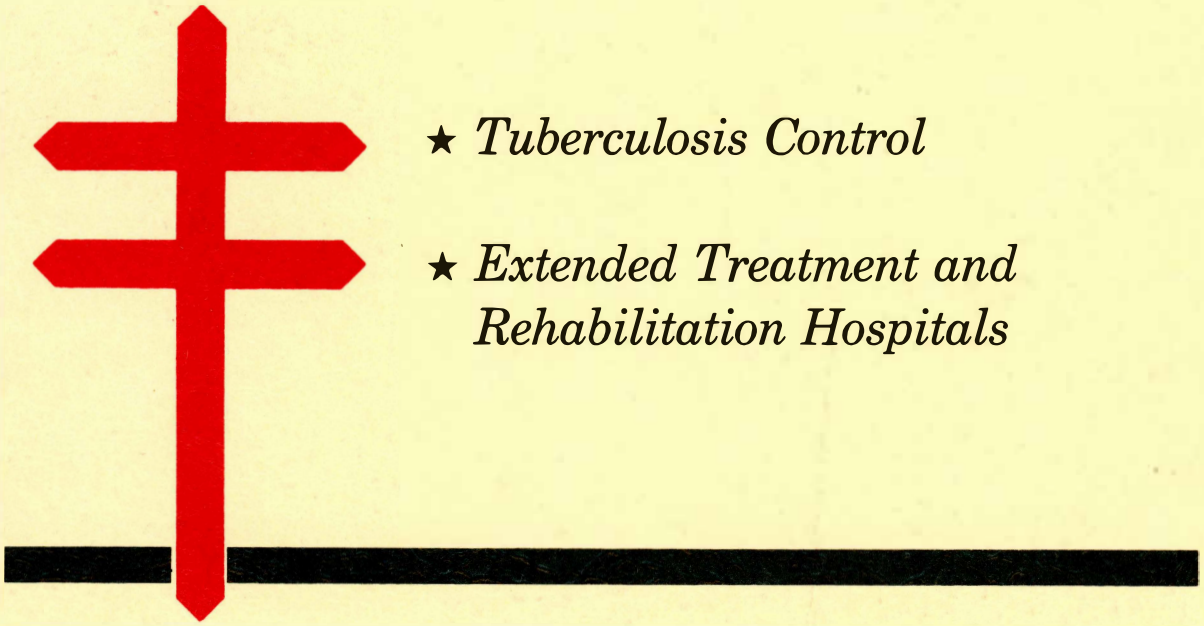
Sanatorium Board of Manitoba



★ *Tuberculosis Control*

★ *Extended Treatment and Rehabilitation Hospitals*

ANNUAL REPORT 1960

A Health Education Service of the
CHRISTMAS SEAL FUND
MANITOBA LUNG ASSOCIATION
SANATORIUM BOARD OF MANITOBA
629 McDERMOT AVENUE
WINNIPEG, MANITOBA R3A 1P6

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

CO-OPERATING WITH

Other Health and Welfare Agencies in the Province

ASSOCIATED WITH THE SANATORIUM BOARD

St. Boniface Sanatorium — St. Vital

REPORT FOR THE YEAR 1960

Winnipeg, Manitoba

Contents

Printed in Canada

STATEMENT BY THE HON. J. WALDO MONTEITH

It is a pleasure for me to again record the thanks and appreciation of my department for the splendid co-operation received from the Sanatorium Board of Manitoba in our campaign against tuberculosis among the Indians, not only in Manitoba, but also in the northern territories and some parts of Western Ontario.

I have followed with interest the progress you have been making in implementing your plans for the care and rehabilitation of Manitoba citizens disabled by illnesses other than tuberculosis, and I appreciate the fact that these services are liberally extended to include the Indian population of the areas served.

May I wish you continued success in your fight against tuberculosis, and I hope that your new program will be as successful in bringing proper care to the other classes of patients as has been the case with tuberculosis control.

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

STATEMENT BY THE HON. GEORGE JOHNSON, M. D.

The story of Tuberculosis Control in Manitoba over the past twenty years has been one of continuous progress, and the reports in this volume record, in many respects, the most encouraging signs yet, that this disease may ultimately be completely conquered. The following facts are of significance in the steady decline of tuberculosis in the province; the death rate is the lowest ever recorded; the beds occupied by tuberculosis in our Sanatoria are the lowest ever recorded; the percentage decrease in treatment days is the highest on record, and at year-end there were still 150 empty beds.

The credit for this heartening trend in the control of tuberculosis must in a very large measure go to the Sanatorium Board of Manitoba and their most efficient staff. The Department of Health is most gratified that the Board have accepted greatly expanded responsibilities as agents for the government, in the broad field of rehabilitation and care of the chronically ill. We look forward to continued co-operation and further progress in all these partnership enterprises.

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

SANATORIUM BOARD OF MANITOBA

EXECUTIVE

Chairman	MR. J. W. SPEIRS
Vice-Chairman and Chairman, Assiniboine Hospital Committee	MR. J. N. CONNACHER
Chairman, Manitoba Sanatorium and Preventive Services 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

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MR. A. E. LONGSTAFFE
MR. I. PITBLADO, Q. C., LL. D

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
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Representing St. Boniface Sanatorium	DR. A. C. SINCLAIR
Representing the City of Winnipeg	MR. J. R. McINNES

ELECTED MEMBERS

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MR. R. L. BAILEY
MR. J. F. BALDNER
DR. L. G. BELL
MR. R. H. G. BONNYCASTLE
MR. FRANK BOOTHROYD
MR. D. W. CASEY
MR. GEORGE COLLINS
MR. J. N. CONNACHER
MR. H. T. DECATUR
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MR. G. E. MAYNE
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MR. T. A. MOORE
MR. E. B. PITBLADO, Q. C.
MR. S. PRICE RATTRAY
MR. J. W. SPEIRS
MR. H. T. SPOHN

EXECUTIVE DIRECTOR AND SECRETARY-TREASURER

T. A. J. CUNNINGS

AUDITORS

RIDDELL, STEAD, GRAHAM AND HUTCHINSON

ST. BONIFACE SANATORIUM

ADVISORY BOARD

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Secretary	REV. SR. M. ROY

MR. E. G. CASS
MR. C. JESSOP
MR. N. VADEBONCOEUR
MR. E. BOLES
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. ROPER CADHAM
DR. M. H. CAMPBELL
DR. S. L. CAREY
DR. R. M. CHERNIACK
DR. ROSS CREIGHTON
DR. M. R. ELLIOTT
DR. C. C. 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. L. H. TRUELOVE
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.
JAMES HENDRY, M. B., Ch. B., G. M. C., D. P. H.
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.

CENTRAL TUBERCULOSIS CLINIC

Resident Medical Staff

DR. D. L. SCOTT (Medical Superintendent)
DR. P. P. MARI

MANITOBA SANATORIUM

Resident Medical Staff

DR. A. L. PAINE (Medical Superintendent)
DR. R. A. REILLY
DR. LESLIE SALAY
DR. DAVID KAAN

Consultants

Anaesthesiology: DR. WASYL ZAJCEW, M. D., L. M. C. C.
DR. S. O'BRIEN-MORAN, M. B., B. Ch., G. M. C., D. A., R. C. P. &S. (Eng.)
DR. H. P. CAMRASS, M. B., Ch. B., G. M. C.
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 (Chief of Medical Services)
DR. WILLIAM SHAHARIW
DR. D. G. COGHLIN *

Active Medical Staff

DR. F. W. ALLPORT
DR. R. P. CROMARTY
DR. A. J. ELLIOTT
DR. H. S. EVANS
DR. J. A. FINDLAY
DR. F. FJELDSTED
DR. JAMES HENDRY
DR. W. P. HIRSCH
DR. D. D. IRELAND
DR. N. Y. JOUBERT
DR. A. C. KLASSEN
DR. M. KOZAKIEWICZ
DR. D. K. LIDSTER
DR. J. M. MATHESON
DR. R. O. McDIARMID
DR. G. T. McNIELL
DR. R. F. M. MYERS
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DR. L. C. ROSE
DR. J. E. ROWLANDS
DR. MARK SCHERZ
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DR. V. J. H. SHARPE
DR. E. J. SKAFEL
DR. R. H. D. SYKES

Courtesy Medical Staff

DR. A. M. GRANT
DR. J. E. HUDSON
DR. DOREEN JOUBERT
DR. G. T. McNEILL
DR. B. D. SUTTER

Consultants

Anaesthesiology: S. O'BRIEN-MORAN, M. B., B. Ch., G. M. C., D. A., R. C. P. &S. (Eng.)
H. P. CAMRASS, M. B., Ch. B., G. M. C.
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 and Cardiology: 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.
Pediatrics: R. F. MYERS, M. D., L. M. C. C.
Psychiatry: M. E. BRISTOW, M. D., L. M. C. C., Cert. Psy.
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.

CLEARWATER LAKE HOSPITAL

Resident Medical Staff

DR. S. L. CAREY (Chief of Medical Services)
DR. H. C. NIP
DR. A. P. CHORNOMORETZ

Active Medical Staff

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

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.
Orthopedics: F. R. TUCKER, M. D., L. M. C. C., M. Ch. (Orth.), F. R. C. S. (Edin. and Can.), Cert. Orth. Surg.

* Deceased, May 13, 1961.

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. J. C. GRAHAM
Resident ..... RICHARD CHAN TAN

Consultants

Anaesthesia: MARJORIE BENNET, M. D., L. M. C. C., Cert. Anaes.
Bronchoscopy: D. S. McEWAN, M. D., L. M. C. C., Cert. Int. Med.
Cardiology: L. R. COKE, M. D., L. M. C. C., Cert. Int. Med., F. A. C. C. P., F. A. C. P.
J. H. MARTIN, M. D., L. M. C. C., Cert. Int. Med.
Dentistry: T. J. COOKE, D. D. S.
J. M. BENSON, D. D. S.
Dermatology: W. G. BROCK, M. D., L. M. C. C., M. S. (Derm.) Cert. Derm. Syph.
Gynecology: R. L. WILLOWS, B. A., M. D., L. M. C. C., Cert. Obst. Gyn., F. R. C. S. (C)
Medicine: J. D. ADAMSON, M. D., M. R. C. P., Edin., F. R. C. P. (C)
Obstetrics: H. GUYOT, M. D., L. M. C. C.
Ophthalmology: R. M. RAMSAY, M. D., L. M. C. C., Cert. Ophth., M. Sc. (Ophth)
Orthopaedics: W. B. MacKINNON, M. D., L. M. C. C., Ch. M. (Man.), Cert. Orth. Surg., F. R. C. S. (C)
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: R. O. BURRELL, M. D., L. M. C. C., Ch. M. (Man.), F. R. C. S., (Edin.), Cert. Gen. Surg., F. R. C. S. (C)
C. E. CORRIGAN, M. D., L. M. C. C., L. R. C. P., (Lond), M. R. C. S., Eng., F. R. C. S., (Eng.), F. R. C. S. (C)
Urology: A. C. ABBOTT, B. A., M. D., C. M. (Man.), L. M. C. C., F. R. C. S., (Edin.), Cert. Urol., Cert. Gen. Surg., F. R. C. S. (C), F. A. C. S., F. I. C. S.
X-ray: A. W. McCULLOCH, M. D., L. M. C. C., Cert. Diag. Rad.

NON-MEDICAL SENIOR STAFF

SANATORIUM BOARD OF MANITOBA

Executive Director	T. A. J. CUNNINGS
Administrative Assistant	EDWARD DUBINSKY
Comptroller	R. F. MARKS
Director of Nursing Services	MISS BENTE HEJLSTED
Director of Dietary Services	MISS NAN. T. CHAPMAN
Director of Pharmacy Services	C. G. BONNEY
Surveys Officer	J. J. ZAYSHLEY
Chief Radiographer	W. J. ANDERSON
Director of Rehabilitation Services	MISS MARGARET BUSCH
Supervisor of Special Rehabilitation Services.	EDWARD LOCKE

CENTRAL TUBERCULOSIS CLINIC

Superintendent of Nurses	MRS. P. TORGERSON
Radiographer	E. W. ACKROYD
Laboratory Technician	HENRY DANELEYKO

MANITOBA SANATORIUM

Business Manager	N. KILBURG
Superintendent of Nurses	MISS DERINDA ELLIS
Food Supervisor	MRS. VERA GRIMSHAW
Chief Engineer	G. STINSON
Radiographer	W. C. AMOS
Laboratory Technician	J. M. SCOTT

ASSINIBOINE HOSPITAL

Business Manager	C. C. CHRISTIANSON
Superintendent of Nurses	MRS. I. A. CRUIKSHANK
Food Supervisor	MRS. E. J. WANKLING
Senior Physiotherapist	GEORGE LENNOX
Occupational Therapist	MISS JANET FOWLER
Chief Engineer	R. N. NEWMAN
Radiographer	F. H. GIBSON
Laboratory Technician	MISS L. E. DELAMATER

CLEARWATER LAKE HOSPITAL

Hospital Manager	HILARY DAVIES
Acting Superintendent of Nurses	MISS V. E. APPLEBY
Charge Physiotherapist	MISS ELIZABETH PETERS
Chief Engineer	L. A. BOYCHUK
Laboratory Technician	MISS JOAN HOCHIN

MANITOBA REHABILITATION HOSPITAL

Hospital Manager	A. H. ATKINS

ST. BONIFACE SANATORIUM

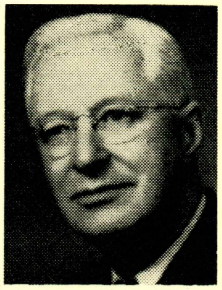
Superior	REV. SR. A. ELL
Secretary-Treasurer	REV. SR. M. ROY
Director of Nursing	REV. SR. E. MAHON
Chief Engineer.....	L. BEAUPRE
X-ray and Laboratory Supervisor	REV. SR. G. CHAMPAGNE
Pharmacist	MRS. H. KROL
Main Kitchen Supervisor	REV. SR. A. DUPUIS

CENTRAL TUBERCULOSIS REGISTRY

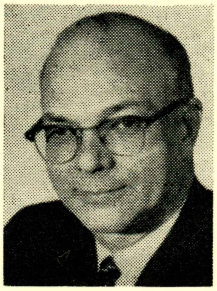
Supervisor	MISS JANET SMITH

Section 1

GENERAL REPORTS



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.



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.

REPORT OF THE CHAIRMAN

GENTLEMEN: At the outset of my remarks to you today, I would like to take this opportunity of welcoming you all to this, the 50th Annual Meeting of the Sanatorium Board of Manitoba.

The year that has just ended was indeed a memorable one in our continual struggle in the prevention and cure of tuberculosis. It is gratifying for us all to know that our efforts, coupled with those of medical science, have resulted in a decrease in the number of deaths in Manitoba per year from 200 deaths per 100, 000 population at the time of our first Annual Meeting to 4. 1 deaths per 100, 000 population at the time of our Golden Anniversary. These are dramatic figures -- figures for which the people of our province can be justly proud. At the same time we must always be mindful that our work will never be finished, our case-finding program will never be closed, our work in the field of research will never end until we have once and for all eliminated tuberculosis as a cause of death in this province.

The beginning of our second half century of service to the people of Manitoba has been marked by the assumption of additional responsibilities by the Sanatorium Board of Manitoba in providing care for those who are sick or disabled due to causes other then tuberculosis. This Board is on record of declaring that we will pursue with equal vigor the task that has been assigned to us and reaffirm our dedication to the making of a more comfortable life for all who are entrusted to our care.

THE BOARD

During 1960 the Board was strengthened by the addition of two new elected members, Mr. John F. Baldner and Mr. Howard T. Spohn. The membership now consists of three honorary life members and 30 active members of whom 18 are elected and 12 are statutory members. All contribute their service on a voluntary basis.

On August 30th, we were all saddened to learn of the death of Mr. William Whyte, a former Chairman and long-time executive member of the Sanatorium Board. Mr. Whyte was elected a member of the Board in 1938, became Chairman of the Finance Committee in 1945 and continued in that office until 1949. In 1950 he was elected Vice-Chairman of the Board and continued in that office until 1954. During the period 1954 to 1957 he served with distinction as Chairman and on his retirement he became an Honorary Life Member. Mr. Whyte was a distinguished gentleman. He devoted much time and thought to the direction of the Board's work, to which he made an outstanding contribution.

The Board lost a second member through death on October 2nd in the passing of the Honorable Maurice Ridley, Minister of Municipal Affairs, who became a Statutory Member on his appointment to Cabinet rank. Mr. Ridley had a great interest in the well-being of the people of Manitoba, and had shown special interest in the work of the hospital in his home town of Manitou. Due to his untimely death, so soon after

taking up his responsibilities with the Government, the Sanatorium Board did not have an opportunity to benefit from his advice but we were aware and appreciative of his deep interest in the Board's activities.

During 1960, there were 32 meetings of the Board or its Committees, I would like to pay special tribute and express sincere thanks 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 and give of their advice and counsel at the frequent Committee Meetings necessary to conduct the Board's affairs. I should like to record special appreciation to members of the Executive Committee who attended almost every Board meeting, namely: Mr. J. N. Connacher, Vice-Chairman of the Board and Chairman of the Assiniboine Hospital Committee; Mr. R. H. G. Bonnycastle, Chairman of the Clearwater Lake Hospital Committee; Mr. Frank Boothroyd, Chairman of the Manitoba Sanatorium and Preventive Services Committee; Mr. S. Price Rattray, Chairman of the Manitoba Rehabilitation Hospital Committee; Mr. R. L. Bailey, Executive Member. We are grateful too, for the continuing service of Dr. J. D. Adamson as Chairman of the Medical Advisory Committee and Dr. F. Hartley Smith, Chairman of the Manitoba Rehabilitation Hospital Advisory Planning Committee.

You will note that the committee formerly known as the Administration and Finance Committee, chaired by Mr. Boothroyd, has had its name changed to the Manitoba Sanatorium and Preventive Services Committee, in order to follow more closely the terminology used in designating other committees of the Board.

The Sanatorium Board has been an active participant in the work of the Manitoba Medical Centre Council through its representatives, Mr. Rattray and Mr. Bailey. We have followed the work and the planning of the Council with keen interest and have contributed financially to its support.

Mr. Bailey has been appointed the representative of the Board on the Executive Council of the Canadian Tuberculosis Association. His contribution to this association has been further advanced by the wise and astute counsel of our Executive Director, Mr. T. A. J. Cunnings, and our Medical Superintendent at the Manitoba Sanatorium, Dr. A. L. Paine. Your Chairman is a Vice-President of the Canadian Tuberculosis Association.

GENERAL

As a direct consequence of the gains that have been made in our battle with tuberculosis, there has been a further decline in the demand for treatment facilities. At St. Boniface Sanatorium, the Board has been able to release 36 tuberculosis beds in order to permit the admission of 58 retarded children. In addition, the decision has been made to release gradually the balance of the beds at St. Boniface Sanatorium for the treatment of those requiring non-tuberculous care and for the hospitalization of long-stay patients. So far, the transition has been made by discontinuing tuberculosis admissions at this hospital, with all new cases going to the Manitoba Sanatorium at Ninette or the Clearwater Lake Hospital, The Pas, or, if the need be for short term care, the Central Tuberculosis Clinic in Winnipeg.

Assiniboine Hospital has been completely turned over to extended treatment care and a new physiotherapy and occupational therapy unit of thoroughly modern standard has been constructed at this hospital to provide an essential special facility for the care of this type of patient. This new unit was officially opened on November 19, 1960.

Two other important events of a special nature took place during the year. On June 6th, Dr. Johnson, the Minister of Health and Public Welfare, officiated at the sod-turning ceremony for the Manitoba Rehabilitation Hospital in Winnipeg, and on September 11th, 1,100 former patients and friends were on hand at Ninette to celebrate the 50th Anniversary of the opening of that hospital.

FINANCE

The Executive Director, Mr. Cunnings, will report in detail on the Board's financial position. In general, it can be said that we have experienced some problems due to declining occupancy of tuberculosis patients on the one hand, and the establishment of new relations with the Manitoba Hospital Services Plan, on the other. However, considerable progress was made during the year in establishing the care of non-tuberculous patients on a satisfactory financial basis through the inauguration of a budget system with the Plan.

Once again, I would like to express the gratitude of the Board to the Associated Canadian Travellers of Winnipeg and Brandon for their untiring support of our work. The Brandon Club has pledged $85,000.00 towards the cost of the physiotherapy-occupational therapy unit at Assiniboine Hospital in Brandon and have already contributed $36,500.00 toward their pledge. The Winnipeg Club has pledged $100,000.00 toward the cost of special equipment for the new Manitoba Rehabilitation Hospital and have already contributed $10,250.00 toward their pledge.

