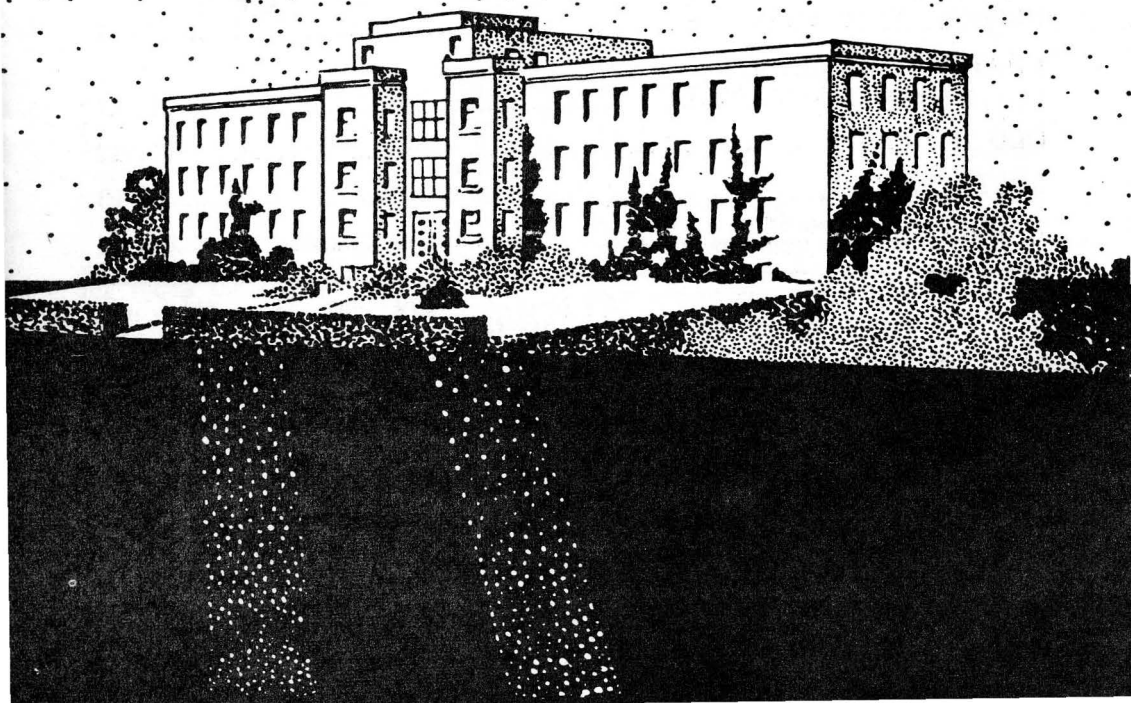
NOVA SCOTIA SANATORIUM
VOL. 49 NOVEMBER, 1968 NO. 10

Health Rays



HEALTH RAYS

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Authorized as Second Class Mail, Post Office Department, Ottawa

Published monthly by the Nova Scotia Sanatorium, Kentville, N. S., in the interests of better health, and as a contribution to the anti-tuberculosis campaign.

SUBSCRIPTION RATES ..... *25 cents per copy* ..... *$2.00 per year*

Printed by The Register, Berwick, N. S.

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Sanatorium Visiting Hours

NOVA SCOTIA SANATORIUM		POINT EDWARD HOSPITAL	
DAILY:	10:15 — 11:45 A.M.	Monday — Saturday:	3:30-4:30; 7:30-8:30 P.M.
DAILY:	3:15 — 4:45 P.M.	Sunday and Holidays:	3:00-4:30; 7:00-8:30 P.M.
DAILY:	7:30 — 8:30 P.M.		

Absolutely NO VISITORS permitted during

QUIET REST PERIOD 1:00 P.M. - 3:00 P.M.

Patients are asked to notify friends and relatives to this effect.

The Sanatorium Cracker Barrel

J. E. HILTZ, M.D.

Our congratulations are extended to Mr. Hector McKean who is in charge of our Medical Records Department. At the recent annual meeting of the Nova Scotia Association of Medical Records Librarians he was elected their President for the coming year. Not only is this a tribute to Mr. McKean's ability and popularity, it constitutes a "first" as there has never been another man elected as President of any provincial branch of the Association. At last, men are getting equal righs!

Congratulations, too, are extended to Mrs. Catherine Boyle, our Director of Nursing Education, who was elected President of the Valley Branch of the Registered Nurses Association at their June meeting. Miss Vilda Skerry, supervisor on our surgical floor, was elected first Vice-President. We know that the Branch has made fine choices. This is another indication of the part played in community affairs by staff members.

* * * * *

On Monday and Tueday, October 21 and 22. over 200 staff members of the Department of Public Health met at the Nova Scotia Sanatorium. There were cars parked from the top of the east hill right around to the main parking lot by the Power House. Miss Quinlan and the other members of her dietary staff did a magnificent job of feeding these two hundred extras at noon hour both days.

The staff at the Dormitory also did an excellent piece of work in providing meeting rooms for sections on Tuesday, and again on Thursday. This latter was part of the program of the Nova Scotia Branch of the Canadian Public Health Association, the annual meeting of which was held at the Cornwallis Inn on Wednesday and Thursday.

We are pleased that we, at the Sanatorium, were given this opportunity to play a part in these two important annual meetings. Many of the Sanatorium staff members were in attendance at most of the sessions.

* * * * *

We welcome to the teaching staff of our Department of Nursing Education, Mr. Joseph LeBlanc, R.N., who previously was Director of Nursing Education at the Nova Scotia Hospital. Mrs. Catherine Boyle, R.N., Director, Miss Elizabeth McPhail, R.N., and Mr. LeBlanc, augmented on a temporary basis by Miss Vilda Skerry, R.N., form a very strong teaching team. We do not claim that our Department of Nursing Education is the best, but we are convinced that there is none better.

* * * * *

It was my privilege during the week of October 14 to attend a postgraduate course on Lung Dust Diseases, especially Coal Workers Pneumoconiosis. This was sponsored by the American College of Chest Physicians and was held in Pittsburg. There were 75 persons in attendance, six of them Canadians and three of them from Nova Scotia, Dr. Charles Gordon, Dr. Donald Grant, and myself.

* * * * *

The Nova Scotia Thoracic Society met at the Nova Scotia Sanatorium on Tuesday evening, October 22. Dr. E. W. Crosson reported on a postgraduate course which he attended earlier in the year in Pittsburg. This course dealt with the intensive care of acute diseases. Mr. Hector McKean, who is in charge of our Medical Records Department, gave a paper on Tuberculosis Discovered in General Hospitals, and Doctor Quinlan gave a historical review of the work at the Sanatorium over the years 1904 to 1947.

Our congratulations are extended to the two newly elected officers of the Society, Dr. C. Edwin Kinley of Halifax, President, and Dr. Charles C. Gordon of Halifax, Vice-President. Mr. Ralph Ricketts of the Nova Scotia Tuberculosis Association continues as Secretary - Treasurer. It was a pleasure for the Sanatorium staff to host this well-attended meeting.

As is evident from the above comments, professional education involves an appreciable amount of time and effort on the part of staff members. This, in turn, is reflected in careful and effective treatment for our patients in keeping with modern times and modern trends.

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Quite a number of our patients recently have been receiving three or four tuberculin tests all at one time. This is because we are trying to determine just what part

(Continued on Page 5)

Breathing Machines

E. W. Crosson, M.D. — Nova Scotia Sanatorium

The history of breathing machines is a rather long one and was probably filled with many disappointments for those attempting to develop such instruments. All the various types of such machines cannot be discussed at this time but the so-called Iron Lung deserves some mention, especially to show the advances which have been made in manufacturing such machines over the past few years and to demonstrate the vast diferences in the mode of operation of that machine and those used today.

