ANNUAL REPORT

1965

SANATORIUM BOARD OF MANITOBA

A Voluntary, Non-profit Corporation

OPERATING

TUBERCULIN AND X-RAY SURVEYS

CONSULTANT TUBERCULOSIS CLINICS

CENTRAL TUBERCULOSIS CLINIC – WINNIPEG

MANITOBA SANATORIUM – NINETTE

NORTHERN TUBERCULOSIS UNIT – THE PAS

MANITOBA REHABILITATION HOSPITAL – WINNIPEG

PROSTHETICS AND ORTHOTICS RESEARCH AND DEVELOPMENT UNIT – WINNIPEG

SPECIAL REHABILITATION SERVICES

CO-OPERATING WITH

Other Health and Welfare Agencies in the Province

REPORT FOR THE YEAR 1965

WINNIPEG, MANITOBA

STATEMENT BY THE HON. C.H. WITNEY

The Annual Report of the Sanatorium Board of Manitoba continues to reflect the changing emphasis of the Board's role in the field of tuberculosis from detection to prevention of tuberculosis. Whereas the program began with the treatment of advanced cases of tuberculosis and gradually shifted backwards to earlier detection, many areas of the province are now almost free of this disease and there has been a shift to increased use of B.C.G. vaccination to increase resistance of selected populations susceptible to tuberculosis.

Again, in the field of accident and chronic disease the rehabilitation services of the Sanatorium Board are restoring the sick and injured to active, useful lives and preventing the development of further disability through use of physical medicine and its related medical sciences.

On behalf of the government and people of Manitoba, I would like to bestow thanks to the many members of the Sanatorium Board who contributed their services, with particular thanks to Mr. J.W. Speirs who has retired after a quarter century of service with the Board and seven years as Chairman.

C.H. Witney,
Minister of Health,
Province of Manitoba.

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SANATORIUM BOARD OF MANITOBA

EXECUTIVE

Chairman	MR. FRANK BOOTHROYD
Vice-Chairman	MR. R.L. BAILEY
Chairman, Manitoba Sanatorium and Preventive Services Committee	MR. JOHN F. BALDNER
Chairman, Manitoba Rehabilitation Hospital Committee.	MR. S.PRICE RATTRAY
Executive Members	MR. R.H.G.BONNYCASTLE
	MR. JOHN B.CRAIG

HONORARY LIFE MEMBERS

Mr. J.W.Speirs

Dr. Ross Mitchell

STATUTORY MEMBERS

Representing Provincial Department of Health

Mr. John Gardner
Dr. J.A. MacDonell
Mr. George Iliffe
Dr. E. Snell

ELECTED MEMBERS

Mr. R.K. Armstrong
Mr. R.L.Bailey
Mr. John F.Baldner
Dr. Lennox Bell
Mr. R.H.G.Bonnycastle
Mr. Frank Boothroyd
Mr. W.C.Bowra
Mr. W.B.Chapman
Mr. George Collins
Mr. J.B.Craig
Mr. E.Dow
Mr. D.M.Dunlop
Mr. G.W.Fyfe
Mr. S.A.Magnacca
Mr. H.L. McKay
Mr. F.O.Meighen,Q.C.
Mr. E.B.Pitblado,Q.C.
Mr. S.Price Rattray
Mr. R.J.Robinson
Mr. H.T.Spohn

MEDICAL ADVISORY COMMITTEE

Dr. F. Hartley Smith - Chairman

Dr. H.S. Evans
Dr. J.E. Hudson
Dr. D.L. Kippen
Dr. R.O. McDiarmid
Dr. C.B.Schoemperlen
Dr. F.R. Tucker

EXECUTIVE DIRECTOR AND SECRETARY-TREASURER

Mr. T.A.J. Cunnings

AUDITORS

Riddell, Stead,Graham & Hutchison

MEDICAL STAFF

SANATORIUM BOARD OF MANITOBA

Consultant, Tuberculosis Services	EDWARD LACHLAN ROSS, M.D. Cert. Int. Med. (TB)

CENTRAL TUBERCULOSIS CLINIC

Resident Medical Staff

Chief of Medical Services	DONALD L. SCOTT, M.D. Cert. Int. Med. (TB) PAUL P. MARI, M.D. EARL S. HERSHFIELD, M.D. F.R.C.P. (C) F.F.C.P.

Consultants

Broncho-Esophagology	C.B. SCHOEMPERLEN, M.D. F.C.C.P., F.A.C.P., Cert.Int.Med.
Orthopaedics	W.B. MacKINNON, M.D., Ch.M.(Man.) F.R.C.S.(Can.), Cert.Orth.Surg.
Pediatrics	HARRY MEDOVY, M.D. F.R.C.P. (Can), Cert. Paed.
Radiology	R.A. MacPHERSON, M.D. C.M., F.A.C.R., Cert. D. & T. Rad.
Urology	C.B. STEWART, M.D. F.R.C.S. (Edin.& Can.), Cert.Urol.

MANITOBA SANATORIUM

Resident Medical Staff

Medical Superintendent	ALFRED L. PAINE, M.D. Cert. Thor. Surg. R.A. REILLY, B.A., M.B., B.Ch., G.M.C. A.P. CHORNOMORETZ (Interne)

Consultants

Anaesthesiology:	H.P. CAMRASS, M.B., Ch.B., G.M.C. S. O'BRIEN-MORAN, M.B., B.Ch., G.M.C., D.A., R.C.P.& S.(Eng.)

Consultants - continued.

Cardiology	V.J.H. SHARPE, M.D., Cert. Int. Med.
Eye, Ear, Nose & Throat	R.O. McDIARMID, M.D., Cert. Ophth. Otol.
General Surgery	H.S. EVANS, M.D., F.R.C.S. (Edin. & Can), F.A.C.A., Cert. Gen. Surg.
Orthopaedics	W.B. MacKINNON, M.D., Ch.M. (Man.), F.R.C.S. (Can)., Cert. Orth. Surg.
Pathology	JAMES HENDRY, M.B., Ch.B., G.M.C., D.P.H.
Radiology	R.A. MacPHERSON, M.D. C.M., F.A.C.R., Cert. D & T. Rad.
Urology	C.B. STEWART, M.D., F.R.C.S. (Edin. & Can.) Cert. Urol.

MANITOBA REHABILITATION HOSPITAL

Chief of Medical Services - L.H. TRUELOVE, M.A., M.B., B.Ch., M.R.C.P. (Lond.), D.Phys.Med., Cert. Phys. Med.

Honorary Consultants

L.G. BELL, M.D., M.R.C.P. (Lond.), INT. MED., F.R.C.P. (Lond & Can.), F.A.C.P.
F.R. TUCKER, M.D., F.R.C.S. (Edin. & Can.), M.Ch., (Orth.), Cert. Orth. Surg.

Chiefs of Service

Director of Physical Medicine	R.R.P. HAYTER, M.B., B.S., Cert. Phys. Med., D.Phys. Med., R.C.P.(Eng.)
Medical Director, Prosthetics & Orthotics Research and Development Unit	F.R. TUCKER, M.D., F.R.C.S. (Edin. & Can.), M.Ch., (Orth.) Cert. Orth. Surg.
Medical Director, Paraplegic Unit	B.J.S. GROGONO, M.B., B.S., G.M.C., F.R.C.S.(Eng. & Can.), Cert. Orth. Surg.

Chiefs of Service - continued

Chief of Anaesthetic Services	D.M. HUGGINS, M.D., Cert. Anaes., D.A.B.A., F.A.C.A.
Chief of Laboratory Services	L.P. LANSDOWN, M.D., D.P.H., Cert. Bact.
Chief of Medical Electronics Services	M.G. SAUNDERS, M.Sc., M.B., Ch.B., V.U. (Manc.)

Consultants

Cardiology	LEON MICHAELS, M.B., B.S., PH.D., F.R.C.P. (Can.), M.R.C.P.(Lond.)
Chest Diseases	R.M. CHERNIACK, M.D., F.R.C.P. (Can.), Cert. Int. Med., F.A.C.P.
Dermatology	R.A.L. Davis, M.B., B.S.,G.M.C., M.R.C.S.,(Eng.), L.R.C.P. (Lond.) R.C.P.S. (Can.), Cert. Derm.
General Surgery	HARVEY COCHINOV, M.D.,B.Sc., (Med.), F.R.C.S.(Can.), Cert. Gen. Surg.
Gynecology	R.F. FRIESEN, M.D., Cert. Obst. Gyn., F.R.C.S. (Can.)
Internal Medicine	B.B.FAST, M.D., F.R.C.P.(Can.), Cert. Int. Med.
	F.D. BARAGAR, M.D., F.R.C.P. (Can.).
Neurology	M.J.D. NEWMAN, M.B., B.Ch., F.R.C.P. (Can.), M.R.C.P.(Lond.) Cert. Neur.
Neurosurgery	DWIGHT PARKINSON, M.D., C.M., M.Sc.(Neur.Sur.),D.A.B.N.S. Cert. Neur. Surg., F.A.C.S., F.R.C.S., (Can.).

Consultants - continued

Ophthalmology	G.M. KROLMAN, M.D., F.R.C.S, (Edin.), F.R.C.S.(Can.Ophth.)
Orthopaedics	P.N. PORRITT, M.D., F.R.C.S. (Eng.)& Can.), M.R.C.S. (Eng.), L.R.C.P.(Lond.), G.M.C., Cert. Orth.Surg.
Otorinolaryngology	W. ALEXANDER, M.D., D.A.B.O., Cert. Ophth.Otol.
Pathology	J.G. FOX, M.D., Cert. Path.
Paediatric Anaesthesia	T.J. McCAUGHEY, M.B., B. Ch., D.A., Cert. Anaes.
Physical Medicine	I.H.K. STEVENS, M.B., L.R.C.P., M.R.C.S., D.Obst., R.C.O.G., M.R.C.P.
Plastic Surgery	D.A. KERNAHAN, M.B., Ch.B., G.M.C., F.R.C.S.,(Edin. & Can.), Cert, Plas. Surg.
Psychiatry	JOHN M. DOUGAN, M.B., B. Ch., D.P.M. (Eng.),
Radiology	R.A. MacPHERSON, M.D., C.M., Cert. D. & T. Rad.
Radiotherapy	R.J. WALTON, M.B., Ch.B., D.M.R.(Lond.), D.M.R.T.
Urology	C.A. SMYTHE, M.D., F.R.C.S. (Can.), Cert. Urol.

Active Staff

Dr. W.Alexander
Dr. F.D. Baragar
Dr. S.Blumenthal
Dr. D.M. Brodovsky
Dr. R.M. Cherniack
Dr. H. Chochinov
Dr. R.A.L. Davis
Dr. M.H.L. Desmarais
Dr. J. Dougan
Dr. B.B. Fast
Dr. J.B. Frain
Dr. R.F. Friesen
Dr. B.J.S. Grogono
Dr. R.K. Hay

Active Staff - continued

Dr. R.R.P. Hayter
Dr. D.M.H.Huggins
Dr. D.A. Kernahan
Dr. G.M. Krolman
Dr. L.P. Lansdown
Dr. M.J. Lehmann
Dr. T.J. McCaughey
Dr. R.H. McFarlane
Dr. L. Michaels
Dr. T.J. Mills
Dr. M.J. Newman
Dr. D. Parkinson
Dr. P.N. Porritt
Dr. M.G.Saunders
Dr. C.B.Schoemperlen
Dr. C.A. Simpson
Dr. C.A. Smythe
Dr. I.H.K.Stevens
Dr. L.H. Truelove
Dr. F.R.Tucker
Dr. R.J. Walton
Dr. W.R.Welply
Dr. L.L. Whytehead
Dr. H.W. Hart (Faculty of Dentistry)

NON-MEDICAL SENIOR STAFF

SANATORIUM BOARD OF MANITOBA

Executive Director	T.A.J. CUNNINGS
Executive Assistant	EDWARD DUBINSKY
Comptroller	ROBERT F. MARKS
Purchasing Agent	K.J. ROWSWELL
Nursing Consultant	MISS E.L.M.THORPE, MBE
Director of Dietary Services	MISS NAN.T. CHAPMAN
Assistant Director of Dietary Services	MISS J.L. ALEXANDER
Director of Pharmacy Services	TED SIMS
Supervisor, Special Rehabilitation Services	ROGER BUTTERFIELD
Supervisor, Christmas Seal Campaign	MISS MARY GRAY
Surveys Officer	J.J. ZAYSHLEY
Chief Radiographer	W.J.ANDERSON

CENTRAL TUBERCULOSIS CLINIC

Director of Nursing	MISS E.G. COULL
Radiographer	E.W. ACKROYD
Senior Laboratory Technologist	MARVIN THORGEIRSON

MANITOBA SANATORIUM

Hospital Manager	NICK KILBURG
Director of Nursing	MISS DERINDA ELLIS
Food Supervisor	MRS. LOIS RICHARDSON
Chief Engineer	GORDON STINSON
Radiographer	WILLIAM C. AMOS

MANITOBA REHABILITATION HOSPITAL

Director of Nursing	MISS E.G. COULL
Supervisor, Out-Patient Department	MRS. D.L. WHIMSTER
Supervisor, Social Services	MISS MARY HAMILTON
Chief Physiotherapist	MISS J.K. EDWARDS
Chief Occupational Therapist	MRS. JOY HUSTON
Senior Speech Therapist	MISS MARIE DAMEN
Director, Volunteer Services	MRS. W.E. BARNARD
Senior Laboratory Technologist	MARVIN THORGEIRSON
Radiographer	E.W. ACKROYD
Plant Superintendent	WILLIAM EVANS

CENTRAL TUBERCULOSIS REGISTRY

Supervisor	MISS JANET SMITH

PROSTHETICS AND ORTHOTICS RESEARCH AND DEVELOPMENT UNIT

Medical Director	DR. F.R. TUCKER
Technical Director	JAMES FOORT

At the annual meeting of the Sanatorium Board of Manitoba on April 29th, 1966, J.W. Speirs announced his retirement as chairman. Mr. Speirs, now an honorary life member, has given 23 years of distinguished service to the Sanatorium Board and has served as chairman since 1958. Here he congratulates his successor, Frank Boothroyd, right, who has been an active member of the Board since 1951 and a member of the executive committee since June, 1954.

