Correspondence Branch, and the Registrar's Office of the Department of Education, as well as that of Success Business College and the Manitoba Correspondence College is acknowledged with appreciation.

There were 658 interviews with patients during the year. Many of the hospital interviews led to academic instruction while in sanatorium, as those who needed assistance with vocational training or job-placement following discharge often did not have the required basic education. Many who had no post-sanatorium rehabilitation problems took advantage of the opportunity for self-improvement either in the academic field or through a correspondence course in a vocational subject. The latter courses range from business subjects to those in the electrical, engineering, mechanical and homemaking fields. The costs are nominal since they are subsidized by the provincial government.

POST-SANATORIUM VOCATIONAL TRAINING

Most of the patients who registered for a training programme following discharge from sanatorium were those who had prepared themselves for this step while in hospital. For example, a young man who is now taking Teachers' Training studied Grade XII subjects while a patient. Another who wanted to go to Business College following discharge raised her high school standing in order to qualify for a secretarial course.

The number in vocational training during 1959	26
The number who completed training in 1959	12
The number who discontinued training in 1959	4
The number still in training on December 31, 1959	10

The students in training were all assisted in some measure through Schedule "R", a federal provincial agreement.

The 12 students who completed training have been satisfactorily placed in the following occupations: Pharmacist, 1; stenographers, 2; salesman, 1; watch repair, 1; clerical, 3; barber, 3; electrician, 1. Of those who discontinued, one was for reasons of ill health, one was transferred to the Canadian National Institute for the Blind, and two were discontinued because of disinterest. Two young men are continuing their apprenticeship in the electrical field, while another is serving his apprenticeship as a surveyor.

JOB PLACEMENT AND FOLLOW-UP

Because of the shorter treatment period, more patients are able to return to their former employment. Whenever necessary, employers were contacted to ensure this, and in two instances an in-sanatorium programme was arranged which would make the employees more valuable to their respective firms following their discharge from the hospital. Where a change of employment seemed desirable, and training necessary and possible, this was arranged through Schedule "R". In a straight job placement we had the full cooperation of the Special Placement Branch of the National Employment Service.

All trainees were seen once a month or oftener, if necessary, and all placements were checked after a three-month period had elapsed. If employee and employer were satisfied, the cases were closed. During 1959, 73 cases were closed as no longer requiring our services. A case load of 102 was carried over to 1960.

MISS M. C. BUSCH,
Director of Rehabilitation Services.

Indians and Eskimos

In 1957 the Sanatorium Board of Manitoba started a programme to meet the particular needs of the physically handicapped Indians and Eskimos in the province. The Indian Rehabilitation Programme was a departure for the Board in that, unlike the programme for the non-Indian, services have not been confined to tuberculosis patients but extended to all, regardless of the cause or nature of their disability. Naturally, the majority of persons dealt with in these early stages have been ex-tuberculosis patients, but there also have been those handicapped by heart ailments, defective vision, defective hearing, paralysis in a variety of forms, epilepsy, amputations and other orthopaedic conditions. A few have been mentally ill.

Apart from physical handicaps, these people are hampered further by a lack of education, the average grade level on referral being Grade IV. Add to these limitations the barriers of language, culture and prejudice and one cannot but respect those who rehabilitate themselves.

REFERRALS

In the years 1957 and 1958 nearly all referrals originated in hospitals operated by the Board. This was again largely true in 1959, but there were also an increasing number of self-referrals. Most of these were relatives of those already benefitting from services or, in some cases, the sons or daughters of older patients. Although not classed as accepted cases these older patients often require assistance for post-hospital care, with applications for old age benefits and, at times, with marital or other problems at home. The Indian has great respect for the wisdom of age and the older patient often encourages the younger people to take advantage of the rehabilitation programme.

Referrals were also received from other agencies and from the Indian Superintendent and other field staffs of the Indian Affairs Branch and the Indian and Northern Health Services. In December, 1959, the Indian Affairs Branch initiated a survey of all persons on reservations, beginning with the bands in the Fisher River Agency. It is intended to systematically screen all persons relative to their work potential. To date we have received reports on six of the eight bands in the agency. Of the 502 persons listed between the ages of 17 and 40, 55 have histories of tuberculosis and 59, of other causes. This makes a total of 114 potential candidates. Of course, all will not be suitable, nor will all require services, but if these figures can be taken as any indication of the number of disabled to be found in the 53 bands in Manitoba, there certainly should be no lack of referrals for some time.

