



JGH news

VOL. 16 No. 1

JEWISH GENERAL HOSPITAL/MONTREAL, QUE.

APRIL 1977

HOSPITAL FACES FINANCIAL CRISIS

(An interview with Mr. A. Deskin, Executive Director)

Q. Is the J.G.H. in real trouble? Is there the possibility of trusteeship?

A. Since 1974, when the Ministry of Social Affairs first informed hospitals that there would no longer be any year-end settlements, the Jewish General's accumulative deficit has significantly increased — thus putting a heavy strain on our cash flow position, that is; our ability to meet payroll and indebtedness to suppliers. If we do not put our house in order, in other words; balance our budget, the Government could very well send in a trustee to do it for us. We would then have no control over the manner in which expenditures would be brought in line with revenues. The Government would decide our priorities for us. We must not allow that to happen.

Q. How much of a loss does the Hospital face for the fiscal year 1976-77?

A. We are estimating a loss in operation for this fiscal period of approximately \$1,900,000. This will bring our accumulated deficit to \$4,600,000. — as of March 31, 1977.

Q. What steps are being taken to balance the budget?

A. The Board of Directors, the Medical Executive Committee and the Administrative Staff have joined forces and collectively have decided on certain steps which must be taken to avert a financial crisis.

The most severe decision was closing down 100 beds commencing May 1st, 1977. This action will lower direct nursing care expenses by close to \$1,000,000. It is hoped that this closure will be temporary. We are taking a hard look at certain Ambulatory Care activities, such as out-patient clinics, the Diagnostic Unit, etc., and in the future, decisions will be made that could seriously reduce the volume of care now being given to a large number of patients. The entire medical community is looking at the "practice of patient care" so that possible efficiencies can be realized. This includes the

number of laboratory and X-Ray examinations that are being ordered and the kind and volume of medical supplies that are used in the Operating Room and on nursing units.

Q. Where will patients who need these services go?

A. With regard to in-patient services, emergency and urgent cases will as always receive top priority. In the area of clinic care, it will be necessary for some patients to receive their care from private physicians in the community.

Q. How exactly will all this affect me if I were awaiting elective surgery?

A. There is no doubt that the waiting period for elective surgery will be lengthened. However, it is hoped that our doctors will use whatever beds are open with great discretion, and on the assumption that the length of stay can be somewhat shortened, it is felt that the waiting period for elective surgery will not change appreciably from the present experience. We will be increasing the number of ambulatory elective surgery procedures, and it is hoped that this step will take some pressure off the request for in-patient care.



Q. Doesn't the Government give the Hospital money for Hospital services?

A. The Ministry of Social Affairs provides funds for what is defined in Chapter 48 as shareable costs. However, in our case, for the past several years because of increased volume in areas such as dialysis, social disease clinic, and other areas of patient care, which did not receive official approval by the Government, the Hospital has been receiving less revenue, mainly in the area of staff salaries, than we have expended for these elements of our budget.

Q. What services are not covered by the government?

A. The Ministry of Social Affairs does not consider as shareable those costs generated by teaching and research activities. In the fiscal period 1976-1977 we will spend \$400,000. — more than our revenue for these activities.

Q. Whence the sources of revenues for these services?

A. Income for research and teaching come from research grants received from the Medical Research Council and monies from our Women's Auxiliary, Allied

(continued page 2)

(Crisis continued)

Jewish Community Services and the Hospital's Research Foundation. It should be noted that the grant from the A.J.C.S. was reduced from \$350,000. — to \$300,000. — in 1976, and they have advised us that they will probably be cutting their grant to the Hospital by another \$50,000. — in 1977. This lowering of community support is having a serious effect on the morale of our Geographic Full Time staff and our ability to provide opportunities for young doctors who are thinking of a full-time career in teaching and research. On the positive side our Women's Auxiliary is annually increasing their support of hospital services. These women are unbelievable and the entire Hospital community is grateful for their generous support.