The Iron Lung, or Drinker Respirator, to give it its proper name, was a large cylinder in which the patient was placed with only his head on the outside. The method of operation was an electric motor that operated a bellows which, in turn, produced an alternating positive and negative pressure within the respirator. This had the effect of expanding and contracting the chest and so moving air in and out of the patient's lungs. One of the most marked disadvantages of this respirator was the very difficult task of providing nursing care for the patient who was almost completely encased within the respirator. However, before we write this machine off as essentially useless by today's standards, we must remember that it did yeoman service during the many severe polio epidemics of some few years ago.

In contrast to the immense, bulky Drinker Respirator which was large enough to accommodate within it a large patient, the working parts of our breathing machines are contained in a small box-like structure measuring only 7½ x 5 x 5 inches. A heavy electric motor is not required to operate these machines as they are powered by gas under pressure, either oxygen or air. A small tube from the respirator delivers the oxygen and / or prescribed medications to the patient. Properly these machines are known as Intermittent Positive Pressure Breathing (I.P.P.B.) Respirators but the term "breathing machines" is used in this article as it is the name so applied by many of our patients.

An attempt will now be made to explain how these respirators work. The term I.P.P.B. means that as the patient breathes in (inspiratory phase of respiration) the gas and medication are delivered to the patient under pressure. This pressure is pre-set on a respirator dial and can be altered according to the patient's needs. When the pre-set pressure is reached the respirator stops automatically and the patient then breathes out (exhalation phase of respiration) against normal atmospheric pressure. It is evident, therefore, that the pressure is applied or delivered intermittently as the breathing continues. This cycle is repeated again and again indefinitely.

Mention has already been made of medications given by means of these respirators. Some explanation of how this is done is probably in order. Situated in the tube leading from the respirator to the patient is a small container called a nebulizer. Various liquid medications can be placed in this and as the gas passes through the nebulizer under pressure the liquid is broken up into very small droplets which are carried into the patient's lungs. Because these droplets are exceedingly small and are delivered under pressure it can be seen that this medication can now be delivered to all parts of the patient's lungs. Some of the type of medications used are antibiotics (to control infection), bronchodilators (medication used to enlarge the air passages), and mucolytic agents (medications used to make the secretions more liquid and thus more easily raised).

These respirators are simple to operate and cause no discomfort to the patient. However, the use should be under the control of a physician who decides upon the appropriate pressure setting, the proper medications, and length of time for certain types of treatments. Well-trained technicians are also required to see that each part of the treatment program is carried out and to be sure that the respirators are in good working order.

Before discussing specific treatment procedures, it should be mentioned that the gas and medications may be delivered to the patient by any one of a number of methods. A simple mouth-piece may be used for many treatments in the conscious

patient who is able to hold his mouth-piece firmly in place. A mask covering the mouth and nose may be used in an unconscious patient or in one who has difficulty holding a mouth-piece firmly in his mouth. This mask, I may add, is usually the first method of treatment in emergency cases.

A tube (endotracheal tube) may be introduced through the patient's mouth into the trachea (main air passage) and the respirator connected to this. There is also a nasotracheal tube which, as the name applies, is introduced through the nose into the trachea and once again the respirator is connected to this tube. For long-term treatment a small opening is made in the trachea and a tracheostomy tube is introduced into it. The respirator is connected to this.

These respirators may be used for treatment of a variety of disease conditions or chest injuries as well as a method of collecting sputum for special examination.

In any chest disease it is of utmost importance when making a diagnosis to collect specimens of sputum from the actual site of disease. In spite of the fact that a person may have quite marked lung disease, he may be able to produce little or no sputum. By introducing a bronchodilator and a mucolytic agent by means of a respirator, we frequently see a marked temporary increase in sputum production. These specimens can now be examined for various types of bacteria or in the case of suspected cancer for abnormal tissue cells.

Diseases such as asthma, chronic bronchitis, and emphysema are frequently treated in the same general manner, often using the same medications as previously mentioned. In bronchitis and emphysema it is usually these thick secretions in the lungs that cause the patient much difficulty, and there may also be some construction of the bronchi or breathing tubes. Treatment periods on the respirator of about 15 minutes once or twice daily often bring about very marked relief and assist greatly in clearing thick secretions from the lungs.

At the Sanatorium we frequently see cases of pneumonia that have improved slowly or not at all on treatment with various antibiotics that were given by injection or by mouth prior to admission. Some cases actually had progressed to the formation of lung abscess. Using a respirator, we can administer various antibiotics by inhalation with extremely good results. In the case of lung abscess, this type of treatment frequently brings about such good results that surgery is not necessary.

The respirators are frequently used following surgery, usually chest or abdominal operations. Sometimes after such operations the patient does not breathe deeply because of the pain so produced. This results in areas of the lung becoming airless and collapsed. These areas may be small and multiple, but are often quite large. The term applied to such a condition is atelectasis. In years gone by, the method of treatment was deep breathing exercises. These, of course, could produce pain which was followed by very shallow respiration and so the atelectasis was not effectively treated. A respirator reduces the work of breathing so that the muscles of respiration are not actively used and so this does not cause pain. In addition, the lungs are now completely inflated. Areas of atelectasis become properly aerated and soon disappear. People suffering from chest injuries often require respirator care to prevent the formation of atelectasis as well as to assist in the normal mechanism of breathing.

Probably the most dramatic use of respirators is seen in the treatment of so-called respiratory failure. This process may be caused by a number of diseases and is always of a very severe nature and demands prompt and expert treatment. One may say that respiratory failure is basically a failure of the lung to transmit oxygen to the blood and remove carbon dioxide from it. The end result of retained carbon dioxide is that the blood becomes more acid than it should be. This is termed acidosis. By using some type of respirator carbon dioxide is effectively removed and oxygen properly absorbed. The blood will now return to normal insofar as the acid content is concerned and these patients recover quickly. It must, of course, be kept in mind that the underlying disease that produced the acidosis must be treated at the same time.

This, then, has been a rather brief outline of the use of breathing machines or, as they are properly called, Intermittent Positive Pressure Breathing Respirators at the Nova Scotia Sanatorium. It is evident that they are of great value in helping us to diagnose and treat various chest conditions encountered at the Nova Scotia Sanatorium.

The Mail Box

Call Box 81, Pago Pago
American Samoa, 96920
September 19, 1968

Dear Steve,

Your notice of June 20/68 to my home address has been forwarded by surface mail (it took six weeks to reach me) so this is partly to blame for my late reply.

In view of our moving from one job to another it does seem hopeless to keep magazine subscriptions following us, so for the present at least I shall cancel. No doubt copies have been sent since expiration, and as a neighbor looks after my second class mail arriving in Lincoln during our absence I will get the San news from these copies on my return in January/69! At any rate to cover payment for these I am enclosing check for $1.00. Any over-payment can be applied to petty cash.

We have been here several months and have seen the island of Tutuila from one end to the other as it is only 46 square miles. At present we are between Samoan "winter" at 80 degrees F. and the rainy season of November to March, and considering how I have seen it rain at this time of the year it should be quite a revelation when the actual rainy season starts.

Speaking of rain, if you have read Somerset Maugham's works you may recognize the name of Sadie Thompson. Whether she was fictional or not, the local people old enough to know say a character much like the description Maugham gives Sadie lived at a small hotel here. The hotel is now a store and is just 100 yards from where we live in government quarters. It is also the same building where Margaret Head, the well-known anthropologist stayed while she learned the Samoan language prior to her 8-month stay on Manua Island to do research for her book "Coming of Age in Samoa" — so you see the place, while remote, has its share of fame one way or the other.