CHAIRMAN'S REPORT

Ladies and Gentlemen:

I have much pleasure in welcoming you to the 55th Annual Meeting of the Sanatorium Board of Manitoba. The year 1965 was one of considerable change in the Board's operations, the details of which will be outlined in the several reports presented to you today.

THE BOARD

It is with regret that I record the deaths of two honorary life members of the Board since the last annual meeting: Albert E. Longstaffe on September 24th, 1965 and Charles E. Drewry on January 26th, 1966.

Mr. Longstaffe joined the Sanatorium Board in 1955. For several years he acted as chairman of the Dynevor Indian Hospital Committee, was vice-chairman of the Administration and Finance Committee, and an honorary life member since 1959.

Mr. Drewry was an active member of the Sanatorium Board from his election in 1938. He was the son of E.L. Drewry who in 1906 became a founding member of the Board. Charles E. Drewry was chairman of Dynevor Indian Hospital Committee from 1948 until 1954, a member of the Executive Committee and active in many other aspects of the Board's responsibilities. He was elected an honorary life member in 1958.

I would ask you to rise in silent tribute to the memory of these men who contributed so generously to the work of the Board.

Since our last annual meeting we have added one new member to the Board in the person of W.A. Paton, who officially represents the Asso-

ciated Canadian Travellers Club at Brandon. We appreciate the benefit of his advice and assistance.

We are grateful for the consideration and counsel of the Medical Advisory Committee under the chairmanship of Dr. F. Hartley Smith. We are pleased to note that at their annual meeting last week, the Medical Staff of the Manitoba Rehabilitation Hospital elected Dr. Smith an honorary member, as a tribute to his contribution to the planning and development of services in the field of rehabilitation medicine.

During the year 1965 there were 39 meetings of the Board and it's committees. Once again I would like to pay tribute to the individual Board members who give generously of their time, energies and knowledge in the conduct of the Board's affairs.

SERVICES

There have been a number of changes in the Board's operations during the year 1965.

Since it was evident that Clearwater Lake Hospital was no longer needed for tuberculosis treatment, and since the Manitoba Hospital Commission decided there was no alternative use for this institution, it was closed in February, 1965. A more detailed reference was made to this operation in my last Annual Report.

In March, 1965, the Manitoba Hospital Commission announced that the Assiniboine Hospital would be terminated and the old Brandon General Hospital would be renovated to accommodate extended treatment patients. This ruling was in accord with the general policy announced concurrently by the Commission, under which general hospitals would in future operate extended treatment facilities. This, of course, was a reversal of the principle established in 1958 and 1959, when the Sanatorium Board was asked by the government to convert Assiniboine Hospital from tuberculosis treatment, and to undertake the development and operation of the institution as an extended treatment hospital serving as a regional centre for southwestern Manitoba. The Board's efforts to have the Commission reconsider the policy were unsuccessful. Consequently the Assiniboine Hospital was turned over to the Brandon General Hospital for operation on January 1st, 1966, pending preparation of the new facility. At the Commission's request the Board has retained title to the Assiniboine Hospital property, and it has been leased for a nominal sum to the Brandon General Hospital until the renovation of the Extended Treatment Unit is complete and they are ready to withdraw services from the present site. No decisions have been made with respect to the ultimate deposition of the property, including the relatively new Physiotherapy and Occupational Therapy Unit.

Reports have already been distributed to members of the Board covering the operations of Manitoba Sanatorium, the Central Tuberculosis

Clinic and Preventive Services for the year 1965. Due to the diminishing tuberculosis case load, changes have occurred in the service at Manitoba Sanatorium which will be outlined to you in other reports.

The Manitoba Rehabilitation Hospital has continued to give an expanding service in the field of rehabilitation medicine and in its relatively short period of operation it has achieved a national, and indeed an international reputation for its services in this special field.

CONTRIBUTIONS

We are most grateful to those people who have provided bequests or gifts in 1965 to support the work of the Board. The names of those who have made donations of $ 500 or more are listed permanently in our published annual reports. There is a continuing need for voluntary funds, particularly for the development of research and other services not provided under the hospital insurance plan or by way of government grants. Bequests or contributions to the Board have made it possible for us to serve the community in a broader way than otherwise would have been possible.

CHRISTMAS SEAL CAMPAIGN

Our tuberculosis preventive services are basically financed by the Christmas Seal Sale. During the calendar year 1965, income from this source totalled $ 181,482.59. This is the second highest level of income we have ever received from this source and it makes it possible to do the essential work of continuing to seek out unsuspected tuberculosis and to prevent serious and unnecessary illness.

This Christmas Seal Fund is made up primarily of many thousands of small gifts from citizens throughout the province. We are especially grateful for the widespread confidence and support evidenced by these contributions. We also extend our thanks to the hundreds of people throughout the province who lend us voluntary support in so many ways, and in particular, by assisting in our tuberculosis x-ray and tuberculin surveys. We are also deeply grateful to the individuals and groups who contribute generously of their time in voluntary service at the Manitoba Rehabilitation Hospital.

ASSOCIATED CANADIAN TRAVELLERS

The Associated Canadian Travellers at both Winnipeg and Brandon have continued their great work to benefit the people of Manitoba through supporting the services of the Sanatorium Board. During the year 1965, the Winnipeg Club contributed $ 4,111.00 and the Brandon Club $ 18,440.92, and we extend our sincere thanks to these enthusiastic and able men who back their concern for the health of the community with positive and constructive action.

APPRECIATION

I would like to acknowledge the continuing co-operation and confidence of both the provincial and federal governments and the Manitoba Hospital Commission, and the cordial relationships that exist between members of our staff and theirs, which are so essential to carrying out our hospital and health services.

The work which we do is only possible through the loyal and devoted efforts and the spirit of service of our staff, many of whom have achieved special recognition in their professional fields. To each of them I express sincere thanks for their devoted attention to the needs of the patients and to the achievement of the aims and objectives which the Sanatorium Board seeks to accomplish.

On the personal note, and in conclusion, ladies and gentlemen, I must advise you of my retirement as chairman of the Board, effective at the conclusion of this meeting.

Since my first association with the Sanatorium Board of Manitoba, some 23 years ago and as your chairman since 1958, I have been privileged to see the work of the Board broadened and expanded to take on the many new responsibilities that government policy with respect to health and welfare have given us. This trust has been a continual source of confidence to me personally and, I know, to all my colleagues on this Board.

To my successor, I wish the same loyal co-operation and help that has always been given to me by the people of our province, by the staff of the hospitals under our jurisdiction and by the executive director of the Sanatorium Board of Manitoba. Thank you.

J. W. Speirs
Chairman of the Board

EXECUTIVE DIRECTOR'S REPORT

SERVICES TO INDIVIDUALS

	1964	1965
Admissions for Treatment	2,807	2,431
Out-patient Visits	44,550	53,549
TB Preventive Services and Rehabilitation	230,841	157,811
	278,198	213,791
Treatment Days for In-patients	262,054	208,163

Treatment days fell by 53,891 as compared to the previous year. Of these, 53,096 were related to tuberculosis. Despite active measures to reduce operations to correlate with the new conditions, such extensive changes in the scope of service entail difficult financial and administrative problems. Further changes have been brought about by the discontinuance of operation of Assiniboine Hospital on January 1st, 1966, and the continuing reduction in occupancy at Manitoba Sanatorium.

ASSETS AND LIABILITIES

Assets held by the Board as at December 31st, 1965, including Special Funds, totalled $ 6,151,079.00, after deducting accumulated depreciation of $ 1,720,145.00. This represents a decrease of $ 102,878.00.

ANALYSIS OF NET DECREASES IN ASSETS

Deductions from Assets 1964 to 1965		Increases in Assets 1964 to 1965	
Increase in Depreciation Revenue - 1965	$163,876.00	Accrued Receivables including deficit claims	$63,286.00
Decrease in Inventories	26,177.00	Property, Plant and Equipment	71,241.00
Decrease in Investments and Cash in Bank	33,028.00		$134,527.00
Decrease in Prepaid Expenses and Unamortized Bond Interest	14,333.00	Net Decrease in Assets	102,887.00
	$237,414.00		$237,414.00

With respect to the increase in receivables, $43,590.00 represents outstanding deficit claims which remain to be settled by the Manitoba Hospital Commission.

Liabilities of $2,731,798.00 as of December 31st, 1965, were $80,168.00 less than the preceding year.

ANALYSIS OF DECREASE IN LIABILITIES

Accounts Payable	$ 24,024.00
Debentures Redeemed	85,000.00
	$109,024.00
Deduct:	
Increase in Plant Fund Bank Loan	$ 28,856.00
Net Decrease in Liabilities	$ 80,168.00

HOSPITAL OPERATIONS

At the year end we had 593 beds for treatment in our four hospitals. This was further reduced on January 1st, 1966, by the 198 beds transferred at Assiniboine Hospital, leaving a balance of 395 beds.

Assiniboine Hospital: Assiniboine Hospital had a high occupancy during 1965, the average being 93 per cent. The average length of stay was 96 days. We discontinued operation of this hospital on December 31st, 1965.

Central Tuberculosis Clinic: This 64-bed clinic had an average occupancy of 85 per cent and an average length of stay of 57 days.

Clearwater Lake Hospital: The operation of this hospital was discontinued in February, 1965.

Manitoba Rehabilitation Hospital: This hospital continued to expand and develop its services in a very satisfactory manner. Average occupancy in 1965 was 90 per cent and the average length of stay was 53 days.

Manitoba Sanatorium: The capacity of this hospital was reduced from its earlier maximum of 278 beds to 171 beds. Because of these changes it is difficult to get a meaningful figure with respect to the average occupancy. The number of patients on treatment was reduced from a maximum of 223 early in the year to 157 at the year end. During the year, Number Two Pavilion was transferred entirely from patient care to a unit of our special vocational rehabilitation service. It was re-named Pembina House and is operated as a separate entity. The average length of stay at the Manitoba Sanatorium was 364 days.

INVENTORIES

As at December 31st, 1965, supplies on hand, including food, stocks, drugs, engineering supplies, fuel and miscellaneous items, totalled $136,793.00, a decrease of $26,177.00 during the year. The decrease is mainly attributed to the closing of Clearwater Lake Hospital.

TUBERCULOSIS PREVENTIVE AND REHABILITATION SERVICES

The following are comparative expenditures for tuberculosis preventive and rehabilitation services.

Preventive Services

	1965	1964
X-Ray Field Services	$16,193	$16,630
Indian Clinics	13,459	3,996
Travelling Clinics	4,822	7,715
Survey Services	39,647	39,990
National Employment Service X-ray Unit	3,528	3,647
Dauphin Survey and B.C.G. Project	1,571	643
Hospital Admission X-Rays	8,985	66,274
Tuberculin Surveys	20,167	24,437
Health Education	8,531	8,833
B.C.G. Vaccinations	4,818	2,866
Tuberculosis Clinics, Brandon & The Pas	15,669	6,772
X-Ray Follow-up Service	1,269	- - - -
	$138,659	$181,803

Of the reduction in expenditure amounting to $43,144.00, the largest item was a decrease in the cost of hospital admission x-rays by $57,289.00. The Federal Health Grant for the purpose was discontinued and the cost has been assumed by the Manitoba Hospital Commission as part of the individual's hospital budget. There was an additional cost for stationary tuberculosis clinics of about $9,000.00, due to the establishment of a Northern Tuberculosis Unit at The Pas. Additional costs were incurred for an expansion of the B.C.G. vaccination programme and for Indian clinics. It should be pointed out that the full cost of the Indian clinics is recovered from the Department of National Health and Welfare, as the clinics are operated on their behalf.

