The SANATORIUM BOARD News Bulletin OF MANITOBA

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For Patients, Staff, and Friends of the Sanatorium Board | AUGUST, 1962

Winnipeg Salesman Sets Example for all Disabled

It was a cold crisp November night.

Thomas W. J. Irwin, an insurance agent, was driving to his Winnipeg home after a busy day visiting clients and prospective customers. On the outskirts of the city he spotted the familiar x-shaped warning. He peered cautiously into the misty darkness, then proceeded ahead.

After that Mr. Irwin remembers very little of what happened. He hadn't seen the diesel engine up the railway track, nor the low, hulking outline of a flat car standing idle in the crossing. The terrific collision blotted all thoughts from his mind.

Rescuers took Mr. Irwin's mangled body from the twisted wreckage and rushed him to the Winnipeg General Hospital. There, after examination, the doctors made the following report: Multiple fractures to both legs and feet, several fractures of the pelvis, dislocation of a number of joints in the back, fractures of the rib cage, left shoulder and right arm. The number of fractures in all—26.

What happened to Mr. Irwin after that and how he effected his own rehabilitation is a study in human determination. When he woke up in hospital encompassed in plaster and bandages, the thought perhaps crossed his mind that he might be permanently crippled. But slowly, as his bones mended, he took hope.

"I took my recovery step by step," he said. "I was determined to do everything possible to get better, to do all I was told.

"Of course I was a lot luckier than some people, for I had no financial worries to bog me down. Practising what I preached, I carried enough accident insurance to see me and my family over the long months ahead."

As his treatment progressed at the General Hospital Mr. Irwin gradually forced his body and limbs back to activity. Finally he was able to make it from his bed to a wheelchair. A fews weeks later he tried out a pair of crutches.

"I didn't do very well on the crutches at first," he said. "But it was a big step forward, and it occurred to me that if I could learn to manage on crutches I might one day make it onto the canes."

On May 7 Mr. Irwin was among the first in-patients to be admitted to the newly opened Manitoba Rehabilitation Hospital. He arrived at the hospital in his wheelchair.

The following day he began his program of treatment.

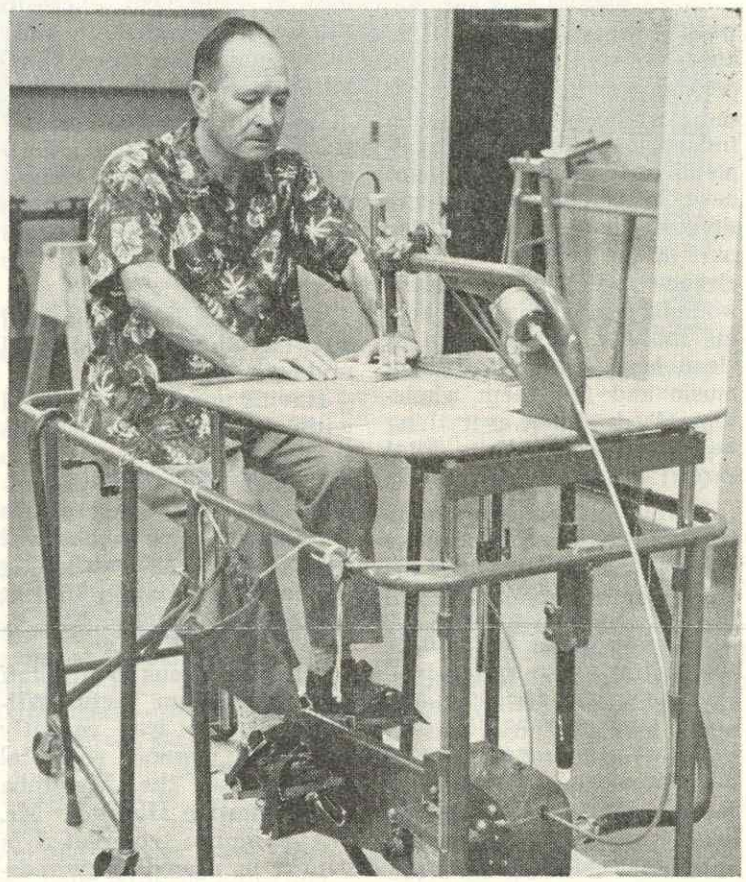
"When Mr. Irwin entered our department," said his physiotherapist Shannon Stone, "he could, in a prone position, bend his right knee to 70 degrees, and his left to 54 degrees.

