1968 Annual Report

SANATORIUM BOARD OF MANITOBA

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

THE SANATORIUM BOARD OF MANITOBA is a voluntary, non-profit corporation incorporated under the Tuberculosis Control Act of 1929 and founded in 1904 when a group of citizens organized to establish a sanatorium at Ninette. Today our Board is not only responsible for the treatment and control of tuberculosis in the province, but by authority of amendments to the Act, it also undertakes the care and treatment of certain other persons disabled by sickness or injury.

To meet the continuing problem of tuberculosis, the Sanatorium Board operates the Manitoba Sanatorium at Ninette and the D. A. Stewart Centre for the Study and Treatment of Respiratory Disease in Winnipeg. Our organization also conducts an intensive program of prevention, which is primarily financed by contributions to the Christmas Seal Fund. This program has been broadened in recent times to include, in addition to tuberculosis case finding, BCG vaccinations and chemoprophylaxis, certain screening techniques for the early discovery of all chronic respiratory disease, along with a few other conditions. Finally, in collaboration with the Medical Services of the Department of National Health and Welfare, the Sanatorium Board has a significant responsibility for the control of tuberculosis among the Indian and Eskimo people of the province.

With respect to our other services, the Sanatorium Board operates the Manitoba Rehabilitation Hospital in Winnipeg, which provides intensive, specialized treatment programs designed to restore as much function as possible to the physically disabled; and a Special Rehabilitation Service at Pembina House, Ninette, which with assistance from the provincial and federal governments, aids socially and vocationally handicapped adults in Manitoba.

SANATORIUM BOARD OF MANITOBA

A Voluntary, Non-profit Corporation

OPERATING

EARLY DETECTION SURVEYS

CHRISTMAS SEAL CAMPAIGN

D.A. STEWART CENTRE – WINNIPEG

MANITOBA SANATORIUM – NINETTE

MANITOBA REHABILITATION HOSPITAL – WINNIPEG

PROSTHETICS AND ORTHOTICS RESEARCH AND DEVELOPMENT UNIT – WINNIPEG

SPECIAL REHABILITATION SERVICES – PEMBINA HOUSE, NINETTE

CO-OPERATING WITH

Other Health and Welfare Agencies in the Province

REPORT FOR THE YEAR 1968

WINNIPEG, MANITOBA

MESSAGE FROM THE HONOURABLE GEORGE JOHNSON, M. D.

Minister of Health and Social Services, Province of Manitoba

Once again, after a period of absence, I have an opportunity to extend my appreciation to the Sanatorium Board of Manitoba for its contributions to the people of Manitoba. For more than sixty years you have been the main cornerstone of the provincial program for the detection, diagnosis and treatment of tuberculosis. During this period you have been well served by a group of dedicated and public spirited citizens and your efforts have been able to attract a devoted staff of outstanding ability. The experience in rehabilitation, which you have gained in the complete treatment of tuberculosis, led you naturally into the broader fields of rehabilitation when the success of your control program allowed you to free beds originally dedicated to tuberculosis. From these beginnings has grown a rehabilitation centre which has become a source of pride to the medical community of Manitoba and to the citizens of the Province.

May I wish you continued success.

CONTENTS

SANATORIUM BOARD OF MANITOBA

EXECUTIVE

Chairman	Mr. Frank Boothroyd
Vice-Chairman	Mr. R. L. Bailey
Chairman - Tuberculosis & Respiratory Disease	Mr. J. F. Baldner
Chairman - Manitoba Rehabilitation Hospital	Mr. S. Price Rattray
Members	Mr. H. L. McKay
	Mr. J. B. Craig

HONORARY LIFE MEMBERS

Dr. Ross Mitchell
Dr. F. Hartley Smith
Dr. E. L. Ross
Mr. J. W. Speirs

STATUTORY MEMBERS

Appointed by Provincial Department of Health:

Dr. John A. MacDonell
Mr. John Gardner
Mr. J. G. McFee
Dr. E. Snell

ELECTED MEMBERS

Mr. R. L. Bailey
Mr. K. Campbell
Mr. E. Dow
Mr. S. A. Magnacca
Mr. F. O. Meighen, Q. C.
Mr. S. Price Rattray
Mr. J. F. Baldner
Mr. W. B. Chapman
Mr. G. W. Fyfe
Mr. D. S. McGiverin
Mr. W. A. Paton
Dr. H. H. Saunderson
Mr. E. P. Stephenson
Mr. Frank Boothroyd
Mr. J. B. Craig
Dr. T. W. Fyles
Mr. H. L. McKay
Mr. E. B. Pitblado, Q. C.
Mr. H. T. Spohn

MEDICAL ADVISORY COMMITTEE

Dr. F. Hartley Smith - Chairman

Dr. H. S. Evans
Dr. J. E. Hudson
Dr. R. O. McDiarmid
Dr. C. B. Schoemperlen
Dr. R. M. Cherniack
Dr. T. W. Fyles
Dr. J. Kettner
Dr. R. H. McFarlane
Dr. F. R. Tucker

EXECUTIVE DIRECTOR and SECRETARY-TREASURER

T. A. J. Cunnings

AUDITORS

Riddell, Stead & Company.

MEDICAL STAFF

TUBERCULOSIS AND RESPIRATORY DISEASE SERVICES

D. A. STEWART CENTRE

Medical Director	R. M. CHERNIACK, M. D., M. Sc. (Med.), F. R. C. P. (Can.), F. A. C. P., Cert. Int. Med.

Associate Medical Directors

Tuberculosis Control	E. S. HERSHFIELD, M. D., F. R. C. P. (Can.), F. C. C. P., Cert. Int. Med.
Education	LOUIS CHERNIACK, M. D., B. Sc. (Med.), M. R. C. P. (Lond.), F. A. C. P., F. C. C. P., F. R. C. P. (Can.), Cert. Int. Med.
Out-Patient Services	C. B. SCHOEMPERLEN, M. D., F. C. C. P., F. A. C. P., Cert. Int. Med.
Consultant, Tuberculosis	DONALD L. SCOTT, M. D., Cert. Int. Med. (TB)

Consultants

Ear, Nose and Throat: D. M. BRODOVSKY, M. D., F. R. C. S. (Can.), D. A. B. O.
Cardiology: T. E. CUDDY, M. D., F. R. C. P. (Can.)
Chest Surgery: L. L. WHYTEHEAD, B. M., B. Ch., F. R. C. S. (Eng.)
Gastroenterology: J. A. HILDES, M. D., F. R. C. P. (Can.), M. R. C. P. (Lond.)
Hematology: L. G. ISRAELS, M. D., M. Sc., F. R. C. P. (Can.).
Metabolism and Endocrinology: J. A. MOORHOUSE, M. D., M. Sc.
Obstetrics and Gynecology: J. C. McCAWLEY, M. D., F. R. C. S. (Can.), F. R. C. O. G. (Eng.)
Orthopaedics: Wm. B. MacKINNON, M. D., Ch., M. (Man.), F. R. C. S. (Can.)
P. N. PORRITT, M. R. C. S. (Eng.), L. R. C. P. (Lond.) F. R. C. S. (Eng. & Can.)
Pediatrics: V. CHERNICK, M. D., F. A. A. P.
Renal Disease: A. E. THOMSON, M. D., F. R. C. P. (Can.)
Radiology: M. K. KIERNAN, M. D., F. C. C. P., D. A. B. R., (Roent), F. A. C. R.
C. J. ZYLAK, M. D., F. R. C. P. (Can.)
Rheumatology: F. D. BARAGAR, M. D., F. R. C. P. (Can.)
Surgery: H. CHOCHINOV, M. D., F. R. C. A. (Can.)
F. W. DUVAL, M. D., D. A. B. S., F. R. C. S. (Can.)
J. F. LUND, M. D., F. R. C. S. (Can.), F. A. C. S.
Urology: H. P. KRAHN, M. D., F. R. C. S. (Can.)

MANITOBA SANATORIUM

Resident Medical Staff

Medical Superintendent — ALFRED L. PAINE, M. D. Cert. Thor. Surg.

H. HERNANDO, M. D.

Consultants

Anaesthesiology: H. P. CAMRASS, M. B., Ch. B., G. M. C.
S. O'BRIEN-MORAN, M. D., B. Ch., G. M. C., D. A., R. C. P. & S. (Eng.).
Cardiology: V. J. H. SHARPE, M. D., Cert. Int. Med.
Eye, Ear, Nose & Throat: R. P. 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.

MANITOBA REHABILITATION HOSPITAL

Honorary Consultants

L. G. BELL, M. D., M. R. C. P. (Lond.), F. R. C. P. (Lond. & Can.), F. A. C. P.

F. R. TUCKER, M. D., F. R. C. S. (Edin. & Can.), M. Ch. (Orth. Liv.)

Chiefs of Service

Director of Physical Medicine — R. R. P. HAYTER, M. B., B. S., D. Phys. Med. (Eng.), C. R. C. P. (C)

Medical Director, Paraplegic Unit — B. J. S. GROGONO, M. B., B. S., F. R. C. S. (Eng. & Can.)

Director, Electrodiagnostic Department — J. F. R. BOWIE, M. B., Ch. B., C. R. C. P. (Can.)

Consultants

Anaesthesiology: D. M. HUGGINS, M. D., D. A. B. A., F. A. C. A.
Cardiology: LEON MICHAELS, M. B., B. S., Ph. D., M. R. C. P. (Lond) F. R. C. P. (C).
Chest Diseases: R. M. CHERNIACK, M. D., F. R. C. P. (C), F. A. C. P.
Dermatology: R. A. L. DAVIS, M. B., B. S., M. R. C. S. (Eng.), L. R. C. P. (Lond), Cert. Derm.
Electrophysiology: M. G. SAUNDERS, M. Sc., M. B., Ch. B. (Manch.)

Consultants - continued

General Surgery: HARVEY CHOCHINOV, M. D., B. Sc., Dip. Surg.
D. A. B. S., F. A. C. S., F. R. C. S. (C)
Internal Medicine: F. D. BARAGAR, MD., F. R. C. P. (C)
J. B. FAST, M. D., F. R. C. P. (C), F. A. C. P.
JOHN GEMMELL, M. D., M. R. C. P. (Lond.), F. A. C. P.,
F. R. C. P. (C).
Neurology: M. J. D. NEWMAN, M. B., B. Ch., M. R. C. P., (Lond.), F. R. C. P.
(C).
Neurosurgery: DWIGHT PARKINSON, M. D., C. M., M. Sc., D. A. B. N. S.,
F. A. C. S., F. R. C. S. (C)
Obstetrics and Gynecology: R. F. FRIESEN, M. D., F. R. C. S. (C)
Ophthalmology: G. M. KROLMAN, B. Sc., M. D., F. R. C. S. (Edin. & Can.)
Orthopedic Surgery: P. N. PORRITT, M. R. C. S. (Eng.), L. R. C. P. (Lond.),
F. R. C. S. (Eng. & Can.)
Otorhinolaryngology: W. ALEXANDER, M. D., D. A. B. O.
Pathology: J. G. FOX, M. D., Cert. Path., Dip. Bact.
D. W. PENNER, M. D., F. A. C. P., D. A. B. P.
Pediatric Anesthesia: T. J. McCAUGHEY, M. D., B. Ch., D. A.
Physical Medicine: J. F. R. BOWIE, M. B., Ch. B., C. R. C. P. (Can.)
R. R. P. HAYTER, M. B., B. S., D. Phys. Med. (Eng.),
C. R. C. P. (Can.)
Plastic Surgery: D. A. KERNAHAN, M. B., Ch. B., F. R. C. S. (Edin. & Can.)
Psychiatry: J. M. DOUGAN, M. B., B. Ch., B. A. O., D. P. M. (Eng.)
Radiology: M. K. KIERNAN, M. D., D. A. B. R., F. A. C. R., F. C. C. P.
Radiotherapy: R. J. WALTON, M. B., Ch. B., D. M. R. (Lond.), D. M. R. T.
Resuscitation (Internal Medicine): T. E. CUDDY, M. D., F. R. C. P. (C)
BRYAN KIRK, M. D., F. R. C. P. (C)
Thoracic Surgery: L. L. WHYTEHEAD, B. M., B. Ch., F. R. C. S. (Eng.)
Urology: H. P. KRAHN, M. D., F. R. C. S. (C)
J. B. McBEATH, M. B., F. R. C. S. (Eng. & Can.)