It has been a disappointment to find so few good beach areas, and I have yet to find sand that has the soft, fine texture of our good Northumberland Strait area; rather it is more like coarse salt, chiefly because of the coral base. The reef areas are the only safe swimming places because of the possibility of sharks, so you may depend I stay within bounds. Even in these shallow depths snorkelling is very rewarding and the many kind of small, colorful fishes as well as coral growth are a delight to see.

Tutuila is the name of the island we are on, and is the largest of the group of seven comprising American Samoa. Pago Pago is the capital and in Nova Scotian language is about the size of Sheet Harbour. The U. S. government's administrative offices as well as Government of A. Samoa are located here, and any commerce comes through this port. The harbor is beautifully located with mountain ranges almost enclosing it. The area could be much more scenic but civilization here includes the litter-bug infestation, and what could be sheer tropical beauty is ruined in many areas by these "locusts" of neatness. Such a pity — but, when I get annoyed with pop bottles and papers blown and thrown around I go out and clean up our driveway, much of the merriment of the locals sitting on the sidewalk waiting for their bus; seeing a "palagi" do such menial work is highly amusing!

Well, this was meant to enclose a $1 and I've rambled in my usual style. My best to all at the San and I am still looking forward to time to visit there. We hope for some time in N. S. in early 1969, the Lord willing.

Sincerely,
Betty McCausland

(Elizabeth (Logan) McCausland was a San patient and Rehab. teacher in the early '50's.)

It Bears Repeating—

Tuberculosis is a SOCIAL plague. Not until man realizes that the reservoir of tuberculosis is in man and helps eliminate that reservoir, will we be free of the threat of infection.

Steve Mullen, our Circulation Manager, modestly at work in The San Post Office.

THE CRACKER BARREL

(Continued from Page 1)

in this disease is played by certain germs that look and act somewhat like the tubercle bacillus. Some little time ago we found these "atypical" germs on over 50 occasions. They cause a special type and degree of skin reaction when a patient who is infected by them is tested by their particular type of tuberculin. I am sure that our patients who are being tested are very happy to assist us in extending our horizon of knowledge in regard to infection caused by these unusual germs in Nova Scotia. Patients and staff form the team that is undertaking this small research project at this time. It is harmless and painless and yet will yield valuable information.

* * * * *

How many of you heard the recent newscast which informed us that twice as many British people died of lung cancer in 1967 as were killed on their highways? This is a shocking figure, especially when it is remembered that the cancer deaths were, to a large extent, self-imposed by cigarette smoking.

* * * * *

Our Health Ray Golden Jubilee Fund is off to a good start as indicated elsewhere in this issue. Individual donations have varied from $10 to $50 each. So far I have been able to acknowledge each contribution with a personal letter and shall continue to try to do so. We are still looking for our "Century" donor of $100 or more, but all donations of whatever size are most welcome. If you think that Health Rays is doing a worthwhile job, please let us hear from you.

Health Rays Golden Jubilee Fund

This Fund has been established in order to put Health Rays Magazine on a firm financial footing and also that it may continue to be published to commemorate its fiftieth anniversary which occurs in 1969.

Already a number of donations have been received from patients, staff members, and other interested persons. We acknowledge them with sincere thanks and trust many others will do likewise in the months ahead. An official receipt will be issued to each donor. Please address your contributions to

Health Rays Jubilee Fund,
Health Rays Magazine,
Nova Scotia Sanatorium,
Kentville, Nova Scotia

Previously acknowledged	$10.00
New donations since last issue	$144.55
"Century" Patrons ($100 or more)	nil

Patrons:

Dr. Oscar Pudymaitis, Dartmouth
Miss Helen Morse, N. S. Sanatorium
Miss Joan Walker, N. S. Sanatorium
New Brunswick Tb. Association
Dr. Vega G. Dawson, Halifax
Miss Madeline Spence, Ellershouse
Miss Anne-Marie Belliveau, N. S. Sanatorium
Rabbi Abraham Greenspan, N. S. Sanatorium

Total to date	$154.55

Question Box

J. J. Quinlan, M.D.

Q. How fast will tuberculosis get worse if it isn't properly treated?

A. In a not inconsiderable number of individuals whose tuberculosis disease is either not treated at all or improperly treated no deterioration whatsoever occurs and there is complete restoration of health. The two important factors involved in the outcome of any given tuberculous infection are the resistance of individual and the virulence of the infecting organism. Twenty-five years ago, a large proportion of the general population had been infected with tuberculosis and had never to their knowledge been clinically ill. Moreover, in many cases there was no evidence that the infection had occurred except for the presence of the positive tuberculin test.

When the resistance of the individual is unequal to the infection the tuberculosis, if untreated, will inexorably progress. In some cases this progression is very rapid with the development of severe forms of tuberculosis such as tuberculous meningitis or acute tuberculous pneumonia. In most instances, however, the extension of the disease process is slow and takes place over a matter of weeks, months or sometimes years.

Q. What is moisture in the lung?

A. There is normally a small amount of secretion in the tracheobronchial system. This is produced by small glands in the lining membrane and is part of the protective mechanism of the lung. In many disease conditions there is a marked increase in moisture both in the bronchial tubes and in the air spaces of the lung. This is what occurs in inflammatory processes such as lobar pneumonia; it forms part of the acute tuberculous lesion. The inhalation of irritants will produce moisture and in many patients with heart disease fluid is found in the air spaces.

Q. After a year or more of chemotherapy is the tubercle bacillus still capable of multiplying?

A. One of the earliest effects of chemotherapy in tuberculosis is antibiosis, the elimination of the germ's ability to reproduce. This may occur after a few weeks of treatment and certainly should be in effect after a year. In many cases, the body's defences are so strong that the tubercle bacilli may disappear but in others the loss of the reproductive power is only temporary and the organism may again be capable of multiplying at some future date.

Q. After recovering from lung tuberculosis can a person do himself harm if he uses a shotgun with a hard recoil.?

A. Whether or not he has had tuberculosis would have no bearing as to the effect of the recoil of the shotgun.

Q. What is the difference between tuberculosis and tuberculosis infection?

A. There is no difference between tuberculosis and tuberculosis infection. Any individual with tuberculosis infection has tuberculosis, and harbors living tubercule bacilli in his body. However, it is possible to be infected with tuberculosis and yet careful examination to reveal no evidence of active tuberculosis disease. Some years ago, it was customary to make a distinction between the person who had a positive tuberculin reaction but no apparent lesion and the individual with definite clinical tuberculosis. The former was stated to have tuberculous infection; the latter, tuberculous disease. Nowadays we attach a greal deal more significance to the positive tuberculin reactor and in many cases drug treatment may be recommended.

HOW TO BE MISERABLE

1. Think about yourself.
2. Talk about yourself.
3. Use "I" as often as possible.
4. Listen greedily to what people say about you.
5. Expect to be appreciated.
6. Be suspicious, envious and jealous.
7. Never forget a criticism.
8. Trust nobody but yourself.
9. Demand agreement on your own views.
10. Sulk if people are not grateful for favors shown them.
11. Never forget a service you have done.
12. Shirk your duties if you can.
13. Do as little as possible for others.
14. Love yourself supremely.
15. Be selfish.

This recipe is guaranteed infallible ! !

C. J. Sodergren
—The Stethoscope

The O. R.: Then And Now

by E. H. M.