Q. What percentage of the increase is paid for by the government?

A. Theoretically the Government is supposed to meet the entire amount negotiated with the unions; however, in our case, we have found that the actual cost of fringe benefits and levels of salary are not always received by the Hospital. We are doing everything possible to convince the government to rectify this situation.

Q. You talk of an enormous deficit and yet there is some construction going on at the Hospital. How do you account for this?

A. There are a few renovation programs going on at the Hospital at this time, one of which is the development of a new medical library and auditorium, a project which started in 1972, and is completely financed by monies re-

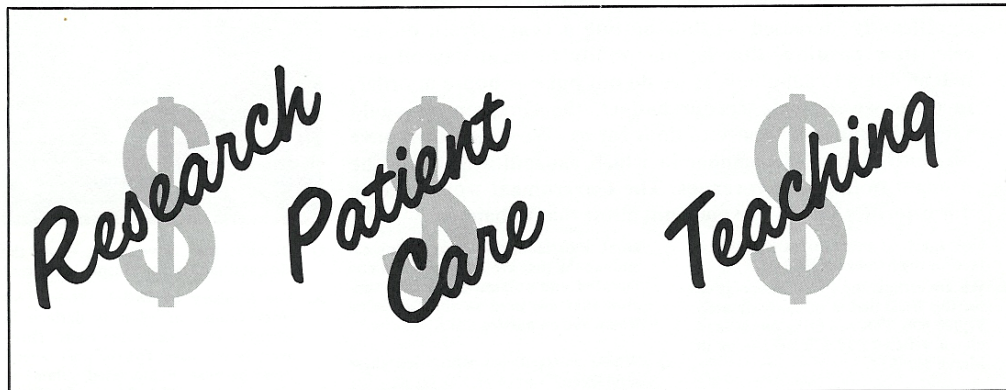
the continual decrease of funding from Allied Jewish Community Services may make it necessary for the Hospital to consider other means of raising money for its teaching and research programs in order to maintain this Hospital as a top rank institution.

Q. If I wanted to donate something is it tax deductible and to whom do I direct my contribution?

A. All contributions to the Hospital are tax deductible and they can be directed to the office of Mr. F. Goldstein, Director of Gifts and Bequests.

Q. I am angered and upset. Outside of financial contributions what can I do?

A. While the Hospital is doing everything possible to make its operation more efficient, it can only provide services to that degree in which it receives revenue



Q. Are we the only hospital facing a financial crisis?

A. We understand that most hospitals in the Province are facing financial difficulty and, like the Jewish General Hospital, are giving serious thought to curtailing services in order to meet their commitments.

Q. When unions negotiate an increase do they do so directly with individual hospitals?

A. The Hospital gives the Association of Hospitals of the Province of Quebec a mandate to negotiate on our behalf with 9 syndicated groups in the Hospital. Members of the Ministry of Social Affairs join with the A.H.P.Q. to negotiate with unions because of the critical importance of monetary agreements

ceived from Government grants and our share of monies raised in honor of Allan Bronfman's 80th birthday. These renovation programs will in no way generate additional expenses in our global budget.

Q. Have you considered a fund raising campaign to directly meet the present crisis?

A. The Jewish General Hospital is a constituent agency of Allied Jewish Community Services and through the latter organization is a recipient of funds raised from Combined Jewish Appeal. The Hospital firmly believes in the non-proliferation of fund raising in our community. We realize that the demands upon our community for local and Israel causes are heavy. However,

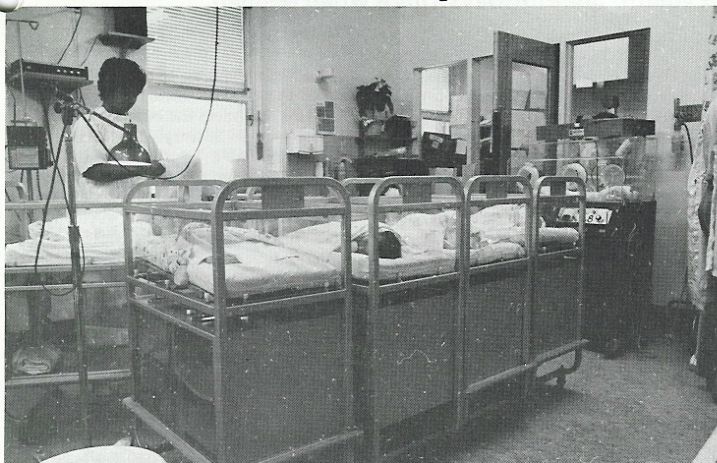
from the Ministry of Social Affairs. If you feel that these services are inadequate to meet your requirements, then I suggest you contact members of the Ministry and make your feelings known to them.