Active Medical Staff

Dr. W. Alexander
Dr. F. D. Baragar
Dr. S. Blumenthal
Dr. J. F. R. Bowie
Dr. D. M. Brodovsky
Dr. R. M. Chermack
Dr. Harvey Chochinov
Dr. R. A. L. Davis
Dr. M. L. Desmarais
Dr. John Dougan
Dr. J. B. Fast
Dr. J. B. Frain
Dr. R. F. Friesen
Dr. B. J. S. Grogono
Dr. R. K. Hay
Dr. R. R. P. Hayter
Dr. D. M. Huggins
Dr. D. A. Kernahan
Dr. M. K. Kiernan
Dr. H. P. Krahn
Dr. G. M. Krolman
Dr. M. J. Lehmann
Dr. I. I. Mayba
Dr. T. J. McCaughey
Dr. R. H. McFarlane
Dr. Leon Michaels
Dr. T. J. Mills
Dr. M. J. Newman
Dr. Dwight Parkinson
Dr. P. N. Porritt
Dr. D. M. Riddell
Dr. M. G. Saunders
Dr. C. B. Schoemperlen
Dr. I. H. K. Stevens
Dr. F. R. Tucker
Dr. R. J. Walton
Dr. W. R. Welply
Dr. L. L. Whytehead
Dr. H. W. Hart (Faculty of Medicine)
Dr. J. W. Neilson (Faculty of Medicine)

NON-MEDICAL SENIOR STAFF

SANATORIUM BOARD OF MANITOBA

Executive Director	T. A. J. CUNNINGS
Assistant Executive Director	EDWARD DUBINSKI
Comptroller	ROBERT F. MARKS
Purchasing Agent	K. J. ROWSWELL
Nursing Consultant and Administrative Assistant	MISS E. L. M. THORPE
Director of Pharmacy Services	TED SIMS
Supervisor, Special Rehabilitation Services	LYNN KUZENKO
Supervisor, Christmas Seal Campaign	MISS MARY L. GRAY
Surveys Officer	J. J. ZAYSHLEY

MANITOBA SANATORIUM

Hospital Manager	NICK KILBURG
Director of Nursing	WILLIAM BROADHEAD
Food Supervisor	MRS. VIOLET DUNSMORE
Acting Chief Engineer	JOHN GUTRAY
Radiographer	WILLIAM C. AMOS

D. A. STEWART CENTRE
and
MANITOBA REHABILITATION HOSPITAL

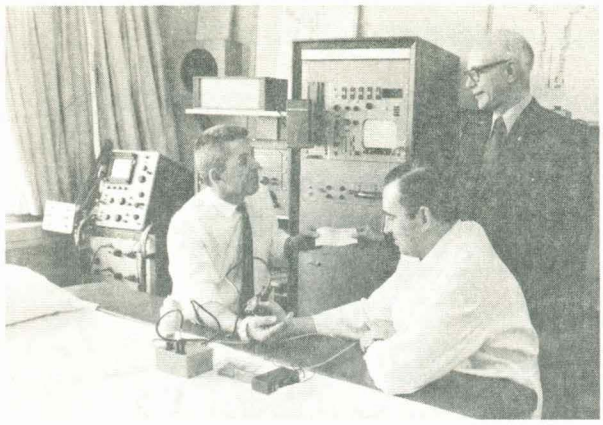
Director of Nursing (Acting)	MISS V. R. PEACOCK
Supervisor, Social Services	MISS MARY HAMILTON
Chief Physiotherapist	MISS J. K. EDWARDS
Chief Occupational Therapist	MISS JEAN COLBURN
Director, Department of Communication Disorders	J. BRAYTON PERSON
Director of Volunteer Services	MRS. W. E. BARNARD
Senior Laboratory Technologist	MISS J. GEIB
Senior X-Ray Technician	MRS. LAURIE HILL
Plant Superintendent	WILLIAM O. D. EVANS

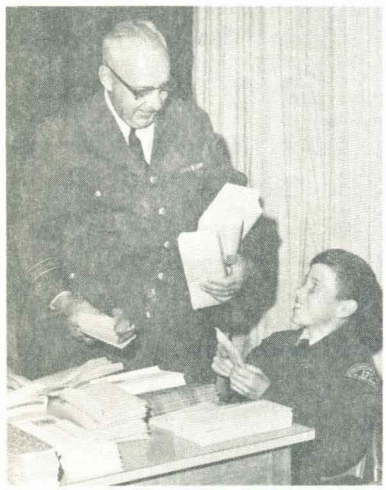
CENTRAL TUBERCULOSIS REGISTRY

Supervisor	MISS JANET SMITH

PROSTHETICS AND ORTHOTICS
RESEARCH AND DEVELOPMENT UNIT

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





THANK YOU ---

WE COULDN'T DO IT ALONE !

The Sanatorium Board of Manitoba expresses gratitude to the thousands of people throughout the province who support our efforts in the preventive and rehabilitative fields. We are much indebted to the volunteer workers who assist in our community screening programs and with preparations for the Christmas Seal Campaign, and who perform so many valuable services for the patients in our hospitals. We are also grateful to the citizens who have made donations to our research and equipment fund. We particularly appreciate the support of the Associated Canadian Travellers, Winnipeg and Brandon Clubs, who from 1945 to December 31st, 1968, have contributed $ 500,246.05 to our work.

CHAIRMAN'S REPORT

Frank Boothroyd

Ladies and Gentlemen:

It is a pleasure to welcome you to the 58th Annual Meeting of the Sanatorium Board of Manitoba.

The detailed reports which will be presented to you today indicate that the treatment and preventive services, and the educational activities that fall within the Board's sphere of operations have been carried out at a high level, and have been modified where necessary to meet current conditions.

In Winnipeg, the Board participates actively in the work of the new Health Sciences Co-ordinating Council. This is composed of representatives from the University of Manitoba, The Cancer Treatment and Research Foundation, The Children's Hospital of Winnipeg, The Sanatorium Board of Manitoba, the St. Boniface General Hospital, and the Winnipeg General Hospital. Mr. H. L. McKay is our representative on the Council and Mr. Cunnings represents us on the Planning Committee.

The plans in the Medical Centre include provision for the expansion of the D. A. Stewart Centre, which will ultimately permit the centralizing of our tuberculosis treatment and control program at this institution. Alternative uses of the facilities at Ninette are being explored; and of course, we have established there already a special vocational rehabilitation service, known as Pembina House. This operates as an integrated part of the provincial rehabilitation service, with a capacity of 50 students.

EXECUTIVE DIRECTOR'S REPORT

T. A. J. Cunnings

SUMMARY OF SERVICES TO INDIVIDUALS

	1967	1968
Admissions for Treatment	1,811	1,803
Out-patient Visits	55,126	62,963
Special Rehabilitation Services, Pembina House	----	154
Preventive Services - Examinations	119,276	129,473
Brandon Tuberculosis Clinic - Examinations	905	1,398
Treatment Days for In-patients	124,943	121,434

ASSETS AND LIABILITIES

Net value of assets held by the Board as at December 31st, 1968, totalled $ 4,020,094, after deducting accumulated depreciation and construction grants of $ 3,896,084. This represents a decrease of $ 233,996 from the preceding year.

The deficit receivable from the Manitoba Hospital Commission, which was $ 90,626 on December 31st, 1968, has been reduced to $ 28,106 as at December 31st, 1968. On the other hand, we have substantial losses at both Manitoba Sanatorium and the D. A. Stewart Centre in 1968. The Province has asked the Manitoba Hospital Commission to act as their fiscal agents in dealing with the financing of these two

institutions, but due to the new arrangements that have to be made and the preoccupation of the Manitoba Hospital Commission with other matters in recent months, we have been unable to reach any final settlement either for 1968 or for the on-going operation in 1969.

Analysis of Net Decrease in Assets

Increase in Assets 1967 to 1968		Decrease in Assets 1967 to 1968	
Increase in Inventories	$ 15,276	Increase in Depreciation	$ 133,400
Increase in Property, Plant and Equipment	33,734	Decrease in Accounts Receivable	125,378
Increase in Investments	34,000	Decrease in Cash in Bank	51,468
	$ 83,010	Decrease in Unamortized Bond Discount	2,796
Net Decrease in Assets	233,996	Decrease in Prepaid Expense	3,964
	$ 317,006		$ 317,006

Liabilities of $ 2,534,178 as at December 31st, 1968, were $ 54,932 less than the preceding year.

Analysis of Decrease in Liabilities

Debentures Redeemed		$ 85,000
Deduct:		
Increase in Bank Loans	$ 14,000	
Accounts Payable	16,068	30,068
Decrease in Liabilities		$ 54,932

INVENTORIES

As at December 31st, 1968, supplies on hand, including medical stores, drugs, engineering supplies, fuel, food, etc., totalled $ 122,575, an increase of $ 15,276 over the preceding year.

HOSPITAL OPERATIONS

D. A. Stewart Centre, with 64 beds, had an average occupancy of 90.6 percent and an average length of stay of 47.4 days. This is a 2.4 percent increase in occupancy compared to 1967, with a small reduction in average length of stay. Out-patient visits totalled 11,984 as compared to 9,885 in 1967.

Manitoba Sanatorium with 149 beds in operation, had an average occupancy of 86 percent. Bed capacity was reduced by 15 during the year. There were 174 admissions and 1,275 patients were seen in the out-patient department.

Manitoba Rehabilitation Hospital with 160 beds, had an average occupancy of 84.7 percent. This is a reduction of 2.8 percent as compared to last year and is accounted for by an unusually low admission rate during the summer. Average length of stay for discharged patients was 43.2 days, which is a reduction of 2.2 days as compared to 1967. There were 1,174 admissions to the wards and 7,842 patients were seen in the out-patient department.

FOOD SERVICES

Last year I reported that we had entered into a contract for our total dietary service in the Manitoba Rehabilitation Hospital and the D. A. Stewart Centre. The quality of the food has remained high and in an analysis covering an eight month period in 1968, we estimate that we had a direct cost savings of $ 12,500 and indirect savings of about $ 5,000.

PREVENTIVE HEALTH SERVICES

Preventive Services - Direct Service Costs

	1968	1967
Surveys Services	$ 58,110	$ 36,546
Tuberculin Surveys	16,173	19,533
X-ray Field Services	22,954	18,758
Tuberculosis Clinic, Brandon and The Pas	13,421	18,266
Indian Clinics	14,193	12,210
Health Education	12,845	9,915
Canada Manpower Service and X-ray Unit	637	4,052
Diabetic Surveys	9,262	3,111
X-ray Follow-up Service	5,880	2,024
B. C. G. Vaccinations	3,694	1,954
Travelling Clinics	197	313
	$ 157,366	$ 126,682

Our expenditures on preventive services substantially exceeded our revenues in 1968. As with everything else, the cost of surveys tends to rise - especially in 1968 when we did fairly intensive coverage of the northern part of the province, particularly from The Pas along the Hudson Bay Railway to Churchill. Federal health grants, which assist such things as tuberculin surveys and the BCG vaccination program, have been reduced to nearly one-third of what they once were, and it is expected they will be discontinued entirely if the present policies of the federal government are

carried out. The Christmas Seal contributions remain at quite a stable level, but again costs have increased. The increased postage rates alone will cost the Christmas Seal Fund 10 to 12 thousand dollars a year. The fact is that our preventive services will have to be curtailed unless additional sources of funds are found. This would be a tragedy because what we need in our health services today is a greater effort on prevention, and the application of modern techniques to screening programs for apparently healthy people, in order to avoid crowding our hospitals with illness and disability that might have been minimized or prevented. The Sanatorium Board of Manitoba has a unique organization and a lengthy experience that can be utilized to great advantage in carrying screening tests into the community. It would be a sad loss if the preventive service is allowed to operate at less than its potential due to lack of funds.