The counselling for non-Indian tuberculosis patients is now provided by the province. The Board spent $29,174.00 on instructional services in the Manitoba Sanatorium and Central Tuberculosis Clinic.

Expenditures on Special Rehabilitation Services for Indian and Metis amounted to $111,334.00, an increase of $38,958.00 over 1964.

FOOD SERVICES

In 1965 we served a total of 1,238,735 meals to patients and in our cafeteria service. We continue to have a highly efficient dietary service, with full provision for selective menus and special diets, under the direction of Miss N.T. Chapman.

NATIONAL HEALTH GRANTS

The appropriation available under tuberculosis control grant from the Government of Canada for the fiscal year 1965-1966 was $94,453.00. This is a reduction of $76,068.00 from the previous year. The following is a comparative statement of claims on the respective projects for the fiscal years ended March 31st, 1965 and 1966 respectively:

	1966	1965
Streptomycin and Other Antibiotics	$ 34,796	$ 35,000
X-Raying of Admissions to General Hospitals	----	56,398
Assistance to Sanatorium Board of Manitoba	18,622	17,606
Assistance to Manitoba Sanatorium	8,712	36,727
Extension of B.C.G. Vaccination Programme	4,818	2,865
Tuberculin Surveys	19,590	21,925
	$ 86,538	$ 170,521

INSURANCE

Fire insurance, including supplementary perils, was carried on the Board's property in the amount of $5,754,000.00. Public liability professional liability, boiler and steam vessel, motor vehicle, fidelity, and robbery cover is carried in appropriate amounts.

PERSONNEL

As at December 31st, 1965, the staff of the Sanatorium Board of Manitoba numbered 548, not including the Assiniboine Hospital staff which were transferred at the year end to the Brandon General Hospital. This is a reduction of 320 as compared to the previous year. At the year end there were 217 employees on the Pension Plan as compared to 347 a year earlier. Effective January 1st, 1965, the surgical coverage under our insurance plan was discontinued and the staff was enrolled under the Manitoba Medical Services Plan, a portion of the premium being paid by the Board. Claims under the insurance plan for the year were as follows.

Manitoba Rehabilitation Hospital and Central Tuberculosis Clinic	$4,256.00
Assiniboine Hospital	4,161.00
Manitoba Sanatorium	3,303.00
Clearwater Lake Hospital	769.00
Preventive and Other Services	1,414.00
	$13,903.00

During the year 1965, there was only one claim under the life insurance benefit, amounting to $1,000.00. This compares to $20,000.00 in benefits paid the previous year.

APPRECIATION

One of the things frequently commented upon by professional visitors to our hospitals and organization is the responsible, enthusiastic and competent way in which members of our staff approach their daily duties. These attitudes are also reflected in the many letters and other evidences of appreciation that are received from patients, their relatives and friends. During 1965 we had to go through the difficult procedure of discontinuing the service of more than one-third of our personnel. Despite this disturbing experience, the support and co-operation of all members of the staff remains at a high level, for which I would like to record my deep appreciation.

On behalf of myself and members of the staff, I should like to express to all members of the Board appreciation for their advice and support and the thoughtful and considerate way in which they carry out their

responsibilities. I also express my gratitude to the chairman and members of the Medical Advisory Committee who have been so helpful in considering policies with respect to professional matters.

T.A.J. Cunnings,
Executive Director.

The Sanatorium Board of Manitoba expresses sincere thanks to the many people throughout the province who support our tuberculosis and other health programs. We are indebted to the thousands of volunteer workers who have helped carry out our tuberculin and x-ray surveys, our Christmas Seal Campaigns, our rehabilitation programs and the various extra services for our patients. We are grateful to the many people in the province who have contributed to both the building and the equipping of our health facilities. We particularly appreciate the magnificent support of the Associated Canadian Travellers, Winnipeg and Brandon Clubs, who from 1945 to December 31, 1965, have contributed $479,364.16 to our work.

TUBERCULOSIS CONTROL

Though tuberculosis today is not nearly the problem it was 20 years ago, it is still a long way from eradication, which to accelerate requires concentration and more selection in some areas of the Board's program. Those who fall victim to the disease must be treated and cured but from now on the emphasis should be on the epidemiological and preventive aspects of tuberculosis.

TUBERCULOSIS 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
1950	22.8	181	12.8	102	438	79
1960	4.3	39	3.8	33	25	6
1961	4.2	39	3.5	31	32	8
1962	3.6	34	2.8	27	26.9	7
1963	4.1	39	3.2	30	34.6	9
1964	2.9	28	2.3	21	25.5	7
1965	3.4	33	2.7	25	28.6	8

(The figures for 1965 are tentative and based on the estimated population for Manitoba of 962,000, which includes 28,000 Indians.)

Thirty-three people died from tuberculosis in 1965, compared with 28 in 1964. Twenty-three of the deaths, or 70 per cent, were 60 years of age or over. Most had disease conditions besides tuberculosis (mainly) cardiovascular), and in some instances it was difficult to be certain which

was the primary cause. This decision is made by the Dominion Bureau of Statistics, who advised us that we could expect a slight increase in deaths attributed to tuberculosis, due to a change in their criteria.

Place of Death

	Whites		Indians	
	Male	Female	Male	Female
At Home	1	1	2	-
In Sanatorium	7	5	3	-
At General Hospital	6	3	-	3
At Mental Hospital	1	1	-	-
	15	10	5	3

Cause of Death:

	Whites Male	Whites Female	Indians Male	Indians Female
Pulmonary	13	5	5	-
Meningitis & Miliary	-	2	-	1
Meningitis	-	1	-	-
Genito-urinary	2	1	-	-
Generalized	-	1	-	1
Congenital Disseminated TB.	-	-	-	1
	15	10	5	3

There was one very unusual death in a child six days old. The mother, an Indian, had tuberculosis and her child was born with disseminated tuberculosis. The mother also died a few weeks later. She had no evidence of the disease seven months before her death.

NEW ACTIVE CASES

Year	Whites Active TB	Indians Active TB	Total
1950	364	239	603
1955	231	101	332
1960	218	66	284
1961	179	56	235
1962	197	86	283) due to
1963	218	68	286) epidemics
1964	166	65	231
1965	158	56	214

The new active case rate, along with the tuberculin positive rate among children, is the most reliable index of tuberculosis control. In Manitoba in 1965 there were 214 new active cases, which gives a new low rate of 21.6 per 100,000 population. Considering only the non-Indian population, the rate is 16.4 per 100,000. For Indians, with a relatively small population of 28,000, the rate is 200 per 100,000 population, nearly 10 times the rate among whites.

Forty-nine new cases, or 23 per cent of the total, were among children under 10 years of age. When the 10-19 year-olds are included, the total is 79, or 32 per cent.

New Active Cases by Age Group and Sex

Whites			Indians		
Male	Female	Total	Male	Female	Total
13	16	20	14	6	20
9	10	19	6	5	11
14	11	25	4	6	10
13	8	21	1	5	6
9	4	13	2	1	3
12	7	19	1	1	2
9	5	14	1	--	1
13	5	18	2	1	3
92	66	158	31	25	56

Of the pulmonary cases, 58 per cent had primary (childhood) disease, minimal or pleurisy, but it is significant that 42 per cent of the new cases were moderately or far advanced when first reported. Non-pulmonary disease accounted for 17 per cent of the new cases, most of which involved glands in the neck or the genito-urinary tract.

The diagnosis of tuberculosis was made or confirmed by the Central Tuberculosis Clinic in 133 patients, or 62 per cent of the total, and the remainder by other agencies of the Sanatorium Board. However, the patient's own physician referred most of these so he must be credited with the action that led to diagnosis. The general practitioner is becoming increasingly important in the anti-tuberculosis campaign, especially as greater emphasis is placed on home treatment.

REACTIVATIONS

Relapses or reactivations of old disease require special attention. Ex-patients are not only at high risk and are potential sources of infection, but they also afford evaluation of the efficacy of original treatment and home chemotherapy. The results of shortened hospitaliz-

ation and earlier out-patient treatment will in time be reflected by the number of breakdowns.

Year	Whites Male	Whites Female	Whites Total	Indians Male	Indians Female	Indians Total	Combined Total
1955	40	57	97	21	19	40	137
1961	20	21	41	10	9	19	60
1962	20	18	38	7	5	12	50
1963	26	16	42	6	16	22	64
1964	20	15	35	11	5	16	51
1965	15	14	29	13	7	20	49
	141	141	282	68	61	129	411

The results of treatment have not deteriorated during the last four years. There has been a marked decrease in reactivations, due in part to fewer cases to reactivate. Most of those who did break down did so 10 years or more after treatment. This is especially true of Whites; Indians tended to relapse earlier.

PREVENTION

Examinations by Clinics, Hospitals and Surveys

Year	Stationary Clinics	Travelling Clinics	Films Rec'd from General Hospitals	Tuberculin and X-ray Surveys*	Totals
1960	8,003	1,977	69,686	145,681	225,347
1961	8,368	1,969	67,316	171,037	248,690
1962	7,348	1,257	63,515	144,583	216,703
1963	7,525	1,141	67,403	141,433	217,502
1964	7,167	1,629	62,065	159,980	230,841
1965	7,402	960	10,758	137,495**	156,615

*Including Indian Surveys

**Tuberculin Test only ____ 65,263
Tuberculin and X-ray ____ 4,512
X-Ray only ____ 67,720

A total of 137,795 Manitobans were tuberculin tested or had chest x-rays or both. This includes 17,319 Indians and 452 Eskimos examined on surveys. If the 10,758 general hospital films sent to us for reading are included, the total receiving service from the Board's clinics was 156,615. Only 25 new active cases of tuberculosis were discovered. Among the 119,724 ex-

amined on white surveys, only 12 new active cases were found; that is, one in 9,977 surveyed. This paucity of findings in relation to the number of surveys is even more striking when one considers that five of the 12 were not found by our mobile units, but rather by survey units at the National Employment Service, Headingly Gaol and the Central Tuberculosis Clinic basement unit. This leaves only seven active cases discovered out of 111,160 attending the mobile clinics. We should take a critical look at this case-finding program on a mass community basis.

We have tried to confine surveys to areas where most new cases have been reported in the past few years, but we must realize that a large part of the province is relatively tuberculosis free. Out of 146 municipalities and unorganized areas no new cases were reported in 93 and only one each in 30 others. Forty of the new cases were from 16 municipalities; 64 from Winnipeg. We know about those people at higher risk and have been concentrating case finding among them. Areas of the province that contain predominantly Metis populations receive special attention, as do, of course, the Indians. Tuberculosis contacts are another high risk group and through clinics, surveys and health units they are x-rayed and followed. People known to have previous tuberculosis are watched closely; also nursing homes, homes for senior citizens, the Salvation Army Hostel, the National Employment Service and prison inmates. High school students, teachers, barbers and food handlers are being examined.

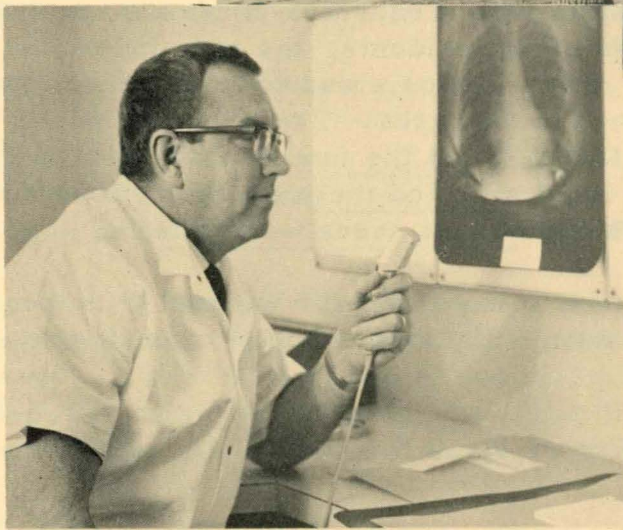
Many of the municipalities surveyd have a good tuberculosis record and receive this service every five or six years. The question is whether or not it is needed that often. The number surveyed was 22,000 less last year, the lowest since 1960. The southwestern part of the province is relatively tuberculosis free.

In the central core of Winnipeg, where economic and living conditions are considered below average, 14,134 persons were surveyed last year. In spite of good publicity and house-to-house canvassing, only 35 per cent of those x-rayed were residents; the remainder just worked there. One active case of tuberculosis was found and a follow-up of family contacts revealed two more cases. The Winnipeg public health nurses spent much time trying to get the families of children with a positive tuberculin test in for x-rays to find their source of infection. They had only moderate success and no new cases were found.