"In the beginning his treatment consisted of exercises in the hydrotherapy pool, walking re-education, resistance exercises and active exercises in a leg class. As he improved the program was stepped up and became more difficult."

On May 24 Mr. Irwin started walking on two canes for short periods. By June 4 he could walk without them for half days. A little later he played a game of ping pong standing alone without aid.

During this time he also took treatment in the occupational therapy department. Where his job in the physiotherapy department was to increase his range of movement, his main task in occupational therapy was to sustain this increased range, build up power in his muscles and increase his work tolerance.

Mr. Irwin worked primarily on the Oliver Rehabilitation Machine — a British designed, bicycle-type fret saw machine which has great value for the treatment of persons with disabilities involving the lower limbs. It consists basically of a saw and pedal unit and a seat unit, adjustable horizontally and vertically according to the patient's range of movement and how much power he has to work with. A speedometer and mileometer are also incorporated so that patients and therapists can keep track of how much work they do.



Tom Irwin, who suffered 26 fractures in a car accident, had a lot of fun and exercise "working out" on the Oliver Machine in the Manitoba Rehabilitation Hospital's Occupational Therapy Department. (Photo by The Winnipeg Tribune)

Mr. Irwin doesn't remember how many miles he pedalled on the Oliver, but during the two months in hospital he enthusiastically cut out dozens of wood patterns for other disabled patients.

On June 29, two months after he entered the Manitoba Rehabilitation Hospital, Mr. Irwin was discharged home. Although he was not completely recovered, he had made such fine progress that he walked out of the hospital with the aid of only one cane.

According to the physiotherapist his range of movement had increased to such an extent that he could now bend his right knee to 90 degrees and the left to 80 degress. Lying on his stomach he could also lift a 20-lb. weight on his ankle — about ten times the weight he managed to lift when he entered hospital.

At present Mr. Irwin drives to the hospital three times a

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Hospital Has Economic Role In Community

Apart from the human considerations in hospital work, hospital operations represent a significant economic factor in the Manitoba community, T. A. J. Cunnings, executive director of the Sanatorium Board of Manitoba told a meeting of The Pas Rotary Club on July 25.

To illustrate his statement Mr. Cunnings pointed out that in 1961 the Manitoba Hospital Services Plan paid a total of 33½ mililon dollars for hospital care in this province. In addition, approximately 10,000 persons were employed in the 74 general hospitals, four extended treatment hospitals and other related facilities in 1961, and a total of 175,000 persons were admitted for treatment under M.H.S.P., excluding the 55,000 persons who received care as outpatients.

Many millions of dollars were spent on hospital construction during 1961.

This is an important flow in the business world, the director said. In some places hospitals provide one of the main community industries.

For example, the Sanatorium Board of Manitoba, which has a total of 804 beds for the

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The Great Barber Surgeon

Many of us are inclined to think that rehabilitation in medicine is a relatively new thing, introduced during this century following the two great wars. Actually rehabilitative measures have been practised in some form or other ever since primitive man discovered that a splint placed alongside an injured limb gave considerable relief, or that a crude crutch enabled him to get around.

The Chinese, for example, are said to have employed remedial exercises as early as 3000 B.C., and in ancient Egypt, Greece and Rome the temples of the gods were often used as hospitals where the sick were administered to both in body and soul. Here, in addition to medicaments, priests treated disease by such measures as sunlight, fresh air, exercise, diet, massage and what we know today as hydrotherapy. Even so the great Hippocrates employed baths and fomentations, devised special boots for deformed feet and gave much sound advice. "Exercise strengthens," he wrote. "Inactivity wastes."