Q. You have not painted a very optimistic picture; are you sure it is not a question of calling wolf?

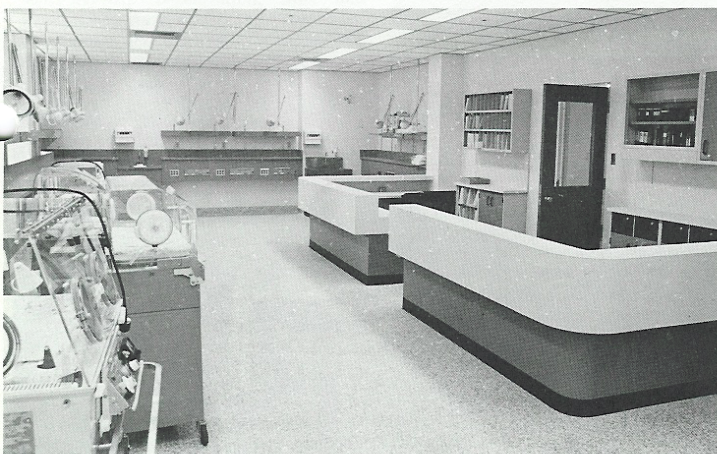
A. The Hospital is doing everything within its means to trim its expenditures to meet the available Government resources for health, etc. The financial situation in Quebec is well known and we can only speculate on the possibility that the Government will increase Hospital budgets by a percentage that is within its means. Unfortunately, this percentage is inadequate to meet rising prices of supplies and other services.

Pollack Intensive Care Nursery

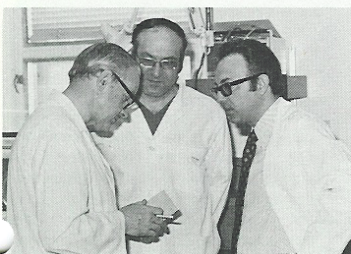
JGH leads way in low infant mortality



Things were getting a bit too close for comfort in the old Intensive Care Nursery



The new Pollack Intensive Care Nursery solves over crowding



Involved in a series of dialogues at nursery opening are Drs. Dechene, Souris, Papageorgiou and Drs. Gelfand, Kravitz and Ruchbinder



The Jewish General Hospital can look with pride at its new 30 unit neonatal intensive care nursery. Under the supervision of Dr. A. Papageorgiou, neonatologist in chief, this nursery will function as one of the most modern and up to date in North America. Dr. S. Pedvis, Pediatrician in chief, regards the nursery as the end in a long series of negotiations but a beginning of the finest treatment possible for special care of high risk infants.

Looking back on the history of the premature nursery, Dr. Pedvis recalls that when he arrived at the Hospital in 1961 there was one intensive care room equipped with 6 cribs. At that time there were approximately 1,600 babies being born annually at the Hospital.

Improvements to the room came about in 1964 with space for 12 cribs, a chart room, x-ray machines and a nursing mothers area. By this time births at the JGH had increased to 1,850. Until 1967 pediatricians administered medical care to their own high risk new-born babies. However, realizing the specialization involved in the field of neonatology the Hospital hired two neonatologists on a part time basis to supervise the premature nursery. A neonatologist is a certified pediatrician who has, on top of his/her pediatric training, at least two extra years of special training in the care of the newborn infants and fetal physiology. He/she is prepared to help obstetricians to carry out successfully any high risk pregnancies, by advising them on the time and type of delivery and subsequently to take immediate care of the newborn infants.