REHABILITATION UNIT

Successful rehabilitation is the result of co-operation, trust and confidence between the individual and the rehabilitation team. The Rehabilitation Unit at Brandon provides the atmosphere and the opportunity to foster this relationship. In 1959 the Unit functioned as an effective buffer zone, providing a gradual introduction of the Indian from the reserve or the hospital to non-Indian society. Given purpose, direction, opportunity and encouragement, graduates have responded with an enthusiasm which is a credit to themselves and to the staff.

Edward Locke has directed the Sanatorium Board's unique programme for the handicapped Indian since its inception in November, 1956. Having attended school and worked in both rural and urban areas of the province he has long been interested in the Indian and the problems of their acculturation.

The results of this unique experiment are drawing widespread interest. During the year the Unit played host to a number of visitors. Among others, we were honoured by visits from the Hon. Ellen Fairclough, Minister of Citizenship and Immigration; Senator J. Gladstone, Canada's first and only Indian senator; and Col. H. M. Jones, Director of the Indian Affairs Branch.

PRE-VOCATIONAL AND VOCATIONAL TRAINING

The opportunity which the time spent in hospital provides for pre-vocational academic training is particularly valuable to the Indian patient, and it is extremely important that he be encouraged and given every opportunity to make the best use of this time. In spite of the disrupting effect the increased number of transfers among the three hospitals at Ninette, Brandon and The Pas has had on the in-hospital teaching programme, the teachers continued to see that all patients received the maximum instruction possible. At Manitoba Sanatorium the additional workload, which the increased number of transfers of Indian and Eskimo patients placed on the teaching facilities, was relieved by the addition of a new classroom and by increasing the teaching staff by one. Transfers also affected the teaching staff at Assiniboine Hospital which was reduced by one.

Academic instruction is also provided in the Rehabilitation Unit. For those who showed some potential for academic training beyond this point instruction was provided at Manitoba Commercial College in Winnipeg. In a few instances younger students were returned to the normal school routine or arrangements were made for their attendance at special schools—as in the case of two lads now attending the School for the Deaf in Saskatoon.

The low academic level of the Indian rehabilitant and the relatively high levels required for formal vocational training present a major problem. There is still a need for pre-vocational training facilities which would provide not only academic instruction but also manual training for those for whom formal vocational training is not practical. Training-on-the-job programmes are a means of training those whose lack of education is due to circumstances rather than to lack of mental ability. However, even with the wage-sharing possible under this plan, employers are hesitant to employ persons who haven't some basic knowledge of tools and materials.

In 1959 one young man was trained as an orderly at the Winnipeg General Hospital and is now employed at Assiniboine Hospital, Brandon. His success has led to our arranging with the General Hospital for the training of three others. This vocation appears to be one in which a number of our Indian rehabilitants are showing interest and to which they would seem to be particularly suited.

JOB PLACEMENTS

The greater number of rehabilitants are still those for whom vocational training is not possible. The placement of these people presents a major problem since their physical limitations necessitate light or sedentary employment. Although we meet it occasionally, prejudice has not been the great barrier one might imagine. Most employers are willing to accept the Indian as an individual and, although many ask questions about life on the reserve, they are generally more interested in the particular man and his job qualifications. Good placements and good employer relations paid dividends in 1959 and on several occasions we were able to make further placements with satisfied employers.

SUMMARY

All persons referred for rehabilitation services are not necessarily accepted. For many we do not, as yet, have the required facilities. There are also those who are either incapable of making the degree of social adjustment required or who are simply unwilling to put forth the effort. An accepted case is one which, following preliminary screenings, shows a reasonable chance of achieving some economic independence.