The Board and the people of Manitoba cannot adequately express their appreciation to these men who give so generously and unselfishly of their time and effort in the public interest.

CONTRIBUTIONS

The Sanatorium Board of Manitoba gratefully acknowledges the bequests and gifts that it has received during the past year. The money and gifts that have been received have gone toward the purchase of special hospital equipment and for special services to patients for which no provision is otherwise made. All donations of amounts exceeding $500.00 are listed on a memorial page at the back of this book. We are all grateful indeed to those who have remembered us in this way.

During the calendar year 1960, the sale of Christmas Seals amounted to $180,621.00. This amount represents the individual contributions of many thousands of donors throughout the province. It is a graphic illustration of the widespread support of our work and is an inspiration to us all. We deeply appreciate this continuing and vital interest.

Our thanks are extended to the hundreds of people who gave voluntary assistance to the Board throughout the year, at our Community Tuberculin and X-ray Surveys, in the preparation for the Christmas Seal sale, in our rehabilitation services, and in many other ways. A great deal of the success that the Board has achieved in past years rests on this volunteer support.

We gratefully acknowledge the co-operation of officials of both the Provincial and Federal Governments, the Manitoba Hospital Services Plan, and other agencies, who have worked with officers of the Board in a most cordial and co-operative way throughout the year.

APPRECIATION

You will be receiving the financial report of our Executive Director, Mr. T. A. J. Cunnings. His untiring efforts on behalf of the patients and his staff have earned him widespread respect among his colleagues. His business acumen and administrative abilities have earned him a place of honor among hospital executives in Canada.

I would be remiss in my duties were I not to acknowledge with grateful thanks the loyalty and devotion to their tasks of all our staff members. Theirs has been the responsibility to solve and surmount the countless problems that confront them every day, every hour, yes -- every minute of the year. Sickness knows no hours and illness has no respect for the clock. These men and women who are, in actual fact, the Sanatorium Board of Manitoba, have given us an example of dedication to duty for which they can all be justly proud. We can only give them our profound thanks.

J. W. SPEIRS,
Chairman of the Board.

REPORT OF THE EXECUTIVE DIRECTOR

During 1960 the Sanatorium Board of Manitoba, through its services of case-finding, treatment, rehabilitation, and health education, continued to serve the health needs of the people of Manitoba in a substantial and far-reaching manner. Our services were utilized by a total of 153, 930 persons:

Admission for treatment -	1, 649	
Outpatients -	7, 506	
Preventive Services & Rehabilitation -	144, 775	153, 930

Treatment days for inpatients - 179, 897

A considerable degree of progress was achieved in modifying the structure of our services to continue in full measure our efforts towards maximum advance in the control of tuberculosis, and at the same time develop the new resources necessary to meet our responsibilities for the care of patients requiring rehabilitation and long-term treatment. Standards in all aspects of our work have been maintained at a high level, and all our hospitals (with the exception of the Central Tuberculosis Clinic, which has not been surveyed) are fully accredited by the Canadian Council on the Accreditation of Hospitals.

ASSETS AND LIABILITIES

At December 31, 1960, 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 $3, 452, 346 against which depreciation of $1, 038, 643 has been written off. This is an increase of $1, 140, 139 as compared to the previous year. Of this increase $840, 534 is accounted for by the Manitoba Rehabilitation Hospital. Liabilities of $1, 138, 139 are increased $816, 714 as compared to December 31, 1959, but of this $742, 736 is connected with the financing of the construction of the Manitoba Rehabilitation Hospital and the tunnel connecting this hospital with the Winnipeg General Hospital, the Children's Hospital and the new cancer treatment and research building.

At the year end bank loans totalled $552, 308. Of this amount $322, 000 was borrowed on account of construction of the Manitoba Rehabilitation Hospital and $56, 000 on account of construction of the new Physiotherapy-Occupational Therapy Unit at Assiniboine Hospital.

HOSPITAL OPERATIONS

Our total treatment capacity is 624 beds at the present time.

Assiniboine Hospital - was completely transferred to an extended treatment hospital by the end of 1960. During the year the Physiotherapy-Occupational Therapy Unit was completed at a gross cost of $224, 718. This will be covered by Hospital Construction grants and funds raised by the Associated Canadian Travellers.

A number of wards were modified to better accommodate the altered type of care at a cost of $3,406. It is proposed to write this expenditure off over a five year period, but no confirmation of this has yet been received from the Manitoba Hospital Services Plan although our budget was submitted last November to provide for this write-off. In other places I understand a direct grant has been made by Manitoba Hospital Services Plan or the Government to cover the cost necessitated by change in type of care and if our write-off proposal is not acceptable we will require a similar grant.

Our services and facilities at Assiniboine Hospital now enable us to offer a first-rate standard of care for extended treatment and rehabilitation patients, serving the Western part of the province.

Central Tuberculosis Clinic - continued to operate on Ward C-3 at the Winnipeg General Hospital. This ward was leased and staffed by the Board to provide temporary accommodation for the Clinic during the period of construction of the Manitoba Rehabilitation Hospital. It accommodates 18 patients.

Clearwater Lake Hospital - now has 58 beds assigned to extended treatment and non-tuberculous respiratory disease care, and 90 beds for tuberculosis. In recent times the demand for beds for non-tuberculous patients has exceeded our approved capacity and we have asked government authorities to approve an additional unit which would give us 69 beds for this service. However, up to this time approval has not been given although occupancy has been running at about 60 or 65 patients. The treatment service has been improved by the establishment of a small physiotherapy department, this being the only important change in physical facilities during the year.

Manitoba Rehabilitation Hospital - Construction is proceeding satisfactorily. Interim financing for construction has been made under a line of credit of $750,000 from the Bank of Montreal. You will be asked today to approve a By-law providing for a bond issue of $1,000,000, this being the first portion of a total issue of $2,750,000 that has been approved under guarantee of the province. When complete this hospital will accommodate 222 inpatients and up to 200 outpatients daily. Sixty-four of the beds are presently being assigned for tuberculosis care; and the tuberculosis control services will be carried on from this Central Tuberculosis section.

Manitoba Sanatorium - The plant has been well maintained during the year but operation of the institution was made difficult by a sharply lowered occupancy during 1960. With the change of St. Boniface Sanatorium on a gradual basis to non-tuberculous care, and with new tuberculosis admissions going to Ninette or Clearwater Lake, the occupancy status at Manitoba Sanatorium has improved subsequent to the end of the year. The only major change in plant was the conversion of the Gordon Cottage to provide two chapels, one Protestant and one Roman Catholic. This has been a pressing need at Manitoba Sanatorium for many years and has been welcomed alike by the clergy, patients and staff.

WILLARD REPORT

Following an extremely comprehensive study of present hospital

facilities and future requirements in Manitoba, the Willard Commission issued its report a few weeks ago. This is certainly one of the most detailed studies in this field that has ever been undertaken on a provincial basis, and it will have a strong influence on development of hospital services for years to come.

Representatives of the Sanatorium Board met with the Commission on a number of occasions, particularly to discuss methods of meeting the need for the care of long term patients. Members of the Commission visited Assiniboine and Clearwater Lake for a first-hand review and inspection. We presented detailed formal briefs with respect to the operation of these hospitals. A number of recommendations affecting the Board's operations appear in the Report, and these have been extracted and are going forward to members for individual study.

FINANCE

Financial administration during 1960 has continued to be complicated by the transition to non-tuberculous care and the establishment of budgetary arrangements with the Manitoba Hospital Services Plan, along with the reduced tuberculosis patient occupancy. We have not yet received a final settlement from M. H. S. P. for our Clearwater Lake and Assiniboine Hospital operations for 1959, or 1960. M. H. S. P. rates for 1960 were not established until July and rates for 1961 have not been settled. Delays of this nature necessitate larger borrowings than we like to see, in order to operate the hospitals. The Plan does not provide payment for medical care and although this matter has been the subject of negotiations with government authorities and others since 1958, no satisfactory solution has been found. In the meantime these medical treatment costs for Province of Manitoba patients have largely been financed by the Board. Indian and Northern Health Services have made payment for their share of these medical costs but it is obvious that a satisfactory method of dealing with this matter be established very soon.

PREVENTIVE AND REHABILITATION SERVICES

Expenditure on preventive services was almost the same in 1960 as for the previous year, since it is essential to aggressively continue this part of our program if our gains in tuberculosis control are to be maintained. The following are details of expenditures in the various preventive service departments:

Preventive Services		
X-ray Field Services	$10,746	
Indian Clinics	4,012	
Travelling Clinics	5,580	
Industrial Surveys	2,966	
Survey Services	44,040	
City Hall	3,410	$ 70,754
Hospital Admission Chest X-ray		64,600
Tuberculin Surveys		20,702
Health Education		11,881
BCG Vaccinations		1,905
		$169,842

Expenditures on rehabilitation services in 1960 amounted to $88,399. This is an increase of $26,000 over the previous year, of which $16,000 applied to the Indian Rehabilitation Service program which we operate on a reimbursable cost basis for the Indian Affairs Branch of the Department of Citizenship and Immigration. This program has been the subject of a good deal of interest and commendation on the part of the Federal Government officials and others interested in the assimilation problems of the Indians.

INVENTORY

As at December 31, 1961, supplies on hand including commissary stores, engineering and maintenance supplies, fuel, diesel fuel oil, drugs, and miscellaneous supplies totalled $146,113, an increase of $18,333 as compared to the previous year.

NATIONAL HEALTH GRANTS

The appropriation available for the fiscal year 1960 - 61 under the National Health Grants to assist tuberculosis control in Manitoba was $180,662. Expenditures in the fiscal year ended March 31, 1961, were:

Streptomycin and other antibiotics	$ 18,632
X-raying of admissions to general hospitals	64,600
Assistance to Sanatorium Board of Manitoba	25,900
Extension of industrial and other chest x-ray surveys	1,977
Assistance to St. Boniface Sanatorium	7,590
Assistance to Manitoba Sanatorium	37,898
Extension of BCG vaccination program	1,905
Tuberculin Surveys	18,343
	$176,845

This grant was reduced by about $25,000 as compared to the previous year.

INSURANCE

Fire insurance with cover for supplementary perils was carried on the buildings and equipment at Manitoba Sanatorium, Ninette, and Winnipeg, and at the physiotherapy unit at Brandon in the amount of $1,391,000. In accordance with government policy no fire insurance is carried on the buildings and equipment at Assiniboine Hospital or Clearwater Lake Hospital which are the property of the Federal Government.

Other insurance is maintained as in previous years.

PERSONNEL

At December 31, 1960, the staff of the Sanatorium Board of Manitoba numbered 538. This is an increase of 18 as compared to a year earlier but a changed pattern of care at Assiniboine Hospital and Clearwater Lake Hospital necessitated an increase of 31 in those hospitals.

There has been a reduction in staff in other departments.

With respect to staff training, our Comptroller is presently enrolled in the course in Hospital Organization and Management sponsored by the Canadian Hospital Association. An excellent Nurses' Assistant Training Program has been worked out and established by the Director of Nursing Services. During 1961, 71 student practical nurses spent six weeks each at Manitoba Sanatorium, and 16 student nurses from the Brandon General Hospital spent four weeks each at Ninette, receiving training in communicable disease and tuberculosis nursing. Under the Board's bursary program three student nurses were assisted financially in obtaining their training as registered nurses, as well as three licensed practical nurses. Bursary students spend one year on the staff of the Sanatorium Board of Manitoba after they have completed their training.

At the end of 1960, 441 persons participated in our Group Insurance plan, an increase of 11 during the year. These members of the staff are insured for $1, 154, 000 of Life Insurance and $10, 945 Weekly Accident and Sickness Indemnity. There are also 160 members who carry dependent surgical coverage. Weekly indemnity surgical and related benefits were paid during the year in the amount of $15, 618, an increase of $5, 000 over the previous year. Almost all this increase took place at Assiniboine Hospital. There were two death claims, both at Assiniboine Hospital, coverage being in the amount of $10, 000.

With respect to the Board's pension plan, in order to take advantage of sharply increased interest rates, the retirement annuity contract with the Government Annuities Branch was discontinued and the pension cover placed with Great West Life Assurance Company.

APPRECIATION

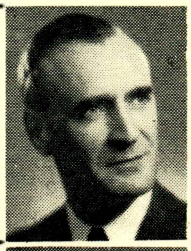
I should like to record again my gratitude for the good counsel and direction of the Chairman and Vice-Chairman of the Board and the Chairmen and members of the advisory and administrative committees. I also have much pleasure in recording appreciation for the cordial relationships enjoyed throughout the year with the Medical Director and medical officers of the Board; officials of the Provincial and Federal Governments and the Manitoba Hospital Services Plan; and hospital and other agency personnel throughout the Province.

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

Section 2

TUBERCULOSIS CONTROL

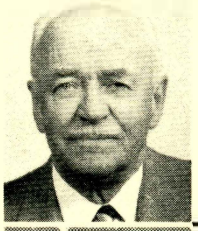
Dr. E. L. Ross has been associated with the Sanatorium Board of Manitoba for 36 years. A Certified Specialist in Internal Medicine (Tuberculosis), he has directed the medical affairs of the Board's institutions, travelling chest clinics and X-ray and tuberculin surveys since 1937.



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.

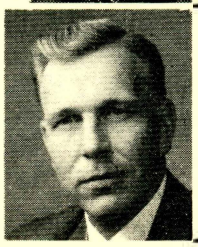
Dr. A. L. Paine, a thoracic surgeon, started his medical career at Manitoba Sanatorium, Ninette, as a Medical Assistant. In 1936 he joined the Sanatorium Board's Travelling Clinics, and in 1947 he was appointed Medical Superintendent of Manitoba Sanatorium.

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.



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.

Miss Margaret C. Busch has directed the Sanatorium Board's Rehabilitation Department for the past five 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.



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.

REPORT OF THE MEDICAL DIRECTOR

Advances in our knowledge of tuberculosis and the increased effectiveness of treatment have brought about an almost spectacular change in the TB picture in recent years. Today it is difficult to appreciate how serious the tuberculosis problem once was, and how terrible the odds against controlling the disease must have seemed to the farsighted and resourceful men who formed the Sanatorium Board 50 years ago. I have in mind the long waiting lists of patients, the advanced stage of disease on admission to sanatorium and the appalling death rate. Progress since that time has been remarkable, especially during the last 15 years, but even yet the battle is far from won. We still have with us a hard core of residual infection which will require some years to eradicate. Indeed, in terms of sickness and death, tuberculosis still occupies a very important place among human diseases.

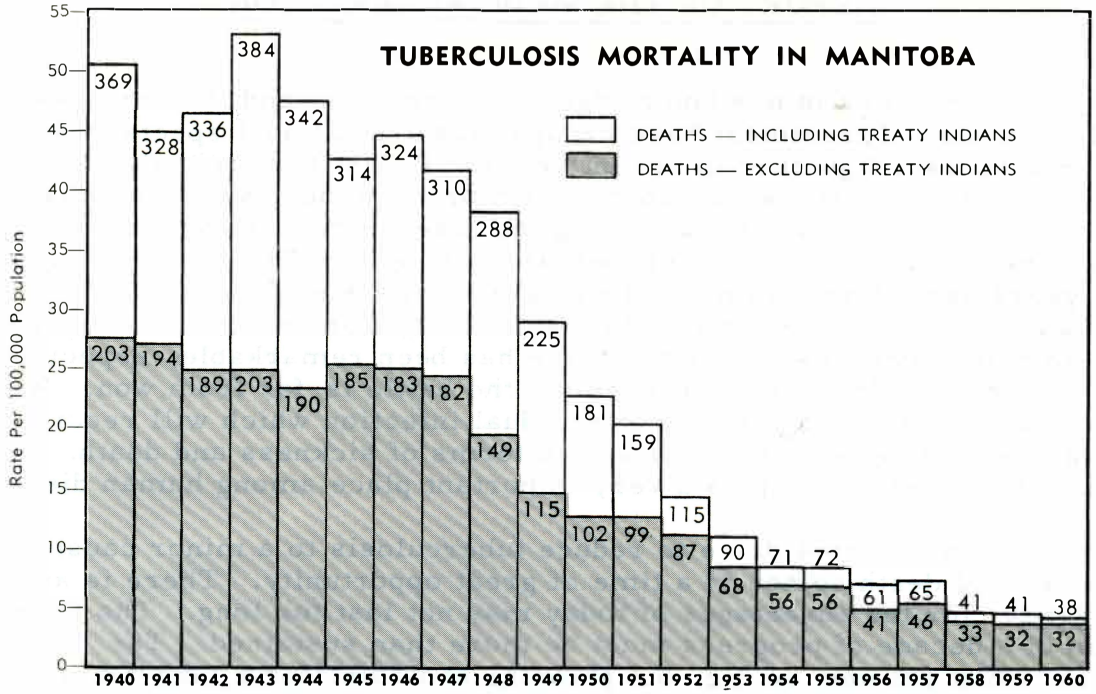
The current drive to reduce tuberculosis to a minor cause of illness and death comes at a time of great opportunity. There is an urgency, for the advantages of today may not last for long. The momentum of a decade of progress must be more than sustained. The "big push" must not only be big, but planning should be for a long-term, continuous programme.

NEW ACTIVE CASES

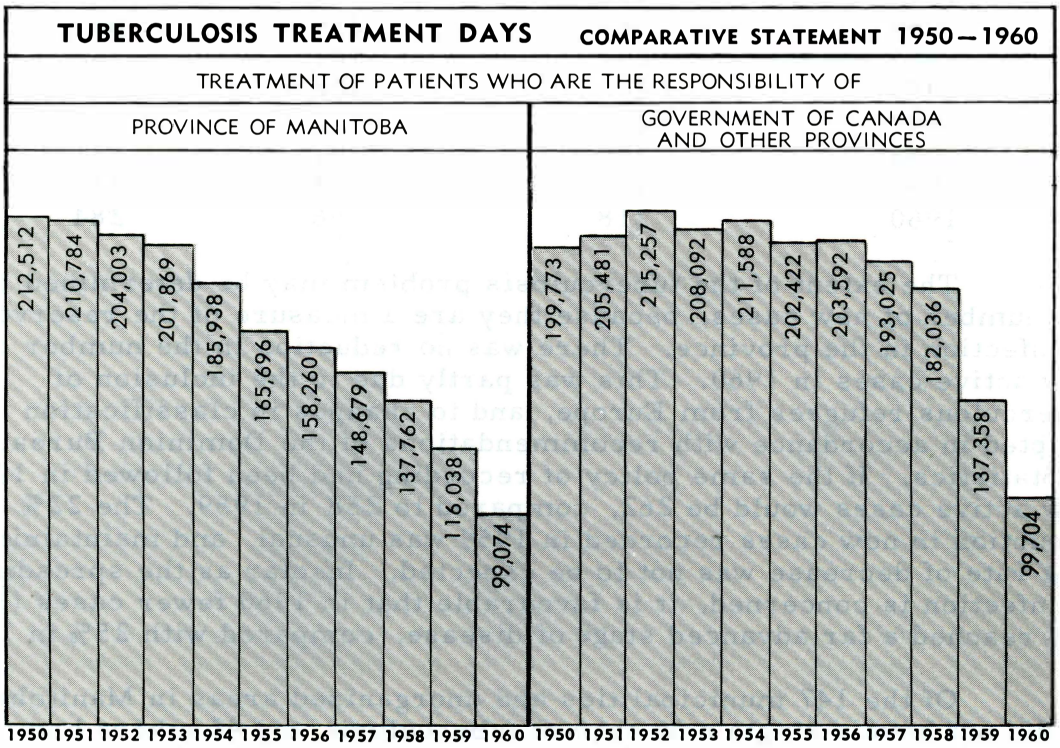
Year	Whites Active TB	Indians Active TB	Total
1945	438	134	572
1950	364	239	603
1955	231	101	332
1956	268	108	376
1957	239	118	357
1958	239	92	331
1959	196	62	258
1960	218	66	284

The extent of the tuberculosis problem may be determined by the number of new cases, because they are a measure of the reservoir of infection in the province. There was no reduction in the number of new active cases in 1960. This was partly due to the inclusion of tuberculous refugees from Europe, and to changes in classification adopted in accordance with recommendations of the Dominion Bureau of Statistics. If the same policy of recording had been followed in 1960, new active cases would be 262, compared to 258 in 1959. The 22% reduction in new cases recorded in 1959 was unusual, and maintaining that rate of decrease was not to be expected. Insofar as the spreading of infection is concerned, it is favourable that in 1960 fewer cases (18%) had reached a far advanced stage of disease, compared with 25% in 1959.