Nova Scotia Sanatorium

A short time ago I happened to pick up an old book, written at the turn of the century, in which were described safe practices in surgical techniques and surgical nursing. Some of the things mentioned are just as pertinent today as when they were written, but so much has been changed or, if not changed, at least improved, that they seem to be completely new ideas.

One of the things this little book stressed was the importance of the surgical staff having healthy, well cared for bodies, and an interested, keen mental outlook. The way it was written seemed very quaint, prim, and Victorian. At first it gave me quite a laugh — it really seemed so 'stuffy" — but then, I thought a little more about it and somehow it did not seem to be such a joke. For, no matter how much we modernize our equipment and the operating area, if the people in that area are not interested and anxious to learn new methods and practices, then these material improvements are of little importance. So I decided this book had served a useful purpose by reminding me again that personal health practices and constructive ways of thinking are important, not only for myself, but even more so for the benefit of those with whom I work and for whom I provide professional care.

By today's standards the preparations made to perform an operation at that time were very simple. So much more effort and planning are present in the operating room of today. The area is a very special room, indeed. The lighting is arranged so that no shadows fall across the operative site and the surgeon can see the area where he is working exceptionally well. Auxiliary, battery-type lamps are always ready in case the electricity should fail during surgery.

Since flammable anesthetics are heavier than air, the electrical outlets and switches are placed high on the walls to eliminate the danger of fire if sparks should occur. Or, if there are wall outlets at a low level, they are of a special safety type. The electrical systems in the operating room are on a circuit which is monitored constantly to show any fault developing in any of the appliances or wiring.

The floor is not just ordinary tiling but is made of conductive material. The doctors and nurses wear shoes or shoe protectors that are also conductive. This so that if anyone has static electricity on their bodies it passes out through the shoes, into the conductive flooring and so transmitted out of the operative area. Shoes, flooring, and all other conductive materials and furniture are tested intensively to determine if they are safe and to be sure that the conductivity has not been destroyed in any way.

The instruments and linens are sterilized in chambers or autoclaves by means of steam being introduced into the chamber. This steam is maintained at a high temperature under pressure, and is a very effective way of destroying all germs. Here, again, the efficieny of this machine is tested weekly by special laboratory tests, and daily by special tests in the operating room.

All the water and saline solutions used in the operating room are made from distilled water which is autoclaved and stored in vacuum-sealed flasks which will remain sterile indefinitely if the vacuum is not broken.

Periodic sterility checks of the operating room and its furniture are made by means of swabs and cultures. This is done to see if our methods of cleaning are satisfactory.

I am sure that most of the people who have had surgery recently will remember having nose and throat cultures taken before their operation. The doctors and nurses also have this done on a routine basis. This is to determine if anyone is harboring harmful bacteria which could cause a wound infection. If so, he or she is treated to eliminate the dangerous organisms.

And, of course, there is the heart monitoring machine to which the patient is always attached during surgery and which gives an accurate and immediate indication of how well the heart is tolerating the surgical undertaking.

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Personal View

George H. Day, M.D.
The Sanatorium, Mundesley, Norfolk, U.K.

Unless we are merely paying lip-service to treating the Whole Man in Body, Mind, and Spirit, the job of chaplain should surely be as vital in our hospitals as that of physician, surgeon, or psychiatrist. And yet I'm afraid doctors are apt (perhaps with some justification) to regard the chaplain as an innocuous regimental mascot: a traditional appendage, to be trotted out on state occasions and privileged to wander freely about on his own business, so long as he doesn't get in the way. This may be an exaggeration, but I've recently been thinking what I would do if I were suddenly offered a chaplaincy to a hospital. I should immediately scratch my head and ask myself, "Has this happened because I am considered the right man for the job? Or have I proved such an awful misfit in all my previous parishes that the Bishop in sheer desperation hopes to mew me up in a cloister where I can't do much harm?"

* * * * *

Granted that I should inevitably plump for the first alternative, I think I should refuse unless the job were full-time, or such that I would be one of a roster of clergy giving 24-hours-a-day cover seven days a week. A first-aid post manned only Sunday mornings and from 2 p.m. to 5 p.m. on Tuesdays is nonsense.

In any case I should need to be paid enough.

Assuming my desiderata were satisfied, I should set to work to permeate the hospital, shoving my nose into everything—not merely the wards, the chapel, and the mortuary, but also the kitchens, the laboratories, the x-ray and physio departments; getting to know and to be known by everybody; learning as much as possible about the work done, the way it was done; the spirit in which it was done — and the spirit of those who did it.

Above all I would make a point of lunching and dining quite frequently in the resident house doctors' mess, and keeping my ears open. I would even drop in for a late-night beer or coffee — or even lose half a crown to them at their poker school. In this way I would come to learn more about the hospital than the matron, the medical superintendent, and the hospital secretary all rolled into one: more about the things that matter—that is, the personalities, the clash of personalities, and the fluctuating morale. For these young chaps are in the front line of the battle, holding the fort during the hours of darkness and at weekends, when their chiefs are away.

This transaction would not be all one way. Many housemen go through a phase of deep despair; despair that they will ever get on top of their job; that they will ever give satisfaction to their sometimes thoughtless and exacting chiefs; despair that they cannot afford their patients all the unhurried attention they once hoped to be able to give. They often become exhausted in body, mind and spirit. Amour propre, conformity, and tradition make them conceal it. It does not pay to squeal. It would kill their chance of acquiring a good testimonial, which is so necessary for preferment.

They need befriending. They need to be reassured that they are doing a fine job—as fine a job as anyone could do in the circumstances. They need their spirit renewing within them — to be made to feel worth while.

* * * * *

One thing leads to another, and soon one would be allowed, perhaps invited, to cooperate with succouring the distressed. Just imagine; a body is wheeled from the ambulance to the casualty department, dead, unconscious, or seriously ill. It is followed by the tremulous relatives who are bidden to sit on a wooden bench outside in the corridor, where they wait, tense and distraught. Every possible attention is given to the body on the stretcher. The relatives are apt to be neglected, although their agony may be the greater. What an opportunity is missed here. They also need befriending. They certainly need it more than the smiling old girls in the wards upstairs recovering from successful appendicectomies.

Again, speaking personally, I should importune that my chaplain's office should

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Editorial Comment

The golden season of autumn has just about ended and I cannot remember ever having seen a lovelier one. We hope that most of you have been able to have some drives and have seen the Valley at its best, with the orchards laden with apples made more colorful this year by the long summer of sunshine. One doesn't have to travel however, to see beauty, for the view from almost any window at the Sanatorium is pleasant. Bob Middleton, as always, has planned his gardens so that flowers are blooming right up until the time of severe frosts.

Besides the beauty we also have the clear fresh air of autumn, with occasional pleasant aromas from the kitchens and from the apple processing plant. I wonder if we appreciate this air as much as we should. This thought came to me while attending the Public Health meetings where, among other topics, air pollution was discussed. Under present legislation something can be done about industrial pollution which can be proven to be injurious to health. It was of interest, however, to hear discussions regarding the sulphurous and acrid fumes from paper mills and oil refineries, and the "distinctive aroma" from the fish meal and fertilizer plants. It was reported that this is a nuisance to people living even some distance away and apparently it can be termed only a nuisance, not being necessarily detrimental to health. That is unless one thinks in terms of loss of appetite, etc. as having a more or less direct bearing on physical or mental health. Such things seem inevitable, however, as we change gradually to an industrial economy and we had better appreciate our smog-free air while we have it.