It was at this time that the Maurice Pollack Foundation established a \$10,000 a year fund to help support the nursery.

During 1968-1969 it became obvious to Dr. Pedvis that the JGH was outgrowing its enlarged space. The average number of babies in the premature nursery was 12 with 18 being registered one month. As the number of births increased so proportionately did the number of babies requiring intensive care.

During 1973 the government decided to consolidate obstetrical and neonatal units in many hospitals authorizing three hospitals in the Anglophone community to continue to expand their obstetrical and neonatal programs. The Jewish General Hospital was assigned by the Quebec Government to become one of the major perinatal centres. The goal of the governmental policy, was not only to take care of our own population delivering at the Jewish General Hospital, but also to care for any high risk pregnancy transferred antenatally to our Hospital.

(continued page 4)

(Nursery continued)



Dr. S. Pedvis discusses new equipment during nursery opening. Official dedication will take place in May.

The cost of the new nursery was over a quarter of a million dollars. This money supplied by the government covered the physical facilities but was not adequate enough to cover the cost of the new equipment...so as they had in the past the Maurice Pollack Foundation offered their help. They donated \$50,000 towards the purchase of new equipment as well as raising their annual donation to \$15,000.

During this time of consolidation the Jewish General hired its first full time neonatologist, Dr. A. Papageorgiou. Assisting Dr. Papageorgiou in the new Pollack Intensive Care Nursery are other neonatologists, fellows in Neonatology, a senior resident of McGill pediatric program, 4 interns, third year McGill medical students and an experienced nursing personnel of about 30 nurses. The neonatal intensive care unit, provides teaching for at least half of the McGill medical students.

Dr. Papageorgiou in his 1976 perinatal mortality report prepared for the Hospital with the cooperation of Drs. M. Gelfand, R. Kapusta, R. Shatz, A. Neuman, S. Pedvis, H. Srolovitz and A. Lisbona, proudly points out the low neonatal and perinatal mortality rate for the JGH. The neonatal mortality, death of any liveborn infant, was 2.9 as compared to Quebec at 6.1 and Canada being over 8 per 1000 births. The perinatal mortality, which includes neonatal and stillbirths, was 7.5 compared with 13.1 in Quebec, and over 16 per 1000 in Canada. These figures are for infants weighing over 1000 grams at birth. For infants weighing between 501 and 1000 grams neonatal mortality was 385 per 1000 live births versus 843 deaths per 1000 live births in the province. This is particularly interesting in view of the fact that Quebec has the lowest perinatal and neonatal mortality in North America.

At the Jewish General Hospital there is a team approach which is responsible for the incredible low mortality figures. If they could I'm sure all those babies, saved through the skill of the intensive care unit team, would like to give a collective THANK YOU.