At the time of the chest x-ray survey in Central Winnipeg, 1,000 persons also had blood tests for diabetes. One per cent were found positive.

CHRISTMAS
SEALS
fight
tuberculosis

PROTECT YOUR HEALTH
BUY
CHRISTMAS
SEALS
BE
SURE
SAFE
X-RAYED
REGULARLY
THE
SANATORIUM BOARD OF MANITOBA



Tuberculin Surveys

Age Groups	Negative	Positive	Total	Percentage of Positives
Under 5	3,820	7	3,827	0.18
5 - 9	9,858	120	9,978	1.20
10-13	9,505	415	9,920	4.18
14	2,666	218	2,884	7.56
15-19	16,611	2,287	18,898	12.10
20-24	4,984	1,208	6,192	19.51
25-29	2,050	792	2,842	27.87
30-39	3,704	1,743	5,447	31.99
40-49	2,538	2,629	5,167	50.88
50-59	1,347	2,208	3,555	62.11
60-69	615	1,222	1,837	66.52
70 and over	294	630	924	68.18
	57,992	13,479	71,471	18.86

The above figures on positive reactors include those who attended the surveys and were previously known to be positive. They received chest x-rays only.

Year by year the percentage of positive tuberculin tests is not of much comparative value as different parts of the province are covered. However, it shows the areas where the infection rate is highest and indicates where the incidence of disease has been highest over the years. Although the average positive rate for the population is about 20 per cent in the municipalities surveyed in 1965, there was a wide variation ranging from 11 per cent to 34 per cent. Among the population over 60 years of age the positive rate is over 60 per cent, due to much higher prevalence of infection years ago. Up to 10 years of age the positive rate averaged about one per cent last year, but it is of some concern that 7.56 per cent of the 14-year-olds were positive. It is difficult to understand or explain some of the variations. However, if properly administered and interpreted, the tuberculin positive rate is a good index of the prevalence of infection in the community.

Consultant Chest Clinics

These travelling clinics have an accompanying doctor and examine only referred cases or persons who have had previous disease or are tuberculosis contacts. They were reduced to about half the number in 1965 because many old cases and contacts are being x-rayed in

their local hospitals.

Number examined	960
New diagnoses	-
Known tuberculous patients reviewed	197
Contacts	440

Stationary Clinics

Central Tuberculosis Clinic

Number of examinations	4,697
New diagnoses	159
Disease active in	145
Known tuberculous patients reviewed	2,174
TB contacts reviewed	2,158
Number of referred films	1,227

The Central Tuberculosis Clinic not only plays a key role in the preventive and case-finding service, but it also provides an important chemotherapy service to out-patients. A total of 665 out-patients were given chemotherapy at the Central Tuberculosis Clinic in 1965, and 388 were still on chemotherapy at the year end.

Manitoba Sanatorium

Number of examinations	1,174
New diagnoses	3
Disease active in	1
Known tuberculous patients reviewed	377
TB contacts reviewed	372

Northern Tuberculosis Unit (March 1, 1965 to March 1, 1966)

Clearwater Lake Hospital was closed in February, 1965, the occupancy by then being too low to warrant continued operation. Since the closure of the hospital, a consultation out-patient clinic has been provided at The Pas by Dr. S.L. Carey. In December, 1965, the Northern Tuberculosis Unit was opened providing x-ray and laboratory services.

In a year's operation the Northern Tuberculosis Unit has been responsible for the diagnosis of 29 cases of tuberculosis, two of which were reactivations. The out-patients examined were mainly contacts, known cases, suspects and other referrals

from doctors. The inmates of the jail are x-rayed routinely. Most of the cases of active disease were identified through films referred to the unit from many scattered points in the far north, from The Pas, Flin Flon and Lynn Lake and x-ray surveys conducted from The Pas.

Number of examinations	531
Number of referred films	4,606
(Eskimos - 2,617)	
(Indians - 1,600)	
(Whites - 389)	
Number of clinic or survey films	2,509
Cases considered to have active disease	29
Known tuberculous patients reviewed	138
TB contacts reviewed	350

Assiniboine Hospital

Number of examinations	1,287
New diagnoses	4
Disease active in	3
Known tuberculous patients reviewed	149
TB contacts reviewed	225

Chest Films from General Hospitals

The general hospital admission chest x-ray program was controlled by the Board until December 31st, 1964, and since then has become the responsibility of the hospitals. The Hospitals, through the Manitoba Hospital Association and the Manitoba Hospital Commission, assured us of their co-operation. Sixty hospitals sent 10,758 films to the Central Tuberculosis Clinic for reading. This is about half the number received in 1964. From the 10,758 films, we found seven new cases (five active and two inactive) and 87 ex-patients were x-rayed. Tuberculosis identified by the hospital radiologist is reported to the Central Tuberculosis Registry through the Department of Health.

B.C.G. Vaccinations

The total B.C.G. vaccinations in Manitoba in 1965 was 8,397 as compared to 5,602 in 1964. The main increase was among the Indians, although nearly twice the number of non-Indians were vaccinated. The most important group is the 5,939 who were vaccinated by the Medical Services branch of the Department of National Health and Welfare.

For the third year the high school students in the Dauphin Health Unit area were vaccinated. This is 1,704 more than the number vaccinated

in this area in 1964, because those previously vaccinated were re-tuberculin tested and, to our surprise and disappointment, 532 of those vaccinated in 1963 and 1964 were found negative. We think the main reason was deterioration of the vaccine. The scarification method was used and after two months the tuberculin test (Mantoux) was positive in 92 per cent. Incidentally, the original tuberculin positive rate was 2.4 per cent among the 14-year-olds, which is not far from the one per cent considered by the World Health Organization to indicate a state of tuberculosis control.

In 1966 some extension of the programme is planned, particularly among the school children of the predominantly Metis communities of Duck Bay and Camperville.

Tuberculosis Contacts	14
Newborn	46
Student Nurses (General Hospital)	502
Student Nurses (Mental Hospital)	12
Student Nurses (Practical)	190
Nurses Assistants	28
Sanatorium and Hospital Staff	36
Medical Students	81
Dental Hygienists	4
Dental Students	13
Laboratory Students	80
X-ray Students and Technicians	1
University Students - Faculty of Nursing	37
Dauphin B.C.G. Project	1,414
	2,458
By Medical Services, Department of National Health & Welfare	5,939
Total	8,397

TREATMENT

Tuberculosis

	Bed Capacity		Bed Occupancy	
	Dec. 31/64	Dec. 31/65	Dec. 31/64	Dec. 31/65
Manitoba Sanatorium	268	201	173	155
Central Tuberculosis Clinic	64	64	52	52
Clearwater Lake Hospital			53	-
			278	207
On treatment in mental hospitals			5	6

Fifty-three beds were occupied at Clearwater Lake Hospital on December 31, 1964. When the hospital was closed in February, 47 patients were transferred to Manitoba Sanatorium.

The 37.7 per cent decrease in treatment days in 1965 is striking. Forty-five per cent of the treatment days were Province of Manitoba and approximately 55 per cent were Government of Canada (Indian and Eskimo). The decrease has been due to fewer new cases and to the shortening of treatment in hospital.

Treatment Days for Tuberculosis

Year	Province of Manitoba	Gov't of Canada & Other Provinces	Total	% Decrease	#TB Beds Occupied
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	457
1961	71,765	70,827	142,592	28.2	388
1962	60,084	83,575	143,659	.7(Inc.)	400
1963	58,277	94,151	152,428	6.1(Inc.)	433
1964	64,010	76,782	140,792	7.6(Dec.)	278
1965	40,032	47,630	87,662	37.7(Dec.)	207

Drug therapy must be continued at home and requires supervision, which we are constantly trying to improve. We are receiving the co-operation of health units and the field services of the Medical Services Branch of the Department of National Health and Welfare and we hope to obtain even more supervisory participation. For a successful end result it is necessary to take anti-tuberculosis drugs daily and continuously for 12 to 24 months. There is always an element of doubt as to how faithfully this is carried out, so patients are not discharged unless there is a reasonable likelihood of them taking drugs and their living conditions and nutrition are acceptable. Patients are not discharged until they have at least six months sanatorium treatment, and in the case of Indians the average was 14.5 months in hospital before their discharge on chemotherapy.

In the last year the number of patients on treatment in Manitoba has decreased from 278 to 207. This decrease has been greater than

anticipated and has necessitated reconsideration of Dr. G.J. Wherrett's recommendation that a 200-bed hospital be built in Winnipeg for tuberculosis and non-tuberculous chest diseases. The Medical Advisory Committee has recommended to the Board that no action be taken, having in mind that as far as tuberculosis is concerned some additional beds could be provided at the Central Tuberculosis Clinic. There would be a gradual phasing out of Manitoba Sanatorium as a treatment centre during the next two or three years, and it would become a rehabilitation centre for the Indians and Metis.

CENTRAL TUBERCULOSIS REGISTRY

The work and function of the Central Tuberculosis Registry is increasing. Epidemiological data and its analysis are a necessity and in the future will be even more so. The registry now has more responbility in connection with tuberculosis surveys, it has added records regarding tuberculin tests and B.C.G. vaccinations, and it will be more involved in the records and responsibility for the out-patients on chemotherapy. The registry keeps information on Indians and Eskimos; some is also kept by Medical Services, Department of National Health and Welfare. It should be together and we recommend that all records pertaining to Indian and Eskimo tuberculosis be centred in the registry, thus making it a complete tuberculosis registry for Manitoba.

E.L. Ross, M.D.,
Consultant,
Tuberculosis Services.

	1955	1965
CASES UNDER SUPERVISION	4,777	7,502
TOTAL EXAMINATIONS	324,342	156,615
NEW ACTIVE CASES	370	214
DEATHS	72	33

In 1965 there were five deaths from tuberculosis in Winnipeg, 64 new active cases and eight reactivations. All five deaths occurred among persons over the age of 60; two were in people over the age of 80.

In the large urban areas in North America at the turn of the century, tuberculosis was a leading cause of death. Sixty years later we are in a position to speak about and hope for eradication of the disease. The following table illustrates the total deaths from tuberculosis and the rates per 100,000 population in several selected years since 1910.

Deaths from Tuberculosis per 100,000 Population

Year	Number	Rate per 100,000
1910	164	123.6
1940	52	23.0
1950	21	8.3
1960	16	6.3
1961	10	3.8
1962	7	2.7
1963	12	4.7
1964	10	3.9
1965	5	2.0

NEW ACTIVE CASES

Our most important contribution in the tuberculosis control program has been the investigation of the new cases and ensuring adequate follow-up of approximately 1,000 patients listed in our active files as having had the disease in the past.

The 64 new active cases in Winnipeg last year is the second lowest figure ever reported. The majority belonged to the adult and older age groups, but some cases were discovered among the young and on two occasions, infants were victims of the disease.

New Cases of Tuberculosis with Rates per 100,000 Population

Year	New Cases	Rate per 100,000	Found on Surveys
1962	65	25.3	4
1963	74	28.8	6
1964	67	26.2	4
1965	64	25.1	1

Tuberculin Tests in Winnipeg

The total number of tests done during the 1965 surveys was 20,422, as compared with 25,594 in 1964. No active cases were found.

	Tests	Tests Read	Positive	Negative
Schools	12,423	11,605	986	10,619
%		93.4	8.5	91.5
Colleges	1,705	Not available	Not available	1,561
%				91.5
Industrial	6,294	5,827	908	4,919
%		92.6	15.6	84.4
TOTAL	20,422	17,432	1,894	17,099
%		85.3	10.9	98.1

X-ray Surveys in Winnipeg

	Number	New Active Cases
Industrial	7,531	-
Schools and Colleges	1,117	-
National Employment Services	4,145	1
Central Tuberculosis Clinic, Survey Unit	2,644	3
Central Winnipeg Survey	13,983	1
	29,420	5

In the fall of 1965 a partial follow-up was carried out on a number of children and their contacts. The children were tuberculin tested in city schools and found to be highly reactive. Tracing and visiting these people took the time of several nurses for almost two weeks. Fortunately, no active cases of tuberculosis were found.

Our department extends its thanks to the Sanatorium Board of Manitoba, without the work and help of which not one aspect of our public health tuberculosis preventive program would be possible. We also wish to thank those who assisted us in our work, including our public health nurses and health inspector G. McCulloch who spared no effort in helping us deal with our most difficult cases during the year.

R.G. Cadham, M.D.,D.P.H.
Medical Health Officer.

TUBERCULOSIS CONTROL AMONG INDIANS AND ESKIMOS

As in previous years the tuberculosis control program was conducted by the Central Region, Medical Services Branch of the Department of National Health and Welfare in close association with the Sanatorium Board of Manitoba. Without the excellent co-operation of the Sanatorium Board of Manitoba, in the areas of case detection, advice, treatment and follow-up, the program would not be nearly as effective and would entail duplication of services. Our department, therefore, wishes at the beginning of this report to gratefully acknowledge the Board's services performed on behalf of the Indian and Eskimo people in Manitoba.