Speaking of air pollution nearer home, one wonders what could be done to encourage some of our patients to smoke less, or give up smoking entirely. I so frequently hear non-smokers mention how much "second-hand" smoke they get from their smoking roommates. One might argue that a person has a right to smoke. It is, after all, his own health. It could be argued, too, that a non-smoker has a right to enjoy smokeless air. This thought is not original, having come to me second-hand — like the smoke.

Referring again to the Public Health meetings, it is reassuring to see how few people there were smoking. Some years ago quite the opposite was true. Now, if we can only find a way to keep the young people of school age from getting into the smoking habit — probably the best way to influence would be by good example. Another way would be to make the smoking ads look less exciting and inviting.

* * * * *

We were pleased to see that Miss Maude McLellan was honored by the presentation of a life membership in the Canadian Public Health Association. Miss McLellan was Public Health Nurse in Kentville for a number of years and a regular visitor at the Sanatorium until her retirement six years ago. Many will recall that her sister, Miss Isobel McLellan was on our teaching staff at the Rehabilitation Department for two years.

The tree that never had to fight
For sun and sky and air and light,
That stood out in the open plain,
And always got its share of rain,
Never became a forest king.
But lived and died a scrubby thing.
The man who never had to toil,
Who never had to win his share
Of sun and sky and light and air,
Never became a manly man,
But lived and died as he began.
Good timber does not grow in ease;
The stronger wind, the tougher trees,
The farther sky, the greater length,
The more the storm, the more the strength;
By sun and cold, by rain and snows,
In tree or man good timber grows,
Where thickest stands the forest growth
We find the patriarchs of both,
And they hold converse with the stars
Whose broken branches show the scars
Of many winds and much of strife—
This is the common law of life.

—Writer Unknown

The girl about to travel alone was warned about talking to strange men. At the station the conductor asked:

"Where are you going?"

"To Detroit," she answered, so he put her on the Detroit train.

As the train pulled out she looked out and said: "Ha, ha! I fooled him that time. I'm going to Chicago.

PERSONAL VIEW

(Continued from page 8)

be near to the casualty department, where distraught relatives could grieve in private, be given cups of tea and words of hope and encouragement; and where I would have a divan bed or couch on which I could doss down the nights I was on duty.

This process of permeation would not be easy going at first. Some ward sisters get hostile if one chats with junior nurses. Some show signs of jealously even if one chats with patients. And quite understandably, for their unconscious role of mother figure — and mother-knows-best-figure — is threatened by the disruptive intrusion of a father figure. In many of the best families, I suspect, there exists unconscious jealousy and jockeying for position between parents.

But love conquers all, they say, and the process of permeation in time should reach the level of matrons — and even consultants — but it will take time. However, I challenge any establishment to stand out against a man who shows genuine interest and concern, dogged patience, humility, and undaunted acceptance of inevitable conflict — and who keeps his criticism to himself until asked for it.

* * * * *

Ideally, chaplains should be specially trained for their job. In the States, theology and the higher criticism are rapidly disappearing from the training of all priests, and more and more attention is directed towards human behaviour, sociology, and economics. Yes, economics — one of the major motivations in human behaviour. We, books, lectures, and seminars are doubtless helpful on an intellectual level; but the feeling level has to be experinced before the book-learning really comes to life.

Specifically how should chaplains be trained? Assuredly, by apprenticeship; but experience should not proceed faster than it can be assimilated. The young, recently qualified doctor, it must be remembered, has been conditioned to meet death, disease, and mutilation from the very first moment he started dissecting a cadaver three or four years previously. To pitchfork young clergymen into traumatic situations such as obtain in the casualty department itself is both cruel and dangerous. In one hospital where it was tried, of ten trainees three broke down with psychoneuroses, and two chucked the ministry and became medical students.

The 64,000 dollar question is—when will hospital physicians and surgeons come to realize what useful and essential colleagues they might find among hospital chaplains? To a large extent it depends, I suppose, upon the chaplains demonstrating their potential value; but it depends more largely, I fear, upon the necessary change of heart among the doctors.

Which reminds me:

When I was an army psychiatrist I wrote a little hymn for the use of all doctors three times a day after meals.

It ended: Grant, dear Lord, a proper sense
Of therapeutic impotence.
Keep us humble, Lord. Amen.

(It never caught on).

(Reprinted from the
BRITISH MEDICAL JOURNAL,
1968, Vol. 3, page 182,
by permission of the Author and Editor.)

Chapel Notes

The Chapel Service on Sunday morning, October 6th, was conducted by the Sanatorium Co-ordinating Protestant Chaplain, Rev. Dale MacTavish, assisted by Lic. Alton Alexander, who read the scripture and preached a most inspiring sermon. It was a real privilege to have Mr. Alexander with us again, after an absence of two years. He is presently in his final year of theology at Acadia Divinity College.

* * * * *

One of our patients, Miss Pauline Smith, has very kindly acted as pianist at a few of the Sunday morning Protestant Services. This is a much appreciated gesture.

* * * * *

A quartette of student Certified Nursing Assisants — Misses Cheryl Matthews, Gloria Webster, Kay Veinot, and Linda MacKenzie — sang "Breathe on Me, Breath of God" at the Sunday morning service, October 20th. Their beautifully blending voices were also a rich contribution to the congregational singing.

After all, the kind of world one carries about in one's self is the imporatnt thing, and the world outside takes all its grace, color, and value from that.

—James Russell Lowell

Chaplain's Corner

Rev. Dale MacTavish
Co-ordinating Protestant Chaplain,
Nova Scotia Sanatorium

In August, 1961, the communists in East Berlin started building a concrete wall with barbed wire around the top. Since that time the Berlin wall has become a household word throughout the world. It has become notorious because of the many people murdered there by their own countrymen.

The wall has, in effect, created the world's largest prison. It separates many relatives and friends. Parents are separated from children. Husbands are separated from wives.

The wall has become a symbol of separation and division. A symbol of man's fragmented existence in the twentieth century. It is a symbol of hate, fear and folly. It is a monument to failure, stupidity and sin. Perhaps it is modern man's "Wailing wall."

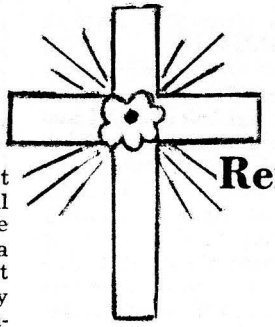
But sad as is the Berlin wall doesn't it remind us of the many walls in our own lives? These walls, though less tangible, are just as real and certainly, in their subtle way, are every bit as destructive.

There is, for instance, the wall of selfishness and greed. There is the wall of hatred and prejudice. There is the wall of envy and jealousy. There is the wall of suspicion. There is the wall of deceit.

There are the walls of sin and the nature of sin is that it separates and alienates. These walls separate many people from friends and relatives. Parents and children find these walls come between them. Husbands and wives, though they live under the same roof for years, remain strangers because of these walls. These walls prevent honest and open communication. They even divide us internally, and we become cut off from ourselves and from God.

Christ died that He might break down these "middle walls of partition" (Eph. 2:14) that separate and divide. He came to reconcile us with God, with our neighbor and ourselves.

The Scripture speaks of this where it says "when we were enemies we were reconciled to God by the death of His Son" (Rom. 5:10) Let us then place our trust in God, for the walls in our lives, like the Berlin wall, can be torn down only by love and understanding.



Remembrance Day

(November 11)

O valiant hearts, who to your glory came
Through dust of conflict and through battle flame;
Tranquil you lie, your knightly virtue proved
Your memory hallowed in the land you loved.

Proudly you gathered, rank on rank to war,
As who had heard God's message from afar;
All you had hoped for, all you had, you gave
To save mankind — yourself you scorned to save.