women's auxiliary does it again

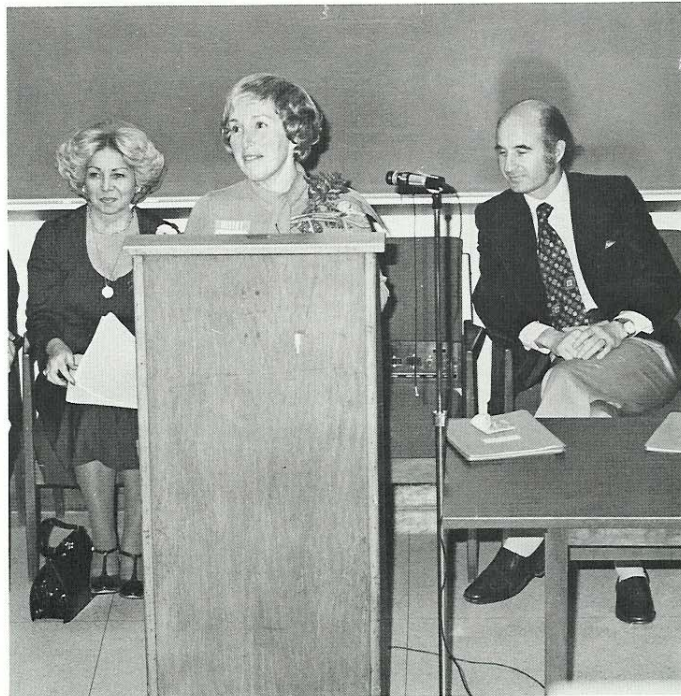
Always There When Needed

"The Women's Auxiliary of the Jewish General Hospital was able to contribute \$295,601,000 to the Hospital in 1976." In so saying Claire Sheiner immediate past president of the Women's Auxiliary opened the 41st annual meeting held February 16, 1977 with an inspiring speech emphasizing that "our long and often sad history has taught us that 'am I my brother's keeper?' can have only one possible answer for us. It is a lesson we have learned well and I am therefore confident that in the years to come, the record of our service and profound commitment to this hospital and the community it represents, will reveal that Yasher Koach continued to be the blessing and the stimulus which guided both our heads and our hearts."

Mr. Peter Bronfman, President of the Hospital Centre Board seconded the reports presented, thanked the Auxiliary

for their contribution both monetarily and service as well. He cautioned however that "the Hospital faces the most serious financial crisis in its history. The financial resources available to the Hospital from Quebec and from our own community are limited. The help that this Hospital receives from the work of its Women's Auxiliary is more vital than ever and the entire Hospital community is grateful to you for the generous support received. Without it, the Hospital could not continue to deliver first rate health care."

The new slate of officers was moved and accepted and President Rita Finestone received the gavel from Mrs. Sheiner. The staff and administration of the Hospital wish Mrs. Finestone and her board the wisdom to continue the difficult years ahead with the same sense of commitment that has always been the policy of the Auxiliary.



Women's Auxiliary President Rita Finestone gives inaugural address as Claire Sheiner and Peter Bronfman look on.

let me help . . . I've been there too

Self-help Groups Assist Patient to Full Recovery

"Some years ago when the first Ileostomy Society and its visiting group was formed, its purposes were regarded with some skepticism. With the passage of time, it has become apparent that patients who have undergone major surgery, resulting in a radical change of their life style, greatly welcome the support of a patient who has been through the experience, and who is evidently well. It has been traditional for people who are having a difficult time in life, to consult for courage and reinforcement, those who have already had the same experience."

Reach to Recovery-Toujours Femme has been performing a valuable service for women who must undergo the removal of a breast. The help given has been most beneficial, and is now requested by many of the patients with the doctor's written approval.

The Ileostomy/Colostomy Association of Montreal is another example of a volunteer self-help organization. Men and women who have undergone ileostomies, colostomies and urostomies visit patients undergoing the same experience.

It is interesting to note that doctors themselves who daily give advice concerning serious medical and surgical problems, welcome, when ill, almost more than the attention of their own physician, the friendly counsel of a medical colleague who has been subjected to the same disease or operation.

I believe that the above organizations and those established for different major illnesses, have contributed significantly to overall patient management, and particularly to the acceptance of a "seldom mild," fact of life."*

*Robert M. Levine, M.D., F.R.C.S.(C)

A great deal had already been written about Reach to Recovery-Toujours Femme, but it might do to repeat the fact that the Jewish General Hospital was the first Canadian hospital to adopt the program thereby recognizing the advantage to a patient of being able to relate to someone who has experienced the same procedure.

The women of Canada who have had mastectomies and were visited by a Reach to Recovery-Toujours Femme volunteer can, to a large extent, thank the Jewish General for leading the way by providing an example for other hospitals to follow.

Through media coverage of the surgeries of Betty Ford and Happy Rockefeller, mastectomies have become an open subject, discussed on radio, television, in newspapers and through films. However, surgery of the bowel still suffers under a stigma of silence. Some noted Hollywood



Literature available for ostomy patients

personalities who have had ostomies are afraid that should the fact become known their images would suffer. Fortunately there are people who are not afraid to speak out and lend their support when called upon to do so. They have formed the Ileostomy-Colostomy Association of Montreal and have demonstrated that the psychological rehabilitation of an ostomy patient can be greatly hastened by a visit from one who has successfully adjusted to the same surgery. Just the presence of such a person can raise the morale of the patient, dispel fears and perhaps prevent depression. This visit can provide the patient emotional and social support. Having a visitor who has had an ostomy come in to see the patient is one way in which to prove that he/she can live a future productive life and demonstrate to the patient that they are not alone.