In view of the fact that the incidence of new and reactivated cases remains relatively high (viz. 270 per 100,000 population of Manitoba Indians and 985 per 100,000 population of Eskimos in the Central Arctic), our index of suspicion must remain at a high level and our prevention and case-finding techniques improved wherever possible. Constant and perhaps closer vigilance must also be maintained of discharged patients, particularly since patients are discharged earlier to continue drug therapy - even though there was an apparent drop in the percentage of reactivated cases over the total number of new cases from 23 per cent in 1964 to 18 per cent in 1965.

Sixty-two per cent of the new and reactivated cases were discovered by community chest x-ray surveys. In the Central Arctic one case per 115 x-rays proved active and in Manitoba one case per 596 persons x-rayed was active. It should be stated that in the Central Arctic a continuous chest x-ray service was established whereby people were x-rayed at the nursing stations as they become available. Whale Cove and Repulse Bay were surveyed by the usual community survey technique.

The percentage of population x-rayed in the various areas was as follows: Central Northern Zone, 100 per cent; The Pas Zone, 99 per cent; Norway House Zone, 90 per cent; Southern Manitoba Zone, 48 per cent. The Pas and Southern Manitoba zones were surveyed by the Sanatorium Board. The overall coverage was much improved over previous years.

The number of active and reactivated cases in the native population in 1965 was 21 in the Central Arctic and 78 in Manitoba, a total of 99 admitted to hospital for treatment during the year. At the year end there were 23 Eskimos and 71 Indians in Manitoba sanatoria.

The age distribution of detected cases revealed that in the Eskimos over 50 per cent were in the 0 to 14 year group, whereas in

the Manitoba Indians 50 per cent were in the 0 to 24 age group. The majority of reactivations occurred in the 15 to 40 age groups. Tuberculosis is still a disease of the very young and of the young adult native.

As to the type of tuberculosis treated in the Manitoba Indian and Eskimo population at the end of the year, 24 were primary, 15 minimal pulmonary, 24 moderate advanced pulmonary, 16 far advanced pulmonary, one miliary and 14 were other non-pulmonary conditions. Eight-four per cent were pulmonary tuberculosis and 16 per cent, non-pulmonary.

TUBERCULOSIS - CENTRAL REGION, 1965

Zone	Population Jan.1,1965	New Cases	Reactivated Cases	Totals	Rate per 100,000
Southern Manitoba	15,887	26	8	34	214
The Pas	5,793	13	5	18	311
Norway House	7,153	22	4	26	363
Sioux Lookout	14,436	35	4	39	270
Central Northern (Eskimo)	2,132	16	5	21	985
Totals	45,401	112	26	138	304
Central Region (Indians)	43,269	96	21	117	270
Manitoba Indians	28,833	61	17	78	270

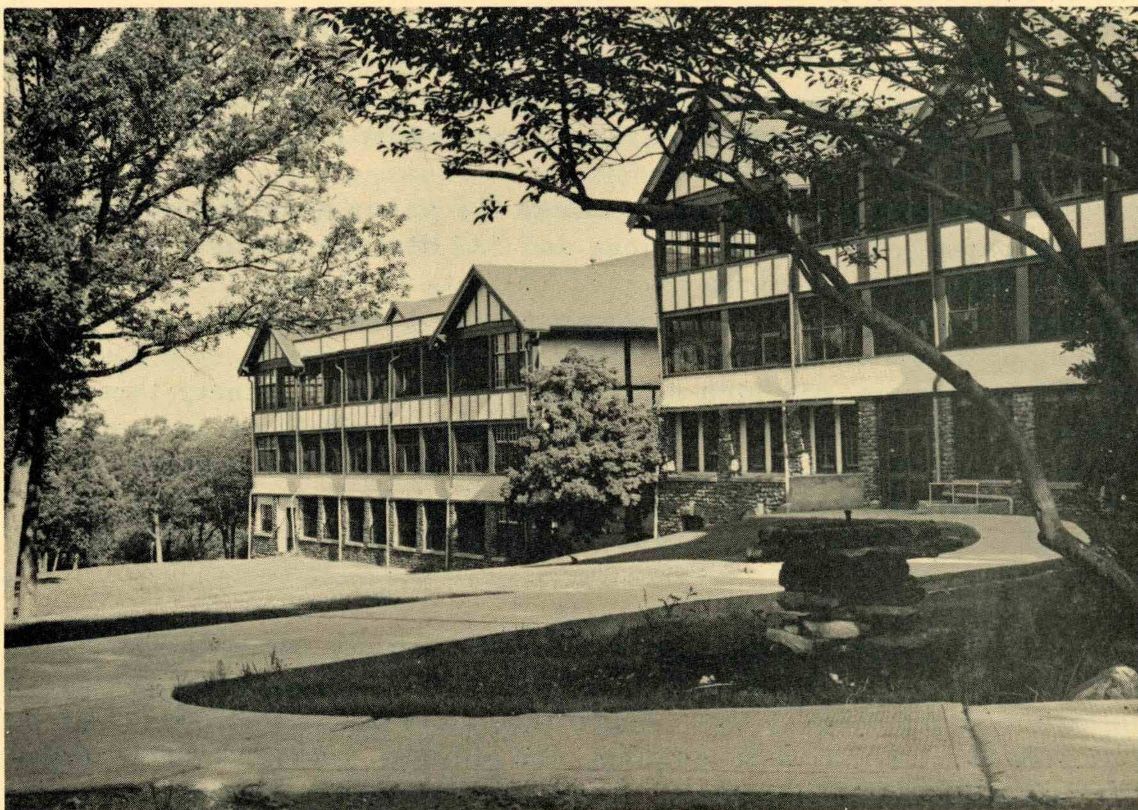
All Indian and Eskimo tuberculosis patients were admitted to Manitoba Sanatorium, the Central Tuberculosis Clinic and Clearwater Lake Hospital until it closed.

There were two Eskimo and seven Manitoba Indian deaths from tuberculosis in 1965; the majority were in the 60 and over age group. The mortality rate for tuberculosis is still 10 times greater than that of the non-native population, but the rates are gradually declining.

The tuberculin testing and B.C.G. vaccination program was intensified and in 1965 a total of 5,274 Manitoba Indians and 665 Eskimos were vaccinated. The B.C.G. is administered intradermally since the results are much better than administration by the scratch or multiple puncture methods.

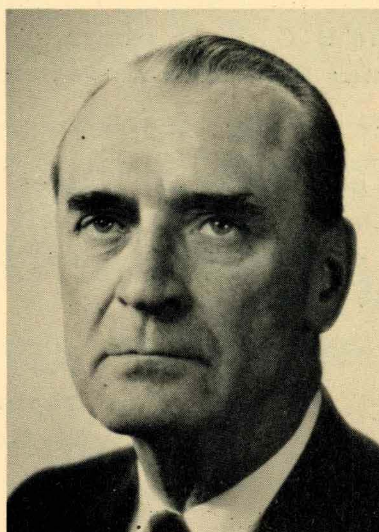
Although our statistical indices indicate some improvement in the control program, continual emphasis on control and awareness of the continuing threat of this disease in our Indian and Eskimo populations must remain at a high level.

O.J. Rath, M.D., M.P.H.,
Regional Director, Central Region,
Medical Services Branch,
Dept. of National Health & Welfare.



Infirmary, Manitoba Sanatorium

CENTRAL TUBERCULOSIS CLINIC



The Central Tuberculosis Clinic has a key role in anti-tuberculosis work in the province. The 64 treatment beds have, for the most part, been occupied during the year and our out-patient diagnostic unit and chemotherapy services have been very active. The Central Tuberculosis Clinic is also the headquarters for our tuberculosis preventive program; these services include consultant (travelling) clinics, tuberculin and x-ray surveys and the reading of hospital admission x-ray films. Information about our preventive services is given in the report of Dr. E.L. Ross.

There were 405 admissions to the wards and 405 discharges in 1965, compared with 315 admissions and 327 discharges in 1964. The average length of stay for discharged patients (excluding reviews) was 57.03 days. Many patients were admitted for short periods; i.e. those admitted for diagnosis and found not in need of treatment, and ex-patients admitted for review, of which there were 45 in 1965. Ninety-three patients were transferred to Manitoba Sanatorium and 37 to general hospitals for investigation of other conditions or for special surgery. The majority of patients, however, spent their hospitalization period in the clinic; 124 of them were discharged home to carry on chemotherapy as out-patients.

Treatment on the wards consisted mainly of the administration of streptomycin, INH and PAS, some patients taking all three drugs, some only two and others, one. Some secondary drugs were given as well but considering the major drugs only, 162 patients received streptomycin, 176 received INH and 119, PAS. There were 15 deaths during the year, 10 from tuberculosis and five from non-tuberculosis disease.

OUT-PATIENTS

Examinations in the out-patients department totalled 4,697. From day to day we receive films from various sources for our interpretation, and these totalled 1,227 in 1965. There were 159 new discoveries of tuberculosis, an increase of 21 over the previous year. The highest incidence (22 cases) occurred in the 30-39 age group. Eighty of the 159 new cases were in the respiratory tract, 68 of which were bacillary and therefore were infectious and a potential danger to others. In the age group over 40, there were 62 cases, 41 with respiratory tuberculosis.

Chemotherapy is an important part of out-patient treatment. During 1965 a total of 6,582 streptomycin treatments were given to 132 patients, and 533 patients were on the other anti-tuberculosis drugs at home. At the end of December, 71 patients were reporting to the clinic for streptomycin treatment and 317 were on other drugs at home. We keep a close check on all patients on chemotherapy.

LABORATORY AND X-RAY DEPARTMENTS

These departments are an essential and very busy part of our effort and they provide excellent service to both the Manitoba Rehabilitation Hospital and the Central Tuberculosis Clinic. In the laboratory, a total of 21,739 examinations were done, compared to 15,576 in 1964. More interest was shown last year in the B.C.G. vaccination program and 1,015 vaccinations were done at the Central Clinic, as compared to 814 in 1964.

In the x-ray department a total of 5,319 varied x-ray films were made for the Central Tuberculosis Clinic alone.

D.L.Scott, M.D.,
Chief of Medical Services

MANITOBA SANATORIUM

The year 1965, the 56th of operation of Manitoba Sanatorium, saw a further decline in patient population despite the closing of Clearwater Lake Hospital in February. During the year there was also a further shift in racial extraction of patients; on December 31 only 15 per cent were classed as white. Fifty-three per cent were Treaty Indians, 13 per cent were Eskimo and 19 per cent, Metis. The number of patients was 155, compared to 173 at the end of 1964. Forty-three per cent were 15 years of age or younger, 38 per cent were between 16 and 59 years and 19 per cent were 60 years of age or over. This represents a 13 per cent increase in the young age group, a corresponding decrease in the middle age group with the old age group remaining the same. Male patients still outnumber females, but the ratio was three to two, rather than two to one as in 1964.

Treatment days for the year totalled 65,876, compared to 79,505 in 1964, while the average patient population dropped from 218 to 181. The average length of stay increased from 301 days in 1964 to 364 in 1965. This was not due to a change in treatment policy (which indeed tended towards a shorter stay) but rather to the racial shift in discharges; 20 per cent more Treaty Indians and Eskimos went home in 1965 than in 1964 and there was a corresponding drop of 10 per cent each in the Metis and white discharges. The average stay of Treaty Indians and Eskimos was 131 days longer than that of the Metis and 281 days longer than that of whites. This would largely account for the over-all increase of 63 days.

ADMISSIONS AND DISCHARGES

Admissions, totalling 239, were classified as follows: First admissions 52, re-admissions 39, transfers 145, review 3. Of the 190 with respiratory tuberculosis, 144 were classified as reinfection, disease

being minimal in 35, moderately advanced in 62, far advanced in 44 and miliary in three. Eleven patients had pleurisy with effusion and 35 had primary tuberculosis. Non-respiratory tuberculosis included: meningitis 1, mesenteric glands 1, knee joint 2, cervical glands 7, genito-urinary 1, maxillary sinus and nasal septum, 1. Disease was bacillary in 62, non-bacillary in 83 and status undetermined in 57. Four children were admitted as tuberculin converters. Of the 34 non-tuberculous admissions, three were newborn, the remainder came for diagnosis or review.

Patients with reactivated tuberculosis are of special interest. They numbered 30, or 14.6 per cent of all tuberculosis admissions. Of these, 12 presented positive sputum while in 18 tubercle bacilli were not found, but clinical, radiological and other laboratory findings gave sound evidence of reactivation. Twenty-one of the 30 had had chemotherapy over an average of 17.5 months. Pulmonary resection had been done in three, plombage in one, phrenic in one. The time elapsing between previous treatment and reactivation ranged from nine months to 17 years, with an average of 8.6 years. Twenty-eight were of native extraction.