Splendid you passed, the great surrender made;
Into the light that nevermore shall fade;
Deep your contentment in that blest abode,
Who wait the last clear trumpet-call of God.

O risen Lord, O Shepherd of our dead,
Whose Cross has bought them, and whose star has led,
In glorious hope their proud and sorrowing land
Commits her children to Thy gracious hand.

—J. S. Arkwright

I find the great thing in this world is not so much where we stand, as in what direction we are moving. To reach the port of heaven, we must sail sometimes with the wind, and sometimes against it; but we must sail, and not drift, nor lie at anchor.

—Oliver Wendell Holmes

* * * * *

The highest pinnacle of the spiritual life is not happy joy in unbroken sunshine, but absolute and undoubting trust in the love of God. — A. W. Thorold.

Old Timers

Harvest Festival and Thanksgiving are over for another year, but the colorful magic of autumn lingers and beckons. Thus, the goodly number of old timers coming to visit relatives and friends at the Sanatorium recently, must have thoroughly enjoyed the trip. Among those who Anne Marie either saw or heard about were Jimmie and Blair Schrader, who came up from Halifax to see their grandfather, James MacKinnon. And how those two have grown in the five years since they were mere tots in the Children's Annex!

Several of our 1965 patients wandered back, too. Gladys Creighton called in after attending a Teachers' Convention in Halifax. Gladys is very well indeed, and is principal of the Elementary School in Pictou.

Mildred Romaine of Yarmouth and Emelia Maillet of Saulnierville, were also among the visitors. Both are well.

Miss Lyda Spencer, who lives in Stoneham, Massachussets, spent the summer at her brother's home in Centreville, Digby County. Before returning to the States, she paid a welcome visit to the Sanatorium.

Jean LeBlanc came up from Wedgeport and Laura Anderson came down from Abercrombie, Pictou County. Both were Sanatorium patients in 1966. Laura and her husband have just built a new home.

Jessie (Burchell) Corsbie, who cured here in 1949, looks the picture of health. For the Thanksgiving weekend, Jessie had as her guest at her Kentville home, a 1946 patient, Gertrude Lake of Walton, Hants County.

Several ex-patients attended the Medical Records Librarians Seminar held at the Sanatorium on Saturday, October 19th: Kay "Tat" Bernasconi (1949) from St. Martha's Hospital, Antigonish; Sister Mildred MacKenzie (1956) from Bethany; Don Silver (1960) from Fisherman's Memorial Hospital, Lunenburg; our own Hector McKean (1955), who was elected President of the Nova Scotia Association of Medical Librarians; and C. H. Kennedy (1939), who was one of the speakers. Mr. Kennedy, a former Director of Rehabilitation at the Sanatorium, is now Director of the Division of Public Hospitals, Hospital Insurance Commission.

While attending the Department of Public Health Convention held at the Sanatorium in late October, Dr. D. S. Robb, Medical Superintendent of Point Edward Hospital, took time to call briefly at the Rehab. Department. Dr. Robb was Medical Superintendent of Roseway Hospital in Shelburne until the tuberculosis section was closed out some eight years ago, and prior to that, was on the staff of the Nova Scotia Sanatorium. Those of us who knew him in those earlier days were pleased to see him again.

We hear that Mrs. Jessie Burgess who was here in 1966 is well and living in Bishopville, Hants County, with her son.

News of Ross Jewers has also come our way. Mr. Jewers, who was a Sanatorium patient during the earlier 'Sixties, is well and living with his son in Hunt's Pont. He still does leatherwork as a hobby.

October Seminar

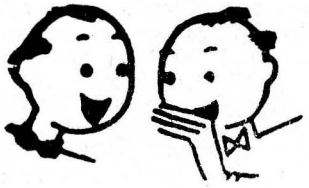
"Suggested Improvements for the Nova Scotia Sanatorium" was the topic of a half-day seminar held in Miller Hall on October 11, 1968. Members of the medical and senior nursing staffs, departmental heads, and a number of other personnel were present.

In his preliminary remarks Dr. Hiltz referred to similar meetings that had been held in the past, citing improvements that had resulted from them. Notable among these was the establishment of the attractive modern patients' dining room in 1965.

A panel consisting of Mrs. Hope Mack, Superintendent of Nurses; Miss Eileen Quinlan, Senior Dietitian; Dr. Helen Holden, Assistant Medical Superintendent; and Mr. Hector McKeen, Medical Records Librarian, with Dr. J. E. Hiltz, Medical Superintendent, as Moderator, launched the discussion. Each of the panellists pointed out a number of areas in which they felt changes ought to be brought about for the most effective functioning of the Sanatorium. When discussion moved to the floor others were equally prepared to present queries and suggestions for change.

Time moved too swiftly to allow thorough or lengthy consideration of any one point, but those present were given a great deal to think about, and the way was paved for early continuation of the discussion.

Just Jesting



Helen: "Wake up, quick, wake up!"
Edith: "Can't"
Helen: "Why?"
Edith: "Ain't asleep."

* * * * *

Visitor: "Are we quite safe in this elevator?"
John: 'Sure! These wire ropes are guaranteed for five years, and the guanrantee isn't up until tomorrow."

* * * * *

Elizabeth: "Rachael often gets historical with me."
Rosalie: "You mean hysterical."
Elizabeth: "No, historical. She digs up my past."

* * * * *

The minister had just married an elderly and rather dour Scot to a woman considerably younger, and after the ceremony he remarked to the bridegroom, 'Well, MacPherson, you'll be going on a honeymoon now?"

" 'Honeymoon?' " echoed Mac, "What's that?"

"Oh, you know," laughed the clergyman, "A little trip somewhere together before you settle down in married life,"

The bridegroom shook his head morosely. "A Na!" he said, "I dinna hold wi' gallivantin' about wi' a strange woman."

* * * * *

Boss: "My wife heard that I took you out to dinner the other evening."
Secretary: "Well, what does that make me?"
Boss: "That makes you my former secretary."

* * * * *

Kenneth: "Do you like codfish balls?"
George: "I dunno; I never attended any."

* * * * *

Rosalie (struggling over a jigsaw puzzle): "I can't seem to make this piece fit anywhere."
Rachael: "No wonder. That's an animal cracker you're holding."

* * * * *

"Flowers — Earth's laughter."

—Emerson

Ardena: "My uncle can play the piano by ear."
Nina: "That's nothing, my grandpa fiddles with his whiskers."

* * * * *

John: "Are you acquainted with the 'Barber of Seville'?"
Cecil: "No, I'm not. But, then as a rule I shave myself."

* * * * *

Patricia: "I hear they are starting a new campaign against malaria."
Jane: "Good Heavens! What have the Malarians done now?"

* * * * *

Ella: "Have you ever been in a stupor?"
Evelyn: "No, we never had anything but a Ford."

* * * * *

Geraldine: "What would a chicken say if a hen laid an orange?"
Joan: "I'll bite."
Geraldine: "Look at the Orange Marmalade."

* * * * *

Ardena: "Don't you think the water is awfully hard here?"
Florence: "Yes — but it rains harder here."

* * * * *

A backwoods mountaineer one day found a mirror which a tourist had lost.

"Well, if it ain't my old dad," he said as he looked in the mirror. " I never knowed he had his pitcher took."

He took the mirror home and stole into the attic to hide it. But his actions did not escape his suspicious wife. That night while he slept she stole up to the attic and found the mirror.

"Hum-um," she said, looking into it, " so that's the old hag he's been chasin."