But it was, perhaps, a Renaissance barber surgeon named Ambroise Pare who was the greatest forerunner of modern rehabilitation. Pare, a Frenchman, was born about 200 years after the invention of gunpowder (which is also said to have been a potent force in the devolpment of rehabilitative measures), and he lived during one of the most turbulent times in history. During his life he witnessed the great struggle for supremacy between Francis I of France and Emperor Charles V. A few years after his birth in 1510 Martin Luther nailed his 95 theses to a church door in Wittenberg; and two years before his death the English fleet drove the Spanish Armada into the sea.

Pare was born in Bourg Hersent, the son of a common servant. In 1529 he went to Paris to learn the profession of a barber surgeon. He became a dresser at the Hotel Dieu, the largest and best hospital in Paris at that time, and after three years of training went off to the wars as a lowly surgeon in the army of Francis I. Later, as he became famous, he attached himself to many great men until finally he became chief surgeon to four successive French kings.

One of Pare's earliest achievements was to revolutionize the treatment of gunshot wounds. When he studied surgery on the battlefield the cautery was used to stop hemorrhage and boiling oil, molten pitch or red hot irons were applied to bleeding surfaces, with the result that the healing of wounds was as agonizing as it was slow. Pare discovered that with a simple bandage and soothing ointment (containing among other things the fat of puppies) the wounds healed better and patients suffered less. He later re-introduced the use of ligatures (tying the ends of severed blood vessels together) in amputations as a means of checking bleeding.

Pare's success as a surgeon was the result not only of his operative skill, but even more perhaps of the care and observation he gave his patients. Indeed, it is said that his treatment of patients could not have been bettered by any surgeon living in the latter part of the last century. He cleaned and treated their wounds, massaged their aching muscles, placed them in clean beds, ordered soothing music and fed them wholesome food—doing everything he could to give them total care.

During his lifetime he introduced many other medical innovations. As a result of his work, for example, limb and brace making became an accepted business among the armor makers and locksmiths. He popularized artificial eyes, made artificial noses out of gold, silver or stiff linen, artificial teeth, metal corsets for spinal deformities, walking splints, leg braces and several types of shoes for club feet. He also introduced new methods of treating certain fractures, invented numerous surgical instruments, re-introduced massage, and made great contributions to obstetrics.

Pare spent about 30 years with the army in times of war. In peace time he lived in Paris where he conducted a private practice and wrote voluminously of his work. He died in 1590.

Of Pare one can truly say that he had the finest medical mind of his century. In an age devoted to weird superstition, erroneous anatomy and absurd chemistry, he managed to revive some of the wise teachings of the ancients and introduce numerous reforms. He was a gentle man of great humanity, who administered equally to nobleman and peasant, who in caring for his patients often performed all the offices of physician, surgeon, nurse, apothecary and cook. And invariably, when he remarked on the successful outcome of a case, he used the simple phrase, "I dressed him, God cured him, he went happily on his way."

Roger Butterfield Among Many To Join Sanatorium Board Staff

Among the new staff members we welcome to the Sanatorium Board of Manitoba this month is **Roger Butterfield** who on July 16 began his work as guidance counsellor in the office of Ted Locke, supervisor of Special Rehabilitation Services.

Mr. Butterfield was born and educated in Norquay, Saskatchewan, and worked for a number of years with the Hudson's Bay Company both at their head offices in Winnipeg and at their posts throughout Northern Saskatchewan and Manitoba.

Later he joined the firm of Gardner-Denver Company and for a while had charge of their Fort William office. He returned to Winnipeg as assistant manager of the company.

Mr. Butterfield is married and has three children, all under the age of five.

Having worked and lived with the Indian people, he should be a great asset to our special rehabilitation office. One of his first duties for the next few weeks will be to take over counselling at the Rehabilitation Unit at Assiniboine Hospital.

* * *

Other additions to our staff include **William Victor Williamson** who was recently appointed senior remedial gymnast at the Manitoba Rehabilitation Hospital. Mr. Williamson completed a course in remedial gymnastics in 1946 and before coming to our hospital worked for two years as a remedial gymnast at Misericordia Hospital. Before that he was head remedial gymnast at Municipal Hospitals.