The 257 discharges were classified as follows: From tuberculosis, 216; from diagnosis or review, 38; newborn, three. The 216 tuberculosis discharges were classified as 133 inactive, 78 active improved, one active unimproved, one undetermined and one dead. The 41 non-tuberculosis discharges included four deaths from other causes in tuberculosis patients. There were two disciplinary discharges and 12 against medical advice. None were bacillary, four returned to sanatorium.

OUT-PATIENTS

Total attendance in the out-patient department was 1,174, as compared with 1,199 in 1964. In all, 374 old patients and 372 contacts were examined. Of 428 coming for diagnosis, three had tuberculosis and 12 had non-tuberculous conditions.

TREATMENT

The treatment program has changed very little. Sick patients still require rest but there tends to be an earlier return to activity which during the latter part of the patient's stay is directed into the rehabilitation program. Chemotherapy has not changed, most patients being on some combination of streptomycin, INH and PAS and at least on two drugs. Second line drugs are substituted in patients who develop resistance or intolerance. No new drug has been used but one old drug TB 1, which was abandoned years ago due to toxicity, has been applied in reduced dosage to some patients with improvement. In-pa-

tients on drugs were as follows: 375 on streptomycin, 331 on INH, 318 on PAS, 4 on viomycin, 42 on D'Cycloserine, 5 on trecator, 34 on pyrazinamide, 28 on seromycin, 54 on isoxyl, 5 on TB 1. Out-patients on drugs: 10 on streptomycin, 100 on INH, 114 on PAS, 6 on D'Cycloserine, 1 on trecator, 10 on pyrazinamide, 17 on seromycin and 25 on isoxyl.

The number of Treaty patients discharged on drugs rose from 8 to 42, or 58 per cent of all tuberculous Treaty Indians discharged from hospital. Of these 24 or 33 per cent went home and 18, or 25 per cent were admitted to the Brandon Rehabilitation Unit or to other schools. The total number of Metis patients leaving on drugs was greater in 1964 than in 1965, due to more being on treatment and to a group discharge of 18 patients to supervised chemotherapy at Thicket Portage. However, the total incidence of discharges to out-patient chemotherapy was slightly greater last year, 60.5 per cent as compared to 58 per cent in 1964, and this was again partly due to more entries to the Brandon Unit. No Eskimos went home on drugs but three were discharged on drugs to the Brandon Unit. There was no significant change in the over-all incidence of white discharges on drugs. The total incidence of discharge on drugs for all patients rose from 44 to 54 per cent and this mainly because of the change in management of Treaty patients.

There was a further decrease in chest surgery, but we still find it useful in patients not responding to conservative measures and in those of unstable personality who, despite rehabilitation activities, tend to leave treatment and so face relapse. Isolated solid lesions in native patients are also resected by choice. Mandatory indications were present in 30 per cent of surgical cases and included persistent positive sputum, recurrent cavitation, pulmonary sepsis including fistula and empyema. The remaining 70 per cent were classed as elective. The 48 major chest operations during the year were classified as follows: Lobectomy 10, lobectomy and decortication 1, segmental resection 13, wedge resection 12, thoracotomy 2, thoracoplasty 3, plombage 3, repair of bronchopleural fistula and chest wall sinuses 4. Tracheostomy was done in two poor risk patients. There were no operative deaths. One drug resistant patient continued a downhill course and died 27 days after plombage done in the hope of arresting otherwise hopeless disease. Two pregnant patients were confined during the year. Minor procedures included resection of cervical glands 5, bronchoscopy 40, bronchograms 15, chest aspirations 10, casts 4, blood transfusions 104, intravenous infusions 162.

X-RAY AND LABORATORY DEPARTMENTS

The x-ray department made 3,318 radiographic examinations. In addition 97 electrocardiographic tracings were taken and clinical photography totalled 132, of which 38 were color slides of surgical specimens.

The laboratory did 17,073 tests for a total of 41,110 units of work. Aside from routine procedures, the growing of cultures of tubercle bacilli and

testing for resistance is an important part of the work. Blood is also frequently cross-matched to augment that sent from the Red Cross.

REHABILITATION

Rehabilitation is the greatest challenge in treatment at Manitoba Sanatorium. Because of its chronicity and tendency to relapse, tuberculosis has always posed a special problem for those with little means. There was a time when the disease had no respect for class or distinction and many of high estate, or already marked for genius, suffered from its ravages. Now, with few exceptions, tuberculosis strikes at those with poor living conditions, low standards of education and little opportunity for advancement.

Rehabilitation is an integral part of treatment as well as its ultimate goal. Over a year ago, the rehabilitation department was enlarged and reorganized with activities directed primarily towards social education and integration. The program begins in sanatorium and when the patient is ready for transfer, it is carried forward and expanded at the rehabilitation units at Brandon and Ninette. For many this ultimately leads to a satisfactory job after training in trade schools or elsewhere.

It is not the function of this report to deal with the mechanics involved, but to indicate how an active rehabilitation program affects the total treatment effort. Soon after the patient's admission to sanatorium a counsellor begins investigation of his social background, education and ability. Very often this prompt and effective social service results in better adjustment to a hospital stay. The patient is happier and more willing to stay his allotted time when he realizes that it leads to training and a job.

The program allows for earlier discharge to more suitable living conditions and supervised chemotherapy. It is significant that almost all young native patients reject a return to their former communities as having no future and are eager for training. It is true that many older patients are not suitbale for training, but even they benefit from the individual attention given to their personal problems and home situation, both of which can often be improved. Gradual education in improved living standards and rules of health leads to a more responsible and co-operative attitude and it has encouraged us to begin a program of home chemotherapy in selected native patients after adequate hospital care.

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

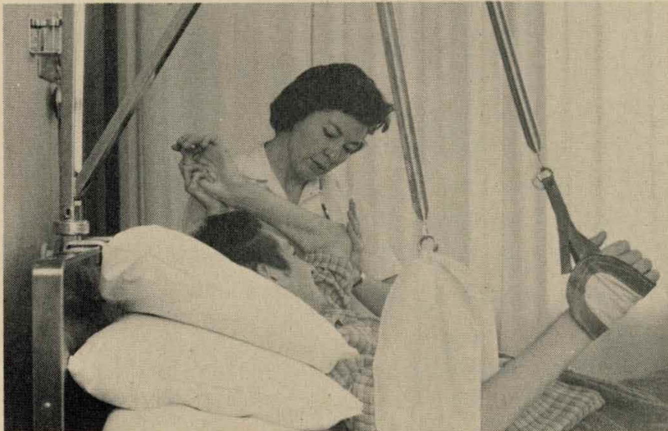
TUBERCULOSIS RECORDS

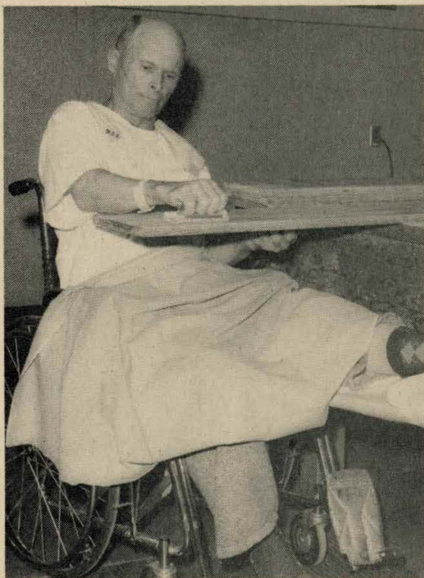
CENTRAL TUBERCULOSIS REGISTRY

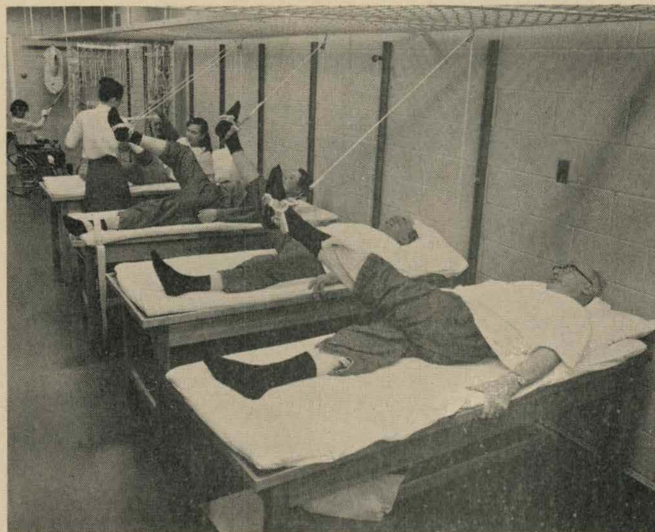
	Whites		Treaty Indians		Eskimos	
	1964	1965	1964	1965	1964	1965
Patients on file, Dec, 31	5,227	5,215	1,864	1,845	637	442
Primary Type	98	157	72	72	61	56
Re-infection Type	5,129	5,058	1,792	1,773	576	386
New Cases Diagnosed	197	201	75	74		
Primary Type	27	22	16	16		
Re-infection Type	170	179	59	58		
New Active Cases	166	158	65	56		
Primary Type	27	22	16	16		
Minimal	40	43	10	6		
Moderately Advanced	38	29	22	10		
Far Advanced	22	22	5	11		
Pulmonary Tuberculosis Extent not stated	--	2	--	--		
Tuberculous Pleurisy	20	10	3	5		
Non-pulmonary Tuberculosis	18	30	9	8		
New Diagnoses Admitted to Sanatoria	132	117	59	51		

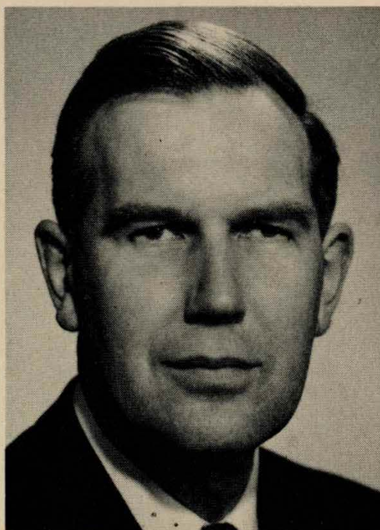
STATIONARY AND TRAVELLING CLINICS AND SURVEYS

	Whites	Indians	Eskimos
Total X-rayed at Clinics, Surveys,	62,620	17,522	452
Stationary Clinics	7,249	153	
Consultant (Travelling) Clinics	910	50	
Surveys	54,461	17,319	452
Total Tuberculin Tested	71,471		
New Diagnoses of Tuberculosis	160	50	
Stationary Clinics	134	31	
Surveys	26	19	
Old Tuberculosis Patients Reviewed	3,308	942	
Contacts Examined	3,235	112	









The year 1965 saw continued development of established services. All departments of the hospital showed a substantial increase in the number of patients treated and the amount of work done. A notable feature has been the development of specific programs of treatment of various categories of disability. A fundamental principle is the treatment of patients in groups and classes wherever possible, with such individual attention as may be required. The advantages of group therapy are the stimulation which results from physical activity involving some degree of competition, the opportunity for patients to learn from one another and the economy which results from the organization of group therapy.

The major grouping of patients with various disabilities treated in the Manitoba Rehabilitation Hospital remain as in previous years, the largest sub-divisions being those suffering from arthritis, hemiplegia and other chronic neurological disorders, orthopaedic conditions, paraplegia and amputations, with speech therapy having a significant proportion of the out-patient work.

The organization of the hospital has emphasized its role as a rehabilitation centre for the treatment of disorders requiring a comprehensive approach rather than the provision of isolated treatments for a single specific purpose, facilities for this latter service being available elsewhere. The majority of patients attend for a program of treatment involving more than one department of the hospital.

OUT-PATIENT DEPARTMENT

A total of 1,686 patients were registered as new out-patients in 1965. This represents a 35 per cent increase over the previous year. Members of the medical staff conducted 4,100 review examinations.

IN-PATIENT SERVICES

During the year 1,016 individuals were admitted as in-patients. This is a very similar figure to that of 1964, the increased demands on the hospital being represented by a lengthening waiting list. A careful assessment of patients requiring admission is attempted by the medical staff to ensure that the best use is made of hospital facilities since it is usually important that the rehabilitation process begin as early as possible in the course of a person's disability.

The average daily bed occupancy was 89 per cent of the 160 established beds. Again I would like to record appreciation of the high standard of work maintained by the resident staff headed by Dr. E. Bosley.

The average length of stay for the hospital was 53 days.