Training sessions and programs take place before a visitor is sent out to rehabilitate a patient. Courses are conducted by the Ileostomy-Colostomy Association where a visitor learns how to visit, how to act, what to do, what to say, and how to approach the subject. Do's and don't's are necessary items on the agenda and a skit is performed to show the right and wrong way to visit. Visitors are matched to the patient with regard to age, sex and language.

Upon a request from the patient's surgeon a visitor goes out to acquaint the patient with what it will be like to live with an ostomy. Even a child can have an ostomy. When that occurs the Doctor will call the

(continued page 6)

1,000,000 Ostomates in U.S. & Canada
110,000 Ostomy surgery done
annually

80% are Colostomies
10% are Ileostomies
10% are Ileal Bladder or Ureterostomies.

1. **ILEOSTOMY:** An ileostomy opens into the small intestine. The entire colon is usually removed at the time of surgery. The rectum may or not be removed at this time — if not, then at a later date. Most ileostomy surgery is done for Ulcerative Colitis, Crohn's disease, occasionally for multiple polyposis or tumors. Since there is no storage capacity, an appliance must be worn at all times.
2. **COLOSTOMY:** opens into the large bowel and is done: due to accidents, temporary blockage, obstructive tumors, or disease of the colon. The diseased portion is removed and the rectum is usually removed. When the stoma (opening) is on the left side, it can be regulated by diet or irrigation. A high colostomy, which could be temporary is sometimes referred to as a Wet Colostomy and is similar in daily care to an ileostomy.
3. **ILEAL BLADDER: (Urostomy)**
An artificial passageway for urine necessitated by removal of the bladder for cancer, birth defects, injury or failure of bladder function. A permanent type of appliance must be worn at all times.

(Help continued)

Association and a visiting member will go out to see the parents to help aid them to help their child cope. A child with an ostomy at a young age should be taught self-care just as he/she is taught toilet training. The visitor is the support the child needs, not the crutch.

Most problems that Ostomates encountered in the past including equipment, skin problems, diet, odour, job discrimination, travel, sports, sexuality and child bearing have been solved. Answers to these questions are supplied by the volunteer, an Enterostomal Therapist and/or the Ostomy equipment centres. Mrs. B. Segal is a nurse at the JGH involved in helping ostomies. She helps advise the patient as to the necessary equipment they will need as well as aiding the nurse in caring for the post operative patient.

The relationship between the Doctor, Nurse, Hospital and Association is one of the most important aspects of coping with ostomy life. If a patient has confidence in his/her surgeon, it is natural that any course of action suggested by the Doctor will be accepted, thus the close contact with the Hospital and the Doctor is one of the main functions of the Association.

As with Reach to Recovery-Toujours Femme the Ileostomy-Colostomy Association has been called upon, many times, to talk before Nurses, Doctors, Interns and service clubs on the pre- and post-operative care of the patient. Both organizations are quite knowledgeable about the equipment on the market for their particular type of surgery, but are very careful not to endorse one product over another.

Assuming that successful surgery has been performed, the emotional support a patient can receive is of utmost importance in his/her rehabilitation. Through the Ileostomy-Colostomy Association of Montreal and Reach to Recovery-Toujours Femme that support is available. In no way does either Association give out information on medical issues. They are both strictly rehabilitation and mutual aid groups.

The telephone numbers for both groups are: The Ileostomy-Colostomy Association 845-1743... Reach to Recovery-Toujours Femme 481-6635. Both are answered 24 hours a day.

Out of fear for the future the idea of these associations was born. But with help from trained volunteers the future need not be fearful. The Jewish General Hospital has accepted and encouraged both these programs, indicating that patient care has been, is, and will continue to be the Hospital's number one priority.

diet and discussion aid

heart patients

Over 100 patients have been seen and counselled by the Cardiac Rehabilitation team since its inception in May 1976.