Accepted Cases, 1959	125
Closed—Lacking Interest or Otherwise Unsuitable	21
Of these there are seven who it is believed would benefit from an extended period of vocational and social training in a controlled atmosphere.	
Closed—Rehabilitated (Considered to no longer require services)	27
Carried Over to 1960	77
Post-Hospital, Academic Training and Social Orientation 1959	33
Attended Schools	6
Pre-Vocational Academic Training	9
Vocational Training (in school)	11
Vocational Training (on-the-job)	3
Completed Vocational Training	7
Job Placements—Full Time	32
Still Employed	27

It will be noted there were five persons for whom jobs were found in 1959 who were not working at the end of the year. Two of these persons were withdrawn for reasons of health and it is expected that more suitable employment will be found for them. One girl was returned to the reserve because she could not cope with day-to-day social problems. It is felt that she requires a much longer period of social orientation than the Brandon Unit can provide. The fourth was a young man who also had problems of social adjustment but who, it was felt, would benefit from a period in the Unit. The fifth, an ex-polio confined to a wheelchair, was employed on a temporary basis with the Civil Service. The position was that of a clerk-typist but his typing speed, limited by residual paralysis, prevented him from passing the examinations for permanent employment. Although he failed to meet the requirements of clerk-typist, this man is quite competent as a machine operator.

Looking back on it, 1959 may be viewed as a period of levelling off. There were no dramatic changes in the programme, although a few of the more obvious gaps were filled. As a result of the training provided at the Rehabilitation Unit those persons brought to Winnipeg required less supervision. Most are members of one or more organized social groups and, in general, they appear to be adjusting to city life with little difficulty.

EDWARD LOCKE,
Indian Rehabilitation Officer.

Minister of Citizenship and Immigration Ellen Fairclough visited the Rehabilitation Unit at Assiniboine Hospital in the summer of 1959. Here she is greeted by several young Indian rehabilitants.

An attractively decorated float, illustrating the Associated Canadian Travellers' work in tuberculosis prevention and other club projects, was a highlight of the Red River Exhibition parade in June, 1959.

Associated Canadian Travellers

For more than 15 years the Associated Canadian Travellers of Winnipeg and Brandon have been enthusiastic supporters of the work of the Sanatorium Board of Manitoba. Through house-to-house surveys and yearly Search for Talent broadcasts over Radio Stations CJOB in Winnipeg and CKX in Brandon, they have not only made a sizeable cash contribution to tuberculosis prevention in Manitoba, but they have also played a valuable role in the Board's health education programme.

During the past year the A.C.T. clubs expanded their programmes of financial assistance to include other health and hospital services recently undertaken by the Sanatorium Board. The Winnipeg Club has pledged $100,000 towards the cost of special equipment for the Manitoba Rehabilitation Hospital, which will be constructed by the Board during the next two years.

Through their special fund-raising projects, the Brandon Club is helping to finance the construction of a physiotherapy and occupational therapy unit for the extended treatment patients at Assiniboine Hospital in Brandon. The club has already contributed $24,000 towards this work; their total donation will amount to something over and above federal-provincial hospital construction grants.

Altogether both clubs have contributed $321,174 to Sanatorium Board services since they first began their programmes of voluntary assistance in 1945. The Sanatorium Board, and indeed the people of Manitoba, are deeply grateful for this generous and wholehearted support.

Among staff members who attended the Western Institute of Hospital Administrators and Trustees in Winnipeg last September were left to right: Nick Kilburg, business manager, Manitoba Sanatorium; C. C. Christianson, business manager, Assiniboine Hospital; R. B. McIvor, business manager, Clearwater Lake Hospital; Edward Dubinsky, administrative assistant for the Sanatorium Board; R. F. Marks, SBM comptroller; and T. A. J. Cunnings, executive director.

Mayor Stephen Juba of Winnipeg joined in the publicity campaign for the 1959 Sale of Christmas Seals. Here he receives his seals from a Winnipeg postman.

Alex Roh, supervising radiographer for the Sanatorium Board demonstrates the tuberculin skin test to bystanders at the Western Restaurant Suppliers Exhibit in Winnipeg.