The numerical distribution of patients by diagnosis under the most common categories was as follows: Rheumatoid arthritis - 248, osteoarthritis - 64, hemiplegia - 141, multiple sclerosis - 28, paraplegia and quadriplegia - 73, amputees - 85. Orthopaedic cases: Fractures - 112, post-operative - 39, other - 39.

The organization of the program for the treatment of patients with rheumatoid arthritis has continued with the particular assistance of Dr. F.D. Baragar. Minor modificationsin the program have been made but the system as a whole has showed excellent results. There has been an increasing tendency to perform various surgical procedures on patients treated under this program, the surgery being an incidentin the overall management of the disease. This type of surgery is done in one of the general hospitals, the patients being transferred back to this hospital for continuation of their program of rehabilitation.

On the neurological ward, the program forpatients suffering from hemiplegia continued under the direction of Dr. I.H.K. Stevens. An interesting feature of the work of this ward has been a program of assessment and rehabilitation in conjunction with surgical procedures again undertaken in a general hospital for the treatment of paralysis agitans. Although the hospital as a whole is concerned with training patients in the activities of daily living, this is a particular feature of this ward and is undertaken jointly by the occupational therapy and nursing staff.

The physical treatment of patients with orthopaedic conditions and prosthesis following amputation has progressed under the

able direction of Dr. R.R.P. Hayter, who in April 1965 was appointed Director of Physical Medicine with particular responsibility towards the Physiotherapy and Occupational Therapy Departments.

The Paraplegic Unit under the direction of Dr. B.J.S.Grogono is established on the orthopaedic ward. Dr. Grogono has worked closely with the Canadian Paraplegic Association in the development of a comprehensive and stimulating program.

CONSULTANT SERVICES AND TEACHING COMMITMENTS

Members of the medical staff have continued to take part in regular clinics at the Assiniboine Hospital in Brandon,Dauphin General Hospital, the Canadian Arthritis and Rheumatism Society, rural clinics and the Manitoba School at Portage la Prairie. In addition, clinics are held by various members of the staff at the Winnipeg General Hospital, St. Boniface Hospital and the Children's Hospital of Winnipeg.

The residency training program continued throughout the year with regular ward rounds, seminars, and therapeutic conferences. Weekly seminars were conducted in the fields of orthopaedics and neurology and the resident staff encouraged to attend teaching sessions in other hospitals within the Medical Centre area.

Two courses in Rehabilitation Nursing were conducted during the year and members of the medical staff took part in these, as well as in teaching at the School of Medical Rehabilitation and the Faculty of Medicine at the University of Manitoba. A three-week University Extension Course under the auspices of the Society for Crippled Children and Adults of Manitoba was held in the hospital in June. Clinical sessions of the Fifth Manitoba Symposium on Orthopaedic Disabilities and Rehabilitation were held in December. Various other professional meetings and teaching activities were undertaken resulting in an atmosphere of stimulating academic activity.

SOCIAL SERVICE

The work of this department under the direction of Miss Mary Hamilton has continued to expand and has changed in emphasis. All in-patients were seen on admission by one of the four social workers and problems were assessed at that time. A certain proportion of patients are over 65 years of age and a much larger proportion are incapable of working or are completely self sufficient so that employment problems have been a rather relatively minor feature of the work of the department. The major problems presented to the department have been in the areas of financial assistance and housing suitable for handicapped persons. The Third

major area has been related to social problems. These three problems constituted 54 per cent of those presented to the department, eight per cent were concerned with employment and an additional nine per cent were those presented by the Workmen's Compensation Board.

The work of the department has been greatly facilitated by the co-operation received from the Municipal and Provincial Departments of Welfare and most particularly from Care Services. Other agencies and individuals who have assisted were the Society for Crippled Children and Adults of Manitoba, the Victorian Order of Nurses, the Canadian Arthritis and Rheumatism Society, the National Employment Service and many volunteers who have visited patients both in and out of hospital.

Particular mention should be made of the two hospital chaplains who not only visited the patients in the hospital but also contacted local churches to ensure follow-up after the patient's discharge.

The appointment of a psychiatrist, Dr. J. Dougan, to the medical staff has greatly assisted the work of the department.

Among the many areas of major concern are the lack of adequate housing for the physically handicapped, the difficulties encountered in transporting the handicapped for non-medical purposes, and the great lack of social activities which will give meaning to the lives of those incapable of working.

OCCUPATIONAL THERAPY DEPARTMENT

Under the direction of Mrs. Joy Huston, during the year the department increased some of the facilities for treatment, notably a Back Unit Program, designed to be a specialized treatment for the increasing number of patients admitted to the hospital with back problems and to give added attention to female patients.

The demand for orthotic devices increased to such an extent that this service had to be separated from the department and is now a self-contained unit with a full-time technician in charge.

A total of 1,962 patients were treated, an increase of 19 per cent over 1964. An average of 164 new patients were treated each month an increase of 27 per cent over the pervious year.

PHYSIOTHERAPY DEPARTMENT

During the year, 2,471 new patients were treated, an increase of 19 per cent over 1964.

The development of the department has continued under the direction of Miss J. Edwards. The type of work done by each therapist is varied at three-monthly intervals, with each section of clinical responsibility supervised by a senior therapist.

SPEECH THERAPY

This department showed a rapid expansion of its work during the year, under the direction of Miss M. Damen. The staff consisted during most of the year of two full-time and one part-time speech therapists. In addition, the work of the department was augmented in September by the appointment of Mr. P. Humenik to the position of audiologist. A total of 254 new patients were seen during the year, an increase of 16 per cent over the previous year.

ELECTROMYOGRAPHY SERVICE

This department's services were augmented by the addition of another medical staff member, D.C.A. Simpson. A total of 518 patients were examined, a 25 per cent increase over 1964.

PAPERS AND PRESENTATIONS

Dr. F.D. Baragar: "Rheumatism and Arthritis"
Society for Crippled Children and Adults, June, 1965.

. . . : "Splint-making for Arthritis Patients"
College of General Practice of Canada, April, 1965.

Dr. B.J.S.Grogono: "Congenital Dislocation of the Knee"
British Orthopaedic Association Meeting, Bristol, April, 1965.

"Flexor Accessories Longus"
Journal of Bone and Joint Surgery, February, 1965.

"Problems in Rehabilitation of Cervical Spine Injuries"
Canadian Medical Association, October, 1965.

"Complication of Upper Limb Injuries"
Symposium, St. Boniface, October, 1965.

Dr. R.R.P. Hayter: "Rehabilitation Methods"
Manitoba Medical Association
Annual Meeting,
October, 1965.

"The Development and Use of Temporary Prostheses with Adjustable Units in the Training of Leg Amputees"
Canadian Association of Physical Medicine and Rehabilitation,
August, 1965.

"Clinical Evaluation of Early Fitting of A/K and B/K Amputees"
Rehabilitation Institute of Montreal,
May, 1965.

Dr. L.H.Truelove: "The Treatment of Rheumatoid Arthritis in a Rehabilitation Hospital"
Third Canadian Conference on Research in Rheumatic Diseases,
February, 1965.

"Rehabilitation in Hemiplegia"
Canadian College of General Practice
Annual Meeting, Banff, Alberta.

"Professionalism"
Canadian Physiotherapy Journal.

The increase in the work of the various departments of the hospital of between 20 per cent and 30 per cent noted during 1964 was repeated in 1965. There is every reason to suppose that this tendency will continue at the same rate and will call for additional facilities in both staff and accommodation.

L.H.Truelove, M.A., B.M.,
B.Ch., M.R.C.P., D. Phys.Med.
Chief of Medical Services.

MANITOBA REHABILITATION HOSPITAL RECORDS

IN-PATIENTS	1964	1965
Admissions, Jan. 1 to Dec. 31	1,080	1,016
Discharges, Jan. 1 to Dec. 31	1,080	989
Deaths	2	2
Average Length of Stay	48 days	53 days
Patient Days	51,834	52,728
Average Daily In-Patient Occupancy	143(or 89.4%)	147 (or 91.8%)

OUT-PATIENTS	1964	1965
New Registrations, Jan. 1 to Dec. 31	1,242	1,688
Medical Reviews	2,680	4,100
Consultations by Staff Doctors	1,087	1,208
Average Daily No. of Out-Patients	95	134

TREATMENT DEPARTMENTS (New Patients - In-Patients and Out-Patients)	1964	1965
Physiotherapy	2,074	2,524
Occupational Therapy	1,526	1,962
Speech Therapy	218	254
Social Service	966	1,154

RESEARCH IS A VITAL FUNCTION OF MODERN MEDICINE

At the Manitoba Rehabilitation Hospital a Research Fund has been established to finance important investigation into basic problems related to major disabilities. A contribution or bequest to the Research Fund offers an opportunity to support the search for greater understanding of the means of preventing and treating disabling illness and injuries. Contributions or inquiries should be directed to the Executive Director of the Manitoba Rehabilitation Hospital.

SPECIAL REHABILITATION SERVICES

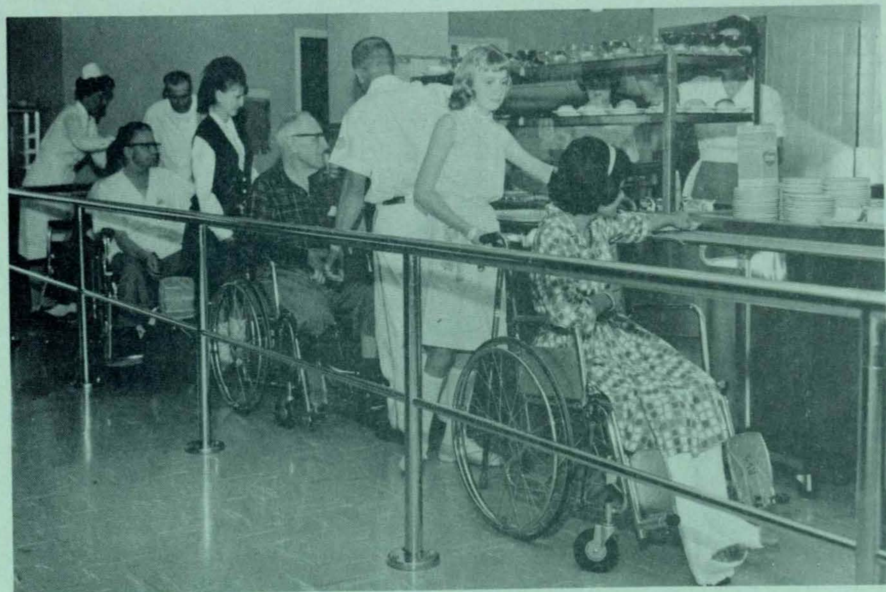
Rehabilitation is a process and philosophy which in Manitoba was begun as an organized program for tuberculosis patients in 1942. Since 1957 this process has been applied at the Rehabilitation Unit in Brandon to those individuals with social and occupational handicaps who were unable to achieve on their own maximum usefulness and personal satisfaction compatible with their capabilities. In 1965 the program was expanded.

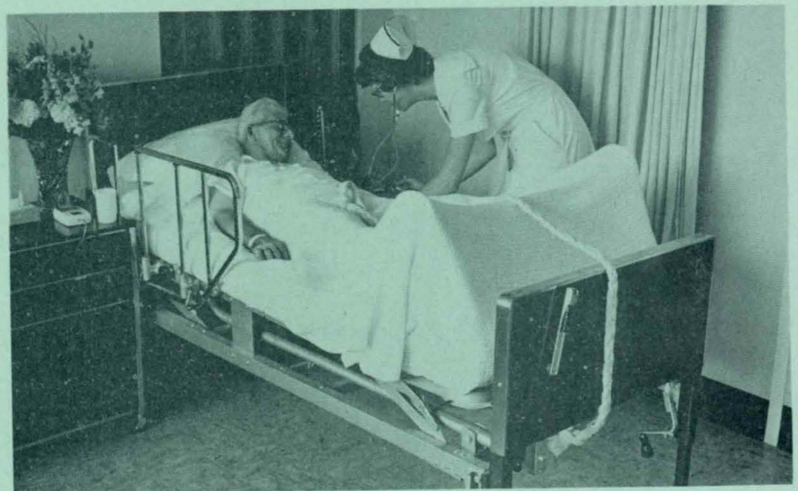
The Rehabilitation Advisory Committee agreed to the opening of a second social orientation and work conditioning unit at Manitoba Sanatorium, Ninette, on November 1st, 1965. The project maintained the same philosophy and criteria as that of the Brandon Program. The facilities of the Number Two Pavilion were utilized and it was renamed Pembina House. On November 1, the Rehabilitation Services of the Province of Manitoba also accepted responsibility for the rehabilitation of post-tuberculosis non-Indians. On December 1, 1965, all persons entering the rehabilitation unit at Brandon and Ninette were approved under the Federal Provincial Canadian Vocational Training Agreement, Program 6. As a result, the provincial Department of Education extended the Basic Training Course for Skill Development (upgrading) to our units. Theoretically, rehabilitants now graduating from the units qualify for any vocational course requiring a Grade 10 entrance. The services previously extended to the physically handicapped have remained the same.