Mrs. Earline Neal has assumed her post as medical technologist in the laboratory of the Rehabilitation Hospital. Born in Biloxi, Mississippi, she is a graduate of the Grady School of Medical Technology in Atlanta, Georgia. She also studied biology for four years at Asbury College in Kentucky. Her husband is Dr. Fred Neal.

On August 1 **Miss Dorothy Prockter** arrived at the Manitoba Rehabilitation Hospital to take over her duties in the Physiotherapy Department. Miss Prockter, who was formerly head of the physiotherapy department at the Winnipeg Clinic, recently returned to Winnipeg from California where she completed a special course in proprioceptive neuromuscular facilitation!

Another new member of the Rehabilitation Hospital staff is **William John Morgan** who has been appointed the stores keeper.

Clearwater Lake Hospital at The Pas welcomed a new member to its nursing staff with the arrival there this month of Miss Cora L. Scott.

Miss Scott was born and educated in Jamaica and for six years taught fine arts and handicrafts to underprivileged boys.

She went to England in 1954, worked for two years as an accountant's secretary, then entered nurses' training at Harefield Hospital in Middlesex. She took two courses in general and chest nursing, completed Part I of her midwifery, then worked for several years in a London thoracic unit.

A talented girl who first thought of ballet as a career, Miss Scott used to get lots of extra work in London dancing with her brother's 14-piece show band.

She has another brother doing agricultural research in Hartford, Conn.

HOSPITAL

(Continued from page 1)

care of the sick and disabled, employs a staff of 135 at its extended treatment and tuberculosis hospital on Clearwater Lake. Many of these people come from the neighboring town of The Pas.

Since the establishment of Clearwater Lake Hospital in 1945, an estimated 5.6 million dollars has been spent on its operation; another one-half million on capital expenditures.

A total of $91,000 has been spent on hospital equipment which, when available, was purchased locally, he said. Food supplies are almost always obtained locally.

In his address to the Rotarians, Mr. Cunnings paid tribute to the staff at Clearwater Lake Hospital and to the service this hospital provides to the people of Northern Manitoba.

The hospital has 71 beds assigned to the care of long-term, chronically ill patients and to patients with respiratory (non-tuberculous) diseases, he said. It also has 58 beds for the treatment of tuberculosis patients, and it operates a fully equipped emergency service for accident cases in the North.

During 1961 the average bed occupancy of the hospital was 87%; around 600 patients were admitted for treatment.

Although the work at the hospital has been carried on under a considerable degree of difficulty, with the hospital suffering acute staff shortages from time to time, Clearwater's quality of patient care has always remained high, he said. The hospital was among the first to be accredited by the Canadian Council on Hospital Accreditation when the council was formed six years ago.

Five TB Cases Discovered By N.E.S. Program

One of the most valuable but perhaps least known tuberculosis preventive services in the city of Winnipeg is the chest x-ray program carried out at the National Employment Service building on Edmonton street.

This service, provided jointly by the NES and the Sanatorium Board of Manitoba and financed through the yearly sale of Christmas Seals, was established last November, and since then, a total of 6,552 persons applying for employment at the office have received free examinations.

That the service has proved valuable is graphically illustrated by the fact that of the total number of people x-rayed during the past eight months, five active cases of tuberculosis have been found.

One of these persons had far-advanced disease, two had moderately active disease and two were minimal. All but one were new cases of tuberculosis and all but one were bacillary (infectious).

As the service is becoming better known to Winnipeg's employers, the number of requests for pre-employment x-rays has increased. At present more than 1,500 firms in the city have asked that applicants starting work with them have a chest x-ray.

The result is that the unit now examines around 1,000 persons a month. The applicant has his x-ray while waiting for an interview, and he is always assured that he will not lose his interview spot.

Remarking on the NES service in his annual report, Dr. E. L. Ross, medical director of the Sanatorium Board, said that the establishment of the program followed a decision by the Sanatorium Board to concentrate more of its preventive efforts on special groups and segments of the population with a higher incidence of disease.

Because tuberculosis can be expected to prevail more among people in poorer economic circumstances, he said, a chest unit was set up . . . among other places . . . at the NES building.