RECORDS

Central Tuberculosis Registry

	Reported as: Whites		Indians		Eskimos	
	1958	1959	1958	1959	1958	1959
PATIENTS ON FILE, DEC. 31	2,754	2,526	1,204	1,203	402	415
Primary type	95	112	69	68	63	79
Re-infection	2,659	2,414	1,135	1,135	339	336
NEW CASES DIAGNOSED IN MANITOBA						
January 1—December 31	340	277	142	88		
Primary type	27	21	16	10		
Re-infection type	313	256	126	78		
OF THESE, NEW ACTIVE CASES—CLASSIFIED	239	196	92	62		
Primary type	27	21	16	10		
Minimal	53	45	32	21		
Moderately advanced	39	46	15	11		
Far advanced	40	31	9	7		
Pulmonary tuberculosis, extent not stated	5	—	1	—		
Tuberculosis pleurisy	20	15	5	3		
Non-pulmonary tuberculosis	55	38	14	10		
NEW DIAGNOSES ADMITTED TO SANATORIA	166	153	80	57		

Stationary and Travelling Clinics and Surveys

	Whites	Indians	Eskimos
EXAMINATIONS at all clinics and surveys			
January 1—December 31, 1959	72,694	15,372	878
Stationary Clinics	8,157	326	—
Travelling Clinics	1,353	63	
Surveys	63,184	14,983	878
TOTAL NUMBER TUBERCULIN TESTED	81,749		
NEW CASES of tuberculosis diagnosed at clinics and surveys	175	35	
Stationary Clinics	129	22	
Travelling Clinics	5	—	
Surveys	41	13	
OLD TUBERCULOUS PATIENTS REVIEWED	3,941	1,127	
Stationary Clinics	3,136	114	
Travelling Clinics	245	6	
Surveys	560	1,007	
CONTACTS EXAMINED AT CLINICS	4,004	52	
Stationary Clinics	3,029	35	
Travelling Clinics	975	17	

nstitutional Statistics

	Reported as: Whites		Indians		Eskimos	
	1958	1959	1958	1959	1958	1959
ATIENTS IN SANATORIA as at December 31	379	315	273	225	147	74
ATIENTS ADMITTED TO SANATORIA January 1 to December 31	667	463	401	264	131	64
Of these the number found to be tuberculous	507	342	223	212	58	46
IRST ADMISSIONS	224	188	107	92	49	35
Primary type	14	18	14	16	20	6
Re-infection						
Minimal	55	43	36	33	18	19
Moderately advanced	52	50	27	18	7	4
Far advanced	44	34	7	10	4	2
Tuberculous pleurisy	23	15	5	4	—	1
Non-pulmonary tuberculosis	36	28	18	11	—	3
E-ADMISSIONS	151	117	80	76	8	9
Primary type	3	1	2	2	2	—
Re-infection						
Minimal	31	29	32	24	4	2
Moderately advanced	46	42	22	26	2	5
Far advanced	50	36	10	8	—	—
Tuberculous pleurisy	4	—	2	—	—	—
Non-pulmonary tuberculosis	17	9	12	16	—	2
ATIENTS ADMITTED FOR REVIEW	132	37	36	44	1	2
UBERCULOUS PATIENTS TRANSFERRED	183	161	140	168	51	42
ATIENTS DISCHARGED FROM SANATORIA January 1 to December 31	744	535	431	322	182	135
UBERCULOUS PATIENTS DISCHARGED	562	402	252	230	109	80
Discharged after review	127	33	35	43	1	2
Discharged with inactive tuberculosis	208	192	176	150	103	77
Discharged with active improved tuberculosis	176	133	27	25	3	1
Discharged with active unimproved tuberculosis	28	22	8	3	2	3
Discharged dead	23	22	6	9	—	—
UMBER DISCHARGED AGAINST MEDICAL ADVICE	46	57	27	12	—	—

Thoracic Surgery

On Patients Discharged from Sanatoria during 1959:)

	Ninette	St. Boniface	Assiniboine
Thoracoplasty	8	5	—
Lobectomy	8	16	6
Pneumonectomy	1	1	2
Wedge or Segmental	29	11	2
Cavernostomy	—	—	—
Plombage	2	—	—
Decortication	1	—	—
Total	49	33	10