* * * * *

Stan: "When anything goes wrong around here I always fix it."
Curtis: "Yes. I know. Since you fixed my clock, the cuckoo backs out and asks 'what time is it?' "

* * * * *

Every hour comes with some little fagot of God's will fastened upon its back. — F. W. Faber.

Ins And Outs

NOVA SCOTIA SANATORIUM

Admissions: September 16 to October 15

CLINTON ARCHIBALD AALDERS, South Alton, Kings Co.; JOHN LAURIE BABIN, Sluice Point, Yarmouth Co.; GEORGE AMBROSE CLUETT, 3245 Robie St., Halifax; JAMES JOSEPH COMEAU, Meteghan, Digby Co.; RAYMOND ALEXANDER CONN, Cherryfield, R.R. 3, Springfield, Annapolis Co.; CECIL FULTON FOX, Tangier, Halifax Co.; RABBI ABRAHAM GREENSPAN, 5959 Spring Garden Road, Halifax; MRS. ROSE MARIE HARNISH, Ketch Harbour Road (Armdale 252, Box 4-4-361); RONALD FRED JEFFERSON, Wilmot Station, Anna. Co.; MRS. GERTRUDE MAY LAKE, Walton, R.R. 1, Hants Co.; FRANKLYN SIMEON LANGILLE, Blockhouse, Lunenburg Co.; GORDON VINCENT MacDOW, Blue Mountain, R.R. 2, Kentville; JAMES JOSEPH MacKINNON, 6224 Lawrence St., Halifax; MRS. MILDRED WINNIFRED MOORE, 16 James St., Kentville; MRS. ANNIE IRENE MURPHY, 9 MacLearen Avenue, New Glasgow; MRS. LILLIAN MAY O'HEARN, 2309 Barrington St., Halifax; THEODORE JOSEPH PAUL, Eskasoni; JAMES MANNING OHRLING, Stellarton; PHILIP POIRIER, 37 Henry St., Sydney; HOWARD OAKLEY POTTER, R.R. 2, Clementsport, Annapolis Co.; ROBIE VINCENT RICHARDS, 2545 Barrington St., Halifax; ARTHUR GORDON RICHARDSON, Osborne Harbour, Shelburne Co.; SYDNEY CLIVE ROBERTS, 80 Belcher St., Kentville; MRS. JUNE ELEANOR STATES, R.R. 1, Hantsport, Kings Co.

Discharges September 16 to October 15

BURRELL SAMUEL ACKER, Little Harbour, Shelburne Co.; KEITH EDWARD AMERO, Weaver Settlement, Digby Co.; ROSS JAMES CAREY, Margaretsville, Annapolis Co.; JOHN DANIEL CHAPMAN, 31 Elizabeth St., Truro; RAYMOND ALEXANDER CONN, Cherryfield, Annapolis Co.; PATRICK CONNORS, R.R. 1, Hopewell, Pictou Co.; HERBERT ALEXANDER CROSSMAN, 39 Hickman St., Amherst; CHARLES BASIL FIELDING, Harmony Road, Truro; FRANCIS GODFREY GARRISON, 25 Gibhardt St., Fairview, Halifax Co.; MRS. SARAH ANN GRAVES, 41 Tupper Road, Kentville; RONALD FRED JEFFERSON, Wilmot Station, Annapolis, Co.; ROBERT H. JOHNSON, Newport Station; Halifax; MRS. LAI FONG LEE, 5359 Inglis St., Halifax; GORDON VINCENT MacDOW, Blue Mountain, Kentville R.R. 2, Kings Co.; MURRAY JOSEPH MacISAAC, 2057 Oxford St., Halifax; MILDRED MacLELLAN, 217 Munroe Avenue, New Glasgow; HERBERT CAMERON MacQUARRIE, Foord St., Stellarton; MARSDEN WILLIAM MOXON, 559 Prince St., Truro; GENE WILLIAM MUISE, 12 Commercial St., Yarmouth; JAMES MANNING OHRLING, Stellarton; THEODORE JOSEPH PAUL, Eskasoni; ARTHUR ALBERT RAFUSE, Gold River, Lunenburg Co.; JOHN WALLACE REID, Joggins, Cumberland Co.; NIL JOSEPH SAULNIER, Meteghan Station, Digby Co.; MRS. EVELYN JOAN SICARD, 121 St. Margaret's Bay Road, Halifax Co.; EVERETT SAMUEL SLAUENWHITE, Billtown, Kentville, R.R. 1, Kings Co.; JOHN MOSHER TAYLOR Upper Nine Mile River, Hants Co.

THE O. R.: THEN AND NOW

(Continued from page 7)

All these things are in use here now, but I suppose in the hospital of the future one will see surgery performed in air-conditioned, pressurized chambers with the air completely free of bacteria. There will be monitoring devices to record all the patient's vital signs, and one may find the surgeon and his staff in helmeted suits, looking as if they were contemplating a flight into space, rather than some relatively simple surgical procedure.

Brady: Too bad about your falling off the ladder, Mike.

Grady: Well, it could have been worse. I had to be coming down for nails, anyway.

The Call For Help

"Anyone who has the so-called cigarette cough should know that he has bronchitis."

This is just one of the statements made by Dr. Reuben Cherniack of Winnipeg to the audience at the nurses' institute on respiratory disease sponsored each year by the Canadian Tuberculosis Association, but it brings up a subject to which a great deal of attention should be paid by a lot of people who choose to ignore it.

How many people go to a doctor when they (or their spouses) first notice that they have a cough in the morning? Not very many. Yet the cough is a warning. The cough is the body's hacking announcement that something is wrong, that things should change, that the lungs are having difficulty. Many serious ills come on without warning — strokes, various kinds of heart disease, fulminating infection, and adrenal upsets. The ills affecting our breathing give us warning and usually the first warning is a cough and that we can't shake off. Next is shortness of breath.

Maybe one feels a bit of a fool going to the doctor with a cough. For one thing, we may have an awfully strong suspicion about the advice he will give us. We could take that advice perhaps without even asking but the doctor puts a professional seal on it. He can tell you just how serious your cough is. It could be TB. It is likely bronchitis. You might be on the road to emphysema.

Whatever you do, don't ignore a persistent cough. It isn't just an annoyonce to you and the family. It's your lungs calling for help.

— T B . . . and not T B

A waiter in a delicatessen suddenly took sick and was rushed to a doctor who lunched regularly where the waiter labored.

"The pain is killing me," he moaned as he lay waiting in the emergency ward. "Help me! Help me!"

The doctor eyed him coldly and told him with deep satisfaction, "This isn't my table."

The Laboratory

FOCUS OF THE TB PICTURE

Today there is only one sure way to diagnose tuberculosis: laboratory analysis of body fluids, especially sputum.

Damage that shows up on X-rays of the lungs are suspicious signs. So are positive reaction to tuberculin tests. But neither—nor even both together—are proof posiive of TB. For conclusive proof, the TB germ itself must be spotted under the microscope.

Symptoms are deceiving. Some patients, labeled as active TB cases and put on drug therapy, show all the signs of TB. But could have a fungus disease or lung cancer. Or a pseudo-TB infection, one that may look like tuberculosis but doesn't respond to the tried and proven anti-TB drugs.

Laboratories that use up-to-date procedures can find out for certain — in about three to six weeks — two vital pieces of information: whether or not the patient's sputum contains the TB germ, and which anti-TB drugs will be effective for him. Even before the patient himself swallows a single pill, the laboratory analysis can determine which drugs he will respond to most effectively.

Not all physicians, unfortunately, use laboratories that perform TB work. Recent Public Health Service figures show that 14 per cent of the new, active cases diagnosed as TB had no laboratory confirmation.