There can be no doubt, he said, that the service is paying off.

Craft Work Is Popular Pastime in Sanatorium

By P.A.H.

On a visit last month to our Manitoba Sanatorium at Ninette, I dropped in at the sanatorium's crafts room to chat for a while with the instructress, Miss Mitzi Newmark, Mitzi's workshop is a favorite haunt of many visitors to the sanatorium, for it is by far one of the most interesting and busiest of any of the sanatorium's departments.

Located in a small, cramped room in the basement of the infirmary, it is fairly bursting with many beautiful things. Finished articles and raw materials line the walls, overflow the shelves, hang suspended from the ceiling and take up nearly ever inch of available floor and table space. But somehow Mitzi knows where everything is and for each article she lays her hands on she can tell a good story about the item and the person who made it.

Small, dark-haired Mitzi has had charge of the crafts department for seven years. She herself was a tuberculosis patient for ten long years during the "pre-drug" era and, except for two years of convalescence in her native Winnipeg, has since made the sanatorium her home. Interested in all types of crafts since childhood, she took a job following her recovery as a part-time crafts instructress at the sanatorium. She took courses in leather work and weaving, gradually mastered a multitude of other crafts, and eventually assumed complete charge of the department. She energetically manages the whole show herself, except for the occasional help of partially recovered patients.

Mitzi is proud of her patients' work — and justly so. For instance, at the Ninette Fair on June 23 they copped 32 handicraft prizes (32 first prizes), and at Winnipeg's Red River Exhibition a week later she sold nearly $350 worth of their work, took orders for a lot more.

But profitable as it has become, craftwork at Manitoba Sanatorium is primarily diversional. The patients like to make things for themselves or give them away as gifts. What they do not want or need they may sell, but they are never encouraged to make profit the sole object . . .

"The moment we make an industry out of craftwork," says Mitzi, "it would cease to become a pleasure . . . just a lot of hard work."

Perhaps the most interesting handicraft at the sanatorium are the Eskimo soapstone carvings. Despite the law laid down by the hospital, this sculpture has become a profitable business, with the Eskimo patients filling orders from all parts of Western Canada and the United States. Indeed, their work is so popular that the carvings are usually sold before they are completed.

At present there are about 20 Eskimos at the sanatorium, but only six are carvers. They turn out their work with no direction from Mitzi: they have, she says, their own natural talent for it.

Working a short time each day (as long as their state of health permits), it takes top carvers from seven to ten days to make a large figure; from three to four days to make a small one. The tools they use are few and simple: a file and knife for the carving, and steel wool and sandpaper for smoothing. As a final touch, fastidious Eskimos will spend many hours rubbing oil into the finished product with their hands.

Nearly all the carvings depict some action: an animal running after his prey, a bird poised for flight, an Eskimo carrying off his kill. And the figures are all complete to the last detail: a kayak, for example, will include very bit of equipment that the Eskimo uses for hunting; a polar bear's mouth will be scooped out to show the tongue and fangs.

Miss Mitzi Newmark, crafts instructress at Manitoba Sanatorium, hands a piece of soft soapstone to one of her Eskimo patients. The quarried stone, brought in from Quebec, is sawn to the dimensions required, then carved by the patient with knife and file.
(Winnipeg Free Press Photo)

For many years soapstone carving at the sanatorium has been done only by the older Eskimo men — but seeing the fun and profit they get out of it, some of the younger men are beginning to take an interest in this primitive art. Even the Indians have tried their hand with the knife and file.

Recently a 60-year-old Indian picked up a piece of the soft soapstone, skillfully carved a big, handsome moose and gleefully registered his satisfaction. "There," he said. "If they can do it, so can I."

"We go along with it," says Mitzi, "for we always encourage a latent skill."

But Mitzi does insist that, like the Eskimo, the Indians carve only those animals they know. As a result the seals and polar bears on the workroom shelves are now sharing space with soapstone otters, bears and hawks.

Soapstone carving, however, is just one of many activities carried out in the department. Nearly all patients who are able get into the act, turning out almost every conceivable form of handicraft. Leathercraft and copper tooling are always tops with the men, and needlepoint, knitting, crocheting and sewing are favorite pastimes for the women.