During 1968, the Board made grants to the Canadian Tuberculosis and Respiratory Disease Association for their operation, for their international commitments, and for research totalling $ 13,601.

In 1968, the Board spent $ 36,239 on instructional services for patients in Manitoba Sanatorium and the D. A. Stewart Centre.

NATIONAL HEALTH GRANTS

The appropriation available under tuberculosis control grants from the Government of Canada for the fiscal year 1968 - 1969 was $ 85,650, a reduction of approximately $ 5,000 from the previous year. The following is a comparative statement of claims on the respective projects for the fiscal year ended March 31st, 1968 and 1969 respectively.

	1969	1968
Streptomycin and other Antibiotics	$ 35,331	$ 35,399
Assistance to Sanatorium Board of Manitoba	25,441	20,723
Assistance to Manitoba Sanatorium	NIL	9,055
Extension of B. C. G. Vaccination Program	6,224	2,416
Tuberculin Surveys	17,220	21,135
	$ 84,216	$ 88,728

Under the research grant for the Prosthetics and Orthotics Research and Development Unit, $ 68,867 was expended. In addition, the Board made a special grant for equipment for the Research Unit amounting to approximately $ 7,000.

SPECIAL REHABILITATION SERVICES

The operation of the Special (Vocational) Rehabilitation Service for persons referred through the Community Development Service has continued to operate satisfactorily at Pembina House, Ninette, Through a monthly advisory committee meeting attended by appropriate officials of the province, Canada Manpower Service, and federal Medical Services there has been a continuing review and development of this program. There is a general concensus that it contributes substantially to the rehabilitation services of the province.

Expenditures on the Pembina House service totalled $ 101,518 in 1968.

INSURANCE

Fire insurance, including supplementary perils, was carried on the Board's property in the amount of $ 5,750,000. Public liability, professional liability, boiler and steam vessel, motor vehicle, fidelity and robbery cover is carried in appropriate amounts.

EDUCATION

The programs in medical education in our hospital have been extended in 1968. We have resident training programs in respiratory disease, physical medicine, urology, and radiology. Members of our medical staff are active in both undergraduate and postgraduate teaching. The School of Medical Rehabilitation, operated by the University of Manitoba on our third floor, has about 175 students in training in physiotherapy and occupational therapy. In addition to the regular diploma course the school offers a degree course, which has attracted students from all provinces of Canada and from other parts of the world. We have an active program of in-service education for nursing department staff in which 21 registered nurses, 9 licensed practical nurses, 10 orderlies and 13 nurses assistants had formal courses in rehabilitation nursing at their particular levels of responsibility. Conducted tours of the Rehabilitation Hospital and talks by senior nursing personnel, were provided for 409 student nurses in 1968. The weekly conferences on respiratory disease continue to have a large professional attendance. Three students had training in our prosthetic department.

Our health education service for the public reaches thousands of people each year, through pamphlets, films, radio, television and the news media.

We take pride in the large number of our staff who have had the initiative to undertake evening and other courses to improve their ability to fulfill their responsibilities.

PERSONNEL

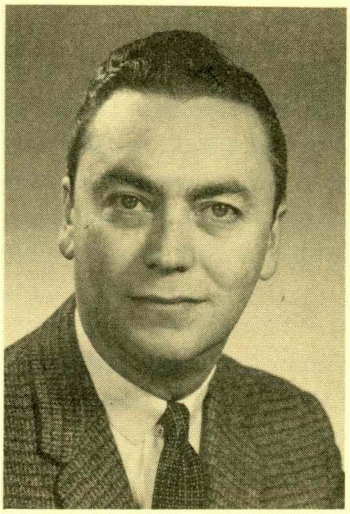
Our staff numbered 536 as at December 31st, 1968, compared to 516 a year earlier. There were 208 employees enrolled in the pension plan. Four members of the staff retired on pension - Miss Anne Law, who had been a member of our nursing staff since January, 1937; Mr. Ivan Phillips, who had been on the maintenance staff at Manitoba Sanatorium since 1950; Miss Derinda E. Ellis, who joined our staff in 1952 at Dynevor Hospital, was later transferred to Clearwater Lake Hospital and in 1955 became the Director of Nursing at Manitoba Sanatorium; and Mr. Louis Daigle, who had been on the maintenance staff at Manitoba Sanatorium since 1956. There was one claim under our Group Life Insurance Plan amounting to $ 9,000.00.

The responsibilities of the Board can only be carried out through the devoted service of a competent and conscientious staff. It is a pleasure to report to you the individual concern they display in maintaining a high standard of excellence in their work. I would also like to congratulate Mr. E. Dubinski, the Assistant Executive Director, on his election as president of the Manitoba Hospital Association.

On behalf of myself and the members of the staff, I wish to express warmest appreciation to the chairman and members of the Board for their continued good counsel and direction of our affairs. I also express appreciation for the interest and support of the officers and members of the active medical staff in the Manitoba Rehabilitation Hospital and the D. A. Stewart Centre, and the Manitoba Sanatorium.

T. A. J. Cunnings
Executive Director

TUBERCULOSIS AND RESPIRATORY DISEASE SERVICE



Dr. R. M. Cherniack

During the year covered by this annual report, the name of the Central Tuberculosis Clinic was changed to the D. A. Stewart Centre for the Study and Treatment of Respiratory Disease. This was consistent with the change in philosophy and policies which was adopted last year, with integration of prevention, investigation and treatment of tuberculosis into the mainstream of respiratory disease and medicine as a whole. To a large extent this integration has been accomplished because of collaboration with the University of Manitoba, so that new professional staff were added at the Centre and their activities were incorporated into the teaching program in respiratory diseases of the Faculty of Medicine and its affiliated teaching hospitals in the Medical Centre. However, the sanatorium at Ninette remains completely divorced from the academic atmosphere, and even the facilities in the Medical Centre are physically quite separated. Thus achievement of maximum benefit in teaching, investigation and patient care has not been possible.

Hopefully, this will be possible in the near future. If present plans materialize, a respiratory centre, which integrates all aspects of respiratory teaching, research and patient care, will be developed in the Health Sciences Centre. Plans for this development foresee a central area for respiratory teaching, clinical investigation, and special diagnostic procedures, which is closely integrated and physically connected with the areas for acute respiratory problems in the general hospitals, on the one hand, and with the area for chronic respiratory disease (including tuberculosis) on the other. Obviously this would operate most effectively if the activities of allied health professionals in the area were also integrated in close proximity. To complete the picture, it is hoped that close relationships

with as many other sub-specialties (in particular cardiology, infectious disease and immunology) will be part of the developments.

TEACHING ACTIVITIES

Residency Training - Appropriate emphasis on the prevention, diagnosis and treatment of tuberculosis during the residency training has been achieved through integration of the respiratory residency programs in the Medical Centre. The complement of residents on the chest program throughout 1968 consisted of two senior assistant residents who alternated six months on the chest service at the Winnipeg General Hospital and six months at the D. A. Stewart Centre, plus two junior assistant residents from Medicine every three months. The chest program was designed to provide exposure to a broad spectrum of respiratory disease including tuberculosis. This entailed responsibility for the management of in-patients in the D. A. Stewart Centre as well as outpatient chest clinics at the Centre and the Winnipeg General Hospital, provision of a consultant service in respiratory diseases at the Winnipeg General Hospital, and endoscopy. In addition, two residents from the Department of Pediatrics and the Children's Hospital of Winnipeg participated in a pediatric outpatient clinic at the D. A. Stewart Centre and provided consultation services to the in-patients, under the guidance and supervision of Dr. Victor Chernick.

Undergratuate Teaching - Undergraduate teaching clinics have been organized more and more around the patients in the D. A. Stewart Centre. The physicians in the D. A. Stewart Centre were involved in the teaching of physical diagnosis to first and second year medical students, and of clinical science to second year students; they gave lectures and twice weekly "clinics" in respiratory disease to third year students, and conducted sessions with clinical clerks on the medical services during fourth year medicine.

Conferences - Chest conferences of an interdisciplinary nature, one formal and one informal, were held weekly, and admission conferences twice weekly. Radiological rounds were conducted daily. In addition there were two weekly seminars, one dealing with basic physiological principles and research in progress, and one dealing with interpretation of pulmonary function tests.

SERVICE ACTIVITIES

The report on the service work of the D. A. Stewart Centre further reflects the integrated activities of the Centre. Of the 7,460 patients seen about two thirds had tuberculosis. More than one third of the patients seen were referred to the physicians in the Centre, who are practicing on a consultant basis. In addition, there were many patients seen on consultation in other hospitals, and a large number of endoscopies performed. The majority of the patient care activities, however, still centre around the problem

in tuberculosis.

TUBERCULOSIS

MORBIDITY AND MORTALITY

It must once again be emphasized that tuberculosis continues to be a health problem in Manitoba. Last year 225 new active cases and 38 cases of reactivation of tuberculosis were found among residents of Manitoba, as compared to 202 new active cases and 31 reactivated cases in 1967. This is an 11.4 percent increase in new active cases.

Altogether, a total of 287 cases of active tuberculosis were diagnosed in our Manitoba tuberculosis facilities last year; 24 of these were patients from outside the province. Of the 287, a total of 247 were new active cases, with 12 fewer Eskimos but eight more whites (including Metis) and 15 more Indians.

Twenty-one percent of the new active cases were in children less than 9 years of age. There were fewer new cases among Eskimo children, but the number of white (including Metis) and Indian children has increased. An important point to note is that 24 percent of the new active cases and 48 percent of the reactivations occurred in patients who were over the age of 50 . In the white patients (including Metis)60 percent of the reactivations occurred after the age of 50. Reactivation can occur at any time, and even more than 20 years following the last classification of active disease.

	REACTIVATIONS				NEW CASES			
Year	Whites	Indians	Eskimos	Total	Whites	Indians	Eskimos	Total
1961	41	19	--	60	179	56	--	235
1966	32	14	--	46	160	54	23	237
1967	24	7	2	33	161	41	34	236
1968	29	9	2	40	169	56	22	247
Change from 1967	+5	+2	0	+7	+8	+15	-12	+12

There were 24 deaths attributed to tuberculosis, which is a rate of 2.5 per 100,000 population. One death occurred in a patient under 30 years of age, while 18 of the patients (75%) were 50 years of age or over and 33 percent were over 70 years of age.

Year	WHITES Total Deaths	WHITES Rate per 100,000	INDIANS Total Deaths	INDIANS Rate per 100,000	WHITES AND INDIANS COMBINED Total Deaths	WHITES AND INDIANS COMBINED Rate per 100,000
1950	102	12.8	79	438	181	22.8
1960	33	3.8	6	25	39	4.3
1966	23	2.5	5	16.6	28	2.9
1967	26	2.8	2	6.7	28	2.9
1968	20	2.1	4	12.4	24	2.5

(The figures for 1968 are tentative and based on the estimated population for Manitoba of 971,000, which includes 32,313 Indians).

CLINICS

Drs. Hershfield and Paine have submitted full reports of the D. A. Stewart Centre and the Manitoba Sanatorium. Dr. Povah, the Board's tuberculosis consultant in Brandon, conducts a weekly chest clinic and supervises patients in the hospital for mental diseases. The Northern Tuberculosis Clinic was closed in July, 1968, and x-rays are now taken at St. Anthony's Hospital in The Pas and referred to the D. A. Stewart Centre for reading and recommendations, which are usually telexed back the day they are received. The following is a brief summary of the activities in these units:

	D. A. S. C.	Man. San.	Assin. Hosp.	The Pas	Total
Number of Examinations	6,118	1,242	1,398	323	9,081
New Diagnoses	169	1	2	---	172
Disease Active In	151	1	---	---	152
Known TB Patients Reviewed	2,444	109	109	31	2,693
TB Contacts Reviewed	1,940	56	107	---	2,103

CHEST FILMS FROM GENERAL HOSPITALS

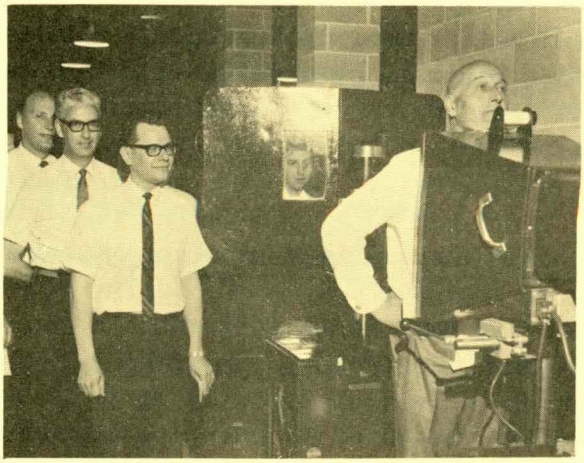
The D. A. Stewart Centre continues to read films for hospitals who do not have the service of a radiologist. Sixty-seven hospitals have taken advantage of this worthwhile service and in 1968 referred 13,935 hospital admission films for reading - an increase of more than 2,000 over 1967.