Of the 147 municipalities and unorganized areas in Manitoba, 78 did not have a single new case of tuberculosis and 42 others had only one each. With respect to age, the distribution of new cases is fairly even, with 25% over 50 years of age. Twenty-seven (or 9%) of the new cases were under 10 years of age, which is somewhat surprising as the



	1950	1960
CASES under supervision in Manitoba	5,092	3,744
EXAMINATIONS	233,821	175,375
NEW ACTIVE CASES	603	284
DEATHS	183	38



infection rate for children (1.54%) is so low. Ten of these cases were examined because of family contact with tuberculosis. In all children disease was amenable to treatment.

It is not easy to determine with confidence just when tuberculosis becomes cured and when the recurring nature of the disease is threatening to the patient and to others through the spread of infection. It has always been difficult to obtain reliable figures on relapses because all re-admissions to sanatoria are by no means due to reactivation of disease. Actually, only 37% of the re-admissions in 1960 were due to reactivated disease, and of all the admissions, 67, or only 14%, could be considered relapses. Most of these were not treated adequately originally, an indication of this being that only half of them had chemotherapy. Only four (or 6%) of the 67 relapses had resectional surgery, which suggests that surgery contributed to future safety. Obviously it is important to examine and x-ray periodically those who are known to have had tuberculosis at one time.

DEATHS

	Whites and Indians Combined		Whites		Indians	
Year	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	9
1960	4.1	38	3.6	32	25	6

(The figures for 1960 are tentative and based on the estimated population for Manitoba of 906,000, which includes 24,000 Indians.)

The preceding table shows the number of deaths and the death rate from tuberculosis. It will be noted that there has been a further slight decrease in the number of deaths, with the new rate of 4.1 per 100,000 population the lowest ever recorded in Manitoba. The 32 non-Indian deaths were the same as in 1959, but there were three fewer Indian deaths. Contributing to the lower rate is a slight increase in population. Nevertheless, the remarkable reduction in deaths during the past 20 years is impressive and has been mainly responsible for allaying fear of this disease in the minds of the public. The reduction in morbidity, although substantial, is less impressive.

Of the 38 people who died from TB last year, only two were under the age of 30 and only seven were under the age of 40. Nearly one-third were 70 years of age or over. Among the non-Indian deaths, twice as many males as females died. All of the six Indians who died were males. Ten of the tuberculosis deaths were in general hospitals,

usually following illnesses of short duration, and were not recognized as tuberculous until autopsy.

INDIANS

The story of tuberculosis control among Indians is remarkable and demonstrates what can be accomplished by organized, determined effort and cooperation between a voluntary agency and a governmental department. Twenty years ago, 166 Manitoba Indians died of tuberculosis. Last year only six died. In 1940 this two per cent of our population produced 45 per cent of the TB deaths in Manitoba. On December 31, 1956, 475 Indians and Eskimos were on treatment and four years later, 189. This has made possible the conversion of Assiniboine Hospital to a treatment and rehabilitation centre for chronic, non-tuberculous diseases, and the allocation of a section of Clearwater Lake Hospital for this same purpose. New cases have dropped accordingly and the discovery rate by x-ray surveys is steadily decreasing. There will be some modification in the frequency of Indian Reserve x-ray surveys.

TREATMENT

TREATMENT DAYS FOR TUBERCULOSIS

Year	Province of Manitoba	Gov't of Canada & Other Provinces	Total	%Decrease	#TB Beds Occupied
1949	233, 143	188, 304	421, 447		1, 157
1950	212, 512	199, 773	412, 285		1, 152
1951	210, 784	205, 481	416, 265		1, 137
1952	204, 003	215, 257	419, 260		1, 106
1953	201, 869	208, 092	409, 961	2.2	1, 116
1954	185, 938	211, 588	397, 526	3.0	1, 064
1955	165, 696	202, 422	368, 118	7.4	1, 014
1956	158, 260	203, 592	361, 852	1.7	999
1957	148, 679	193, 025	341, 704	5.5	940
1958	137, 762	182, 036	319, 798	6.4	799
1959	116, 038	143, 352	259, 390	18.8	625
1960	99, 074	99, 704	198, 838	23.3	484

Tuberculosis

	Bed Capacity				Bed Occupancy				
	Dec. 31 1957	Dec. 31 1958	Dec. 31 1959	Dec. 31 1960	Dec. 31 1957	Dec. 31 1958	Dec. 31 1959	Dec. 31 1960	Feb. 28 1961
Manitoba Sanatorium	250	250	267	265	212	173	196	165	214
Central Tuberculosis Clinic	53	46	46	18	38	29	27	15	17
St. Boniface Sanatorium	284	284	284	239	250	230	223	179	143
Clearwater Lake Hosp.	187	127	127	90	192	137	77	73	61
Assiniboine Hospital	227	167	167	24	248	230	91	25	-
	1, 001	874	752	636	940	799	614	457	435
On treatment in Mental Hospitals								27	
								484	

Extended Treatment Section (Non-TB)

	Bed Capacity			Bed Occupancy		
	Dec. 31 1959	Dec. 31 1960	Feb. 28 1961	Dec. 31 1959	Dec. 31 1960	Feb. 28 1961
Clearwater Lake Hospital	58	58	69	47	53	64
Assiniboine Hospital	103	181	198	94	142	178
	161	239	267	141	195	242

You will note that bed occupancy and treatment days for tuberculosis have continued to decrease, the latter by another 23.3 per cent in 1960. On December 31, 1959, 614 tuberculous patients were in hospital and on the same date in 1960 the number was 484. The drop in bed occupancy created a steadily increasing number of vacant beds and obviously it was necessary to further consolidate treatment facilities. This was done gradually by transferring patients from Assiniboine Hospital to Manitoba Sanatorium, which was completed by January 31, 1961. The Board now operates Assiniboine Hospital solely for extended treatment, non-tuberculous patients.

Even with these changes there were still 150 empty beds in Manitoba Sanatorium at the end of the year. This led to a decision by the Provincial Government, the Sanatorium Board of Manitoba, and the Advisory Board of St. Boniface Sanatorium to gradually reduce tuberculosis occupancy in St. Boniface Sanatorium and to use beds in that institution for treating chronic non-tuberculous conditions. This changeover will be gradual and brought about mainly by discontinuing admissions, by normal discharges and the transferring of patients to Manitoba Sanatorium. By the time this conversion will have been completed there will be other provision in Winnipeg for treating a number of tuberculous patients from the Metropolitan area.

On December 31, 1960, 457 patients were in sanatorium, compared to 614 on the same date in 1959. Most of the decrease is due to fewer Indians and Eskimos. Besides the above, 27 patients in mental hospitals are being treated for tuberculosis. Of all those admitted with pulmonary disease, 11.4 per cent were classified as far advanced. This is a decided improvement, as in 1959, 21 per cent had reached a far advanced stage.

One-third of the patients admitted were re-admissions and 34 per cent of these had far advanced disease. Not all of the re-admissions were actual relapses. There were more non-pulmonary tuberculosis admissions - 53 compared to 42. This increase was entirely due to more cases of cervical adenitis.

Of the 651 tuberculosis discharges, 67 per cent were classified as inactive, 25 per cent as active improved, 3 per cent as active unimproved, and 5 percent dead; 7.7 per cent left sanatorium against medical advice, which is a slight improvement over previous years.

Treatment of tuberculosis in the past has been confined to those with manifest disease. We have shown, mainly in connection with case finding, that interest is now being focused on infection, the prerequisite to disease. This interest has extended into the treatment field and in 1961, 43 people, mostly young children who had a positive tuberculin test but negative x-ray, were treated by the drug INH.

REHABILITATION

The basic principles of the Board's rehabilitation program remain the same but changing of emphasis has been necessary to meet changing conditions. Treatment in hospital is now of shorter duration and recovery more complete. More patients have very little schooling, so elementary teaching has wider application. Fewer patients have the

educational background needed for vocational studies and technical training, which is becoming more necessary for job placement. More patients are of older ages, for whom it is difficult to plan any program of rehabilitation.

THE CENTRAL TUBERCULOSIS REGISTRY

The Central Tuberculosis Registry is the medical accountancy department and without this service it would be impossible to direct effectually the preventive program of the Board. All information about tuberculosis - the deaths, new cases, medical and social data about all cases in or out of sanatorium and their family contacts - is recorded and analyzed and readily available. The Registry is also responsible for the following through of medical advice to patients examined at clinics and surveys, and provides a close liaison with the Public Health Nursing Service and the Health Units throughout the province. Information about 3, 744 tuberculous patients, which includes 1, 009 Indians and 414 Eskimos, was on file in the Registry on December 31, 1960.

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

SUMMARY

1. The death rate from tuberculosis continues to decline, having reached in 1960 a new low of 4.1 per 100,000 population.

2. New cases of the disease after a substantial decrease in 1959 did not decrease in 1960. This indicates that there still is a considerable amount of infection in the province and emphasizes the need for an even more intensive case-finding program.

3. An encouraging feature is that the new cases had less advanced disease than in any previous year, and also that relapses after treatment were fewer.

4. Tuberculin testing was introduced in the Board's x-ray survey program in 1959 and during 1960 was continued more extensively. Over 110,000 people were tuberculin tested and for those showing no evidence of previous tuberculosis infection, chest x-rays are not necessary. The overall tuberculin positivity rate was 18.2 per cent.

5. Hospital bed occupancy continued to decrease and treatment days were 23.3 per cent less than in 1959. However, on December 31, 1960, 457 patients were still in tuberculosis hospitals.

6. Decreasing bed requirement for tuberculosis enabled complete conversion of Assiniboine Hospital to the treatment of extended treatment (chronic), non-tuberculous disease.

7. A decision was made to utilize St. Boniface Sanatorium for the treatment of chronic, non-tuberculous conditions. This conversion will be gradual throughout 1961, as the need for beds for tuberculosis decreases.

8. An all-out effort to eradicate tuberculosis was never more timely - indeed, there is an urgency because the advantages of today may not last for long. The momentum of a decade of remarkable progress must be more than merely sustained.

PREVENTIVE SERVICES

From the Report of the Medical Director

The objective of the tuberculosis prevention program is to prevent people from becoming infected with the tubercle bacillus, by identifying sources of infection and potential sources before the germs spread to others. When the disease manifests itself by symptoms it has usually reached an infective stage, so to discover tuberculosis early, well people must be examined. Over three million x-ray and tuberculin examinations have been carried out by the Sanatorium Board in the last 10 years. This year in and year out combing of the province may seem tedious and, indeed costly, but in the long run it is paying off by the preservation of health, the saving of life and the saving of dollars.

"The big push to eradicate tuberculosis" is the current slogan on this continent. There is a special urgency to achieve our goal as there is growing evidence that the tubercle bacillus is becoming resistant to the "wonder" drugs of the past decade.

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
1960	8, 003	1, 977	69, 686	64, 984	144, 650
	115, 051	47, 363	889, 605	2, 211, 387	3, 263, 406

TUBERCULIN TESTING AND X-RAY SURVEYS

In 1959 tuberculin testing was incorporated into surveys and in 1960 the same program was followed to a more complete extent. Tuberculin testing has been exceptionally well received by the public -- indeed, it has created more interest. The tuberculin testing (Sterneedle technique) is carried out by a trained team of three: Two practical nurses and one medical laboratory technician. They are followed by the x-ray unit in a few days to x-ray those who reacted to the test.

A total of 110, 391 persons were tuberculin tested in 1960, of which 104, 678 (95%) returned for a reading of their test. The number of people x-rayed by all surveys (both Indian and white) was 64, 984, compared with 79, 045 in 1959. X-rays in 1960 decreased by 15, 061 and tuberculin tests increased by 28, 642. In these surveys one in approximately 2, 000 tuberculin tested and/or x-rayed was a new

diagnosis of tuberculosis. But only one in 4, 600 had active disease. Of those x-rayed (both Indians and whites) tuberculosis was found active in one in 2, 700. New discoveries of tuberculosis among Indians are very much reduced compared to a few years ago.

Besides the finding of new cases, surveys performed a valuable service, as 1, 424 ex-patients were x-rayed. Tuberculosis contacts, which are a high incidence group, totalled 968.

Most people, even if infected with the tubercle bacillus, fortunately do not develop manifest disease. A person can only have tuberculosis if he is infected, and the tuberculin test, as far as infection goes, merely distinguishes the "haves" from the "have nots". Only the former need a chest x-ray. These tests are not only of value for screening and for diagnosis, but they also provide information about the infection rate for persons of various ages and for municipalities. More attention needs to be focused on those with the highest rates.

COMMUNITY TUBERCULIN SURVEYS

Age Groups	Negative Reactors	Positive Reactors	Total	Percentage of Positives
Under 5	9,705	38	9,743	0.37
5 - 9	15,894	249	16,143	1.54
10 - 14	14,504	553	15,055	3.66
15 - 19	7,842	547	8,389	6.53
20 - 24	3,555	426	3,981	10.7
25 - 29	3,675	838	4,513	11.9
30 - 39	8,065	3,323	11,388	29.1
40 - 49	6,196	4,241	10,437	40.6
50 - 59	3,258	3,205	6,463	49.6
60 - 69	1,934	2,254	4,188	53.8
70 and over	1,104	1,145	2,249	50.9
Age not stated	30	14	44	31.8
Total	75,760	16,833	92,593	18.2

WINNIPEG HIGH SCHOOLS AND UNIVERSITY OF MANITOBA SURVEYS

Age Groups	Negative Reactors	Positive Reactors	Total	Percentage of Positives
Under 5	-	-	-	-
5 - 9	-	-	-	-
10 - 14	536	19	555	3.42
15 - 19	7,668	397	8,065	4.91
20 - 24	1,751	192	1,943	9.93
25 - 29	284	82	366	22.4
30 - 39	166	72	238	30.2
40 - 49	346	50	396	12.6
50 - 59	35	25	60	41.7
60 - 69	5	14	19	73.7
70 and over	2	1	3	33.3
Age not stated	-	5	5	100.0
Total	10,793	857	11,650	7.35

INDUSTRIAL TUBERCULIN SURVEYS

Age Groups	Negative Reactors	Positive Reactors	Total	Percentage of Positives
Under 5	-	-	-	-
5 - 9	-	-	-	-
10 - 14	-	-	-	-
15 - 19	53	-	53	0.
20 - 24	82	11	93	11.8
25 - 29	49	22	71	30.9
30 - 39	63	37	100	37.0
40 - 49	20	45	65	69.1
50 - 59	12	26	38	68.4
60 - 69	6	9	15	60.0
70 and over	-	-	-	-
Age not stated	-	-	-	-
Total	285	150	435	34.5

The most striking feature of these tables is the low infection rate for children -- indeed, the low overall rate. It will be noted that up to the age of nine, infection with tuberculosis is rare. The rate steadily rises after 20 but remains fairly constant after 50. These figures suggest that the children of today have little opportunity for infection and that homes may not be responsible for most present-day infection. The higher rate among those in their twenties and later years could have been due to infection acquired when they were children, at which time tuberculosis infection was much more general.

The overall infection rate in community surveys, which includes all ages, was 18.2. This is low compared with the few, similar studies on this continent.

TRAVELLING CHEST CLINICS

These clinics are distinct from the large mobile van surveys. With a doctor in attendance, examinations are confined to TB suspects, contacts, and reviews of ex-sanatorium and known cases. A total of 1,977 examinations were carried out, about 600 more than in 1959. Three new cases of tuberculosis were discovered.

STATIONARY CLINICS

These are the out-patient clinics of each tuberculosis hospital, mainly the Central Tuberculosis Clinic. Examinations in 1960 totalled 8,003, slightly less than the preceding year. The value of these clinics is evident by the fact that 140, or 71%, of the new diagnoses of TB were made by these agencies, and that examinations and advice were given to 3,224 TB contacts and 3,051 ex-tuberculosis patients. The patients who attend these clinics are referred by private physicians, and, through reports and consultation with them, an important liaison with the medical profession is maintained.

THE CENTRAL TUBERCULOSIS CLINIC

The Central Tuberculosis Clinic performs an important role in the overall program - in diagnosis and in prevention, and through its contact with the medical profession, the hospitals of Manitoba and medical and nursing students. It is, however, primarily a centre for the diagnosis of tuberculosis and other chest diseases and for the periodic examination of, and advice to known tuberculosis cases, ex-sanatorium patients, and TB contacts. All x-ray films from surveys, travelling clinics and general hospital admissions in 58 Manitoba hospitals are interpreted and reported upon.

GENERAL HOSPITAL ADMISSION X-RAY PROGRAM

Patients admitted to general hospital constitute a large segment (15%) of the population and they have a higher discovery rate of tuberculosis than the general population. So, for the last 11 years, chest films have been taken of these persons. In hospitals with over 1,000 admissions annually, x-ray units which take miniature films are installed. In the smaller hospitals these admission films are taken by the hospital's own equipment and sent to the Central Tuberculosis Clinic for reading.

It is gratifying that tuberculosis found in general hospitals is steadily decreasing, and it is noteworthy that no active tuberculosis was found by these routine films among 8, 715 hospital staff.

Of the 139, 589 patients admitted to general hospitals, 51, 962 or 37%, had routine chest films. The main reason for not chest filming all hospital admissions are: (1) the exclusion of children; (2) exclusion of those who have been x-rayed within the year; (3) more patients on admission are now having chest films ordered by their attending physicians than before the Manitoba Hospital Services Plan came into effect.

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 51, 962 admissions x-rayed, 20, or one in 2, 598, had apparently active tuberculosis.

2. 403, or one in 129, had tuberculosis that was considered inactive.

3. 58, or one in 896, had tuberculosis of doubtful activity.

4. 113, or one in 459, were considered tuberculosis suspects.

5. Taking into account all the above, 594, or one in 87, had evidence of present, past or suspected tuberculosis.

6. Of the 9, 009 out-patients, 4, or one in 2, 252, had apparently active tuberculosis.

7. Among 8, 715 hospital staff x-rayed, none had apparently active tuberculosis.

8. The value of this program and, indeed of all our surveys, is not confined to discovering tuberculosis because many other abnormalities are drawn to attention and referred to the private physician. This is evident by the fact that among 51, 962 patients x-rayed on admission, 2, 565 (one in 20) had non-tuberculous chest conditions, and 2, 403 (one in 21) had suggested cardiac abnormalities.

This program does contribute to the control of tuberculosis and, apart from the specific and tangible findings listed above, there is value of general importance. With falling infection rates, fewer needing treatment for tuberculosis and a marked reduction in deaths, a complacency, understandable but dangerous, is developing, not only among the public but also among the medical profession. This program creates and helps to maintain the interest of physicians and hospitals in tuberculosis, and provides a relationship with the official tuberculosis control body, viz., The Sanatorium Board.

B. C. G. VACCINATIONS

The number of B. C. G. vaccinations has remained the same for the last few years. A total of 1, 267 vaccinations were administered in 1960 to tuberculosis contacts, medical and dental students, student nurses, the sanatorium staff, laboratory technicians and others who might come in contact with tuberculous persons. It is generally accepted that vaccination affords some protection to persons who have a greater than average opportunity to become infected with the tubercle bacillus. With our low infection rate we consider vaccination on a mass scale unnecessary. The fact that the tuberculin test is of increasing diagnostic and epidemiological significance is also a deterrent to a general B. C. G. programme, as the vaccine artificially produces a positive tuberculin test.

B. C. G. Vaccinations - 1960

Tuberculosis Contacts	-	142	
Medical Students	-	46	
Dental Students	-	28	
Physiotherapy Students	-	15	
Student Nurses (General Hospital)	-	332	
Student Nurses (Mental Hospital)	-	50	
Student Nurses (Practical)	-	83	
Nurses' Assistants	-	33	
Sanatorium Staff	-	29	
Laboratory Technicians	-	22	
Others	-	28	808
By Indian and Northern Health Services	-		459
Total	-		1, 267

SOME CURRENT RECOMMENDATIONS REGARDING TUBERCULOSIS CONTROL

1. Tuberculin test everyone - all ages.

2. Have a chest film of those with a positive tuberculin reaction - any age.

3. Tuberculin test or at least chest x-ray the household contacts of children with a positive tuberculin test.

4. Those with a negative tuberculin test should have the test repeated every two years, if possible.

5. Those with a positive tuberculin test and negative chest film between the ages of 15 and 24 should have a chest film every year. Those of other ages with a positive tuberculin test should be x-rayed periodically - that is, every three to five years, unless more frequent chest films are advised.