Patients Admitted and Discharged

	Manitoba Sanatorium	Central Tuberculosis Clinic	St. Boniface Sanatorium	Assiniboine Hospital	Clearwater Lake Hospital
ADMISSIONS					
First Admissions	41	221	26	39	83
Re-admissions	29	84	40	13	46
Transfers	179	25	126	22	20
To continue treatment	13	9	6	—	8
For diagnosis, review	—	40	3	13	87
Newborn	—	—	7	—	—
Total	262	379	208	87	244
Male	164	222	104	45	125
Female	98	157	104	42	119
Bacillary	71	123	129	30	17
Non-Bacillary	141	148	57	56	203
Bacillary status undetermined	5	—	—	—	—
Diagnosis on Admission					
Minimal	84	55	32	30	109
Moderately advanced	61	81	79	24	41
Far advanced	53	69	56	10	10
Miliary	—	—	—	1	—
Primary	4	16	4	4	33
Pleurisy with effusion	5	14	5	—	5
Tracheo-bronchial	—	1	—	—	—
Other respiratory	—	—	1	—	—
Non-pulmonary tuberculosis	10	35	22	17	22
Non-tuberculosis	45	108	9	1	24
DISCHARGES					
On medical advice	150	152	35	67	251
Against medical advice	13	7	34	2	3
Disciplinary	3	2	6	—	—
Transfer	28	164	13	129	39
Deaths	10	9	24	4	2
To continue anti-microbial treatment	34	47	103	—	8
Total	238	381	215	202	303
Respiratory Cases					
Inactive	129	55	69	46	164
Active improved	37	31	90	107	44
Active unimproved	5	152	4	12	1
Undetermined	2	5	—	—	1
Died	8	1	21	—	2
Total	181	244	184	165	212
Bacillary	16	127	38	28	2
Non-bacillary	171	155	146	162	228
Bacillary status undetermined	3	—	—	—	—
Non-respiratory tuberculosis	9	38	20	25	18
Average days treatment (tuberculosis)	288	28	373	323	125
Out-patient exams	1.101	7,627	848	1,425	322

SANATORIUM BOARD *of* MANITOBA

Balance Sheet As At 31st December, 1959

ASSETS

Institutional Accounts:

Cash on hand and in bank		$ 14,616.00	
Accounts receivable		285,769.00	
Inventories and prepaid expenses		137,996.00	
Land, buildings, plant and equipment, net (after deducting accumulated depreciation of $907,576)		428,422.00	$ 866,803.00
The above amount does not include buildings and equipment at Brandon and Clearwater Lake owned by the Government of Canada.			

General Account:

Cash in bank		25,355.00	
Accounts receivable		97,109.00	122,464.00

Endowment Funds:

Cash on hand and in bank		138,023.00	
Canada Trust Company, deposit account		19,041.00	
Accounts receivable		23,396.00	
Investments at par	$215,955.00		
Accrued interest on investments	2,688.00	218,643.00	
Bequests at nominal value		2.00	
Inventories, prepaid expenses and deferred charges		5,406.00	
Vehicles and equipment net (after deducting accumulated depreciation of $78,784)		12,253.00	416,764.00

Employees' Emergency Funds:

Cash in bank		485.00	
Investments at par	$ 12,500.00		
Accrued interest on investments	124.00	12,624.00	13,109.00
			$1,419,140.00

LIABILITIES

Institutional Accounts:

Bank:			
Overdrafts	$105,360.00		
Demand loan	7,500.00	$112,860.00	
Accounts payable and deferred credits		119,651.00	
Patients' store and contingent accounts		13,522.00	
Capital surplus		153,402.00	
Reserve for special construction		28,830.00	
Surplus		438,538.00	$ 866,803.00

General Account:

Old Age Assistance Trust Fund		1,895.00	
Accounts payable		120,569.00	122,464.00

Endowment Funds:

Accounts payable and accrued liabilities		27,433.00	
Capital accounts		389,331.00	416,764.00

Employees' Emergency Funds:

Capital accounts		13,109.00
		$1,419,140.00

Thank You

The Sanatorium Board extends sincere thanks to those named below, in respect to the Institutions they have helped:

Manitoba Sanatorium

CLERGY

Belmont: Mr. L. Daley, Archdeacon Horsefield, Pilot Mound Anglican Church. **Brandon:** Pastor N. Mellecke, Lutheran Church; Rev. Fr. S. Tarnowecky, Ukrainian Catholic Church. **Dunrea:** Rev. Fr. F. Bertrand, Rev. Fr. R. Rio, Winnipeg Roman Catholic Church Missionary. **Morris:** Mennonite Evangelical Church. **Ninette:** Rev. T. A. Payne, United Church.