A total of 338 known cases of tuberculosis were reviewed and three new active cases of tuberculosis were uncovered.

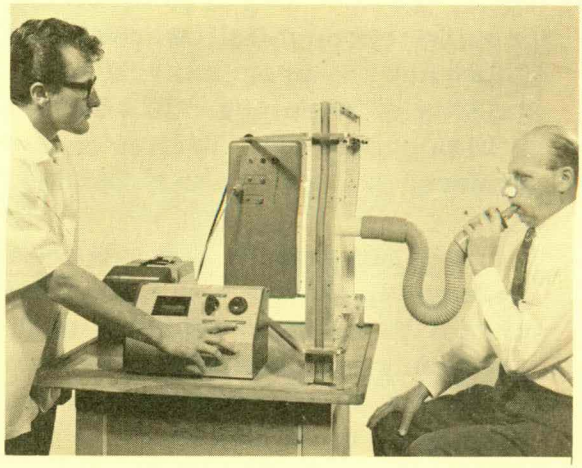
In addition, one new active case of tuberculosis was discovered in 4,829 chest x-rays, taken of Eskimos by Northern Health Services and of Indians and whites at hospitals and nursing stations and read at the D. A. Stewart Centre.

SURVEYS

The Sanatorium Board's preventive surveys program, which is co-ordinated by Mr. J. Zayshley in an extraordinary exceptional fashion, has been altered in several ways in an attempt to discover other respiratory and cardiac disorders earlier, as well as to improve the prevention and control of tuberculosis. Mass chest x-rays of all individuals over 16 years of age were begun during the latter part of 1968. In addition, a respiratory questionnaire and pulmonary function tests were added to the survey program. This latter project is supported by a Federal-Provincial Health Research Grant and is an attempt to see whether obstructive pulmonary disease can be discovered early, as well as to learn more about the incidence and natural history of this disorder, the influence of environment, occupation, cigarette smoking or other pollutants, and the relationships between symptoms and disturbances in function.



Back to mass chest x-rays..



Plus pulmonary function studies

We have continued to reduce community TB surveys and have been more selective in our choice of areas, i.e. those with more tuberculosis. High risk segments of our population such as the Metis population and tuberculosis contacts (mainly family) receive priority. Students and employees working in the health sciences also receive special attention. People known to have previous tuberculosis are followed closely; as are people in nursing homes, old folks homes, the Salvation Army Hostel, the National Employment Service, and prison inmates. Teachers, barbers and food handlers

are being examined mainly as sound public health practice.

During 1968 x-rays were taken on 82,922 individuals and tuberculin tests were carried out in 19,737 and a further 2,450 individuals who were seen on survey and known to be positive reactors. Respiratory questionnaires and pulmonary function tests were carried out in 5,003 individuals and blood sugar determinations on 22,880 individuals. With respect to the latter, 1.1 percent of the people screened were discovered to have previously unknown diabetes. Over two percent were classed as possible diabetics.

The incidence of reaction to tuberculin testing serves to point out the direction which must be taken in case finding and control of tuberculosis in this province.

There is a low rate of reaction in children up to the age of nine (1.84%). However, following this, there is a 100 percent increase to the age of 14, a further 100 percent increase from ages 15 - 19, and still another 100 percent increase from ages 20 - 24. Thereafter, there is a continuing smaller rise in the rate of positive reaction.

TUBERCULOSIS CONTROL

Because of the aforementioned, at several communities, with the co-operation of Dr. Snell and Dr. Elias, and the Directors and staff of the health units, we have begun to tuberculin test all grade one school children, and provide thorough follow-up of the families and contacts of any positive reactors. This year the program will be expanded to encompass other health units and the City of Winnipeg. In addition, because of the increased rate of reaction at high school age, it is proposed to continue to tuberculin test all school leavers.

Our attitude towards treatment of tuberculosis is also constantly undergoing change. We are treating all highly positive tuberculin reactors even with no other evidence of disease, as well as all tuberculin converters and young children who have been exposed to infection. In addition, the high incidence of reactivation, particularly in individuals over 50 years of age, is leading us more and more to consider treatment of all patients with radiological evidence of inactive disease, who have never received chemotherapy.

In addition, the Sanatorium Board is continuing to co-operate with the Medical Services branch of the Department of National Health and Welfare in waging an intensive anti-tuberculosis campaign in the Keewatin District and in conducting a study of the effects of chemoprophylaxis among the population of Eskimo Point.

B.C.G. VACCINATION

The Medical Services, Department of National Health and Welfare, gave BCG to 3,695 individuals in Manitoba in their program of B.C.G.

vaccination of new-born Indians and Eskimos. The Sanatorium Board administered this vaccine to 1,776.

Through the co-operation of the Department of Health, 752 students have been vaccinated with BCG in the high schools in the Dauphin Health unit area and in the elementary schools of Duck Bay and Camperville (in Swan River area). In addition, 1,024 health science personnel or other high risk groups with negative tuberculins have been vaccinated with BCG.

TREATMENT

There has been a considerable reduction in length of treatment stay for whites (including Metis) and Indians and Eskimos compared to 1967, while there has been a slight increase in length of stay by the Eskimos. The figures for white patients are affected by a few chronic patients who could not be discharged for various reasons. The Indian and Eskimo patients are kept in hospital longer for socio-economic reasons, particularly the difficulty of supervision of outpatient chemotherapy.

TREATMENT DAYS FOR TUBERCULOSIS

Year	Province of Manitoba	Gov't Canada & Other Provinces	Total	No. of TB Beds Occupied as at December 31.
1955	165,696	202,422	368,118	1,014
1960	99,074	99,704	198,838	457
1966	32,832	36,926	69,758	201
1967	31,733	42,108	73,841	191
1968	36,841	31,387	68,228	176

Average Length of Treatment Stay for Patients Discharged in 1968

	Whites	Indians	Eskimos
For Reviews	12.6 (14)	12.0 (10)	8.0 (1)
Non-TB Patients	35.2 (90)	39.2 (41)	16.3 (3)
For Tuberculosis	190.2 (210)	255.1 (101)	360.5 (33)

(Bracketed figures are the number of patients).

During 1968 there were 1,160 patients receiving outpatient chemotherapy. Of these, 878 were on drugs as of December 31, 1968.

The results of this shift in responsibility to the patient, the public health nursing service, the family physician and clinic services, under the organization and supervision of the Sanatorium Board is very gratifying. *Credit must be given to the staff of the Central Registry who centralize all*

information about out-patient chemotherapy, and to the close follow-up through the health units and their staff.

Through the excellent work of Miss J. Smith and her staff, the Registry continues to play a major role in the tuberculosis control program. The total number of patients in the active Registry file is 8,117.

RESEARCH ACTIVITIES

Your Medical Director of Tuberculosis and Respiratory Disease Services was the recipient of research grants from the Medical Research Council, the Department of Health and two pharmaceutical firms and was also responsible for supervision of two fellows: Drs. Snorri Olafson and Peter Duke, who were recipients of Medical Research Council Fellowships. The total budget supported by research funds was $ 112,000.00. In addition to the study on the incidence and natural history of chronic obstructive pulmonary disease, research into the mechanics of breathing, and its relationship with gas exchange and control of breathing in health and disease, is being carried out.

ACKNOWLEDGEMENTS

In conclusion, it is important to point out that this large program is a success only because of the efforts of the entire staff of the Sanatorium Board and the wonderful co-operation we have received from the members of the Medical Advisory Committee, the Executive Office and the Board. On behalf of the Medical Staff may I offer our sincere thanks to all.

Dr. R. M. Cherniack
Medical Director.

TUBERCULOSIS CONTROL PROGRAM
MANITOBA ZONE - MEDICAL SERVICES

Manitoba Zone has continued to receive co-operation from the Sanatorium Board of Manitoba in the conduct of tuberculosis control programs among the Indian population. The incidence of tuberculosis in Indians is still higher than that in other Canadians. During 1968 a total of 45 new active cases were found by surveys, and 43 were uncovered by other means. Thus it is obvious that in isolated areas surveys continue to play an important part in case finding, as well as in the investigation of tuberculosis contacts.

Out of a population of 32,233 in the Manitoba Zone, 17,487 people were x-rayed, showing an average of 54 percent of the population at risk in comparison to an average of 45 percent last year. This varied from 41 percent x-rayed in Southern Manitoba to 71 percent x-rayed in the Norway House area. Of every 388 people x-rayed, we found one active case of tuberculosis. In the Norway House area, one active case was found in 145 people x-rayed. This area will require an intensive program of case finding for at least five more years.

We have continued our BCG program and during the year provided it to 3,949 people. We believe BCG to be of value in higher risk areas and we intend to continue this program.

Our highest incidence of tuberculosis is found in the 5-9 and 15-24 age groups. We note that we had five new cases in the 60-64 age group. It has also been noticed elsewhere that with better control measures in the younger and middle age groups, older people are developing tuberculosis. When I was a medical student some 37 years ago this age group was considered to be immune to tuberculosis.

During the year we had 10 reactivated cases of tuberculosis, indicating that x-rays should be repeated at regular intervals in all arrested cases. Four people died of tuberculosis in 1968.

While we are pleased with our achievements this is no time to become smug. In TB control we either go ahead or slip backwards; we can never stay in the same place. It is our intention to increase our program of detection and prevention in the mid-north where the need is still great.

Dr. M.J. DeKoven
Director, Manitoba Zone, Medical Services
Department of National Health and Welfare

THE D. A. STEWART CENTRE

Dr. E. S. Hershfield

The year 1968 was eventful for the old Central Tuberculosis Clinic. A new medical staff and change of name heralded increased activity. The addition of rotating residents to the in-patient service emphasized our increased teaching role in the Joint Respiratory Program. In addition, the medical staff were involved in other university teaching programs.

There were 11,984 visits to the D. A. Stewart Centre in 1968 as compared to 8,885 in 1967. Not only was there an addition of 2,734 non-tuberculosis visits, but the number of tuberculosis visits also increased from 8,885 to 9,250. There were 169 new discoveries of tuberculosis, of these 151 were active and 18 inactive. Patients admitted to the wards rose from 441 in 1967 to 455 in 1968, and treatment days rose from 20,595 to 21,167.

A total of 796 patients were supervised as out-patients on anti-tuberculosis chemotherapy as at December 31. Throughout the year 4,697 streptomycin treatments were given to out-patients. The number of in-patients on various drugs were: 276 streptomycin, 271 para-aminosalicylic acid, 294 INH, 12 cycloserine, 22 ethionamide, 26 seromycin with INH, 12 pyrazinamide, 4 viomycin, 1 isoxyl, 6 kanamycin, 7 ethambutal, 2 thiacetazone.

A total of 356 consultations and 561 endoscopic examinations were made by the medical staff in 1968. The number of x-ray films made were 10,892 (which is more than double the number made in 1967), and 32,755 laboratory tests were done.

Dr. E. S. Hershfield
Associate Medical Director

MANITOBA SANATORIUM

Dr. A. L. Paine

Manitoba Sanatorium completed its 59th year of service in 1968, and its activities showed little alteration over those of the previous year. Patient days decreased from 54,003 to 50,758 but still remained slightly above the 1966 figure of 50,095. The average days stay of discharged patients was 266. At the end of the year the patient population stood at 126 as compared to 140 on December 31st, 1967. The proportion of patients of Indian or Eskimo origin dropped from 84 percent to 80 percent.