6. Those with a 4 plus tuberculin reaction should be x-rayed in three months and then at yearly intervals.

7. A known recent tuberculin converter or a child under the age of three years with a positive tuberculin test should be considered for home treatment with INH.

8 Anyone with a positive tuberculin test and any abnormal parenchymal pulmonary lesion showing in the x-ray film should have a large film and advice regarding further follow-up.

9. Anyone with a known inactive tuberculous lesion should be x-rayed yearly.

10. More people in the older age groups are breaking down with tuberculosis, which emphasizes the need for awareness of this possibility. A chest film and sputum examination for tubercle bacilli are still the most important diagnostic procedures.

CITY OF WINNIPEG

Tuberculosis Control 1960

The nationwide trend in the control of tuberculosis is reflected in figures for Winnipeg, although the local figures are becoming too small for fruitful analysis.

DEATHS

There were 15 deaths from pulmonary tuberculosis and one from tuberculous peritonitis. The death rate was 6.3 per 100,000 which does not differ significantly from the figures over the previous ten years.

NEW CASES

Sixty-six new cases of tuberculosis were reported during the year, a rate of 25.7 per 100,000 population. This compares favorably with the national rate for 1959 (37.0) and the provincial rate (40.2). The cases were more common in the older, more crowded sections of the city with three of the statistical districts showing rates in excess of 100 per 100,000 population.

Forty-seven of the new cases were pulmonary tuberculosis - 27 male and 20 female. Three were pleurisy with effusion, all male. The remaining four male and twelve female cases had non-pulmonary disease. Four of the pulmonary cases were in persons aged 75, 77, 76, and 95 who died of other diseases and were found to have extensive active pulmonary disease at post-mortem.

An additional five cases were reported to the City Health Department during the year. These were European refugees admitted to the country with tuberculosis. All had pulmonary disease.

SURVEYS

The Sanatorium Board conducts all surveys in the Winnipeg area. The Health Department assists in arrangements and in follow-up of findings. The number of x-rays taken during the year has been reduced by a practice of not repeating routine and pre-employment films if there has been a film in the previous year, and by increased screening with tuberculin tests.

1. 4 x 5 unit at City Hall -- This unit is now operated on a part-time basis by the Sanatorium Board. A total of 4,463 x-rays were taken compared to 9,183 in 1959.

2. 70mm survey units -- These units operated on 39 different sites offering surveys to 288 office, business, and industrial concerns. Altogether 10,717 x-rays, a decrease from 18,377 in 1959, were taken. Three active cases were discovered.

3. Tuberculin surveys -- Increasing use is being made of the tuberculin test using the Heaf gun. This device can be used by trained technicians to administer the tuberculin test on a mass scale. The nine city high schools were surveyed by this method, and

5, 356 tuberculins were done. A total of 5, 119 were read with 4, 917 negative and 202 positive reactors. One active case was discovered in this survey.

During the year a start was made at introducing the tuberculin test as part of the routine pre-employment procedure of some of the larger employers.

HOSPITALIZATION

An average of 109 Winnipeg residents were hospitalized in the various sanatoria during the year 1960. This is down from 126 the previous year. Most (75) were at St. Boniface Sanatorium. Only 50 of the new active cases were admitted to sanatoria. Eleven of the new cases were treated at home, four coming to the CTC for streptomycin treatment.

PUBLIC HEALTH NURSING

The public health nurses were active in following up contacts, cases on home treatment, and discharged cases still under active supervision. The average number of cases under supervision during the year was 1, 040.

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

CENTRAL TUBERCULOSIS CLINIC AND PREVENTIVE SERVICES

In January of 1960 the medical group of the Central Tuberculosis Clinic moved from its roomy quarters in the Central Clinic Building to Ward C3 in the Winnipeg General Hospital. This move meant a loss of 33 beds for patient care. It also meant a marked decrease in working space, which natually has greatly hampered our efforts and possibly our efficiency. As a result, much of the year's report will show a decrease in total numbers of patients and procedures carried out by our staff. This is so evident that, with the exception of our Outpatient Department, no true comparisons can be made.

OUTPATIENT DEPARTMENT

The Outpatient Clinic, where referrals, contacts, and those suspected of having tuberculosis are examined, has maintained the usual number of procedures. There were 4, 663 examinations, and streptomycin treatments numbered 3, 422. Doctors and Health Units sent us 615 chest x-ray films for interpretation, which, of course, we welcome. There were 135 new discoveries of tuberculosis, 100 of these being found on first examination. These 135 new cases were of all ages, from infancy to over seventy. The highest number came from the 30 - 39 age group, but of great interest is the 70 and over group, from which there were 17 new cases. At this age people tend to become careless with cough and therefore are more liable to be infectious. Almost half of the new discoveries were 40 years of age or more. Those forty and over belong to a generation born and raised while tuberculosis was a much more common disease. Gradually the incidence of disease will lessen as this more exposed group dies off.

Of the 135 new cases, 68 had open active respiratory tuberculosis. Of these, 22.06% were far advanced, 30.88% were moderately advanced, and 47.06% were in a minimal stage. This is quite a change from the 1920's and 1930's when most - indeed, about 80% - of our new cases were far advanced.

An outpatient treatment clinic is conducted to administer streptomycin and to advise patients who have been sent home from sanatorium to continue rest therapy and chemotherapy. These patients come for intramuscular injections of streptomycin and so are constantly being reminded of the importance of looking after their own and their family's health. During 1960 a total of 378 patients attended the Central Clinic for this treatment.

TREATMENT

During 1960 there were 257 admissions and 270 discharges. The number of treatment days was almost halved because of our move to smaller quarters, there being 5, 587 treatment days compared to 10, 003 in 1959. Of the 257 admissions, 180 were proven to have tuberculosis of the respiratory tract or other systems, and 77 suspected of having tuberculosis were found on investigation to be non-tuberculous. This, of course, is one of the prime functions of our clinic.

The disposal of discharged cases is interesting. A total of 107 patients were transferred to sanatorium for continued treatment,

90 were discharged on medical advice and considered after full investigation not to be in need of treatment, 43 discharged to continue on anti-microbial therapy at home, and 24 transferred to general hospitals for further investigation of non-tuberculous conditions. Only three patients left the clinic against advice, in spite of our disciplinary problems. Of concern to us were the three deaths, all due to tuberculosis, with an average bed occupancy of only 12 days. The average length of treatment for all discharges was 24 days, which is well within the minimum allowed for a diagnostic clinic.

Chemotherapy is an important part of treatment. A total of 149 patients were given various combinations of chemotherapy, of which 134 were taking SM and INH, six were taking SM, INH and PAS, one was on INH and PAS, and eight on INH alone. Of the 270 patients discharged, 43 were allowed to go home on anti-microbial therapy and many of these were able to carry on at work.

MEDICAL DEPARTMENTS

Laboratory - In the laboratory 9, 393 procedures were carried out; these included blood and blood chemistry estimations, urinalyses, bacteriology, skin testing, vaccinations, etc. During last season the laboratory staff spent four weeks assisting the tuberculin survey team in the field. Their experience with tuberculin testing, of course, is a great help.

X-ray Department - In the X-ray Department training, skilful technique, and care in handling films are essential. There were 3, 993 radiographic examinations made, of which 3, 711 were of the chest. This department also took over the developing, drying and sorting of films for travelling clinics and surveys, which totalled 10, 230 large films, 2, 004 4x5 films, and 136 70 mm. rolls. The majority of these large films were from the Northern Manitoba Indian Surveys because it was found that they could not be handled at Clearwater Lake Hospital. They were processed in record time and, thanks to the efforts of our x-ray staff, we were able to have all Indian Clinics reported on before the end of the year. Hospital admission films are also handled by our X-ray Department.

PREVENTION

Travelling Clinics - Travelling clinics were held in 29 centres in Manitoba and 43 clinics were arranged to deal with patients referred by local doctors, contacts, and suspects. A total of 1,922 whites and 55 Indians were examined in this way. Three new cases of tuberculosis were found and 194 ex-sanatorium patients were reviewed and advised.

Surveys - Last year both Dr. Ross and myself reported that surveys had taken on a new aspect. The current way of dealing with the population of a given area is tuberculin testing, which distinguishes those who have been exposed to tuberculosis and is considered preferable to mass x-raying only.

Hospital Admission X-ray Program - Fifty-eight hospitals in Manitoba sent 25, 231 x-ray films to us for reading and interpretation. This included films of new admissions, outpatients and hospital staff. Eleven cases were reported as probably tuberculous, and many other conditions, such as enlarged hearts, bronchitis and unresolved pneumonias, were brought to the attention of the doctors concerned.

D. L. SCOTT, M. D.
Medical Superintendent.

MANITOBA SANATORIUM

In 1960 Manitoba Sanatorium completed a half century of service in the control and treatment of tuberculosis. The most memorable event of the year was the combined fiftieth anniversary and Second Patients' Reunion held on September 11 and attended by some 1,200 people, most of whom were old patients and former staff members.

The year saw a further drop in patient population; at the same time plans were on foot for more varied and better patient accommodation in anticipation of the centralization at Ninette of tuberculosis treatment for the province. Total patient days dropped from 72,640 in 1959 to 65,241 in 1960. On December 31 the patient population was 165, though standing at 210 at present writing. Two-thirds of the patients were of native blood, either Treaty Indians or Metis. Males outnumbered females two to one. The disproportions between whites and non-whites and between males and females were both due to the small number of white women admitted to the sanatorium. Thus, the females included seven white and 49 non-white, and males were 50 white and 59 non-white. The white patients, especially the men, tended to be in the older age groups than those of native extraction.

The general upkeep and maintenance of the sanatorium has been good and the grounds were in particularly fine condition for the anniversary celebration in September. During the year West Two and Three infirmaries were redecorated, and new tile floors installed. The main building rotunda and offices were repainted, and in the latter part of the year Number Four Pavilion was completely renovated in anticipation of an increased patient load. The most recent project was the conversion of Gordon Cottage into two chapels for Protestant and Roman Catholic services.

ADMISSIONS AND DISCHARGES

Admissions for 1960 totalled 207 and were classified as follows: first admissions, 53; re-admissions, 44; transfers, 103; to continue treatment, 2; review, 5. Tuberculosis accounted for 174 admissions, while 33 proved after investigation to have other chest conditions. Of the 174 admitted with tuberculosis, 144 had pulmonary disease - 31% with minimal disease, 41% with moderately advanced disease, and 28% with far-advanced disease. The remaining 30 had the following tuberculous conditions: pleurisy with effusion, 6; primary infection, 4; tracheobronchial glands, 1; adenitis, 6; bone and joint tuberculosis, 3; meningitis, 1; genito-urinary, 5; other sites, 4. Of the 174 tuberculous patients, 26 or 15% had suffered relapse. Twenty of these had previous chemotherapy. Only two had lung resection.

Of the 238 discharges, 189 had been on treatment for tuberculosis while 32 had conditions which were proved non-tuberculous after various periods of investigation. Of the total discharges 65.1% left sanatorium on medical advice, 4.6% against medical advice, 2.5% were disciplinary and 24.7% were transferred. Three percent died. Of the nine patients discharged with positive sputum, two were dead, two have since died, three have been re-admitted and two are untraced. Thirty patients discharged on medical advice are continuing chemotherapy at home.

Autopsies were performed on all seven deceased patients. It was found that three died of tuberculosis, two had tuberculosis but died from other causes; two had disease other than tuberculosis and it was from these that they died.

OUTPATIENTS

A total of 1, 192 patients attended the outpatient department in 1960, and of these 726 were old patients back for review. Two new discoveries of tuberculosis were made. Thirty-eight non-tuberculous chest conditions were diagnosed.

TREATMENT

The average length of treatment for those with tuberculosis discharged on medical advice was 303 days. This reflects our continuing policy of prolonged rest in sanatorium as basic therapy, especially in patients of native blood. However, rest routines have been liberalized and only very sick patients are given strict bed care. With modern antimicrobial therapy, symptoms rapidly subside and most patients are soon able to be up to the bathroom and to visit on the ward or watch television.

With respect to antimicrobial drugs, a good many patients are started on triple drug therapy - streptomycin, 1 gram bi-weekly; INH, 300 mgms daily and PAS to tolerance (usually 12 grams daily). Due to drug reaction quite a few patients are eventually reduced to two and occasionally to one drug. INH is considered the most effective and best tolerated. Streptomycin has some special merit in being injectible in that it can be given easily in sanatorium but not at home, and one is sure the patient is getting the drug. Daily streptohydrozide is commonly used in very sick patients who may also be given cortisone. Occasional use is made of viomycin, seromycin and pyrazinamide in drug resistant or allergic patients.

Manitoba Sanatorium is now the thoracic surgical centre for tuberculosis. The total volume of work was slightly greater than in 1959 and lung resection actually increased by 15 cases. Altogether 78 major chest operations were performed. These included: resection, 57; thoracoplasty, 9; plombage, 7; Schede, 1; cavernostomy, 1; chest wall sinuses, 3. There were no operative deaths. Tracheotomy was performed on two poor risk cases. No wound infections occurred during the year. Post-operative complications were as follows: One patient with bronchopleural fistula which healed spontaneously; two patients with persistent air-leaks which closed with complete obliteration of air space after thoracoplasty; one patient with post-operative hemorrhage requiring thoracotomy and ligation of an intercostal artery. Generally speaking, poor risk cases, especially those with low cardio-respiratory reserve due to emphysema, were treated with plombage, thoracoplasty, Schede-thoracoplasty or cavernostomy rather than resection. In patients undergoing resection for tuberculous disease, indications were as follows: Drug resistance with positive sputum, 3; intractible hemorrhage, 1; tuberculous bronchiectasis and sepsis, 4; extensive cystic cavitation, 4; residual foci following sputum conversion on chemotherapy, 38.

We have continued to be aggressive in the removal of residual

foci for several reasons. Many of our patients are of native blood and prone to relapse, due to poor living conditions and failure to take drugs at home. Whites are often indigent; alcoholism is not rare and, in other ways, the expectation for sustained effort in conservative treatment is often not good. Finally, there is a recent trend, even in well adjusted, co-operative patients who have well localized lesions, to do early resection as a means to a safe and greatly accelerated recovery. In this respect, 10 patients had resection earlier than the usual six months from the beginning of treatment, the earliest being two months. In patients with residual disease, resected specimens contained tubercle bacilli in 58% of the cases, in spite of gastric washings being negative to culture pre-operatively.

X-RAY AND LABORATORY DEPARTMENTS

The standard of work in both departments continues at the uniform high level maintained over the years and can be credited to the long service of the department heads, each outstanding in his respective field.

During the year the X-ray Department did 3, 638 radiographic examinations, 74 electrocardiographs and 57 colour slides of resection specimens.

The laboratory department performed 12, 258 tests. In addition, 3, 053 tests were done in outside laboratories. A new triplicate record system was introduced supplying one copy of each report to the ward, one to the laboratory and a third for statistical use. There was a shortage of adequately trained technical staff during the latter part of the year.

PHYSIOTHERAPY DEPARTMENT

For most of the year the physiotherapist from Assiniboine Hospital spent two days per week at Ninette and gave valuable aid in chest surgery, intercurrent arthritic conditions and other orthopaedic problems. This service was temporarily discontinued in December.

EDUCATION AND STUDY

The department of Rehabilitation has continued to give a great deal of much needed schooling, especially to Indian and Eskimo patients. Many patients are also instructed in occupational therapy and quite a few receive vocational training.

During the year an affiliate course in infectious disease nursing was given to students from the Brandon General Hospital and the Practical School of Nursing in Winnipeg. Altogether 16 graduate affiliates and 71 practical affiliates took the course. Besides ward instruction lectures were given by members of the nursing, medical, laboratory, dietetic and physiotherapy staffs. Nurses assistants were also given lectures and ward training.

PAPERS

"Salvage Surgery in Pulmonary Tuberculosis" presented at the Canadian Tuberculosis Association meeting in Ottawa in June 1960 by A. L. Paine, M. D.

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

ASSINIBOINE HOSPITAL

Assiniboine Hospital is a 198-bed hospital operated by the Sanatorium Board of Manitoba in the city of Brandon. Formerly known as Brandon Sanatorium, it served for over a decade as a 227-bed treatment centre for tuberculous Indians and Eskimos. In recent years, however, the demand for TB beds has declined and, at the request of the provincial government, the hospital has gradually been converted into a treatment centre for non-tuberculous patients requiring hospital care for 30 days or more, for certain respiratory and orthopedic cases, and for Indians and Eskimos with acute and chronic conditions.

One year ago 97 beds on five of the hospital's nine wards were set aside as a general hospital section. By the end of the year only 27 tuberculosis patients, most of whom were children and orthopedic cases, remained in the hospital. By January 31, 1961, these patients also had been evacuated, making the conversion of Assiniboine Hospital complete.

TUBERCULOSIS ADMISSIONS AND DISCHARGES

During 1960 patient days for the tuberculous numbered 20,111 as compared with 47,313 in 1959. Sixty-four TB patients were admitted to hospital, most of them for review or diagnosis. Twenty-two were admitted with pulmonary tuberculosis and of these, nine had minimal disease, seven were moderately advanced and six, far advance. Nine patients had non-respiratory disease.

Of the 64 tuberculous admissions, 16 had active disease, 18 had inactive disease, three were bacillary and 31 non-bacillary. Thirty were found to have non-tuberculous disease after investigation. Most of these had pneumonitis or pneumonia, two had bronchiectasis, 12 had no disease and six had miscellaneous conditions.

Of those admitted for investigation, four new active cases of tuberculosis were found. Three were immediately transferred to Manitoba Sanatorium at Ninette and the fourth, a one-year-old child, was retained at Assiniboine because facilities for children were not yet available at Ninette. It is perhaps interesting to note that one of the patients transferred to Ninette was an 85-year-old women who was originally admitted to our extended treatment section. On examination we found to our surprise that she had moderately advanced pulmonary tuberculosis, active and bacillary.

A total of 135 patients were discharged from the tuberculosis section in 1960. Only two left against medical advice and both of these were non-bacillary. Ninety-four patients were discharged home, and 39 were transferred to other institutions, six to Clearwater Lake Hospital and the rest to Manitoba Sanatorium.

No one died from tuberculosis during the year.

The discharge status of the respiratory cases were: active improved, 38; active unimproved, 2; inactive, 44; bacillary, 5; non-bacillary, 79. Of the non-respiratory tuberculosis discharges, five were active improved and 13 were inactive. All were non-bacillary.

The average length of stay of all patients discharged was 405. 82 days. The average length of stay of those discharged on medical advice was 599 days. This is longer than the average length of stay in other TB institutions as many of the remaining patients were of the chronic type.

TREATMENT

During the year 22 thoracotomies were performed for tuberculous conditions; 19 of these had residual bronchiectasis and one a tuberculous cavity with broncho-pleural fistula. These were treated by lobectomy (14), pneumonectomy (3), segmental resection (4), and wedge resection (1). There were six thoracoplasties performed as space filling procedures.

There was one post-operative death following thoracotomy and excision of an emphysematous bulla in an Eskimo patient who had been hospitalized since early in the 1950's. Death was due to a cardiac arrest during intratracheal suction.

OUTPATIENT SERVICES

Outpatients examined in 1960 totalled 1, 085. As mentioned previously, four were admitted for further examination and found to have active tuberculosis.

Assiniboine Hospital continued routine x-raying of school teachers, the Royal Canadian Mounted Police, employees of the Manitoba Power Commission and inmates of the Brandon Jail. We made monthly visits to the Brandon Hospital for Mental Diseases and kept a close check on inactive and questionable cases. Consultation service for respiratory diseases, including bronchoscopy, was also made available to this hospital.

A tuberculin and chest x-ray survey was conducted at Brandon College. Of the 243 students who received the tests, 4. 8% were positive.

LABORATORY AND X-RAY

During the year the X-ray Department carried out 6, 169 radiological examinations, as compared with 5, 948 in the previous year. In addition to this numerical increase, there was a considerable increase in the number of more complex examinations required by the general hospital patient. For example, 39 gastro-intestinal and barium series were conducted; 24 gall bladder and kidney visualizations, 19 skull and paranasal sinuses, 92 spines, 148 pelvises and 281 extremities examined.

We are fortunate to have as consultant, Dr. R. Sykes, radiologist at Brandon General Hospital. All examinations that require fluoroscopic study are performed in our department. X-rays which require his reading are sent to the Brandon General Hospital.