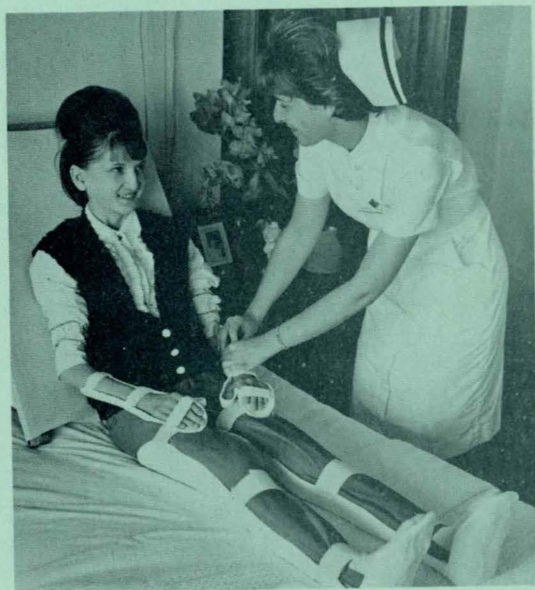
SOCIAL ORIENTATION AND WORK CONDITIONING UNITS

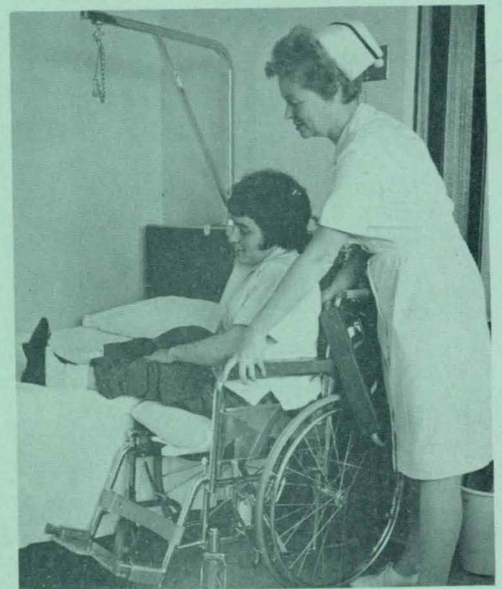
Brandon Rehabilitation Unit: There was an increase in the number of graduates this year. This placed extra demands on the staff who are responsible for supervision and follow-up.

Attended Rehabilitation Unit	64
Graduated to Basic Training for Skill Development	27
Placed directly on job and Training on the job	9
Transferred to mental hospital	2
Transferred to hospital for further treatment	1
Married	1
Transferred to Pembina House	3
Referred to other agencies	1
Returned to regular schools	1
Returned home, lacking interest	11
Still in Unit - carried over to 1966	13
Under supervision outside unit	49









NURSING DEPARTMENTS

The past year has been one in which the pride of achievement has been tempered with regrets for something accomplished and now forever gone. The closure of Clearwater Lake Hospital in February and the relinquishment of Assiniboine Hospital to the Brandon General Hospital in December were counterbalanced by pride in the achievements of the Manitoba Rehabilitation Hospital, Manitoba Sanatorium and the Central Tuberculosis Clinic.

"Clearwater" had for many years become a way of life and there are members of our former staff who will find it difficult to forget either the hospital and its Eskimos and Indian patients or the call of Manitoba's north.

We had great hopes for demonstrating in a new Assiniboine Hospital the type of care the Sanatorium Board of Manitoba thought that the long-term patients needed. Those hopes were dispelled at the end of the year. There is considerable conflict of opinion as to whether or not extended treatment patients are best treated in general hospitals or if something more specialized and relaxed is really what meets the need. These diverse points of view are likely to be expressed for a very long time to come.

Manitoba Sanatorium: The nursing staff, under the direction of Miss Derinda Ellis, continued to do excellent work. We were able to fill most of our general staff nurse positions at Manitoba Sanatorium during 1965, and nursing standards were favourably commented upon at the time of re-accreditation.

Central Tuberculosis Clinic: The staff continued their excellent work. Patients still come to us from widely separated areas and many have their tuberculosis complicated by other conditions. This is particularly true of patients in the older age groups and a different nursing pattern is evolving both at the Central Tuberculosis Clinic and Manitoba Sanatorium.

Manitoba Rehabilitation Hospital: This hospital is always busy and some extremely involved medical conditions present the nursing staff with great demands on their professional skills. The quality of nursing care is very high indeed and is the subject of much favourable comment.

NURSING EDUCATION

Post Graduate Courses in Rehabilitation Nursing: Two courses were held in 1965 and for the first time, registered nurses from other hospitals participated in the programs.

In-service Program for Licensed Practical Nurses: This was a new departure at the Manitoba Rehabilitation Hospital.

Nurses' Assistants Training Program: In-service training for nurses' assistants and orderlies continued at our hospitals throughout the year.

Affiliation Programs: These programs for nursing students from the Brandon General Hospital and the Hospital for Mental Diseases at Brandon were continued at Manitoba Sanatorium.

Sanatorium Board of Manitoba Bursaries: Two bursaries were awarded for registered nurses and two for licensed practical nurses.

Student Public Health Nurses: Students from the University of Manitoba have gained field experience in rehabilitation through association with the Manitoba Rehabilitation Hospital. Nursing students (degree course) also gained experience at our rehabilitation hospital.

STAFF ACTIVITIES

The policy of encouraging our staff to further their professional education was continued and Mrs. E. Stevenson, C.S.R. Supervisor, Manitoba Rehabilitation Hospital, requested leave of absence for the purpose of proceeding to the University of Manitoba. A nursing workshop for senior nurses and administrators from rural hospitals in Manitoba, arranged by the Manitoba Association of Registered Nurses, was held at Manitoba Sanatorium on April 12 and 13. Mrs. I.A. Cruikshank, Director of nursing at Assiniboine Hospital, attended a Seminar in Rehabilitation Nursing at the University of Manitoba. Miss E.G. Coull, director of nursing, Manitoba Rehabilitation Hospital, Miss D. Ellis, director of nursing, Manitoba Sanatorium, and Mrs. Cruikshank were official delegates at the Manitoba Hospital and Nursing Conference.

NURSING CONSULTANT

Activities of the nursing consultant included: 22 visits to the Sanatorium Board's rural hospitals, participation in teaching programs at the Manitoba Rehabilitation Hospital, attendance at the seminar in rehabilitation nursing at the University of Manitoba, at the Canadian Tuberculosis Association annual meeting and at the Manitoba Hospital and Nursing Conference.

Miss E.L.M. Thorpe, M.B.E.
S.R.N., R.M.N., R.M.P.A.,
C.M.B. (1)
Nursing Consultant

FOOD SERVICES

The over-all operation of food services during 1965 saw a substantial reduction in meal production owing to the closing of Clearwater Lake Hospital early in February. In all, 930,611 meals were served at a labor cost per meal of 22.41 cents, a rise of 1.38 cents per meal as against the 1964 figures. A total of 215,331 fewer meals were served in 1965 than in 1964.

The total supply cost was $ 22,226.29. Supply cost per meal stood at 2.38 cents, a rise of 0.22 cents per meal over 1964.

The patient meals served amounted to 622,487, a decrease of 160,323 as against 1964.

FOOD COSTS

A total of $ 233,355.62 was spent on food during 1965. This represents a decrease of $ 47,048 as against 1964 but, of course, we have the fact of the closing of Clearwater Lake Hospital early in the year.

CAFETERIAS

Our cafeterias served 308,124 non-patient meals in 1965, a decrease of 75,007 as compared to 1964. Again the bulk of the decreases stems from the closure of Clearwater Lake Hospital, but all institutions did experience some decrease in non-patient meals.

The average per cent food cost stood at 60 per cent, a rise of two points over 1964, but the average check rose by 2.3 cents from 30.03 cents in 1964 to 32.33 cents in 1965.

MEALS-ON-WHEELS

"Meals on Wheels", a special program designed by the Home Welfare Association to ensure the adequate nutrition of a selected group of elderly or disabled persons, was instituted in Winnipeg last year. These meals have been prepared five days a week in the kitchen of the Manitoba Rehabilitation Hospital and sent out to various homes across the city. During 1965 the hospital provided 3,043 of these special meals, with both individual preferences and special diets catered to. With the willing co-operation of the Manitoba Rehabilitation Hospital Food Services staff, Winnipeg now distributes more "Meals-on-Wheels" than any other city in Canada and is the only one that caters to both individual preferences and special diets.

STAFF ACTIVITIES

George Howell, Chef at the Manitoba Rehabilitation Hospital, attended the intensive course for professional chefs given annually at the Culinary Institute of America at New Haven, Connecticut.

Miss Jean Alexander, assistant Director of Dietary Services, continued her special series of classes for diabetics and for the overweight.

Throughout the year, Miss Alexander also served as chairman of the Arrangements Committee for the Manitoba Dietetic Association.

Miss N. Tupper Chapman, B.Sc.
M.Sc., R.P.Dt., F.C.F.A.
Director of Dietary Services.

PHARMACY SERVICES

In November, 1964, a survey of pharmaceutical services was conducted in the Sanatorium Board's hospitals to determine the following:

1) The extent and effectiveness of services provided by the Sanatorium Board pharmacy and to develop specific plans for improvement in the light of present demands and opportunities for pharmacy services.

2) The adequacy of present physical facilities to perform required pharmaceutical functions efficiently.

In 1965 the following improvements were established:

1) The development of new record forms to meet specific pharmaceutical and administrative requirements.

2) The development of a more efficient system of drug distribution and control within the hospitals.

3) Distribution and control of all pharmaceutical products from the Board's central pharmacy.

4) Improvements of drug services to the Manitoba Branch of the Canadian Paraplegic Association.

5) The acquisition of pharmaceutical equipment and the expansion of physical facilities to meet the needs for efficient pharmaceutical service.

6) The establishment of pharmacy as a liaison between the drug industry and the hospital medical staffs in proposed drug research projects.

7) The establishment of a manufacturing program for Old Tuberculin and its distribution along with tine tests for tuberculosis surveys and to the medical profession.

8) The establishment of an education service in the form of hospital drug displays for the benefit of the medical and nursing staff.

PLANS FOR 1966

Drug Information Centre: The Pharmaceutical Services is developing a drug information centre of appropriate size to provide comprehensive pharmaceutical information related to patient care, teaching and research to the health team members. The department is also establishing a Audio-Visual Library Service to support the education programs of pharmacy, medicine and nursing.

Pharmacy and Therapeutic Committee: Plans were made to set up an adivsory committee consisting of representatives from pharmacy, medicine and nursing to consider all matters relating to the use of drugs in the hospitals. The recommendations of the committee will be presented to the Medical Standards Committee and to administration for adoption.

Pharmacy and Medical Research: The Pharmacy Services will collaborate with the medical staff in clinical drug trials.

Policy and Procedure Manual: The revision of a pharmacy policy and procedure manual is now under way.

Many changes will be taking place in the development of pharmaceutical services in the Sanatorium Board's hospitals. The hospital pharmacist will be assuming greater responsibilities and by the increased utilization of his specialized knowledge and skills hewill make a greater contribution towards patient care and services to allied members of the health team. Pharmaceutical Services will therefore continue to have as its prime objective the expansion and provision of its scientific and professional services for better patient care.

Ted Sims, B.Sc. (Pharmacy)
Director of Pharmacy Services

RIDDELL, STEAD, GRAHAM & HUTCHISON
CHARTERED ACCOUNTANTS

220 PORTAGE AVENUE
WINNIPEG 2, MANITOBA

AUDITORS' REPORT

To the Chairman and Members
Sanatorium Board of Manitoba

We have examined the combined balance sheet of the Sanatorium Board of Manitoba as at December 31, 1965. Our examination included a general review of the accounting procedures and such tests of accounting records and other supporting evidence as we considered necessary in the circumstances except that we were unable to confirm the Manitoba Hospital Commission operating deficits and salaries recoverable ($75,888) and surplus payable ($26,829) as such amounts are subject to final settlement.

The Manitoba Hospital Commission has made claim for refund of disallowed operating expenses amounting to $37,000 for the years 1962 and 1963. As this claim is presently under appeal no provision for loss has been provided in the accounts.

Except for the provision for loss of $37,000 covering 1962 and 1963 operating expenditures, and subject to the adjustments, if any, which might arise from the settlement of accounts with the Manitoba Hospital Commission mentioned above, and from the ultimate disposal of the buildings as set out in Note 3, in our opinion the aforementioned balance sheet presents fairly the financial position of the Board at December 31, 1965, in accordance with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

April 21, 1966

Riddell, Stead, Graham & Hutchison