ADMISSIONS AND DISCHARGES

There were 174 admissions, of which 53 were miscellaneous (for investigation, checkup, returning from other hospitals or leave). The remaining 121 received definitive treatment for tuberculosis and of these 107 had new disease while 14 had suffered reactivation. In those with new disease, more than one site was at times involved, but the main diagnosis was adult type pulmonary tuberculosis in 67 with extent as follows: minimal 26, moderately advanced 23, and far advanced 18. Three patients had pleurisy with effusion alone. Nineteen children had primary lung disease and two were classed as tuberculin convertors. In 16 patients the main diagnosis was non-respiratory. Sites involved were meninges 2, cervical glands 6, axillary glands 2, spine 2, tarsal joint 1, ankle 1, renal 1, soft tissue 1.

The new cases were analyzed as follows: White 21%, Treaty Indian 38%, Metis 31%, and Eskimo 10%. Age: 0-15 years 30%, 16-59 years 57%, 60 years or over 13%. Sex: males 52%, females 48%. Compared to our figures for 1967 there were 10 percent more white patients, 13 percent fewer Eskimos, 12 percent fewer children.

Of 107 admissions with new disease 85 were persons of Indian or Eskimo origin, and 47 of these had adult type disease. A study of this group is of interest because most patients eventually came to Ninette fordefinitive treatment, and adult type disease (rather than primary or the non-pulmonary variety) is the main source of infection in the community. In this particular group of 47 patients with adult disease, a surprising 85 percent were bacillary, 64 percent had been sick for periods of a few days to several months and 59 percent had been admitted to general hospital for investigation before transfer to sanatorium. These figures give some indication of the extent of infection still being disseminated and the difficulties of tuberculosis control.

As already mentioned reactivation had occurred in 14 patients admitted. Of these four were white, one Metis, six Treaty and three Eskimo. Average time since previous treatment was six and one-half years, with the shortest being eight months and the longest 20 years. All but one patient had had previous chemotherapy, average duration being 18 months. Four patients had had pulmonary resection and one bilateral plombage. Five patients had suffered previous reactivation.

Discharges totalled 188. Of these 68 were miscellaneous, being similar to the miscellaneous admissions already described. Fourteen of this group left against advice; none were bacillary. Four ultimately returned, six are being supervised at home and four are untraced. There were six deaths with two autopsies; two were from tuberculosis and four from other causes in tuberculous patients.

There were 114 discharges classified as definitive in that they left hospital at termination of prescribed treatment. Of these, 30 had completed chemotherapy and 84 or 73 percent went home on drugs. A detailed analysis of the discharge program to out-patient chemotherapy has been done, but only the salient points will be mentioned here. This year, as last, discharge to home chemotherapy markedly reduced stay in hospital, the average stay for those going home on drugs being 280 days as compared to 592 days for the "home without chemotherapy" group. Significant gains have been made in Eskimos where the incidence of discharge on drugs for all ages had risen from 55 percent to 95 percent since last year and in children from 0 percent to 90 percent. A start on home chemotherapy has been made in Treaty and Metis children as well, with the total incidence for all native children increasing from 9 percent to 41 percent. Average hospital days for all definitive discharges fell from 394 to 368 days. However, a detailed study of the various racial and age groups suggests that the increase of discharge to out-patient chemotherapy this year has not reduced hospital days so much as it has increased the total length of chemotherapy.

TREATMENT

Treatment has altered very little in the past year. Rest is no longer necessary except in the early toxic stage but good living standards and

especially uninterrupted long term chemotherapy are essential for permanent arrest. We still believe the surest way to meet these conditions in native patients is by an initial relatively long period of sanatorium care allowing for resolution of most of the disease and establishing good habits of drug taking. With the emphasis no longer on rest, attempts are made to keep patients productively occupied at school work, handicrafts and acceptable recreation. Young adult patients often go on to vocational training after discharge. In Treaty and Metis patients, 91 percent and 79 percent respectively of all adult patients went home on drugs with an average hospital stay of nine months. However, 20 or 43 percent of these two groups had six months or less of hospital care. In Eskimos, although 100 percent of adults went home on drugs, the shortest stay was seven months and the average stay 14 months.

The principles of chemotherapy remain unchanged. In most cases two years of chemotherapy is planned and patients start on all three standard drugs - streptomycin, INH and PAS. After the first year streptomycin is dropped and INH and PAS continued to completion of drug therapy. When resistance or intolerance develops second-line drugs are substituted with at least two drugs being used. Resistance to one or more drugs was encountered in 19 patients during the year and primary resistance was found in 2.8 percent of all admissions with new disease. The number on drugs was as follows: In-patients - streptomycin 270, INH 246, PAS 219, D'cycloserine 8, trecator 2, pyrazinamide 18, seromycin 19, isoxyl 41, thiocetazone 2, ethambutal 7, capreomycin 9. Out-patients: streptomycin 20, INH 43, PAS 119, cycloserine 11, pyrasinamide 3, seromycin 12, isoxyl 29, trecator 1, thiacetazone 2.

Surgery has been gradually reduced over the last few years. Major chest operations totalled 20. All patients except one were of Indian or Metis or Eskimo origin. Procedures performed were as follows: pneumonectomy 1, lobectomy 5, segmental resectional 1, wedge resection 8, thoracotomy 1, decortication 1, thoracoplasty 1, wax pack removal and thoracoplasty 1, wax pack 1. There was one post-operative death in a patient with left upper lobectomy complicated by extensive mediastinal emphysema of undetermined origin even after exploratory thoracoplasty. One patient had a superficial wound infection that cleared quickly on antibiotics and packing.

OUT-PATIENT DEPARTMENT

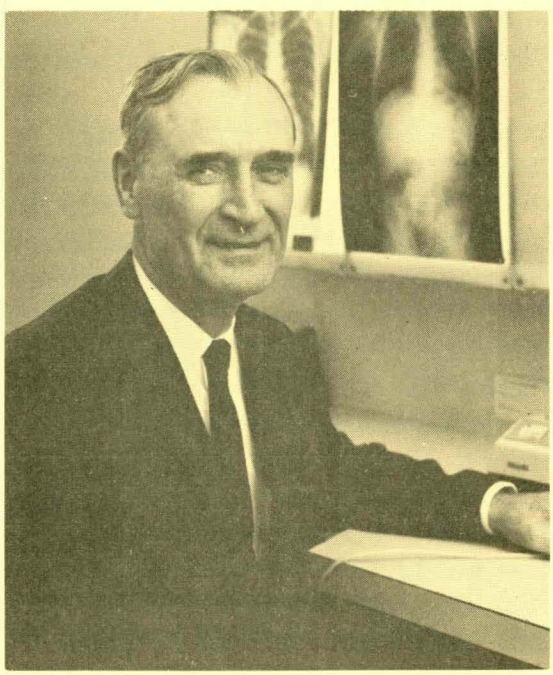
Total attendance was 1,275 as compared to 1,226 in 1967. Altogether 356 old patients were reviewed. Twenty-eight out-patients reviewed were on chemotherapy which included PAS. Of these 17 were positive to the PAS stick test, three were negative and eight untested. Three discoveries of pulmonary tuberculosis were made and placed on treatment. In the remaining 916, non-tuberculous chest conditions were found in 18 and no disease in 898.

X-RAY AND LABORATORY

The X-ray department made 2,481 radiographic examinations, did 53 electrocardiographic tracings and took 104 clinical photographs, of which 19 were color slides of surgical specimens.

The laboratory did 11,824 tests for 30,761 units of work. Besides routine work 1,536 cultures of tubercle bacilli were planted and 40 units of blood cross-matched to supplement routine Red Cross supplies. Pulmonary function tests were done on all current surgical cases and on 12 out-patients with previous lung surgery.

Dr. A. L. Paine
Medical Superintendent



DR. DONALD L. SCOTT, who for 38 years served as medical chief of the Central Tuberculosis Clinic in Winnipeg, was honored in early 1969 for his many contributions to the anti-tuberculosis campaign in Manitoba. As medical head of the C.T.C. since its establishment in October, 1930, Dr. Scott has been deeply involved in both tuberculosis diagnosis and treatment, and in prevention and teaching; and during this long association he has enjoyed a particularly warm and close relationship with hundreds of doctors and patients in all parts of the province. Dr. Scott retired from his post in 1967, but he has remained on at the Clinic to lend valuable assistance as tuberculosis consultant.

Dr. R. R. P. Hayter

The record of this hospital as an active rehabilitation centre continued to be an impressive one during 1968. As reflected in figures shown in this report, the numbers of both in-patients admitted and the out-patients continued to increase. During the earlier part of the year, there were staff shortages in some departments but for the latter part of the year the staff situation was extremely good.

MEDICAL STAFF

A major resignation was that of Dr. L. H. Truelove who had been Chief of Medical Services since the hospital was opened and who left at the end of May, 1968, to take up a post in Vancouver with CARS. The thanks and the good wishes of the hospital staff were extended appropriately to Dr. and Mrs. Truelove, and the active medical staff had a farewell dinner at the Fort Garry Hotel. Other changes included the resignation of Dr. Clifford Smythe who, as Consultant Urologist, had taken a particular interest in the urological problems of paraplegics. We welcomed the appointment of Dr. H. Krahn in his place. Additional appointments approved to the active staff included Dr. M. K. Kiernan in radiology, and Dr. I. I. Mayba in orthopaedic surgery, with a particular interest in prosthetics. During the year there were many physicians appointed to the Courtesy Medical Staff.

The Medical Executive Committee met regularly under the chairmanship of our president, Dr. R. H. McFarlane. Valuable contributions have been made by the active staff members who form the sub-committees and we would particularly like to thank the various chairmen: Dr. D. A. Kernahan, Medical Standards Committee, Dr. Rankin Hay, Admissions and

Discharges Committee, and Dr. J. B. Frain, Credentials Committee.

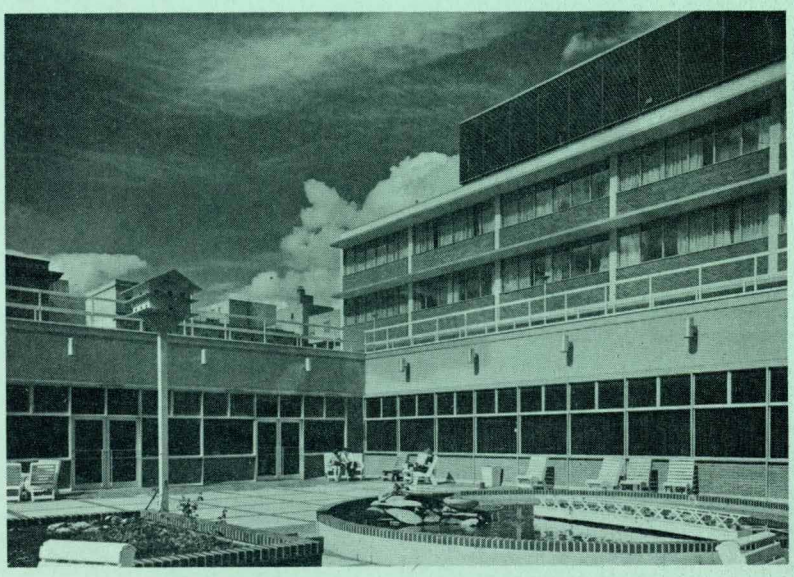
The resident medical staff was slightly under establishment at the beginning of the year. On July 1st, 1968, Dr. S. Lee was appointed Assistant Physician in Physical Medicine and we welcomed Dr. G. Fuzeta in his place as Chief Resident. From July 1 there was a full establishment of six residents plus an additional new post of part-time resident in urology. The Residency Training Program continues to be active and has been placed on a more formalized basis. We are most grateful to those members of the active staff for the contributions they make to post-graduate instruction. However, the program needs to be made even more appealing and thorough so that we may attract residents of as high a calibre as possible into the approved program.