The laboratory carried out 40, 910 units of work in 1960, as compared with 38, 524 units in 1959. Considering this increase in work, plus the fact that the laboratory is now serving a general hospital of 198 beds and over 1, 000 out-patients, it seems desirable that a second trained technician be added to the staff. If this increase were made, it

might permit us to enter into a training program with the Brandon Hospital for Mental Diseases, which would likely give us an additional assistant in training.

With respect to the laboratory work, there has been a marked increase in prothrombin estimations for patients on anti-coagulants, more complex bacteriology and an increase in biochemistry. Electrocardiographic examinations have doubled.

LIBRARY SERVICE

During the year the Ladies Auxiliary of the Associated Canadian Travellers, Brandon Club, organized a hospital library auxiliary. We are grateful to these women for their contribution to the patients' welfare.

A. H. POVAH, M. D.,
Chief of Medical Services,
Assiniboine Hospital.

CLEARWATER LAKE HOSPITAL

The fact that the time for complacency in the tuberculosis case-finding program has not yet arrived was illustrated with startling clarity during the year 1960 at Clearwater Lake Hospital, The Pas.

In Northern Manitoba active nests of tuberculosis were discovered in three small communities, but not until one infant had developed meningitis and another, far advanced miliary disease. The adult sources of infection were proved to have advanced open bacillary tuberculosis. A highly infectious elderly male, previously undiscovered by our surveys, had evaded x-ray examinations for 74 years!

A local epidemic of tuberculosis in the Baker Lake area of the Central Arctic resulted in the hospitalization of 10 active cases.

All this in spite of regular, organized x-ray surveys!

ADMISSIONS AND DISCHARGES

A decline in admissions was anticipated in 1960, but the figure of 228 was in actual fact only 14 less than that of 1959. Patient days numbered 28, 982, a substantial reduction from 37, 836 in 1959.

A summary of disease classifications is tabulated below:

Disease Classification	Number of Cases
Minimal Tuberculosis	97
Advanced Tuberculosis	40
Tuberculosis Meningitis	3

Of the above, 19 proved bacillary, and it is significant that the tuberculous infection was manifested by meningitis in three young children.

Of the 232 patients discharged, 188 left on medical advice and one against advice. Twenty-six patients were transferred to other sanatoria and seven died. In two instances the causative factor of death was non-tuberculous following investigation.

The average days stay of 151. 8 was a marked reduction from previous years.

TREATMENT

The treatment of tuberculosis became more standardized and was charaterized by shortened intervals of bedrest, followed by full ambulance as soon as indicated. Surgical procedures were recommended earlier and streptomycin was rarely used in minimal disease.

Therapeutic days (214) were lower in 1960, due in part to earlier discharge with the provision that INH be taken extra-murally.

The diagnostic procedures included 21 bronchoscopic and eight cystoscopic examinations.

MEDICAL STAFF

A situation of some concern has been the difficulty in obtaining the services of a permanent, qualified medical staff, but some improvement occurred as the year ended.

LABORATORY AND X-RAY SERVICE

A superior staff resulted in the production of more reliable work with a widening scope in our laboratory. Records were maintained meticulously.

Because of the shortened treatment period and the reduction of admissions, x-ray procedures showed a decrease of 50% in 1960. During the year the bulk of Treaty Indian Clinic films was transferred to Winnipeg, but the preventive program, covering the adjacent areas, remained the responsibility of the Clearwater Lake Hospital.

Hospital admission films were interpreted regularly for other institutions.

ACADEMIC TEACHING AND OCCUPATIONAL THERAPY

An average of 25 patients per day received either academic instruction or occupational therapy. Earlier enrolment resulted from accelerated treatment and as a result 56 pupils received the benefit of schooling. The ethnic grouping was as follows: Eskimo, 28; Treaty Indian, 20; Non-Indian, 8.

All ages were represented in the 23 who attended the Grade I classes. During the year educational facilities were extended to Grade VIII.

STUART L. CAREY, M. D.,
Chief of Medical Services.

ST. BONIFACE SANATORIUM

It is a privilege to present this report from the medical department of St. Boniface Sanatorium. It is for the year 1960, the 29th year of operation.

Because of the reduced demand for tuberculosis beds, one ward consisting of 34 beds was closed to tuberculosis patients in April, 1959, with the result that the bed capacity of the sanatorium was reduced during the past year. Patient days in 1960 totalled 79, 044, a reduction of 5, 713 compared with 1959.

ADMISSIONS

A total of 155 patients were admitted to the sanatorium in 1960. Of this number, 37 were classed as re-admissions and three were newborn. Admissions to the sanatorium were discontinued on December 1, 1960, in accordance with an agreement to transfer gradually from the treatment of tuberculosis to that of chronic diseases and retarded children.

Of the 1960 admissions, 137 or 88. 3% had respiratory tuberculosis, and of these 35 or 25. 6% were classified as minimal in extent; 36 or 40. 9% were found to be moderately advanced; 33 or 24. 1% had advanced disease. The remaining 13 cases suffered from respiratory tuberculosis in a form which is not classified as to extent. Of the 137 respiratory cases, 133 were active. Only four patients required further investigation after admission.

The whole anti-tuberculosis program in Manitoba aims at the early discovery of tuberculosis when the disease is more easily controlled, and when there is less likelihood of infection to others. Of all the cases coming to this sanatorium, 47. 5% were found to be non-bacillary on admission and therefore it is not likely that they were dangerous to their associates.

Fourteen patients were admitted with tuberculosis in areas other than the lungs. This is a reduction from the previous year when the total was 22. In 1960, 21. 5% were admitted with genito-urinary tuberculosis and 57. 1% came for treatment of bone and joint disease.

Of the 155 admissions 24. 5% were under 25 years of age: 41. 9% were in the second 25 year period, and 33. 7% were past the age of 50. Male patients exceeded female patients in the ratio of 88 to 67. This is probably explained by the fact that some male patients leave against advice or receive disciplinary discharges, and are admitted again later in the year.

DISCHARGES

During 1960, 199 patients were discharged from the sanatorium. Of these 66. 3% left on medical advice with a good prospect for future health. Among the remaining discharged patients, 14. 1% left against medical advice, 1. 5% were discharged for disciplinary reasons, and 4% were transferred to continue treatment elsewhere.

Twenty-eight or 14. 1% of the patients died. Seventeen of the

deaths were attributed to respiratory tuberculosis and 11, to non-tuberculous causes.

The average length of stay for all discharged patients in 1960 was 402 days. For the patients discharged on medical advice the average was 462 days. The average days stay for those who died was 485 days.

TREATMENT

The treatment of tuberculosis has not changed remarkably in the last few years. The sanatorium is equipped to provide rest when required, graduated exercise as indicated, and training through the Rehabilitation Department. Pneumothorax has not been used at St. Boniface Sanatorium in recent years, having been successfully replaced by the chemicals.

In accordance with recent trends, surgical removal of the destroyed part of the lung still holds the favored position in treatment. This is called pulmonary resection and the success of the program in Manitoba is in no small part due to this form of treatment.

Fortunately a minority of cases require surgical treatment, but when the indications are there, there should be no hesitation in advising the treatment. The results are good and the risk is low. During the year 10 patients underwent segmental resection, 23 had lobectomy, and three had a combination of segmental and wedge resection - the total resectional operations being 37. It is gratifying to report that it was not necessary to remove a total lung and that there was no mortality.

With respect to chemotherapy, it is customary to treat all active tuberculosis with at least two of the major anti-tuberculosis drugs. For example, 214 patients received streptomycin, 224 received INH, and 36, the chemical known as PAS. D. Cycloserine was used for three patients and viomycin was used for the treatment of six patients.

The average duration of chemical treatment is probably two years. This exceeds the average stay in sanatorium and accounts for the fact that almost all patients need to continue their medications on an outpatient basis.

ORTHOPEDIC PROCEDURES

Dr. W. B. MacKinnon has again served in the capacity of orthopedic consultant and surgeon. In this department seven spinal fusions and one hip anthrodesis were successfully carried out during the year. Advice was given and clinics held in the management of the remaining cases of bone and joint disease. Plaster beds, plaster spicas and a variety of plaster casts are usually made by members of the resident medical staff.

OUTPATIENTS

Our outpatient department is supervised by Mrs. Helen Pietuchow, with our assistant medical director acting as senior medical officer.

It gives a great feeling of satisfaction to see former patients

now enjoying good health and to have obviously returned to the community as reliable, self-supporting citizens. The enrollment in this department is, 1,961. A total of 841 patients returned during the year for examination and advice. The majority were found in good health and left with a feeling of reassurance. Twenty patients showed evidence of reactivation of disease and were advised to take more treatment.

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

INDIAN HEALTH SERVICES

Fifteen years ago the battle against tuberculosis in our Indian population was going badly. Casualties were many, funds were low, and the few troops holding the line were making little progress. That year saw a resurgence, a turning point from which we went to success after success until now we can say that the fight is one of finding hidden nests and not the massive engagements of the past.

One may say that we gave the Sanatorium Board the tools and they did the job and continue to do it. Provincial boundaries did not stop Doctor Ross. Until the Ontario Department of Health discovered its North-west frontier and we organized our forces it was the Sanatorium Board of Manitoba that fought TB among Indians in this huge area that amounts to half of Ontario. It was the same in the Central Arctic where we organized surveys by ship and plane and the technicians of the Sanatorium Board found cases that could be cured when previously a trickle of Eskimos came out to die.

The first few years of this fifteen year period showed spectacular results in the discovery of new cases and in the decrease in deaths. There is still some improvement but at a slower rate. The situation in Indians is still ten times as bad as in the white population.

What can we do?

We can devote more energy to the epidemology of TB and attack the source of new cases.

We can increase our efforts in health education.

We can watch for new converts to the tuberculin test and treat them.

But, we shall never eliminate tuberculosis until the standard of living and education of the Indian and Eskimo population approaches that of the non-Indian. Both these aboriginal Canadians are in a transition stage from hunting to machines, from tea to beer and Pepsi, from folk tales to television.

Unfortunately, I shall not be here to watch their progress, for a new regional superintendent will take my place this year. I shall not ask you to co-operate with him for I am sure you would not think of doing anything else.

Please accept on behalf of The Director of Indian and Northern Health Services our most sincere thanks for the splendid help you have been to our Department and to the Indians and Eskimos of Manitoba, Ontario, and the North-West Territories.

W. J. WOOD, M. D.,
Regional Superintendent,
Central Region,
Indian and Northern Health Services.

REHABILITATION SERVICES FOR TUBERCULOSIS PATIENTS

The total rehabilitation program for the tuberculous by the Sanatorium Board of Manitoba implies medical, social and vocational assessments leading to planned rehabilitation goals. These aims can only be achieved when the rehabilitation services meet the requirements of each individual. A complete medical assessment of each rehabilitant is available and this assists in making the other assessments meaningful. The increasing number of admissions with low educational standards, the older group, and the recalcitrant group all need special rehabilitation services which give the extra needed assurance that medical treatment will succeed.

IN-SANATORIUM REHABILITATION PROGRAM

Personnel:

There were no changes in rehabilitation personnel at Manitoba Sanatorium or at St. Boniface Sanatorium, so the work was carried on efficiently and competently. At St. Boniface Sanatorium an extra teacher was provided in January 1960 for a few months to give extra tuition in basic English to the refugees admitted at that time.

At Clearwater Lake Hospital an instructress re-opened the handicraft division. On October 16, 1960, a teacher was employed by the Sanatorium Board of Manitoba to carry on the work begun by the Indian Affairs Branch.

At Assiniboine Hospital in Brandon, the patients were served by the same capable handicraft instructress.

Registrations:

A planned pre-vocational program in our sanatoria is a necessity not only because of its recognized therapeutic value, but more especially because of industry's demand for higher educational qualifications than those held by most of our admissions.

To illustrate the value of the In-Sanatorium program I cite the case of a young Yugoslavian who came to Canada in 1957 as a laborer. He had little knowledge of English, and when enrolled as a student following his admission to sanatorium in June, 1959, he could scarcely make himself understood. He is now doing good work at a Grade VIII level, and he is also receiving a practical work assessment in the sanatorium laboratory. Future rehabilitation plans for him are dependent on how much more he completes before discharge, but he has expressed an interest in watch repair.

Despite the fact that fewer tuberculosis patients were admitted during 1960 than in 1959, it is interesting to note that the number of students registered during 1960 in pre-vocational and vocational courses was not appreciably changed. The numbers given include students of all racial origins.

	Manitoba Sanatorium			St. Boniface Sanatorium		
	Pre-Voc.	Voc.	Handicrafts	Pre-Voc.	Voc.	Handicrafts
1959	240	35	264	128	21	268
1960	245	19	297	121	25	104

On December 31, 1960, at Manitoba Sanatorium 86% of the total enrollment in pre-vocational classes were below a Grade VIII level, while at St. Boniface Sanatorium only 66% were below a Grade VIII level. The difference here is largely due to the preponderance of Indian and Eskimo patients at Manitoba Sanatorium and to the admission of more children. These facts also account for fewer enrolments in vocational courses at Manitoba Sanatorium. An innovation in vocational training through correspondence courses was made early in 1960 to the effect that all courses are now free to in-hospital patients.

Clearwater Lake Hospital had an enrolment of 25 students on December 31, 1960, and these were all studying below a Grade V level, with 13 of the students learning basic English. Most of this group were of Eskimo origin. The handicraft instructress had a group of 25 workers registered.

At Assiniboine Hospital, there was a noticeable decrease in the number of tuberculosis patients receiving instruction in the handicraft department this year. On January 1, 1960, there were 53 patients participating, and only 27 on December 31, 1960. The handicraft instructress here has spoken on Indian and Eskimo crafts on several television programs, and to interested urban and rural groups.

Handicraft Displays

This year the various handicraft departments of our sanatoria severally or collectively set up excellent displays of articles made by patients in conjunction with the following events: The Indian and Metis Conference; Manitoba Education Association Convention, a tuberculin testing survey at the Polo Park Shopping Centre; Red River Exhibition; Rural Folk Festival sponsored by the Manitoba Pool Elevators.

The patients from Manitoba Sanatorium exhibited their work at the Pelican Agricultural Society Fair and again won many prizes as did the group from Assiniboine Hospital at the Brandon Fair.

At Manitoba Sanatorium the employment of ex-patients in various departments is still a contributing factor to rehabilitation. This serves to some extent as a sheltered workshop and is invaluable as an adjunct to the complete assessment of the rehabilitant concerned. It was used successfully in the case of a young Hungarian girl who, while she was a patient, decided to become a nurse. She was registered as a student in academic subjects at a Grade III level. Following discharge as a patient she began work as a nurses' aid at the sanatorium and continued with her studies in English. She eventually applied for and was awarded a Press Radio Scholarship to enable her to continue with high school studies in the city. Ultimately she will reach her objective.

POST-SANATORIUM PROGRAM

The vocational aspect of rehabilitation is still widely considered as the most important one, and during 1960 23 students were registered for a variety of vocational and professional courses at the following schools. These students were assisted financially through Schedule "R", a provincial-federal agreement.

Manitoba Technical Institute	11
Manitoba Commercial College	6
Success Commercial College	1
Medical College	2
Teacher's College	1
Training on-the-job tailoring	1
Betts' Dressmaking School	1
	23

Ten rehabilitants completed training and are now employed. One discontinued for social reasons and three took summer jobs, and as they could remain with their respective employers, they did not complete their training. Nine were still attending classes on December 31, 1960.

This was the first year that Metis patients were admitted to the Rehabilitation Unit at Assiniboine Hospital. Two referrals were made and accepted. The boy left for home before the approved period was over, but the girl profited from the socialization program there and was able to satisfactorily accept life in an urban situation. She is now doing creditable work in a dress making course which had been her goal as expressed in an early sanatorium interview.

Two referrals from the Department of Public Health and Welfare were men who were ex-tuberculosis patients of long standing. One family man was given clerical training through Schedule "R", which enabled him to get suitable employment in his own rural community. The other referral also involved a family who were receiving public assistance. The father is presently being trained as a junior accountant with the hope that he will also be established in his own community. Job possibilities will be explored before he has completed his training.

Four high school students were ready to rejoin their classes at the beginning of the fall term. There were two referrals to the Industrial Work Shop for complete social, work tolerance and aptitude testing, resulting in one job placement and the other being considered as a permanent work shop case.

As patients are leaving the sanatoria sooner, more home follow-up work is necessary. At present there are 10 ex-patients studying high school or vocational courses at home under our guidance and assistance. The progress of the three young men apprenticed in electrical and drafting fields is also checked periodically.

JOB PLACEMENTS AND FOLLOW-UP

Twenty-seven of our 1960 case load were placed in employment. Seven of these were re-employed by their previous firms, and the other twenty were placed through the Special Placements Branch of the National Employment Service, through the training schools concerned,

or other means. At the end of 1960 only three referrals to National Employment Service were still awaiting placement. Periodic follow-up work is still done on all placements before the cases are closed satisfactorily.

I acknowledge financial assistance from the Sanatorium Board in payment of driving lessons for a rehabilitant, and for making possible a loan necessary for the re-establishment of a license to ensure employability.

The Winnipeg chapter of Zonta International again established a fund for indigent patients which is now being used for small exigencies rather than the payment of correspondence courses, for which it had been set up originally.

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

SPECIAL REHABILITATION SERVICES

REHABILITATION or HABILITATION is the process of achieving maximum usefulness, and thereby greatest personal satisfaction. To carry out this process an individual must measure his interests, limitations and abilities against available opportunities. He must be aware of, and know how to utilize available community resources. Some persons are able to carry out this process with no apparent help. However, the majority require assistance to do so, and it is the purpose of the organized rehabilitation programme to provide this assistance. Due to language difficulties, inadequate schooling, and in general, a lack of social awareness and orientation the Indian and Eskimo who is physically handicapped requires a more intensive type of assistance than most other Canadians. Recognizing this fact, the Sanatorium Board of Manitoba, in co-operation with Indian and Northern Health Services, and Indian Affairs Branch, undertook the development of a special rehabilitation programme to meet the need. As a result of this experiment started in 1957, one hundred and twelve men and women whose average schooling on acceptance was not above Grade V, and whose previous work experience had, for the most part, been confined to seasonal, short-term unskilled manual labour, have been assisted in finding full-time competitive employment compatible with their physical capacities. The average annual income of this group, based on starting wages, was $2,122.19. This means that through direct taxation alone the group are repaying the monies invested in their futures at the rate of approximately $17,000.00 annually.

REFERRALS

It was natural that in the beginning the majority of referrals should originate in the sanatoria operated by the Board. In 1960 there was a marked increase in the number of referrals received from outside sanatoria. These referrals were received from clergy, school teachers, and other interested individuals, as well as other rehabilitation agencies and the field staffs of Indian and Northern Health Services and Indian Affairs Branch. The programme was originally designed to meet the needs of physically disabled Treaty Indians and Eskimos, but in 1960, in addition to persons with a diversity of physical handicaps, referrals were also received on behalf of some physically able persons whom it was felt would benefit from social orientation.

In working with the disabled of Indian origin, the Rehabilitation Advisory Committee had noted that the major barriers to success were more often of a social nature than physical or mental incapacity. These are handicaps imposed by environment and lack of opportunity. In 1960, at the request of Indian Affairs Branch, the Committee agreed to accept for rehabilitation a few of these socially handicapped. It had also been noted that many Metis (persons of Indian origin but not of Treaty status) faced similar problems with respect to social adjustment, and at the request of the Provincial Department of Welfare the Committee further agreed to accept, from sanatoria, a limited number of these persons.

Referrals were also received on behalf of children, but, although some cases were accepted, it is felt that children do not require the special services of this programme and can better be dealt with by other agencies.

REHABILITATION UNIT

As suggested previously, the major barriers to the successful rehabilitation of the Indian and Eskimo are of a social nature. To provide the warm and accepting atmosphere in which to impart the knowledge and confidence requisite in a socially mature individual, the Rehabilitation Unit at Assiniboine Hospital, Brandon, was established in April of 1958. The primary function of this Unit is still social orientation, but the shorter duration of sanatorium treatment, and the greater number of referrals from outside hospital have made pre-acceptance screening more difficult, increasing the importance of the unit as an assessment centre. These factors have also increased the need for academic upgrading. However, schooling in the unit remains of secondary importance. In some instances, the unit has also made possible earlier discharge from hospital. In 1960 a number of rehabilitants continued chemotherapy and physiotherapy while at the unit.