The children and younger people like to do foam craft, paint figurines and pictures, make ribbon flowers or decorate a picture album.

The Eskimo women turn their talents to making the typical flat-faced Eskimo dolls or weaving colorful costume sashes. Spurning such equipment as looms and shuttles, they simply tie the wool to the ends of their beds and weave the narrow bands with their fingers, making up the intricate patterns as they go along. The result is always superb.

Beadwork and quilting are the traditional crafts of Indian women. Their moose or deerskin moccasins, with the well-known beaded motifs, are loved by all.

Each year the variety of crafts undertaken by sanatorium patients increases. Always on the lookout for new and interesting ways for patients to occupy their time in bed, Mitzi, who is now vacationing in California, hopes to return with more new ideas to make their life at the sanatorium more pleasurable.

Patient handicrafts of all types were displayed by the Sanatorium Board at the Red River Exhibition in June. In charge of the exhibit were Miss Gertrude Manchester, left, head of the sanatorium's teaching department, and Miss Newmark. (Photo by Dave Portigal.)

SETS EXAMPLE

(Continued from page 1)

week to continue physiotherapy treatment as an out-patient. (He bought another car while he was still in hospital.) He also works at strengthening his limbs at home, exercising his legs one hour in bed each morning, one-half hour while waiting for breakfast, and at any other opportune time. "When I sit and chat with friends, I work my legs then, too," he said.

By mid-September Mr. Irwin expects to be back at his insurance job full time. Even now he is gradually resuming business, with clients coming to see him at his home. He gets around considerably, goes shopping with his wife, spends week-ends at the lake, attends a football game.

Of his stay in hospital he has this to say:

"It gave me insight into another kind of world," he said. "A world which the physically sound do not know.

"I discovered that there is a wonderful kinship between handicapped people, a comradeship that makes disabled people who are total strangers stop to exchange greetings and small talk on the street.

"It was a real experience in living. I developed lasting friendships in the hospital both with other patients and the members of the staff who worked hard for my recovery and gave me encouragement."

And throughout the whole time Mr. Irwin set an exemplary pattern for others. Here was a man who was successful in achieving the aims of our hospital; who, in striving "to live and work to his utmost capacity", actually went beyond what he himself thought possible. He was willing to work hard at his own rehabilitation and because he became such a willing partner in his treatment, made it a pleasure for the other team members to help him achieve his goal.

He was determined to make the best out of every situation. Confined to hospital on his wife's birthday, he held a little dinner for her in the hospital cafeteria.

He never lost his sense of humor, never failed to bolster the spirits of other patients. "We've had 50 years of good health," he once told another patient. "So we shouldn't complain if we have one or two bad ones now."

Outside the hospital Mr. Irwin misses his friends. "I went into a supermarket one day," he said. "I was completely lost. There wasn't one other fellow there in a wheelchair or on crutches."

This 'n That

We sympathized the other day with a friend who came in to work with a severe toothache. "Stop fussing," he said bleakly. "It's my own fault. If I'd seen a dentist six months ago, I'd never be in this misery now!"

Of course we had to agree —just as we also must agree with Dr. Leonard W. Larson, newly elected president of the American Medical Association, who took a swipe at people who fail to make use of medical services now available in the community.

"When I was installed as president of the AMA," he said in a national American magazine, "the first questions asked me were: What's going to be the next big breakthrough in medicine? Is there a cancer cure in sight? What major advances do you foresee in the treatment of heart ills?"

While these reflect an awareness of health problems, said Dr. Larsen, they also show a "fairyland wish for miracle cures and overnight solutions to age-old problems.

"Such wonders may well come from research laboratories — but it is more realistic for us to prepare for a long, step-by-step advance against the complex diseases we find ourselves battling today.

"And it would be even more realistic if we could correct another serious area where people are going wrong in health: ignoring the miracle cures' or at least, the many practical aids we already have available to us."

Using tuberculosis as an example, Dr. Larson said that many people do not take advantage of TB preventive services. Why? Because the dreaded white plague of our grandparents day has already been "conquered" in the minds of many.