IN-PATIENT SERVICES

YEAR	ADMISSIONS	AVERAGE LENGTH OF STAY
1966	1,071	48 days
1967	1,098	46 days
1968	1,165	43 days

There is still a steady increase in the total number of admissions and this is associated with a decline in the average length of stay. In fact the latter has decreased by 10 days in four years since it was 53 days in 1965.

The distribution of patients under major medical categories was as follows: arthritis 388, orthopaedic 332, hemiplegia 133, pharaplegia 113, other neuromuscular 94, amputees 86, other internal medicine 25.



Courtyard at the Manitoba Rehabilitation Hospital

The hospital-based members of the Active Staff have continued to supervise many of the programs to a great extent. The paraplegic unit has flourished under the direction of Dr. B. J. S. Grogono, who has also played a large part in the encouragement of paraplegic games. Dr. Michael Newman has done a good deal of work and research through the hemiplegic program and Dr. F. D. Baragar carries a large part of the burden of the arthritic program. The clinical duties and research in the latter have been ably assisted by Dr. Niak, who is working in the hospital as a CARS research fellow in rheumatology.

OUT-PATIENT DEPARTMENT

YEAR	NEW PATIENTS	MEDICAL REVIEWS	TOTAL
1966	1,918	4,850	6,768
1967	2,758	4,633	7,391
1968	2,818	5,024	7,842

PHYSIOTHERAPY DEPARTMENT

During 1968, the staffing of the department was maintained at the highest average level since the department was opened in 1962. The total units for treatment given to in-patients and out-patients for the year were 1,867,738, compared to 985,741 in 1967 showing a total increase over the year of 881,997 units. The increase in the turnover of in-patients and the steadily rising number of out-patients has given rise to a major problem of space shortage in this department. This causes waiting lists for treatment on occasion, though happily these have been of short duration only. Hydrotherapy, individual treatments, and the classes have been affected from time to time by such waiting lists.

During the year, a full time physiotherapist was appointed as clinical supervisor. This proved to be an excellent move in terms of supervision and organization of the clinical training offered to interns and students. Over 100 students from the School of Medical Rehabilitation, in their second and third years, worked in the department for six weeks at a time during the year. During the summer months interns from the Universities of Laval, B. C., McGill and Saskatchewan spent between two to three months working in the department.

The In-service Training Program has been developed during the year. In addition, the physiotherapists have formed a Journal Club and several overlapping Committees. The latter includes in-service education, a standards committee, equipment committee, a charting-filing committee. Each of these committees has done valuable work and contributed towards a high

standard of patient care.

A brief review of the first 20 patients in the shoulder survey was made during the year and it was decided to continue the scheme, aiming towards 100 patients.

OCCUPATIONAL THERAPY DEPARTMENT

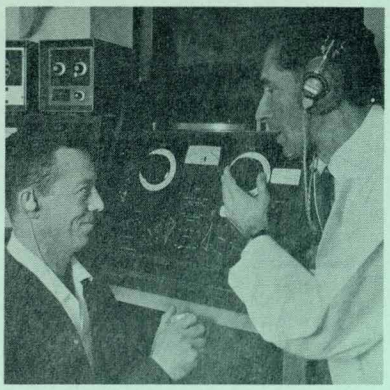
Mrs. Joy Huston, who had been head of the department since it first opened, resigned to take up an appointment as Consultant Occupational Therapist in Ontario and was ably replaced by Miss Jean Colburn in the summer. At the beginning of the year, there was a fairly serious staff shortage which improved considerably during the latter half of the year, so that by the end there were 10 full-time and one part-time occupational therapists, one part-time unqualified therapist and 13 other personnel.

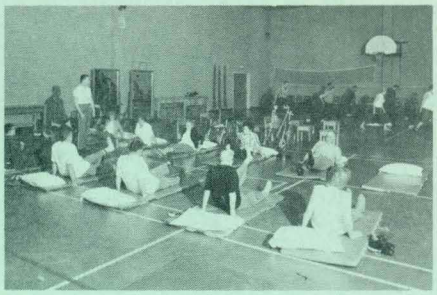
The total number of treatment units given was 681,430, a drop of 123,871 units compared to the previous year. There seemed to be two main reasons for the reduction in the total units. During the first five months the department was understaffed, and secondly, also due to an acute shortage of therapists in 1967, it was decided not to admit patients to the phase one of the back program. Analysis shows that patients with back disorders normally form a very high proportion, in fact over 37 percent of all outpatients admitted to this department and therefore, when it is impossible to treat them, the number of units will decrease significantly.

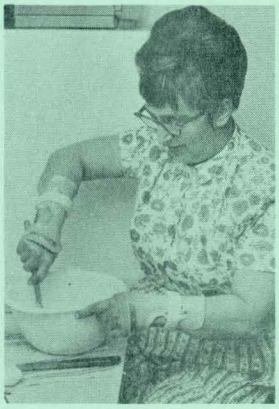
During 1968 additional equipment and projects were started. This included equipment in sheet metal and wrought iron work. A new project of making laminated tables was started in carpentry to provide heavier bench work. A special clamping bench was built for gluing these tables. A high level work bench and wall bars were provided in the medium workshops for standing activities at and above shoulder levels. A treadle lathe was adapted as a rocker-tumbler, and we added jewelry-making in the light workshops. Treadle sewing machines and knitting machines were donated by ex-patients to the light workshop. During the year the particular project of hand function assessment for arthritic patients was continued and, during the year, 167 such hand assessments were carried out. A further feature has been additional forms of assessment for perceptual dysfunction for hemiplegic patients. The Home Unit has continued to provide an important area of evaluation of functional ability or disability - 1,398 patient assessments were carried out in this unit, staffed by one therapist and an aide.

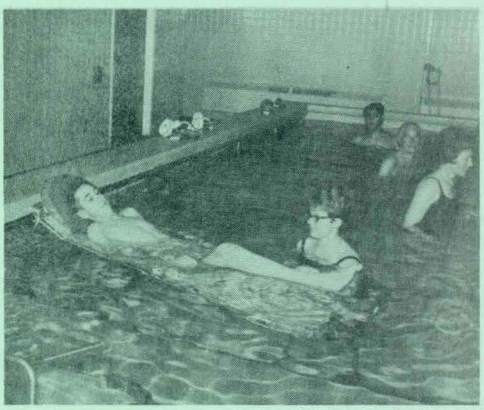
A skilled technician was appointed during the year in orthotic work. The patients for dynamic splints are referred through occupational therapy and the therapist supervises the fitting and use of the splints.

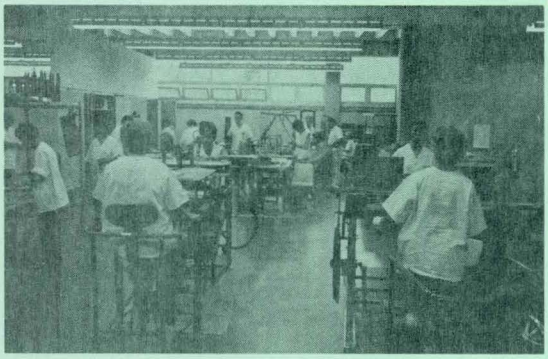
We would like to thank the Department of Parks and Recreation for

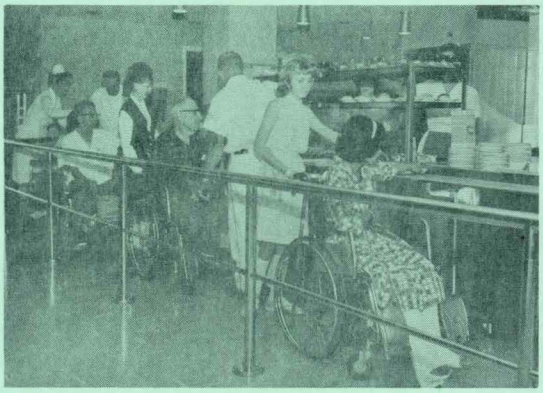


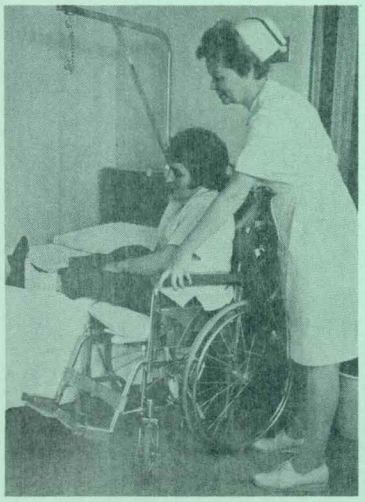


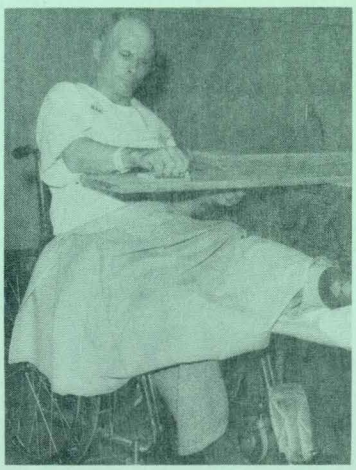


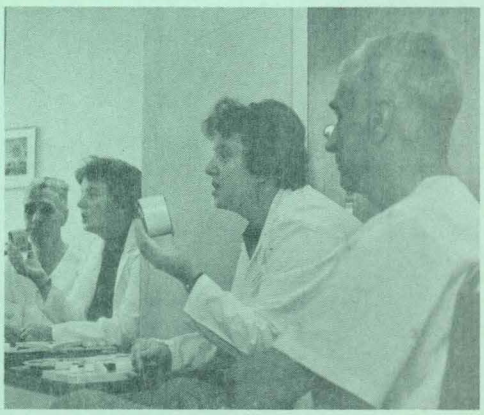












allowing the continuation of a weekly archery group at Sargeant Park , with indoor facilities free of charge through the winter. The program was originally arranged for paraplegic patients, though during the year patients with many other disabilities have participated. Transportation was kindly arranged by the Society for Crippled Children and Adults.

The workshops have continued to make various walking aids, and many types of self-aids and home adaptations. Special orders have been supplied to CARS and other hospitals and equipment is also made and repaired for the other departments at this hospital. Whenever possible, such work is done by the patients under supervision of the technicians and staff.

The department has provided clinical training facilities for students from the School of Medical Rehabilitation. Interns from the Universities of Toronto, Montreal and Alberta worked here throughout the summer months. The graduate staff of the department have participated in many lectures, demonstrations and rehabilitation courses given at the hospital, and senior staff have attended meetings and study courses elsewhere in Canada.

Specific projects for the coming year include research into the treatment of different disabilities, additional work assessment activities in the heavy workshop, a photographic unit with darkroom facilities, and more remedial games.

ELECTROMYOGRAPHY DEPARTMENT

In May 1968, the work of this department was assumed by Dr.J. F. R. Bowie, appointed as head of the department, assisted by Dr. S. Lee. Dr. M. Saunders has continued to act as consultant.

The work steadily increased during the year. A total of 632 patients were examined as compared to 569 patients in 1967. Number of tests rose from 808 in 1967 to 986 in 1968.

During the year plans were made to replace much of the current equipment. The latter was becoming out-moded and there were intermittent breakdowns. It was decided to purchase a Teca Medelec electromyograph after comparing specifications of all commercially available equipment. This will be the most advanced commercial equipment presently available. The initial components will consist of a twin channel EMG, coupled to a twin channel stimulator unit and with camera and audio facilities. This will be sufficient to permit the majority of electroneuromyographic investigations, but it is hoped that further units will eventually be added to allow for a more complete range of investigations and fuller facilities for research.

In addition to the clinical activities, Dr. Bowie has set up programs of lectures for paramedical staff and the students of the School of Medical Rehabilitation. Regular practical sessions were also held for the resident

medical staff, and for the students and graduate therapy staff.

SOCIAL SERVICE DEPARTMENT

During 1968, 1,280 patients were seen by the four social workers in this department. In addition, 9,286 interviews and telephone calls pertaining to patient problems were made during the year. But these statistics reveal little of the real effort and time put into the work of the department.