VOCATIONAL TRAINING AND PLACEMENT

A few rehabilitants qualify for vocational training, but the majority lack the requisite schooling. Many of these are of average, or above average intelligence, and the type of employment most readily available to them without training does not offer sufficient challenge or satisfaction. Consequently, the individual becomes restless and his dissatisfaction with his job is soon apparent in his behaviour off the job. In 1960 one young man who, while employed as a factory worker, attended night school, upgraded himself over a period of six months from Grade VI to Grade VIII and thereby qualified for training. There are usually one or two such persons each year but they are exceptional, and would be exceptional by any standard. For some it is possible to arrange training on the job but these opportunities are not as readily available as one might expect. Employers find training on the job costly during peak production periods and many of the smaller companies are simply not able to justify training programmes during slack periods, even with the wage sharing. The wages of the trainee are often the least of the costs involved. Wages paid to skilled personnel providing instruction, and the materials used in the training process must also be taken into account. There are, however, some fields where on-the-job training is the only means of obtaining skilled personnel. In 1960, through the co-operation of the Winnipeg General Hospital, seven young men were trained as hospital orderlies. This has proven to be a particularly good training programme but, although many young Indian men appear to have a particular aptitude for this type of work, it is simply not possible, under the present arrangement, nor would it be practical at this time, to increase the numbers entering training. However it is felt that similar training programmes could be established in other fields. There were still many unskilled jobs to be found in 1960, but, unfortunately, many of these were too heavy or too low paying, with little opportunity for advancement. There is a real need for pre-vocational training and practical assessment facilities which would provide at least some basic schooling and a knowledge of tools, materials and processes. In 1960 employers were, on the whole, most appreciative of the fact that lack of schooling is not necessarily an indication of lack of intelligence - particularly with those of Indian origin. Given opportunity, purpose, and encouragement, the majority of rehabilitants assisted in 1960 demonstrated that the citizen of Indian origin is much like any other average citizen in his desire to be independent.

SUMMARY

Maximum usefulness naturally varies with the individual. Some persons are capable of only part-time employment, or simply of caring for themselves. Such is the case of the man, the father of eight, who, injured by a falling tree, is now confined to a wheelchair. By co-ordinating the services of the Paraplegic Association, Indian and Northern Health Services, and Indian Affairs Branch, it was possible to provide this man with special prosthetic equipment, arrange for ongoing medical care, modify his home, and to provide the necessary financial assistance enabling him to return to his family even though the home is located in an isolated area. Not only is this man living a fuller, more normal life, but the cost of his maintenance is only a fraction of what it would have been had he been placed in an institution and his family maintained on the reserve. Although rehabilitation planning can and does help some persons like the man mentioned above, for the most part an accepted case is one who, following preliminary screening, is likely to achieve a greater degree of economic independence.

Accepted Cases 1960	-	125
Closed - lacking interest or otherwise unsuitable	-	18
Closed - Rehabilitated (considered to no longer require services)	-	22
Closed - Returned to regular schools or referred to other Rehabilitation Agencies	-	6
Carried over to 1961	-	79
Post-Hospital Academic Training and Social Orientation	-	44
Attended Schools	-	4
Pre-Vocational Academic Training	-	4
Vocational Training (in school)	-	22
Vocational Training (on-the-job)	-	2
Completed Vocational Training	-	13
Job Placements - Full Time	-	33
Still Employed	-	25

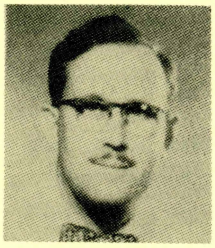
It will be noted that eight persons for whom employment was found were not working at the end of the year. Three left employment of their own accord. Of these, we have lost contact with two. The third returned to the reserve at the insistence of her parents but has maintained contact and is expected to return shortly. Two were withdrawn for reasons of health but as one of these is now employed part-time it is expected that he will eventually return to full-time employment. Two young men, after working several months, were able to qualify for training and are presently on course. The eighth was a young woman referred by the John Howard and Elizabeth Fry Society, who, although a co-operative, capable worker, could not cope with the day-to-day problems of the large urban centre. She has returned to the reserve but is being followed up by the Society and Indian Affairs Branch.

EDWARD LOCKE,
Supervisor,
Special Rehabilitation Services.

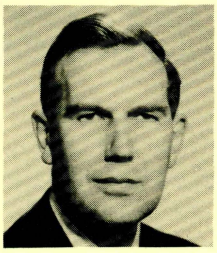
Section 3

EXTENDED TREATMENT AND REHABILITATION HOSPITALS

Dr. A. H. Povah has been a member of the Sanatorium Board medical staff for 14 years and is presently Chief of Medical Services at Assiniboine Hospital, Brandon. He was formerly a resident physician at St. Boniface Sanatorium and Manitoba Sanatorium and came to Brandon as Sanatorium Surgeon in 1948.



Dr. Stuart L. Carey, Chief of Medical Services, came to Clearwater Lake Hospital at The Pas in July, 1952. A graduate of the University of London, England, he has been associated with the Sanatorium Board since 1946 and for several years had charge of the Board's Travelling Clinic programme in Winnipeg.



Dr. Leslie H. Truelove was appointed Chief of Medical Services of the Manitoba Rehabilitation Hospital in February, 1960. A graduate of Oxford University, he received his Diploma in Physical Medicine from the Royal College of Surgeons and the Royal College of Physicians in London in 1959. Before coming to Canada he was a clinical research fellow in the Rheumatic Unit of Northern General Hospital in Edinburgh.

ASSINIBOINE HOSPITAL

As of January 31, 1961, treatment of tuberculosis patients was discontinued at Assiniboine Hospital. It is now entirely an extended treatment hospital for Western Manitoba patients requiring hospital care for 30 days or more.

ADMISSIONS AND DISCHARGES

During the year, 543 patients were admitted to the general hospital section, and 387 were discharged. Because of the type of patient now being admitted, the death rate is high. There were 111 deaths, which is 22.29% of all discharges. Permission for autopsy was obtained in 28 cases, giving an autopsy rate of 25.23%.

Considering the chronic and serious nature of the illnesses treated, it is noteworthy that the average length of stay of the patients discharged was only 88.23 days. Patient days numbered 43,935, as compared with 25,551 in the general hospital section in 1959. A total of 1,398 patients attended the Outpatient Department for examination, oxygen, or physiotherapy.

Assiniboine Hospital has an open medical staff. The patient may be cared for by his family physician or referred to a physician in Brandon or to the resident medical staff at the discretion of the referring physician. However, 100% of the patients admitted to hospital from outside of Brandon have been referred to the resident medical staff. Of the 1960 admissions to the general hospital section, 68% were cared for by the resident medical staff. It should be remembered that in 1960 there was also quite a tuberculosis patient load. At the time of writing, patients cared for by the resident medical staff is 83%.

It is interesting to note the source of admissions. Indian and Eskimo patients admitted to the general hospital section came from Birdtail, Waywayseecappo, Keeseekoowenin, Oak River, Oak Lake, Rolling River, Swan Lake, Cross Lake, Peguis, Pine Creek, York Factory, Churchill, Norway House, Nelson House, Island Lake, The Pas, Koostatak, Shoal River, Long Plain, Sandy Bay, Shamattawa, Valley River, Split Lake, Mathias Colomb, Little Grand Rapids and Camp 20, Churchill.

Source of admissions of white patients to the general hospital section in 1960 were Angusville, Alexander, Arden, Archie Municipality, Arrow River, Baldur, Basswood, Belmont, Birtle, Binscarth, Beresford, Birnie, Boissevain, Brookdale, Cardale, Carberry, Clanwilliam, Cypress River, Dand, Dauphin, Deloraine, Clearwater, Eden, Elgin, Elkhorn, Elva, Erickson, Foxwarren, Fork River, Goodlands, Gilbert Plains, Garland, Grandview, Grand Clariere, Griswold, Hartney, Hamiota, Hargrave, Isabella, Katrime, Kelwood, Kenton, Killarney, Lyleton, McCauley, Makaroff, McConnell, Minnedosa, Miniota, Melita, Minto, Minitonas, Moorepark, Laurier, Neepawa, Nakina, Neelin, Ninette, Nesbitt, Oak Lake, Oak River, Onanole, Olha, Oakburn, Ochre River, Pipestone, Pilot Mound, Portage la Prairie, Rapid City, Rivers Camp, Rossburn, Roblin, Rivers, Reston, Roseau, Roblin, Russell, Selkirk, Strathclair, Shoal Lake, Sidney, Souris, Sandy Lake, The Pas, Transcona, Virden, Vista, Wheatland, Westbourne, Winkler, Winnipeg, Whitewater and Woodnorth.

The patient admitted to the extended treatment hospital is usually one with multiple complaints due to degenerative processes of several systems. Frequently these are arteriosclerotic disease of heart and brain, degenerative changes of lung and bone and joints, and diseases of the elderly, especially those connected with the prostate, and malignancy. Because of the multiplicity of conditions and the debility of the patient, nursing and drug costs are high. The referring physician does not usually send the patient in until he has done all that he can for him. For this reason treatment must be more aggressive to obtain results.

TREATMENT

A total of 31 thoracotomies were performed in 1960 for non-tuberculous disease. The diagnoses were: Bronchiectasis, 22; hydatid disease of the lung, 5; carcinoma of the lung, 2; destroyed lung, 1; enlarged thymus, 1. These were treated by lobectomy (13), pneumonectomy (2), segmental resection (8), wedge resection (1), thoracotomy (7).

Dr. F. R. Tucker, orthopedic consultant, performed 15 major operations. Nine of the major operations were for non-tuberculous conditions. For the investigation and treatment of respiratory disease, 82 bronchograms and 192 bronchoscopies were done.

It should be stressed that the operating room has an important function in the extended treatment hospital. Patients occasionally fall and break their arms; weakened patients develop hernias and urinary and bladder complaints. Among other things we must perform tracheostomies for the unconscious and pulmonary cripple, amputations for peripheral vascular disease, bronchoscopy for the emphysematous patient with suppurative tracheobronchitis to clear his vital airway.

We recently had a ruptured appendix in a patient 86 years of age. This was removed by the consulting surgeon, following which she developed a pulmonary embolus. She withstood all these assaults and made a satisfactory recovery. It would have been a mistake to try to move this patient from one hospital to another. The General Hospital has a long waiting list and emergency admissions only upset their routine and non-emergent admissions would be delayed considerably. I feel for these reasons that the maintenance of an adequate operating room is important.

PHYSIOTHERAPY AND OCCUPATIONAL THERAPY

A new physiotherapy and occupational therapy unit was officially opened on November 19. This unit provides much needed facilities for the treatment of chronic illnesses, particularly those crippled by cerebral vascular accidents, arthritis, rheumatism and other post-traumatic or post-surgical conditions.

The unit is now providing treatment to approximately 80 patients per month under the direction of Dr. Leslie Truelove, chief of staff of the Manitoba Rehabilitation Hospital, Winnipeg, Dr. Gordon Coghlin, chief of internal medicine, Peter Prendiville, chief physiotherapist, and his assistants. During the year, 1,070 inpatients and 96 outpatients received a total of 11,786 physiotherapy treatments and 7,171 pressure breathing treatments, making a grand total of 18,957 treatments. The

treatments available in the unit are short wave, hydrocollator, infra-red, wax baths, ultraviolet radiation, massage, traction, exercises, suspension, resistance exercises, re-education of walking, passive movements, remedial pool treatments, whirlpool baths, plaster splints, hot packs, postural drainage, intermittent positive pressure breathing, occupational therapy and training in daily living.

COMMITTEES

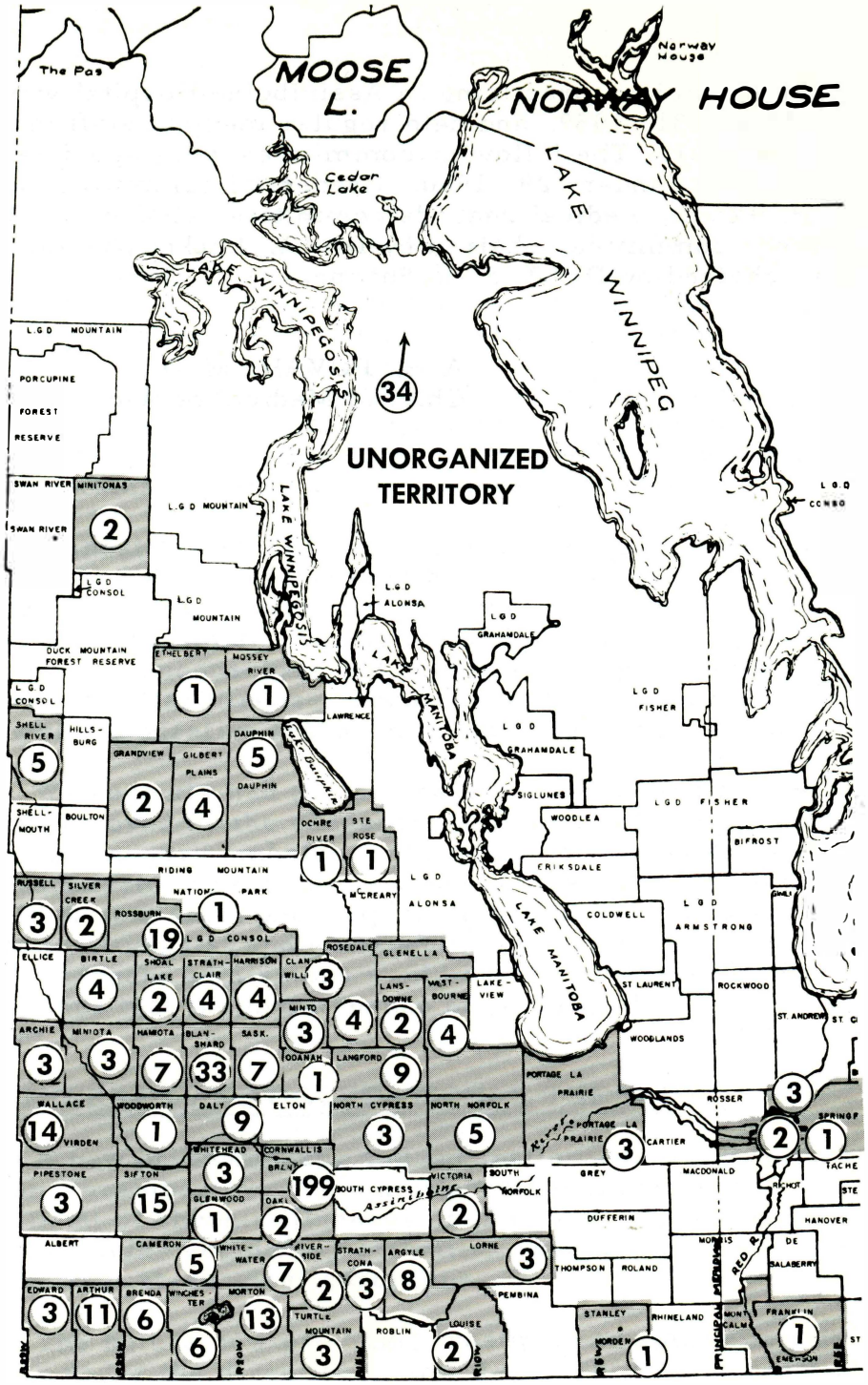
The physicians practicing in Assiniboine Hospital were organized on March 31, 1959, and held regular medical staff meetings throughout the year. The following committees were appointed at the annual meeting on January 29, 1960: Credential committee, chaired by Dr. A. H. Povah; medical records committee, chaired by Dr. G. Coghlin; tissue committee, chaired by Dr. A. Lapko; pharmacy committee, chaired by Dr. V. J. H. Sharpe.

A. H. POVAH, M. D.,
Chief of Medical Services.

Source of Admissions – 1960

To the Extended Treatment Section

Assiniboine Hospital



LGD stands for Local Government District

At the beginning of 1960 it appeared as if the occupancy of the extended treatment section might remain at a relatively low figure. However, as the local physicians became acquainted with the hospital's new services for the chronically ill, more patients were referred. This resulted in an improvement of occupancy from 60% to 98% during the following 12 months. Another factor was the construction of a modest physiotherapy unit, incorporating hydrotherapy, which led to the referral of many hemiplegics and arthritics.

ADMISSIONS AND DISCHARGES

Admissions for 1960 totalled 350 and discharges, 337. It is gratifying that 293 of these left the hospital as either cured or improved. The illnesses treated were extremely varied, with cardiac and pulmonary cases predominating. A rare case of Kartegener's Syndrome was presented for publication.

Deaths in 1960 totalled 13, and seven (53.8%) autopsies were performed.

Patient days rose from 11,197 in 1959 to 16,393 in 1960, while the average length of stay remained stable at 32.1 days.

STATISTICAL REVIEW

Selective Age Groups

Pediatric		Extended Treatment	
Age Group	Number of Patients	Age Group	Number of Patients
0 - 4	71	50 - 59	47
5 - 9	38	60 - 69	29
10 - 14	34	70 - over	56
Total	143	Total	132

The above figures are similar to the previous year, and it should be noted that 143 pediatric cases were treated.

DEPARTMENTS

Physiotherapy and Occupational Therapy - The physiotherapist performed the dual function of both physiotherapist and occupational therapist, so that the latter was mainly diversional. However, active physiotherapy was applied in a thorough and methodical manner to 15 cases a day, and throughout the year 499 treatments were administered.

Operating Room - Of the 60 operating room procedures, 17 were bronchoscopic examinations, nine were bronchographic studies, and eight were cystoscopic examinations. No major surgery was undertaken.

Casualty - This department has existed for many years, but only recently

has it become organized. Registered patients totalled 188, and among the 350 conditions treated were burns, injuries, eye, ear, nose and throat conditions. Many of the patients came from the Guy Indian School and several were admitted to hospital.

Laboratory and X-ray - Although x-ray examinations were substantially reduced during the year, the hospital admission program was continued as before, with 90.3% of all admissions receiving chest x-rays.

The 1,772 laboratory procedures, representing 4,025 units of work, were a slight reduction from 1959 but, as previously noted, the tests were more specialized.

COMMITTEES

The lack of a permanent staff and the remoteness of the hospital from the town of The Pas resulted in a poor attendance to our committee meetings during the year. Minutes of the meetings were kept, but the open staff meeting fell below the requirements of the by-laws. This is a situation that will have to improve.

MEETINGS

The Chief of Medical Services was privileged to attend the Canadian Medical Association meeting in Banff and the "North of 53" meeting at Flin Flon. A full report was submitted.

STUART L. CAREY, M.D.,
Chief of Medical Services.

THE MANITOBA REHABILITATION HOSPITAL

In June, 1960, the Sanatorium Board of Manitoba started the construction of the Manitoba Rehabilitation Hospital in Winnipeg. The six-story, 222-bed hospital is the first of its kind in Manitoba and will be operated by the Sanatorium Board for patients requiring physical and psychological rehabilitation. It will be opened in early 1962.

The hospital will be comprehensive in its scope of treatment, covering all aspects of physical and rehabilitation medicine. Among other things, the services will include physical and occupational therapy, hydrotherapy, remedial gymnastics, speech therapy and a study and evaluation department to determine the rehabilitation potential of disabled persons. Facilities will also be provided for needed research in the field of physical medicine.

The Central Tuberculosis Clinic and the Sanatorium Board's executive offices will be housed in the hospital, and space will be provided for Manitoba's new School of Physiotherapy and Occupational Therapy.

All patients who can benefit from the special rehabilitation facilities of the hospital will be eligible for admission, through arrangements by their doctors. Patients with the following conditions are expected to be most commonly admitted:

Industrial and other accidents
Cerebro-vascular accidents with residual paralysis
Respiratory and cardiovascular conditions
Orthopedic impairments
Diseases of the nervous system
Arthritis and rheumatism
Amputees
Impairments of speech, hearing
Certain congenital malformations

The hospital will have an open medical staff organized in accordance with accepted hospital practices. A physician, specially trained in physical medicine and rehabilitation, will act as chief of medical services.

The services of the hospital will also be closely co-ordinated with other community and rehabilitation services and agencies.

REPORT OF THE CHIEF OF MEDICAL SERVICES
MANITOBA REHABILITATION HOSPITAL

Since beginning my appointment on 1st May 1960 there has been a steady increase in the number and variety of duties. There have been two main aims: firstly, the establishment and organization of the School of Physiotherapy and Occupational Therapy; and secondly, the development of consultant services in the field of Physical Medicine and Rehabilitation, partly with the object of improving the services offered by the Board in the hospitals concerned, and partly to help in publicizing the potentialities of the specialty. This report is a list of my activities in these various spheres.