"These optimists should learn a stern lesson of medicine," he continued. "Research alone conquers no disease — if conquered at all, it is by research plus the cooperation of the public in using the results of research."

Tuberculosis, he said, is still the chief killer-disease of Americans between 15 and 34; it kills about 12,000 each year. Although the death rate has been reduced drastically, it could be cut even further if more people took full advantage of early detection methods and new treatment measures.

Speaking about "breakthroughs" in heart disease, Dr. Larson said that there have been some — but not of headline catching variety.

A doctor can't prescribe a pill to prevent heart disease, he said, but he can give guidance once he knows a patient's family history and living habits. He knows the dangers of overweight, unbalanced diets, lack of exercise, too much drinking and smoking, and he can prescribe moderate routines as preventive measures.

He also can detect heart damage and prescribe a number of remedies, from drugs to diets to surgery.

"He can, that is, if given a chance!"

But it's the phrase "given a chance" that points up the failure of many to take advantage of preventives and cures available, said Dr. Larson. "Despite tremendous campaigns, few people see their doctors for check-ups — even when some danger signs become apparent.

"So if I, or any other doctor, look sour when asked about solving some complex health problem, it isn't that we think solutions are impossible. It's just that we wonder if our questioners won't eventually be victims of a disease already beaten — except for that fact that there is no medical miracle that will drag the patient to the cure."

Old Red Duster

The two staff members were looking at the flag fluttering from atop our rehabilitation hospital's new flag pole.

"It looks beautiful," she said. "I can't understand why Canadians don't accept it as their national flag. Other countries do."

"Impossible," he answered flatly. "It's just an old Merchant Marine flag Canadians fly for want of something else . . ."

And so the argument goes, and has been going for as long as anyone cares to remember. Almost since Confederation, the old Red Ensign, or Red Duster as some call it, has been the centre of much stormy controversy.

It is true that the Red Ensign, with the plain red field, is an old naval flag. It first came into use in the British navy sometime before 1633. By the middle of that century the British merchant marine began to use it, and by 1674 they were ordered to do so by proclamation.

Two hundred years later, in 1867, Canadian naval men, flushed with pride over their new nation, began to fly an ensign of their own design . . . but on land the people could not care less about a flag.

Indeed, at the time of Confederation, many Canadians were so disgruntled about the new union that in some places they flew the Union Jack at half mast and in others, tore it down. A few newspapers even printed black borders around headlines that told of the birth of a new Dominion.

The new Red Ensign of the Canadian navy sported a special emblem in the field so that their vessels might be identified as truly Canadian. The emblem was the coats of arms of the four provinces which had been confederated. The British admiralty took a rather dim view of all this, but in 1892 reluctantly gave them official permission to use the flag — but only at sea.

Even then other countries were slow to recognize it: when a Canadian ship called the Emma S. sailed into Bermuda in 1895, a customs officer gave the flag one disgusted look and ordered it hauled down and surrendered.

As more provinces entered Confederation, their coats of arms joined the others on the Red Ensign, so that by 1920 the field had become so cluttered that it was almost impossible to recognize. In 1921, however, the matter was simplified when the new arms of Canada was granted by Royal Proclamation and the main portion of these were inserted on the flag.

Thus today, our flag looks like this: A red background with the Union Jack in the upper corner near the staff and the arms in the fly. The arms comprise the three golden lions in the red field of England, the red lion and tressure on the golden ground of Scotland, the golden harp on the blue of Ireland and the three golden fleur-de-lis on the blue of Royal France. To give the flag a Canadian touch, green maple leaves were inserted beneath on a white background.

Although the Red Ensign is widely recognized abroad, it has not won much recognition at home. It has been carried into battle, to the Olympic games and to the United Nations. It even received special status here when on V-E Day it was flown from the Peace Tower in Ottawa.

Yet many Canadians still feel that it belongs at sea. They want, they say, a distinctive national flag they can fly on land.