Assistance was given in various ways. Help with housing (18%), employment needs (18%), and requests for financial assistance (30%), were some of the requests from our patients. The remaining 34 percent presented various social and emotional needs which for many would continue after their discharge from hospital. Because of some lack in total community resources, the visiting of patients on their return home was aided by the services of young volunteers from the university, the Mennonite Bible College and the Volunteer Bureau. These personnel also assisted patients with shopping, visiting and in resuming their community acitivites on their return home. The development of this program has been extremely important since it has assisted patients to maintain their level of functioning and at the same time seems to lessen their dependence upon the hospital.

Mrs. J. Vielgut, social worker on Ward R6 and primarily concerned with arthritic patients, is involved with research project on polyarthritis being conducted by Dr. F. D. Baragar. Mrs. L. Hilton, social worker on Ward R4, has also been actively involved during the year in the development of the newly formed Manitoba Amputees' Association. Mrs. M. Wilson, on Ward R5, seems to take in her stride all the various problems associated with large numbers of patients with neuromuscular disorders, especially in the hemiplegic program.

The work of the staff of this department requires much communication with other personnel in the total rehabilitation field and we are grateful for the co-operation of the city and provincial Departments of Welfare as well as that given by such organizations as the S. C. C. A., V. O. N, C. P. A., C. A. R. S., Canada Manpower and Workmen's Compensation Board. Home care programs are now an essential part of our planning and, particularly where problems remain, which could not be resolved during the patient's limited stay in hospital, the staff of this hospital in co-operation with these outside agencies attempts to offer a high quality of service to every patient in need.

DEPARTMENT OF COMMUNICATION DISORDERS

The average professional complement for the year was three full-time and one part-time staff members. Mr. T. Rackley was appointed full-time clinical audiologist in March, 1968, so that for the first time a program of auditory assessment and rehabilitation has been offered.

Total treatment units for 1968 were 60,744 (as compared to 43,413 in 1967); of these in-patients accounted for 6,315 units and out-patients, 54,439. From further examination of the unit system, it is estimated that some 90 percent of assessments and treatment was provided for out-patients.

A total of 1,071 patients were admitted to this department for assessment and/or therapy, and 700 of these were hearing disabilities. Patients with speech disorders form the significant proportion of long-term therapy and for those with hearing impairment, the majority are seen on a short-term basis for initial assessment and subsequent rehabilitation.

Audiology service includes hearing aid evaluation and rehabilitation.

In addition to clinical duties, the staff have participated in many meetings and panel discussions. They have also been involved in various lectures and training programs. In-service training to one student in speech pathology and audiology has been given during the year. Much counselling and rehabilitation work has been provided to patients of many other institutions and agencies. These include the Children's Hospital of Winnipeg, S. C. C. A., and the Child Guidance Clinic of Greater Winnipeg. Children and adults from as far afield as Ontario and Minnesota have been seen in the department.

Over the year the department has acquired a Bekesy audiometer, Language Master and two Ekstein desk auditory trainers.

A pilot-research project in Diabetes Mellitus and Sensory Function has been started under the guidance of Dr. John Moorhouse of the Winnipeg General Hospital.

CONSULTANT SERVICES

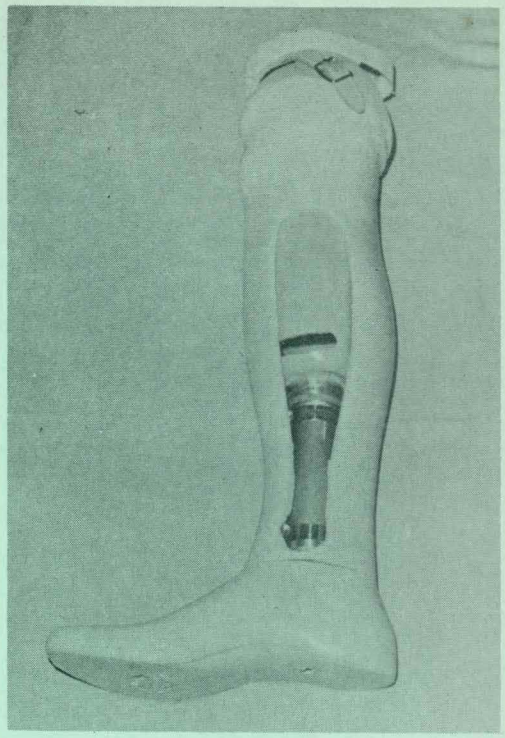
We are grateful to the members of the consultant and active staff who visit the hospital regularly for assessment and treatment of patients. The mainstay of the Consultant Services in rural hospitals has been Dr. J. F. R. Bowie who, in addition to his various duties in the hospital, has continued regular clinics at the Manitoba School at Portage la Prairie and

at the Dauphin and Swan River Extended Treatment Units.

The Annual Symposium on Orthopaedic Disabilities and Rehabilitation was again held in this hospital. In 1968 the theme was "The Rheumatic Diseases", and an outstanding group of guest speakers participated. The co-sponsorship of the Sanatorium Board in this educational event is greatly appreciated.

Dr. R. R. P. Hayter
Director of Physical Medicine

PROSTHETICS AND ORTHOTICS RESEARCH AND DEVELOPMENT UNIT



Prosthesis for shank amputee, showing internal parts. Assembly begins with putting wedge-disc alignment unit on a Sach foot, then using aluminum tubes to connect foot to socket.

Since it was established five years ago (under a grant from the Department of National Health and Welfare), our Prosthetics and Orthotics Research and Development Unit has gained international renown for its contributions to the art of making artificial limbs and braces. Perhaps the finest of these achievements is the Winnipeg Modular System of Prostheses, which has been developed for three levels of lower extremity amputees and consists of simple prefabricated parts connecting foot to socket and encased in one piece cosmetic covers. Because of its easy assembly, adjustability and choice of function, this pylon system of prosthetics has done much to speed up and streamline the rehabilitation process and makes it possible to provide artificial limbs to almost all amputees, regardless of age or physical condition. This approach to the fabrication of prosthetics and orthotics will be the way of the future, according to the unit's technical director, James Foort. "That we are not alone in this belief is indicated by research engineers in other countries who are following in our footsteps and developing other modular systems of prosthetics".

Besides, the modular system, PORDU has developed or is currently working on other design items, largely in response to requests from clinicians. These include a series of prefabricated sockets (for children and adults), an electronic device for aligning prostheses, a cable recovery unit for improving prosthetic arm function, an electric cart for children with quadruple limb deficiencies (which will traverse rough ground and climb curbs), plastic back braces, two types of Perthes braces and a series of plastic-metal splints for arthritis patients. The four engineers and engineering technicians, who comprise the nucleus of this unit, have also collaborated with other Canadian research units in several special projects, including the development of implant units for the control of artificial arms.

With respect to education, PORDU has conducted a number of short courses plus demonstrations and lecture series, workshops and symposia. Hundreds of people over a wide geographical area have been influenced to some degree by this educational program, and some 20 technicians with previous experience in the field have received further training and clinical practice.

SPECIAL REHABILITATION SERVICES
Pembina House, Ninette

L. Kuzenko

In 1968, Special Rehabilitation Services for the socially and vocationally handicapped experienced changes in policy, expansion of facilities and consolidation of services. With these changes, the philosophy of rehabilitation was maintained and efforts were made to place greater emphasis on the individually centred approach.

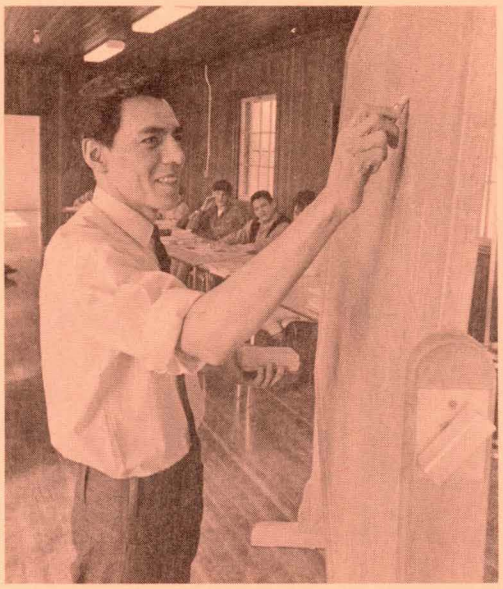
On September 1, 1968, rehabilitants began intensive assessment and training. A new position, Supervisor of Services, was created which meant clients would undergo complete psychological and social assessment. It was felt the assessment program should be of three weeks duration and the length of social training would depend on the recommendations of the initial assessment.

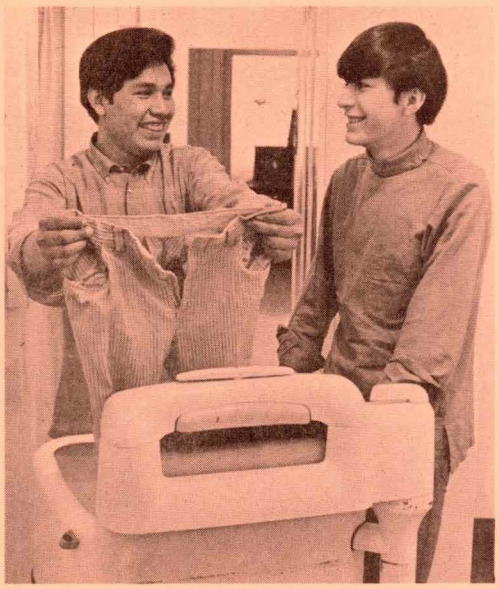
During the year the continued dedication of the staff has enabled Pembina House to expand the list of extra-curricular activities. New activities for 1968 included home economics, physical education classes for males and females, sex education, swimming classes and a first aid course. Speakers from various walks of life created an upsurge of interest in social training and had a marked effect on this program.

The continued interest of the Department of Health and Social Services, the Department of Indian Affairs and Northern Development, provincial Probation Services and other agencies has been a great asset in the development of the total program.

PEMBINA HOUSE

Composition - of the 154 persons admitted to the program, 54 were





Winnipeg Tribune Photos

female and 100 were males. There were six unmarried mothers, five of the men were married. Again of the 154, 88 were Treaty Indians, 65 were non-Indians and one was an Eskimo. With respect to age group, 133 were between 16 and 20 years old, 18 were between 21 and 30 and three were 31 years of age or over.

Academic Level on Admission: No formal education, two persons; grades one to four, 29; grades five to eight, 114; grade 9 or over, nine.

Work Experience on Admission: No work experience, 75; one year or less work experience, 59; more than one year, 20.

Delinquencies on Admission: 35 of the 154 rehabilitants had been charged with minor offences, 30 with serious offences, and the remaining 89 had not been involved with the law.

DISPOSITION OF CASES

(a)	Graduate B. T. S. D. level II at Pembina House ...	30
(b)	Job Placement	50
	- Still working..... 40.....	
(c)	Vocational training.....	19
	- Graduated or still attending 13	
(d)	Provincial upgrading classes	36
	- Graduated or still attending 26	
(e)	Withdrew	25
(f)	After assessment transferred to other agencies .	12

MANITOBA SANATORIUM

The social service program co-ordinates the available community resources and maintains a liaison between the medical team, teaching staff and the patients. A rehabilitation plan is formulated if the individual appears to have the ability to take ongoing training or employment. The worker also obtains details on the patient's home conditions and makes plans for his eventual discharge.