MANITOBA REHABILITATION HOSPITAL

Consultations have been held to assist in the modifications of the physical facilities.

An outline of the basis of medical policy within the hospital has been prepared and approved, after modification, by the Medical Advisory Committee of the Hospital. A general statement, outlining the aims and organization of facilities for treatment is at present under discussion.

ASSINIBOINE HOSPITAL

A regular consultant service, at fortnightly intervals, has been established for both inpatients and outpatients. Patients are seen in consultation with members of the medical staff of the hospital. An increasing number of outpatients are being referred for consultation and treatment.

CLEARWATER LAKE HOSPITAL

A regular consultant service at monthly intervals has been established on the same basis as the clinics held at Assiniboine Hospital. Outpatients requiring further investigation or treatment have been admitted to the Hospital or have been transferred to Winnipeg where problems have arisen requiring particular specialist attention.

OTHER ACTIVITIES

Weekly clinics in Physical Medicine and Rehabilitation have been established at the Winnipeg General Hospital and at the Children's Hospital. In addition regular weekly attendance is made at the Arthritic Clinic in the Winnipeg General Hospital and at the Canadian Arthritis and Rheumatism Society's treatment centre clinic at the Municipal Hospitals. Other clinics are attended from time to time when appropriate and, in particular, regular attendance has recently been made at the Society for Crippled Children and Adults' cerebral palsy clinic at the Children's Hospital.

SCHOOL OF PHYSIOTHERAPY AND OCCUPATIONAL THERAPY

The School is now established as a part of the University of Manitoba under the administrative jurisdiction of the Faculty of Medicine. There are at present 19 full-time students and 2 part-time students taking

single courses. The School, which offers separate courses in Physiotherapy and Occupational Therapy, is in temporary accommodation in the Nurses' Residence of the Children's Hospital. An increased enrolment is expected next year but the intake will continue to be somewhat limited by accommodation, size of teaching staff and opportunities for clinical practise.

It is a pleasure to take this opportunity to acknowledge the considerable help which has been given by the administrative staff of the Board in the establishment of the School.

OTHER APPOINTMENTS

Consultant in Physical Medicine and Rehabilitation to the Municipal Hospitals and to Deer Lodge (Veterans) Hospital.

MEETINGS AND PUBLICITY

Two films have been prepared in cooperation with the C. B. C. in order to illustrate the professions of physiotherapy and occupational therapy. These will be presented on television programmes. Talks on the general subject of rehabilitation have been given to various professional and non-professional societies. These have included: the Winnipeg Clinic; the Winnipeg Hospital Medical luncheon group; the North of 53 Medical Society; the Public Health nurses at their meetings in Winnipeg and Brandon; the nursing staff of the Assiniboine Hospital; the Canadian Hospitals Association summer school; the combined sections of physiotherapy and social work at the annual Hospitals Association convention; the physical education section of the Winnipeg teachers annual convention; the Winnipeg Chamber of Commerce (civics section); the Society for Crippled Children and Adults of Manitoba annual general meeting; the section of women's auxiliaries at the annual Hospitals Association convention; the Mackinnon Guild of the Children's Hospital; the Women's Auxiliary of C. A. R. S.

A paper on the long term effects of conservative treatment in rheumatoid arthritis was read at the second Canadian conference on Research in the Rheumatic Diseases at Toronto.

RESEARCH

It has not been possible to establish a research programme as yet, owing to other pressing commitments, but a start has been made in the investigation of some problems in the field of the locomotor diseases.

TEACHING

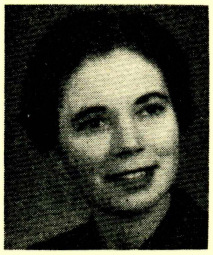
Regular teaching of undergraduate medical students has been undertaken in the outpatient department of the Winnipeg General Hospital in connection with the Arthritic Clinic. Plans have been made for the extension of the Physical Medicine clinic to include undergraduate teaching and it is hoped that this can be further extended next year to include didactic teaching in the field of Physical Medicine and Rehabilitation.

L. H. TRUELOVE, M. D.
Chief of Medical Services.

Section 4

NURSING AND FOOD SERVICES

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.



Miss Nan Tupper Chapman, Director of Dietary Services, joined the Sanatorium Board staff in 1948. She holds a B.Sc. degree, summa cum laude, in Nutrition and Dietetics from the University of Illinois and an M.Sc. in Foods and Nutrition from the University of Alabama. Prior to her appointment with the Board she taught at the University of Saskatchewan.

NURSING SERVICES

It is our aim that the nursing service should provide supportive and rehabilitative nursing care to all patients according to their various needs.

During 1960 the Sanatorium Board of Manitoba has continued to give service to those residents of Manitoba who require care and treatment of tuberculosis and other long-term diseases.

The nursing staff in each of our institutions has continued to work toward providing improved nursing care for the patients.

ACTIVITIES OF THE NURSING DEPARTMENT

ASSINIBOINE HOSPITAL

Facilities and Equipment:

Three additional wards have been converted to give service to extended treatment patients. The previous open wards were partitioned with glass and made into attractive six bed units. The bed capacity was 181 at the end of the year.

To improve efficiency many areas have been slightly altered and further alterations have been planned for 1961. The previous lack of equipment has been overcome by purchase of additional Hoyer lifts, wheelchairs, side rails and easy chairs. These all assist in giving improved care to extended treatment patients.

The purchase and use of additional stainless steel utensils, the adoption of standard cleaning and disinfectant compounds as well as improved procedures have reduced the infection risk in the hospital to a minimum. New medication trays and medication card racks have permitted an improved system of medication administration.

In the basement of the Physiotherapy and Occupational Therapy Unit opened in November 1960, a much needed classroom was provided for the nursing staff. In-Service Education programs for all levels of staff will be conducted here. The classroom has been adequately equipped with students' desks, blackboards, film screen and anatomical charts. An area, consisting of four patient units, has been set up for demonstration purposes.

Nursing Staff:

In the staffing pattern no major changes have taken place. Additional nursing orderlies were employed to give care to the increasing number of male patients.

The staff quota has been revised to meet the need for additional nursing care hours required by extended treatment patients. There has been no shortage of nursing staff at any level.

In-Service Education:

The affiliation of students from the Central School for Practical Nurses was discontinued in April, 1960. We were unable to provide adequate clinical experience in nursing care of patients with infectious diseases as the number of tuberculosis patients decreased.

Meetings and conferences of the nursing staff have been held regularly at frequent intervals, and the nursing staff has derived great benefit from free discussions on matters pertaining to patient care.

A Procedure Book Committee was set up, and has worked diligently on improving and standardizing procedures and revising the Procedure Books. Several of the Registered Nurses have prepared lectures to be given to the staff taking the Nurses' Assistants Training Program which will commence early in 1961.

Regular evaluations of all members of the nursing staff were done and records kept.

The Superintendent of Nurses and the Day Supervisor attended the Manitoba Hospital and Nursing Conference in Winnipeg during the month of October.

Nursing Care:

The fundamental principles of nursing are the same for all types of patients and for all age groups. However, caring for extended treatment patients presents specific problems which nurses must solve.

The nursing staff gives treatments and medications according to doctors' orders. But nurses must also provide care to patients to preserve function, to maintain activity of the body and mind, to ensure adequate nutritional intake, to prevent bedsores, to protect from injury and to manage incontinence. As the patients also have many and varied diseases, the task of giving nursing care to extended treatment patients is one which can only be carried out by staff who have a high degree of knowledge, skill and compassion.

Operating Room Service:

The nurses have assisted with 33 major and 252 minor operations. They have also taken care of preparing and sterilizing equipment for use on the wards, as the Operating Room has been used as Central Supply area.

CENTRAL TUBERCULOSIS CLINIC

Facilities and Equipment:

On January 23, 1960, the Clinic was moved to an 18-bed unit in the Winnipeg General Hospital. This unit has proven adequate for giving nursing care to the tuberculosis patients. Some additional equipment has been purchased to provide better service to the patients.

Nursing Staff:

Some reduction in nursing staff was necessitated by the decrease in number of patients. There has been no shortage of staff.

In-Service Education:

A revision of the Procedure Book was begun. The Head Nurse and one General Staff Nurse attended the Nursing Section of the Manitoba Hospital and Nursing Conference in October.

CLEARWATER LAKE HOSPITAL

Facilities and Equipment:

The bed capacity during the year has been 58 for the Extended Treatment Unit and 90 for the Tuberculosis Unit.

The Purchase and use of a Hoyer lift, additional side rails and easy chairs have assisted in improving the care given to extended treatment patients, and various smaller pieces of equipment have been purchased to improve efficiency of service. New medication trays, medication card racks and Kardex cards have made it possible to improve the system of medication administration.

An Intermittent Positive Pressure machine was purchased and excellent results obtained from its use. Registered Nurses have given these treatments.

Nursing Staff:

The Superintendent of Nurses left May 31, but we were fortunate in having a well qualified nurse from Australia to take over the responsibilities of this position immediately. Regrettably, it was not possible to obtain the services of adequately prepared nurses to fill the vacant supervisory positions.

There has been no shortage of nursing staff at other levels though the turnover rate among Nurses' Assistants has been high.

In-Service Education:

Meetings and conferences of the nursing staff have been held at least once monthly. Discussions have included patient care, communications, records, disaster plan, diets, procedures, relations with other departments and new equipment.

A Procedure Book Committee was appointed and has worked on revising and improving procedures. Several professional nurses have outlined lectures in preparation for the Nurses' Assistants Training Program. A comprehensive orientation program has been given to all professional staff while non-professional staff have received on-the-job training. Evaluation Records were introduced and all members of the nursing staff were evaluated regularly.

The Superintendent of Nurses attended the Institute for Nurse Administrators at the University of Manitoba, May 16 - 20, and the

Manitoba Hospital and Nursing Conference in October.

Nursing Care:

The nursing staff have had ample opportunity to use their understanding, knowledge and skills.

The patients have included Eskimos, Indians and Whites, infants, children, adults and older people. There have been acutely ill patients requiring intensive care, extended treatment and tuberculosis patients needing rehabilitative care and encouragement. Treatments and medications administered have been many. The special conditions of "the North" have necessitated dealing with unforseen problems and admissions and discharges at any time during day or night.

Operating Room Service:

Supervised by the Superintendent of Nurses, the operating room has been used for minor surgical and diagnostic procedures, treatment of casualties and outpatients as well as for preparation and sterilization of equipment for ward use.

MANITOBA SANATORIUM

Facilities and Equipment:

Various areas and cupboards were altered to improve efficiency of service. A new medication cupboard allowed for centralization of medications in the West Infirmary. Chart racks placed above the desks in nursing stations have improved charting facilities. The purchase and use of additional stainless steel utensils and other equipment have improved service to patients, and new medication trays and medication card racks have permitted an improvement in the medication procedure.

Nursing Staff:

There has been adequate staffing at the supervisory and non-professional levels. We have encountered the usual difficulties in obtaining the quota of General Staff Nurses. Fortunately, a few British nurses with adequate tuberculosis experience have joined the staff.

Nursing Education:

Two groups of students from the Brandon General Hospital affiliated for a four week period. The total number of students was 16.

Seven groups of students from the Central School for Practical Nurses have affiliated for six week periods since April 1960. A total of 71 Student Practical Nurses took this experience in nursing patients with infectious diseases.

The teaching of students add to the responsibilities of both the medical and nursing staff. Both doctors and nurses, however, are keenly interested in teaching.

In-Service Education:

Monthly meetings have been held for professional nurses, and occasional meetings have been held for Nurses' Assistants.

A Procedure Book Committee was appointed and the members have given freely of their own time to revise and improve procedures.

New employees have been given an orientation period, and Nurses' Assistants have had some class-room instruction.

Several professional nurses have prepared lectures to be given to staff taking the Nurses' Assistants Training Program which will commence in 1961.

Evaluation of all members of the nursing staff have been done regularly and records were kept.

The Superintendent of Nurses attended the Institute for Nurse Administrators at the University of Manitoba, May 16 - 20, and she and the Day Supervisor attended the Manitoba Hospital and Nursing Conference in October. The Practical Nurse Education Program, December 16, was attended by the Superintendent of Nurses and one Head Nurse.

Nursing Care:

To care for patients with tuberculosis, nurses need a thorough knowledge of general nursing principles, of the symptoms, treatment and prevention of the disease and of the special problems of long term, infectious patients.

The nursing staff have used their wide knowledge to give care to patients of all age groups and of varied cultural backgrounds, to patients before, during and after surgery and to patients at different levels of recovery.

Operating Room Service:

The nursing staff have assisted with the major and minor surgical procedures carried out. They have also prepared and sterilized equipment for use on the wards. The Supervisor has been responsible for dispensing of drugs.

ACTIVITIES OF THE DIRECTOR OF NURSING SERVICES

VISITS TO OUR INSTITUTIONS

A total of 23 visits were made. Various matters relating to patient care, physical set up, administration and teaching as well as current problems were discussed. Rounds of wards and residences were also made, and conferences were held with the Medical Superintendents, Business Manager, Superintendents of Nurses and the nursing staffs. Reports were written following each visit.

RECRUITMENT OF NURSING STAFF

Correspondence with Canadian, British and other overseas

nurses has resulted in the employment of several professional nurses. This has somewhat relieved the extreme shortage in our two rural institutions. A number of personal interviews of prospective staff members have been carried out. Applications for the Sanatorium Board of Manitoba bursaries have been dealt with.

In total, four bursaries have been given to Student Practical Nurses and three to Nursing Students. One Licensed Practical Nurse commenced her 12 months term of employment at Manitoba Sanatorium following the completion of the course.

MANITOBA REHABILITATION HOSPITAL

Conferences with the architects, suppliers and the executive director have been attended. Plans and specifications regarding equipment and physical lay-out have been reviewed.

RECORDS

Monthly records have been kept of the nursing care hours given to different types of patients in our institutions. Evaluation records were drawn up and put into effect for all members of our nursing staff. Temperature and Pulse Record sheets were drawn up and adopted by all our institutions.

Questionnaires regarding equipment and supplies were set up and the information obtained used in planning the budget. A Nursing Staff quota was established for each institution and reviewed regularly during the year. Narcotic control sheets were standardized in collaboration with the Director of Pharmacy Services and put into effect. A Procedure Card for Nurses' Assistants was prepared.

IN-SERVICE EDUCATION

Meetings of nursing staff were attended during visits to our institutions. Various educational material was prepared and sent to each institution. A number of books were purchased which are available to any nursing staff member upon request.

The Nurses' Assistants Training Program was planned and outlined. Meetings of the Medical Records and Pharmacy Committees were attended.

DAY TO DAY CONFERENCES

Informal conferences have been held about mutual problems with the Medical and Executive Directors, the Director of Dietary Services, the Informational Writer, the Administrative Assistant, the Comptroller, and the Rehabilitation Department.

ATTENDANCE AT MEETINGS

May 16 - 20, The Institute for Nurse Administrators at the University of Manitoba.

June 19-24, The 30th Biennial Meeting of the Canadian Nurses'

Association in Halifax. These were five eventful, historical days for Canadian nurses, and it was a privilege to attend.

June 27 - 30, The annual meeting of The Canadian Tuberculosis Association in Ottawa.

October 18 - 20, The Manitoba Hospital and Nursing Conference.

MISS B. HEJLSTED, R. N.,
Director of Nursing Services.

NURSING STAFF

Vacant and Filled Positions, December 31, 1960.

POSITION	ASSINIBOINE HOSPITAL		CENTRAL TUBERCULOSIS CLINIC		CLEARWATER LAKE HOSPITAL		MANITOBA SANATORIUM	
	Filled	Vacant	Filled	Vacant	Filled	Vacant	Filled	Vacant
SUPERINTENDENT OF NURSES	1	-	-	-	1	-	1	-
SUPERVISORS	4	-	-	-	1	2	4	-
HEAD NURSES	4	-	1	-	3	-	2	-
GENERAL STAFF NURSES	10	-	5	-	6	-	7	1
LICENSED PRACTICAL NURSES	9	-	2	-	3	3	4	1
NURSES' ASSISTANTS	64	6	1	-	36	-	30	4
NURSING ORDERLIES	7	-	-	-	3	-	-	-

FOOD SERVICES

Good nutrition is of paramount importance, especially to those who are sick because, excepting the oxygen we breathe from the air, food stuffs are the only source from which the body can draw those elements it needs to form its tissues and carry out its normal functions. In addition, palatable, attractively served food makes a major contribution to the sum total of pleasurable living.

The Sanatorium Board of Manitoba makes every effort to make nutritious, varied and pleasing food available to all of its patients and to the staff members who patronize its cafeterias.

PATIENT MEALS

During 1960 a total of 514, 426 patients meals were served at a total labour cost of $130, 324. 36 and at a total cost of cleaning and other supplies of $13, 640. 34. The average cost per patient meal was 28. 34 cents for food, 18. 73 cents for labour and 1. 97 cents for supplies.

An over-all provision of about three-quarters of a pound of flesh food (meat, fish or poultry) was made available to each patient each day, along with an average of one and a half eggs and one and a half pints of milk. These provisions are considerably more generous than those recommended by the Federal Nutrition Division for adequate adult feeding: one generous serving (4 to 5 oz.) of flesh food or its equivalent each day, an average of three eggs per week, and one half pint of milk daily.

Master Menus are drawn up for each institution. These are not only designed to further the adequate nutrition of all the patients, but also to follow as closely as possible what has been learned of the special tastes of the patients in each area. Four Master Menus are issued to each hospital every year. These roughly reflect the foods available during, or suitable to, the four seasons. Each menu runs for a four week cycle and is repeated three times only. Each is planned specifically for the hospital in question and no two are alike. The recipes and methods of cooking used in producing these menus are continually subject to critical study and revision in the effort to improve the taste and appeal. The production of good tasting meals is never easy when food has to be produced in large quantities.

In order to please as well as nourish, Selective Menus, based on the Master Menu Cycles, are made available daily to all of the patients at Assiniboine Hospital and to the extended treatment patients at Clearwater Lake Hospital. Complete extension of this service is our goal, but this is limited at present by certain problems of production and use.

CAFETERIAS

The Sanatorium Board provides Pay Cafeterias for the convenience of all of its staff and for outpatients, etc. These cafeterias served a total of 171, 345 meals during the year at a food cost of $36, 144. 15. If we apply the over-all labour and supply figures the production of these meals would have cost $35, 470. 41.

The total revenue was $52,024.03. Even if we grant the fact that not quite the same proportion of labour and supply costs apply to cafeteria meals as to patient meals, it can still be seen that cafeteria prices are very reasonable considering the cost of producing cafeteria meals. The Sanatorium Board makes no attempt to profit from the meal facilities it extends to its staff.

Cafeteria patronage increased as a whole in comparison with last year. Clearwater Lake Hospital was the only institution which showed a decreased revenue in 1960 as compared with 1959. However, Clearwater's average check was the highest at 33.84 cents, as compared with 31.24 cents at Manitoba Sanatorium and 25.9 cents at Assiniboine Hospital. This attests to the quality and appeal of the food that Clearwater Lake Hospital offers.

ACTIVITIES

A field trip is made to each institution approximately once every month or six weeks, with a stay made at each institution of from one day to a week or more, according to the need. When "in the field", the director combines the role of sanitary inspector, improver of standards and, when she can, solver of problems. In times of stress she may, however, fill every station the institutional kitchen possesses.

The director also keeps in close touch with developments in and findings of the American Dietetic Association, The Joint Committee on Diet of the American Medical Association, the Canadian Dietetic Association, and the British Food and Cookery Association.

MISS NAN TUPPER CHAPMAN, B. Sc.,
M. Sc., R. P. Dt., M. C. F. A.
Director of Dietary Services.

Section 5

RECORDS

The Sanatorium Board of Manitoba extends sincere thanks to the thousands of people who have supported our tuberculosis and other health programmes. We are especially indebted to the many volunteer workers who helped with our tuberculin and x-ray surveys, our Christmas Seal Campaign and our rehabilitation services. We are grateful, too, for the magnificent support of the Associated Canadian Travellers of Winnipeg and Brandon, who during the past 15 years have contributed $339,924 to our work.