ENTERTAINMENT

Pilot Mound: Pilot Mound Singers. **Brandon:** The Brandon Chapter of the Musician's Union.

FLOWERS

Ninette: W. B. Stewart; Mrs. John Paskewitz; Rev. T. A. Payne.

OTHER GIFTS

Winnipeg: Ladies Auxiliary to the Canadian Legion; Canadian Legion Hospital Committee; Ladies Auxiliary of the Associated Canadian Travellers; Associated Canadian Travellers, Winnipeg Club; Rev. W. H. Davis; Professional Engineer's Wives; T. Eaton Company; Fellowship Club; Mr. E. B. Frost; Mr. A. M. Millar; Miss Isobel McDiarmid; H. L. MacKinnon Company; Mrs. M. A. MacKenzie; Simmons Ltd.; Mr. R. M. Spicer; Major G. W. Northwood; Department of Veteran's Affairs; Ukrainian Voice; Ukrainian Catholic Women's League of Manitoba. **Belmont:** C.G.I.T. Group; Mr. H. E. Dandy. **Berens River:** Rev. G. W. Thompson. **Brandon:** Mr. Walter Dinsdale, M.P.; Mrs. Ethel M. Chapman; Mrs. I. A. Cruikshank; Mrs. Moses Galipeau; Wheat City Chapter, Silver Cross Women of Canada; Mr. Johnston McPherson, R.R. 4; Mrs. Howard Johnston; Mrs. Wilma M. Nichol. **Elgin:** Mrs. M. Ellen O'Reilly. **Grand Marais:** Mr. and Mrs. W. Kowalchuk. **Killarney:** Omega Group; The Samaritan Club. **Lena:** Mr. W. S. Smirl. **MacGregor:** The MacGregor Women's Institute. **Ninette:** The Pelican Lake District Women's Institute; Women's Auxiliary to the Canadian Legion; Eastern Star Chapter. **Ninga:** Women's Missionary Society, Rock Lake Presbytery. **Somerset:** St. Barnabas Anglican Church Woman's Auxiliary. **Waskada:** Busy Bee Group; Mr. Roy Dow. **Wawanesa:** Miss E. McNabb. **Minnedosa:** Mrs. Robert Wood. **Deloraine:** Mrs. Jessie Johnston. **Gretna:** Neuhorst Sewing Circle. **Treherne:** Mrs. Jenny Goodbrand. **Fir Mountain, Sask.:** Mrs. J. Barstad. **Ottawa:** The Queen's Printer. **Whitehorse, Yukon:** Southern Yukon Tuberculosis Association.

Assiniboine Hospital

CLERGY

Brandon: Canon B. O. Whitfield, Rev. T. W. Wilkinson, Rev. Paul Smith, St. Matthew's Cathedral; Rev. D. E. Noonan, Rev. Murray Ames, St. George's Anglican Church; Rev. G. G. Morrison, Rev. H. A. Jerry-Cooper, St. Mary's Anglican Church; Rev. K. Mickelthwaite, St. Paul's United Church; Rev. S. H. Searle, Rev. T. B. Pearson, Knox United Church; Rev. J. A. Berridge, First Church United; Rev. J. B. Inglis, St. Andrew's Presbyterian Church; Rev. R. A. Davidson, First Presbyterian Church; Rev. R. R. Cochrane, South Minster Presbyterian Church; Rev. Fr. Cooney, Rev. Fr. Hall, St. Augustine's Church; Capt. E. Burkholder, Salvation Army. **Rivers:** Rev. J. C. McNeil, C.J.A.T.C.; **Winnipeg:** Rev. Fr. R. Rio, O.M.I.