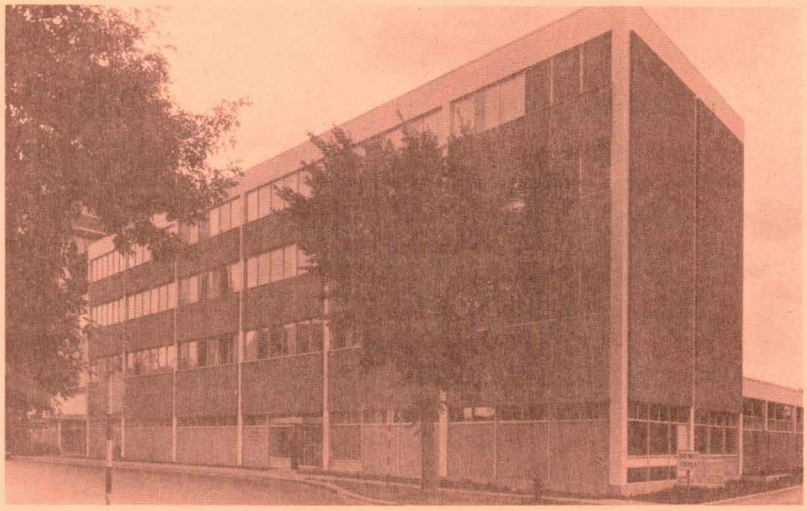
The following statistics were recorded:

ACADEMIC

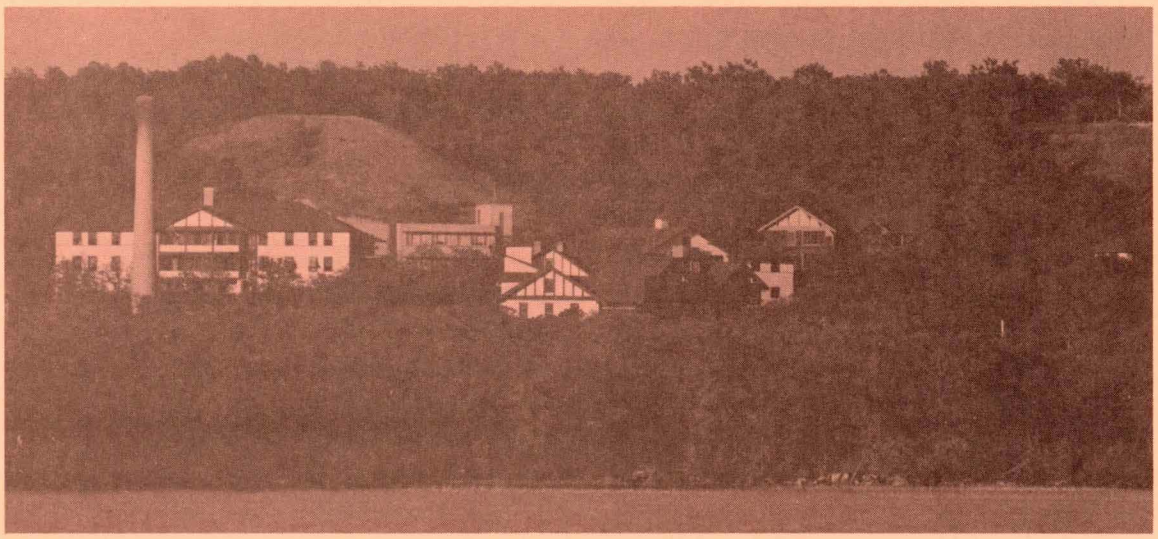
No. of students enrolled January 1, 1968	65	
No. of new students registed during the year	67	
No. of students reinstated during the year	5	137
Less:		
No. of students discontinuing study		
1. For discharge	85	
2. For lack of interest	0	
3. For medical reasons	5	90
No. of students enrolled at year's end		47

Lynn Kuzenko
Director
Special Rehabilitation Services

Manitoba Rehabilitation Hospital, Winnipeg



The David A.
Stewart Centre,
Winnipeg



Manitoba Sanatorium, Ninette

NURSING DEPARTMENTS

E. L. M. Thorpe

Nineteen hundred and sixty-eight was a very satisfactory year. The supply of nurses was better than it had been for a very long time and the turnover of staff, as a consequence, was much reduced.

Manitoba Rehabilitation Hospital: Miss V. R. Peacock very ably continued to perform the duties of acting Director of Nursing, and was given excellent support by our Day, Night and Evening Supervisors, Head Nurses, and indeed, all members of our nursing staff. The standard of nursing care in the Manitoba Rehabilitation Hospital remains at a very high level and is due to a cohesive approach by a dedicated team of people.

Mrs. Doris Setter continues to direct the post-graduate and in-service education programs and achieves excellent results with all levels of personnel. Mrs. E. Stevenson and Mrs. D. Ramsay devote a great deal of time to orientation programs, helping new staff to adjust to the concepts of rehabilitation nursing. Mrs. Ramsay, who successfully completed in 1968 the Nursing Unit Administration course offered by the Canadian Hospital Association, takes a special interest in junior staff in the course of her work as Clinical Instructor. Mrs. Atkinson (Central Supply), Mrs. Burr (R5), Mrs. Thomas (R4), Miss Appleby (R6) and Mrs. Weigart (Out-patients Department) are specially commended for the valuable contribution they made to the continuity of patient care.

The David A. Stewart Centre: If consolidation and continuity have been the predominant themes in the Manitoba Rehabilitation Hospital, the

situation at the D. A. Stewart Centre has been one of response to the demands of change. Our senior staff are to be commended for the adaptability they have so ably demonstrated.

Manitoba Sanatorium: Miss D. Ellis retired from her position as Director of Nursing in May, 1968, and was succeeded by Mr. William Broadhead, Day Supervisor and Nursing Instructor at Manitoba Sanatorium for many years. Miss D. Lewis assumed the position of Nursing Instructor, with responsibility for the in-service education of non-professional staff and the orientation of all grades of new personnel.

CONTRIBUTIONS TO NURSING EDUCATION

Members of our nursing staff continue to make valuable contributions to nursing education. Twenty-one registered nurses completed courses in Rehabilitation Nursing during 1968. In addition to this, groups of student nurses from the Winnipeg General Hospital, St. Boniface General Hospital, The Grace General Hospital, Brandon General Hospital and the Hospital for Mental Diseases, Selkirk, visited the Manitoba Rehabilitation Hospital during the year.

Post-graduate Experience: Just as other people come to us, so do we go elsewhere, looking, seeing, learning, hoping to add to our skills. Visiting the United States, Miss Thorpe and Miss Peacock attended the 10th Anniversary "At Home" at the Rehabilitation Institute at Grand Forks, North Dakota. Mrs. D. Setter and Mrs. P. Torgerson attended the two day Nurses' Institute on Inhalation Therapy arranged by the General Extension Division of the University of Minnesota at Minneapolis.

The 1968 National Nurses' Institute, sponsored by the Canadian Tuberculosis Association and the Sanatorium Board of Manitoba, was held in the auditorium of the Manitoba Rehabilitation Hospital on April 8 and 9. Over 320 nurses attended this Institute and it was a case of "standing room only". I should like to pay a very sincere tribute to all those members of the Sanatorium Board staff who contributed so much to the success of this very important event.

OBITUARY

Mrs. Irene Cruikshank, who was for thirty years a devoted member of the staff of the Sanatorium Board of Manitoba, and continued as Director of Nursing at Assiniboine Hospital, Brandon, after the Board relinquished the control of this hospital, died unexpectedly and prematurely, at Brandon on February 25th, 1968.

ACTIVITIES OF THE NURSING CONSULTANT

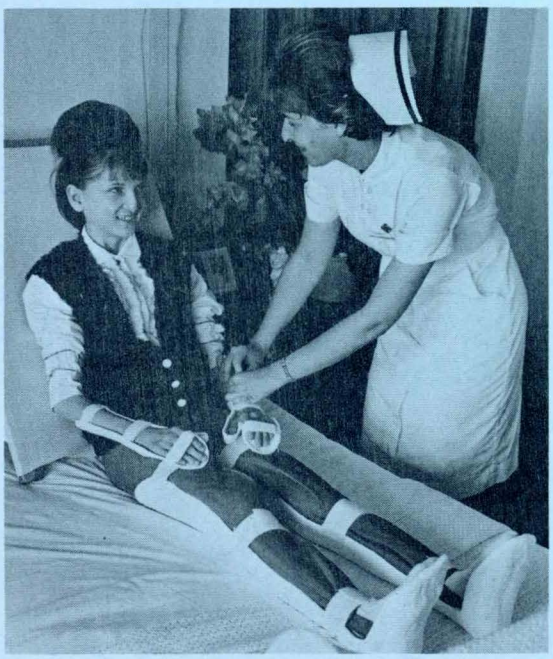
Activities of the Nursing Consultant included: Chairmanship of the

Planning Committee, 1968 National Nurses' Institute entitled the Dynamics of Respiratory Disease Nursing; guest speaker at the luncheon meeting, Nurses' Section, Canadian Tuberculosis and Respiratory Disease Association Annual General Meeting, Vancouver, June 16, completed the Hospital Organization and Management Course offered by the Canadian Hospital Association; completed further courses at the University of Manitoba.

As we move into the era of Medicare and expansion of health facilities, new challenges will be met by our nursing staff, with the emphasis shifting to prevention and preservation of health.

There is no better way to conclude this report than to quote from the address of Prevention of Illness made by our Executive Director, Mr. T. A. J. Cunnings, to the guests attending the dinner meeting of the 1968 National Nurses'Institute, at the Maryland Hotel, on April 9. "Health is related closely to the quality of the individual's personal inter-actions, to his self-discipline, to the principles of moderation, to judgement in meeting life's fortunes or misfortunes with equanimity, as well as to hygiene, nutrition and the practice of safety. It involves the freedom and the responsibility of the individual to select appropriate alternatives of behaviour and act upon them."

E. L. M. Thorpe, R. N.,
Nursing Consultant and
Administrative Assistant



RIDDELL, STEAD, GRAHAM & HUTCHISON
CHARTERED ACCOUNTANTS

804-220 PORTAGE AVENUE
WINNIPEG 1, 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 31st, 1968. 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 able to confirm the Manitoba Hospital Commission operating deficits receivable of $ 28,106 as such amounts are subject to final settlement.

Subject to such adjustments, if any, which may arise from the settlement of the accounts with the Manitoba Hospital Commission, mentioned above, and from the ultimate disposal of the buildings as set out in Note 2 to the financial statements, in our opinion these financial statements present fairly the financial position of the Board as at December 31, 1968, in accordance with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

Riddell, Stead, Graham & Hutchison.

April 11, 1969

COMBINED BALANCE SHEET AS AT DECEMBER 31, 1968

ASSETS

CURRENT ASSETS	1968	1967
Cash	$ 118,611	$ 167,349
Trust funds held for safekeeping	4,225	6,955
Accounts receivable		
Manitoba Hospital Commission		
Patients	10,496	14,340
Deficits from operations	28,106	90,626
Province of Manitoba	55,218	135,288
Other commissions and agencies	230,745	234,194
Other	77,831	50,343
Investments at par value (quoted market value 1968 - $531,265; 1967 - $ 505,610)	581,750	547,750
Inventories at cost	122,575	107,299
Prepaid expense	2,716	6,680
	1,232,273	1,360,824
DUE FROM SCHOOL OF MEDICAL REHABILITATION	9,598	12,581
PROPERTY, PLANT AND EQUIPMENT at cost	6,647,801	6,614,067
Less - Government construction grants	1,886,196	1,886,196
	4,761,605	4,727,871
Less - Accumulated depreciation and amortized capital grants	2,009,888	1,876,488
	2,751,717	2,851,383
UNAMORTIZED BOND DISCOUNT	26,506	29,302
	$4,020,094	$4,254,090

SANATORIUM BOARD OF MANITOBA

LIABILITIES AND BALANCE OF FUND

	1968	1967
CURRENT LIABILITIES		
Bank indebtedness	$ 96,000	$ 82,000
Accounts payable	173,182	156,282
Safekeeping trust funds	4,225	6,955
Unredeemed coupons and accrued interest	20,771	18,873
Current maturities on debentures payable	85,000	85,000
	379,178	349,110
DEBENTURES PAYABLE	2,155,000	2,240,000
UNAMORTIZED CAPITAL GRANTS	46,969	55,219
RESERVES		
Rate stabilization reserve - Department of National Health and Welfare	3,162	75,000
Laundry, building and equipment replacement	15,734	15,796
Employee benefit reserve	36,571	41,571
Other	3,218	6,199
	58,685	138,566
BALANCE OF FUND		
Special funds		
Endowment Fund #1	164,467	332,837
Building Fund	179,795	-
Assiniboine Hospital	291,040	281,684
Other	9,379	10,464
Surplus from operations	494,151	620,541
Construction grants and donations	241,430	225,669
	1,380,262	1,471,195
	$4,020,094	$4,254,090