Liberal Prime Minister Mackenzie King was among the first to take the flag issue to Parliament, but the attempt to replace the Union Jack caused such a furor with the IODE, Veterans' Associations and Orangemen that he was doomed to failure from the start.

His flag committee split on racial lines — the French members wanted a red and white flag with a green maple leaf, while the English wanted a variation of the Red Ensign with a maple leaf.

More than 2,000 flag designs were submitted to Parliament in 1946 and finally a Red Ensign with a golden maple leaf bordered in white on the field was selected. However, the government didn't act on the committee's choice, possibly for fear of losing French votes since Quebec was violently opposed to including the Union Jack anywhere in the field.

Since then thousands of other designs have been submitted to parliament, each with many different symbols. With the influx of immigrants into the country in recent years, one can no longer say that the Canadian people are made up primarily of British, Irish and French stock. This makes the selection of symbols a little difficult.

One wag has suggested that a new Canadian flag might include a beaver, wearing a British Crown, sitting up in a maple tree chewing fleur-de-lis. Under this, he said, there could perhaps be a ring of American dollar bills. And to represent the various ethnic groups in Canada, a cabbage roll might be inserted in the upper left corner.

But until these matters are settled, many of us will go on enjoying the sight of the old badgered Ensign. It did look rather beautiful that day, billowing out proudly from our hospital's new flag pole.

Patients Take Heed

The following letter, written by a doctor, appeared in the South African Tuberculosis Association's magazine.

"Take Regina Melhewana as an example. Before Christmas she approached me for leave. I explained to her that she was a danger to others because of her positive sputum and that she was a seriously ill woman. I refused to let her go. Subsequently she walked out. On January 9 she returned to Orsmond Centre *in extremis* and died the same day."

This is a very sad story, but, unfortunately, one that is well known. Some tuberculosis patients will not realize that is essential to complete their treatment and remain in hospital until they are discharged. The doctor knows the nature of the illness and the course it will take. He won't keep a patient in hospital longer than necessary.

People with TB who leave hospital too early and discontinue their treatment usually suffer a relapse — often a serious one.

So TB patients take warning. Complete your prescribed treatment in hospital and when you eventually leave carry out the doctor's instructions regarding attending the out-patient clinic. TB is a serious and dangerous disease which cannot be cured in a few weeks.

Bulletin Board

The newly appointed Medical Advisory Committee to the Sanatorium Board of Manitoba held their first meeting on July 26. The six new members of the committee are: Dr. F. Hartley Smith, chairman; Dr. J. E. Hudson, Hamiota; Dr. H. S. Evans, Brandon; Dr. L. R. Rabson, Dr. C. B. Schoemperlen and Dr. F. R. Tucker.

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The Sanatorium Board of Manitoba is most grateful to the Salvation Army Band in Winnipeg who arrived at the Manitoba Rehabilitation Hospital one warm evening last month to hold an outdoor concert for patients.

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Dr. L. P. Lansdown, director of the Provincial Laboratory, has been appointed Chief of Laboratory Services at the Manitoba Rehabilitation Hospital and the Central Tuberculosis Clinic.

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Among the recent visitors to the Rehabilitation Hospital during the past month were Miss M. E. Hart, Director of Nursing Education at the University of Manitoba, who toured the hospital on July 27, and Miss Lillian E. Pettigrew, executive secretary of the Manitoba Association of Registered Nurses, and Mrs. Helen Preston Glass, educational secretary, who visited the hospital August 1.

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Thirty-four Eskimos were admitted late last month to the tuberculosis section of our Clearwater Lake Hospital at The Pas. The Eskimos were picked up on an Arctic survey.

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Edward Dubinsky, executive assistant of the Sanatorium Board, was one of two directors appointed to represent Manitoba at the Upper Midwest Hospital Conference. Manitoba is the only province belonging to this five-state organization.

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The Sanatorium Board heartily congratulates Mrs. Marjorie Boorman, secretary to the manager of the Rehabilitation Hospital, who has a leading role in the Caravan Players' production of "Blithe Spirit" to open September 24 at the Club Morocco. Last month Mrs. Boorman gave a splendid performance at Rainbow Stage as Mrs. Paroo in "The Music Man."