TB RECORDS

CENTRAL TUBERCULOSIS REGISTRY

	Whites		Reported as: Treaty Indians		Eskimos	
	1959	1960	1959	1960	1959	1960
PATIENTS ON FILE, DEC. 31	2,526	2,321	1,203	1,009	415	414
Primary Type	112	108	68	55	79	71
Re-infection	2,414	2,213	1,135	954	336	343
NEW CASES DIAGNOSED IN MANITOBA January 1 - December 31	277	277	88	84		
Primary Type	21	11	10	13		
Re-infection Type	256	266	78	71		
OF THESE, NEW ACTIVE CASES - CLASSIFIED	196	218	62	66		
Primary Type	21	11	10	13		
Minimal	45	57	21	18		
Moderately advanced	46	54	11	10		
Far advanced	31	25	7	7		
Pulmonary tuberculosis, extent not stated	-	6	-	-		
Tuberculosis pleurisy	15	13	3	5		
Non-pulmonary tuberculosis	38	52	10	13		
NEW DIAGNOSES ADMITTED TO SANATORIA	153	160	57	59		

STATIONARY AND TRAVELLING CLINICS AND SURVEYS

	Whites	Indians	Eskimos
EXAMINATIONS at all clinics and surveys January 1 - December 31, 1960	60,458	13,313	1,193
Stationary Clinics	7,786	217	
Travelling Clinics	1,922	55	
Surveys	50,750	13,041	1,193
TOTAL NUMBER TUBERCULIN TESTED	110,391		
NEW CASES of tuberculosis diagnosed at clinics and surveys	163	33	
Stationary Clinics	124	16	
Travelling Clinics	3	-	
Surveys	36	17	
OLD TUBERCULOUS PATIENTS REVIEWED	3,596	1,078	
Stationary Clinics	2,969	82	
Travelling Clinics	194	5	
Surveys	433	991	
CONTACTS EXAMINED AT CLINICS	4,165	37	
Stationary Clinics	3,191	33	
Travelling Clinics	974	4	

INSTITUTIONAL STATISTICS

	Reported as: Whites		Treaty Indians		Eskimos	
	1959	1960	1959	1960	1959	1960
PATIENTS IN SANATORIA as at December 31	315	295	225	139	74	50
PATIENTS ADMITTED TO SANATORIA January 1 - December 31	463	449	264	226	64	60
Of these the number found to be tuberculous	342	345	212	148	46	37
FIRST ADMISSIONS	188	200	92	70	35	20
Primary type	18	5	16	9	6	1
Re-infection type						
Minimal	43	62	33	18	19	11
Moderately advanced	50	62	18	10	4	5
Far advanced	34	25	10	7	2	3
Tuberculous pleurisy	15	13	4	6	1	-
Non-pulmonary tuberculosis	28	33	11	20	3	-
RE-ADMISSIONS	117	116	76	44	9	17
Primary type	1	1	2	-	-	2
Re-infection type						
Minimal	29	29	24	17	2	10
Moderately advanced	42	35	26	12	5	3
Far advanced	36	35	8	7	-	-
Tuberculous pleurisy	-	1	-	-	-	1
Non-pulmonary tuberculosis	9	15	16	8	2	1
PATIENTS ADMITTED FOR REVIEW	37	29	44	34	2	-
TUBERCULOUS PATIENTS TRANSFERRED	161	114	168	75	42	39
PATIENTS DISCHARGED FROM SANATORIA January 1 - December 31	535	470	322	307	135	82
TUBERCULOUS PATIENTS DISCHARGED.	402	362	230	230	80	59
Discharged after review	33	34	43	34	2	1
Discharged with inactive tuberculosis	192	170	150	165	77	55
Discharged with active improved tuberculosis	133	122	25	23	1	2
Discharged with active unimproved tuberculosis	22	13	3	2	-	-
Discharged dead	22	23	9	6	-	1
NUMBER DISCHARGED AGAINST MEDICAL ADVICE	57	38	12	6	-	-

THORACIC SURGERY

(on patients discharged from Sanatoria during 1960)

	Ninette	St. Boniface	Assiniboine
Thoracoplasty	7	6	-
Lobectomy	6	15	12
Pneumonectomy	-	1	-
Wedge or Segmental	25	13	8
Plombage	3	1	-
Removal wax pack	1	-	-
	42	36	20

PATIENTS ADMITTED AND DISCHARGED

	Manitoba Sanatorium	Central Tuberculosis Clinic	St. Boniface Sanatorium	Assiniboine Hospital	Clearwater Lake Hospital
ADMISSIONS					
First admissions	53	166	59	9	92
Re-admissions	44	46	37	6	45
Transfers	103	16	55	2	34
To continue treatment	13	3	1	4	4
For diagnosis, review	5	26	-	43	53
Newborn	-	-	3	-	-
Total	207	257	155	64	228
Male	108	161	88	21	126
Female	99	96	67	43	102
Bacillary	70	88	72	3	1
Non-bacillary	89	69	65	31	26
Bacillary status undetermined	15	-	-	-	-
Diagnosis on Admission					
Minimal	44	51	35	9	97
Moderately advanced	59	51	56	7	27
Far advanced	41	39	33	6	12
Miliary	-	-	-	-	1
Primary	4	5	1	2	11
Pleurisy with effusion	6	11	7	-	5
Tracheo-bronchial	1	-	-	-	-
Other respiratory	-	-	5	-	-
Non-pulmonary TB	19	23	14	9	27
Non tuberculosis	33	77	4	30	48
DISCHARGES					
On medical advice	155	90	27	94	188
Against medical advice	11	3	21	2	1
Disciplinary	6	-	3	-	-
Transfer	59	131	8	39	26
Deaths	7	3	28	-	7
To continue anti-microbial treatment	18	43	112	-	10
Total	238	270	199	135	232
Respiratory Cases					
Inactive	128	36	68	44	118
Active improved	53	26	68	38	19
Active unimproved	3	96	3	2	1
Undetermined	-	7	7	-	-
Died	5	3	17	-	4
Total	189	168	163	84	142
Bacillary	10	80	7	5	-
Non-bacillary	179	88	149	79	25
Bacillary status undetermined	-	-	7	-	-
Non-respiratory TB	17	22	16	18	25
Average Days Treatment (tuberculosis)	272	24	402	405	151
Outpatient exams	1, 192	8, 085	841	1, 085	352

EXTENDED TREATMENT RECORDS

ASSINIBOINE HOSPITAL

Total Number of Admissions		543
Total Number of Discharges		387
Number of Deaths		111
Percentage of Discharges who died		22.29%
Total Operations (Major)		33
Infection of clean cases		2
Total Operations (Minor)		252
Hospital Autopsies		28
Percentage of Deaths Autopsied		25.23%
Newborn		2
Alive	2	
Stillborn	0	
Died	0	
Percentage Died	0	
Outpatient Visits		2,483
Casualty Service - No. of Patients		0
Physiotherapy - No. of Patients		21
Average days stay per patient		88.23
Total Patient Days		43,935

RESULTS

Cured	59	
Improved	312	
Unimproved	6	
Not Treated	10	
Died	111	
Total		498

CLEARWATER LAKE HOSPITAL

Total Number of Admissions	350
Total Number of Discharges	337
Number of Deaths	13
Percentage of Discharges who died	3.9%
Total Operations (Major)	Nil
Percentage of Emergency Operations	Nil
Percentage of Complications of all Major Operations	Nil
Total Operations (Minor)	40
Hospital Autopsies	7
Percentage of Death Autopsies	53.8%
Newborn	3
Alive	3
Died	0
Percentage Died	0
Outpatient Visits	352
No. of Patients Registered	188
Physiotherapy - No. of treatments	499
Average days stay per patient	32.1
Total Patient Days	16,393

RESULTS

Cured	175	
Improved	118	
Unimproved	6	
Not Treated	18	
Died	13	
No Disease	4	
Newborn	3	
Total		337

Balance Sheet As At 31

ASSETS

Institutional Accounts:			
Cash on hand and in bank		$ 34,631.00	
Accounts receivable		206,608.00	
Inventories, prepaid expenses and deferred charges		177,529.00	
Land, buildings, plant and equipment, net (after deducting accumulated depreciation of $956,843)		1,538,805.00	
The above amount does not include buildings and equipment at Brandon and Clearwater Lake owned by the Government of Canada			$1,957,573.00
General Account:			
Accounts receivable			329,324.00
Endowment Funds:			
Cash on hand and in bank		153,985.00	
Canada Trust Company, deposit account		10,818.00	
Accounts receivable		32,779.00	
Investments at par	$230,955.00		
Accrued interest on investments	2,760.00	233,715.00	
Bequest at nominal value		2.00	
Inventories, and prepaid expenses		2,990.00	
Vehicles and equipment net (after deducting accumulated depreciation of $81,801)		17,781.00	452,070.00
Employees' Emergency Funds:			
Cash in bank		925.00	
Investments at par	12,500.00		
Accrued interest on investments	124.00	12,624.00	13,549.00
Research Fund:			
Cash in bank			60.00
			$2,752,576.00

BOARD *of* MANITOBA

At 31st December, 1960

LIABILITIES

Institutional Accounts:		
Bank:		
Overdrafts	$ 55,235.00	
Demand Loans	410,582.00	
Accounts payable	516,454.00	
Construction holdbacks payable	101,051.00	
Patients store and contingent accounts	5,322.00	
Capital surplus	235,823.00	
Surplus and plant capital	633,106.00	$1,957,573.00
General Accounts:		
Bank overdraft	94,210.00	
Accounts payable	231,811.00	
Old Age Assistance Trust Fund	1,483.00	
Group insurance reserve	1,820.00	329,324.00
Endowment Funds:		
Accounts payable and accrued liabilities	49,496.00	
Capital accounts	402,574.00	452,070.00
Employees' Emergency Funds:		
Accounts payable	150.00	
Capital accounts	13,399.00	13,549.00
Research Fund:		
Capital accounts		60.00
		$2,752,576.00

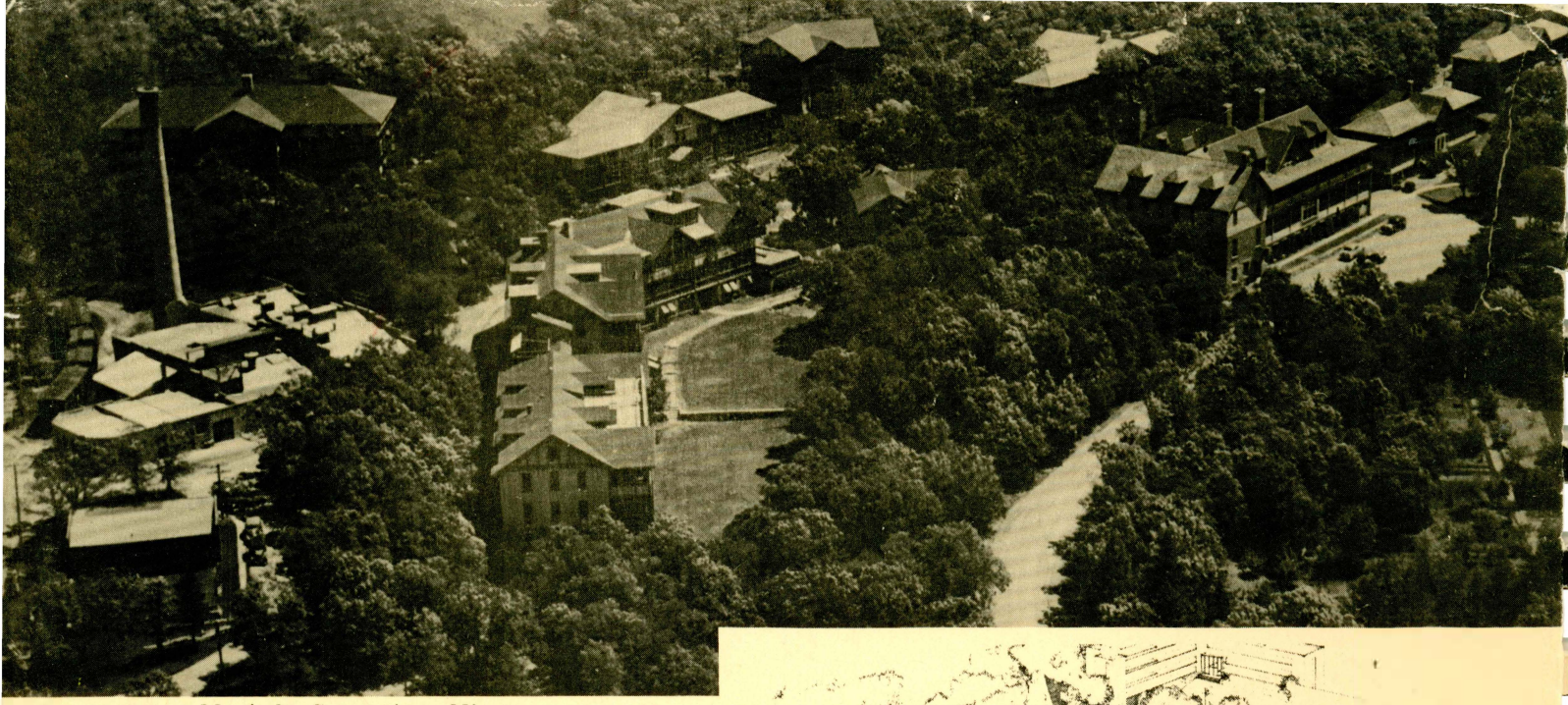
The following friends of the institutions operated by the Sanatorium Board of Manitoba have made bequests or gifts of five hundred dollars or more.

Sir James Aikins, K.C., LL.D.
Mr. W. F. Alloway
Mr. J. H. Ashdown
Associated Canadian Travellers
Mr. Allan S. Bond
Mr. H. H. Bradburn
Mr. J. R. Brodie
Hon. Colin H. Campbell, K.C.
Canada Packers Ltd.
Mr. John Chadbourn
Miss Anna Maude Chapman
Mr. Robert A. Christian
Mr. John R. Clements
Mr. L. R. Clements
Mr. T. R. Deacon
Mr. E. L. Drewry
Mr. F. W. Drewry
The T. Eaton Co. Ltd.
Mr. C. H. Enderton
Mrs. C. R. Erickson
Mr. Mark Fortune
Messrs. G. F. and J. Galt
Dr. Wilfred Good
Great West Coal Co. Ltd.
Mr. Leslie Hamilton
Mr. H. W. Hammond
Mr. E. F. Hutchings
Mr. H. W. Kennedy
Mr. H. Leadlay
Mrs. Agnes F. Lothian
Mr. Wm. J. K. McCracken
Mr. D. A. McDonald
Dr. W. S. McInnes
Mr. Wm. McKenzie
Mr. Martin McKitterick
Mr. A. R. McNichol
Mr. David L. Mellish
Moore's Taxi Ltd.
Sir Augustus Nanton
Mr. F. Nation
Mr. W. McG. Rait
Mrs. Noel Rawson
Rat Portage Lumber Co. Ltd.
Mrs. Jessie I. Scott
Mr. H. E. Sellers, C.B.E.
Mrs. Margaret Shea
Mr. G. Shields
Hon. Clifford Sifton, K.C.
Dr. D. A. Stewart
Mr. F. W. Thompson
Mr. G. Velie
Mr. W. Warnock
Miss Hazel F. Winkler
Mrs. Valentine Winkler
Mrs. R. Wood
Manitoba Brewers' and Hotelmen's Welfare Fund

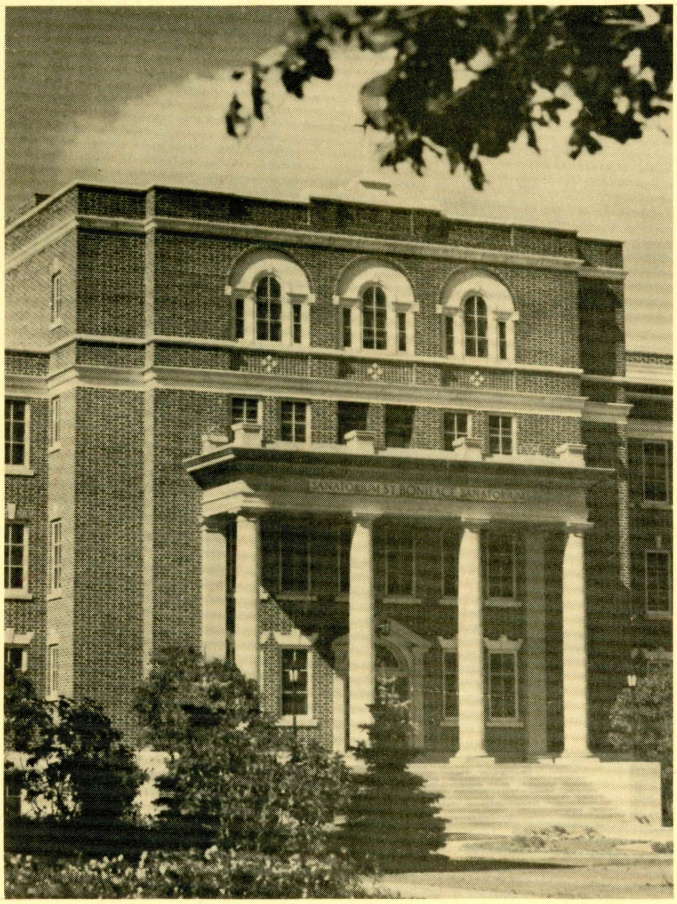
THE SANATORIUM BOARD OF MANITOBA *is a voluntary agency which conducts the province-wide tuberculosis control programme, including prevention, treatment and rehabilitation. It also operates rehabilitation and extended treatment hospitals for patients disabled by other diseases.*

Although the government now supplies a large part of the income for hospitals, it is still necessary to depend on private donors to finance tuberculosis prevention, certain medical and research equipment, and many special services for patients.

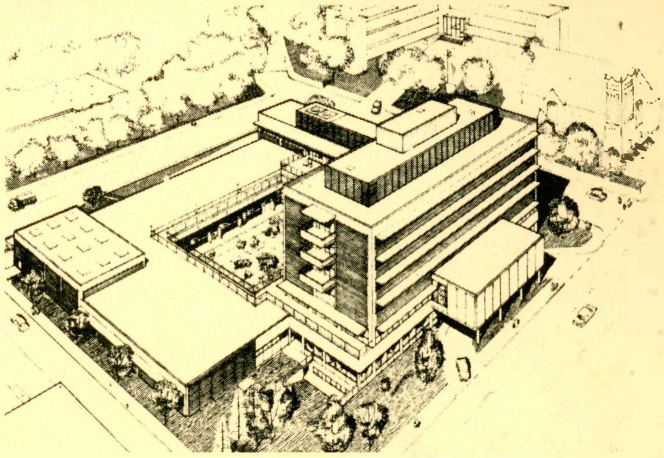
We are grateful to the many people who make special gifts or bequests to assist the work of the Sanatorium Board of Manitoba, and we invite the continued remembrance and support of those interested in our hospital and health services.



Manitoba Sanatorium, Ninette.

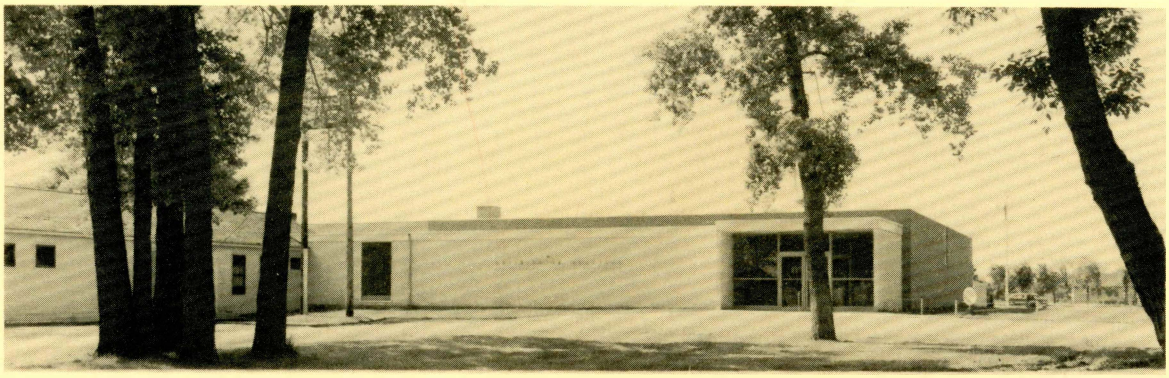


St. Boniface Sanatorium, St. Vital.



The Manitoba Rehabilitation Hospital, Winnipeg.

Clearwater Lake Hospital, The Pas.



Physiotherapy and Occupational Therapy Unit, Assiniboine Hospital