GIFTS

Brandon: Associated Canadian Travellers, Brandon Club; Ladies Auxiliary of the Associated Canadian Travellers; A.N.A.F. No. 70; Brandon Male Barbershop Choir; Brandon Square Dance Federation, Circle 8; Brandon Women's Co-operative Guild; Hi-Y Crocus Chapter, Composite High School; T. Eaton Company; Women's Auxiliary, First Baptist Church; Frederickson Motors Ltd.; Fourth Brandon Company, Girl Guides; Duchess of Norfolk Chapter, I.O.D.E.; Knights of Columbus; Ladies of the Royal Purple; Mrs. W. Mein; CKX-Radio and CKX-TV; Salvation Army; St. Andrew's Sunday School; St. George's Anglican Church Women's Auxiliary; St. Matthew's Cathedral Woman's Auxiliary; Woolworth's Store Ltd.; Wellman's Pharmacy. **Bethany:** St. John's Sunday School. **Chater:** United Church Sunday School. **Carberry:** United Church Explorers. **Winnipeg:** T. Eaton Co. employees —T. M. Miller, Public Relations Officer; H. L. MacKinnon Co. Ltd.; Mr. A. E. Vickers.

Clearwater Lake Hospital

CLERGY

H.E. Most Rev. Bishop Paul Dumauchel, O.M.I.; Rev. Fr. G. Rimi, O.M.I.; Rev. Fr. S. X. Gagnon, O.M.I.; Rev. Fr. L. Poirier, O.M.I.; Rev. Fr. J. Daniel, O.M.I.; Rev. Fr. A. Rivard, O.M.I.; Rev. Fr. J. Chapul, O.M.I.; Rev. Fr. R. Major, O.M.I.

Rev. Murray Thompson, United Church; Rev. C. Roberts and Rev. Joseph McGillvray, Anglican Church; Lt. John Wildes, Salvation Army.

GIFTS

The Pas: Christ Church Junior Woman's Auxiliary; Kelvin and Ramona Campbell; Mrs. J. Cochrane; Mr. B. Hayes; Catholic Women's League; C.N.R. Carmen's Union; Mrs. T. J. Powell; Greek Orthodox Church; Elks Club; Ford McMillan; Mrs. S. Bullock. **Guy Hill:** Katy Keene Club, Ladies Sewing Circle. **Flin Flon:** Dale Peterson; A. Cavendish; Arctic Radio Corporation; Mrs. O. Beauchamp; CFAR-Radio; Preston Ltd. Jewellers; Mrs. M. Dosselquist; Mrs. G. M. Inglis; Brownie Pack 5B; Ross Lake Brownie Pack; Elba Women's Missionary Society; Mrs. M. Grindle; Mrs. Ivan Johnson; Baptist Church Sunday School; Kathleen and Sharon Emery; Mr. and Mrs. E. Thompson. **Winnipeg:** Ich Dien Club; T. Eaton Company; Room 18, Isaac Brock School; Linda Louper; H. L. MacKinnon Co. Ltd.; Mrs. F. R. Smith; Canadian Save the Children Fund; 114 Brownie Pack; Miss Hester E. Wells; Junior Red Cross, Britannia School; Mrs. Hester Wells; Frumer and Shelley Bell. **Neepawa:** Inkerman Mission Band. **Oberon:** Oberon Mission Band. **Lynn Lake:** Lynn Lake United Church. **Brandon:** St. Paul's United Church Explorers. **Snow Lake:** Catholic Youth Club; Northern Lights Club. **Kelwood:** Kelwood United Church Women's Missionary Society. **Brookdale:** Mission Sunday School. **Mather:** Mather School.

British Columbia: Mrs. J. B. Holdcroft, McBride; Mrs. Charles Harbard, St. Aiden's Sunday School, Roberts Creek. **Ontario:** Miss M. McLeod, Mrs. D. Graham, Lucknow; Belmore Presbyterian Church, Mrs. W. Darling, Clifford; Mrs. A. Scott, Teeswater; Mrs. B. McGempsey, Islington. **Saskatchewan:** Mrs. Dave Friesen, Mrs. John Unger, Lac La Ronge. **Quebec:** St. Andrew's Church, St. Lambert; Mrs. B. Stewart, Noranda.