But the trend — in fact the necessity — is for laboratory confirmation. It is essential not only for diagnosis but for checks on the patient's progress—the only sure way to monitor the TB patient's response to drugs.

Your tuberculosis and respiratory disease association is doing all it can to spread this important message: The laboratory is a central focus of the TB picture today.

Sanatorium Outlook

TOOK IT FOR AN OFFER

At a race meeting in London a man was charging $1.00 for parking space for cars. When space began to be at a premium, he raised the price to $1.50, and later to $2.00. It happened that the first car to approach after the second raise in price was a Ford, and as a warning to the driver, the man shouted out, "Two dollars." The driver, mistaking this for a bid, quickly replied, "It's yours."

Cats, Dogs And TB

Farmyard cats that prowl around the barn may be lapping up tuberculosis germs with the raw milk they drink.

Dogs whose masters have active tuberculosis may contract the disease, too.

It is not known yet whether these pets, in turn, can transmit tuberculosis to people.

A study of the prevalence of tuberculosis among cats and dogs exposed to the disease has been carried out in Pennsylvania by William R. Snider, D.V.M., of the Animal Health Division of the U.S. Department of Agriculture, who is taking postgraduate work at the School of Veterinary Medicine, University of Pennsylvania.

Believed to be the first of its kind undertaken in this country, the study encompassed a total of 95 farm animals and dogs and cats from city households where an individual had been found to have active tuberculosis.

The farm animals were exposed to cattle on 12 farms that in routine tests of herds had been found to be infected with Mycobacterium bovis, a bovine strain of tubercle bacilli.

Tuberculosis was proved in 24 farm cats and 3 dogs out of 52 cats and 9 dogs tested.

For a control group, Dr. Snider examined cats from "clean" farms, that is, farms where there were no infected cows. Of 20 cats on seven farms, none had tuberculosis.

No active disease was found in the city animals, although 9 of the 28 were tuberculin positive. Control studies in city households with no tuberculosis showed 2 tuberculin-positive dogs out of 70 tested.

"It is clear from this study," said Dr. Snider, "that cats and dogs exposed to tuberculosis may become infected. We do not as yet know whether they are the final host of the bacilli or whether they can transmit the organism to other animals or to humans.

"The farm cat, drinking unpasteurized milk from tuberculous cattle, is an important host for bovine tuberculosis and a probable reservoir of infection for cattle and man. In an eradication program for bovine tuberculosis, this must be considered."

NTRDA Bulletin, Sept., 1968

"We are having a raffle for a poor widow — will you buy a ticket?"

"Nope, my wife wouldn't let me keep her if I won."

WATCH YOUR ENGLISH

We'll begin with a box, and the
plural is boxes,
But the plural of ox is oxen,
not oxes.
Then one fowl is a goose, but
two are called geese,
Yet the plural of moose should
never be meese!
You may find a lone mouse or
a whole nest of mice,
But the plural of house is houses,
not hice!
If the plural of man is always
called men,
Why shouldn't the plural of pan
be called pen?
If I speak of a foot, and you
show me your feet.
And I give you a boot—would a
pair be called beet?
If one is a tooth, and a whole
set are teeth,
Why should not the plural
of booth be called beeth?
Then one may be that and three
would be those,
Yet hat in the plural would never
be hose;
And the plural of cat is cats, and
not cose!
We speak of a brother, and also
of brethren.
But though we say mother, we
never say methren!
Then the masculine pronouns are
he, his and him,
But imagine the feminine, she,
shis and shim!
So English, I fancy you will agree
Is the funniest language you ever
did see!

—Exchange

When TB Flourishes

Poor general health lowers the body's resistance to TB germs. Frequent exposure to other infections, inadequate diet, poor housing, and similar health and social problems help the germs to gain a foothold.

—Sanatorium Outlook

Nova Scotia Sanatorium

J. E. HILTZ, M.D., D.P.H., C.R.C.P: (C) ..... Medical Superintendent
H. M. HOLDEN, M.D., C.R.C.P. (C) ..... Asst. Superintendent
J. J. QUINLAN, M.D., C.R.C.S. (C) ..... Surgeon
F. J. MISENER, M.D. ..... Radiologist
A. LARETEI, M.D. ..... Physician
MARIA ROSTOCKA, M.D. ..... Physician
G. A. KLOSS, M.D. ..... Physician
E. W. CROSSON, M.D. ..... Physician
V. D. SCHAFFNER, M.D., C.R.S.C. (C) ..... Consultant Surgeon
D. M. MacRAE, M.D., C.R.C.P. (C) ..... Consultant Bronchoscopist
B. F. MILLER, M.D., F.R.S.C. (C) ..... Consultant Orthopedic Surgeon
E. J. CLEVELAND, M.D., C.R.C.P. (C) ..... Consultant Psychiatrist
D. H. KIRKPATRICK, M.D. ..... Courtesy Consultant in Anaesthesia
C. E. JEBSON, M.D., C.R.C.S. (C) ..... Consultant Urologist
MRS. HOPE MACK, R.N. ..... Director of Nursing
MISS EILEEN QUINLAN, B.Sc., P.Dt. ..... Senior Dietitian
DONALD M. BROWN, B.A., B.Ed., M.S.W. ..... Director of Rehabilitation
RONALD GERRARD, B. Comm., C.A. ..... Administrative Assistant

Point Edward Hospital

D. S. ROBB, M.D., ... Medical Superintendent
T. K. KRZYSKI, M.D. ..... Physician
W. MacISAAC, M.D. ..... Consultant Bronchoscopist
D. B. ARCHIBALD, M.D., ... Consultant Urologist
MISS KATHERINE MacKENZIE, R.N. ..... Director of Nursing
MISS JOYCE LEWIS ..... Dietitian
MISS HELEN J. MACKENZIE, R. N. ..... Supervisor of Rehabilitation

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Church Affiliation

NOVA SCOTIA SANATORIUM

ANGLICAN

Rector—Archdeacon L. W. Mosher
Sanatorium Chaplain—Rev. W. A. Trueman

Co-ordinating Protestant Chaplain

Rev. Dale MacTavish

BAPTIST

Minister—Rev. A. E. Griffin
Lay Visitor—Mrs. H. J. Mosher

CHRISTIAN REFORMED

Minister—Rev. J. G. Groen

ROMAN CATHOLIC

Parish Priest—Rev. G. E. Saulnier

SALVATION ARMY

Capt. H. L. Kennedy

UNITED CHURCH

Minister—Rev. K. G. Sullivan
Sanatorium Chaplain—Dr. (Rev.) Douglas Archibald

PENTECOSTAL

Minister—Rev. Robert Cross

The above clergy are constant visitors at The Sanatorium. Patients wishing a special visit from their clergyman should request it through the nurse-in-charge.

POINT EDWARD HOSPITAL

ANGLICAN

Rev. Weldon Smith

ROMAN CATHOLIC

Parish Priest—Msgr. W. J. Gallivan

UNITED CHURCH

Rev. Robert Hutcheson

PRESBYTERIAN

Rev. E. H. Bean

SALVATION ARMY

Mr. William Brewer

The above clergy are visitors at this hospital. Besides the above named many other protestant clergy from the surrounding areas alternate in having weekly services for our patients.

The Canteen . . .

IS OPERATED FOR YOUR CONVENIENCE AND BENEFIT

So Remember . . .

- **A good stock of all occasion cards and stationery**
- **Gift suggestions, Novelties, Cups and Saucers**
- **Clocks, Watches, and Costume Jewellery**
- **A wide variety of grocery items**
- **Ladies' and Men's wear — Nylons**