The Rehabilitation Team consists of a Dietitian, Coronary Care Unit Nurse, Physiotherapist, Social Worker, and Dr. Mel Ross, cardiologist in chief. Meetings are held weekly to discuss patients within the Program and any particular problems related to patient care. In addition, educational classes are held 3 times weekly both for patients and their families. The first lecture is an introduction to Coronary Heart Disease with basic explanations of the anatomy and physiology of heart function, as well as an explanation of the different types of clinical syndromes of myocardial ischemia, including angina, coronary insufficiency, and acute myocardial infarction. The second class consists of diet management, with the emphasis on a prudent diet as recommended by the American Heart Association. The third class, discussed by the Cardiac Resident in the Coronary Care Unit, is a presentation of the risk factors in coronary artery disease. This consists of an informal presentation with discussion following. These classes have been well-attended overall, with much patient interest, and the preliminary feedback is certainly very positive.



Left to right: Miss Yvette Salomon, Mrs. Rose Pinkus, Mrs. Donna Smith, Miss Cindy Mondschein, Miss Marilyn Silverstone

visiting hours change...

NEW VISITING HOURS

10:00 to 20:30

with the following exceptions

Coronary Care Unit (CCU) and
Intensive Care Unit (ICU)

11:00 to 12:00 noon

15:00 to 16:00

19:00 to 20:00

Immediate family only 10 minutes per patient

Psychiatry 4E —

Tuesday, Saturday, Sunday 14:00 to 16:00
Every night 19:00 to 20:30

4N.E. All Day

5N.W. 15:00-16:30

19:00-20:30

5W - 5N 19:00-20:30 Husbands anytime
up to 22:00. Children Wednesday and
Sunday 11:00-12:00

regulations stay the same

Visitors can be excellent "Morale Boosters" but, for the benefit of patients, we must ask family and friends to comply with the following rules:

1. Visitors should refrain from smoking in ALL patient areas.
2. There should be no more than two visitors at any one time for each patient.
3. Visitors should not congregate in the corridors. They are asked to allow free passage to Hospital staff by using the comfortable waiting rooms provided on each floor.
4. Visitors should not sit on the patient's bed.
5. Visits should not be too long. A patient's recovery depends upon adequate rest.

Children under 16 years of age are not permitted to visit. The only exception being visits to the maternity floor. Children accompanied by an adult, are permitted to visit their mothers Sunday and Wednesday between 11 a.m. and 12 noon. Visits must take place in public waiting room and not in patients' rooms.

a kosher group home for our elderly

JGH Refers First Residents

"Sophie" is an elderly Jewish lady who walks with a cane and suffers from brief memory lapses. She needs assistance with meals and laundry, and must be occasionally reminded to take her pills. Although in most other respects she is mobile and independent, she is no longer able to cope alone with daily chores. However, her limitations are not such that she needs nursing or hospital care.

There are many "Sophies" in today's large elderly Jewish population. At least half of the Jewish General's clinical outpatients are elderly, many of whom live in rooms or apartments with limited access to proper care. The Jewish General's Social Services department and other Jewish agencies in our community are concerned: such people need some daily assistance and supervision. Thus, plans have begun for the development of supervised shelter for the elderly, and the first supervised Kosher group home for the elderly opened this March on Mountain Sights Avenue.

A couple has come forward to offer their services as home managers for a Kosher group home accommodating up to nine people. They come highly recommended, with experience related to homes for the elderly in Israel, and cooking in Jewish camps in Québec. They are a warm and understanding husband-and-wife team. A house, which is rented, has been located for them on Mountain Sights, nearly adjacent to the Golden Age centre and Jewish Family Services. It took in nine religious elderly Jews as of March 1st, the first nine of a growing list of people hoping for some supervised home-like Jewish environment in the community.

Through the enthusiastic assistance and generosity of business people, volunteers, and women's and men's groups, the house was furnished and supplied in time for the opening.

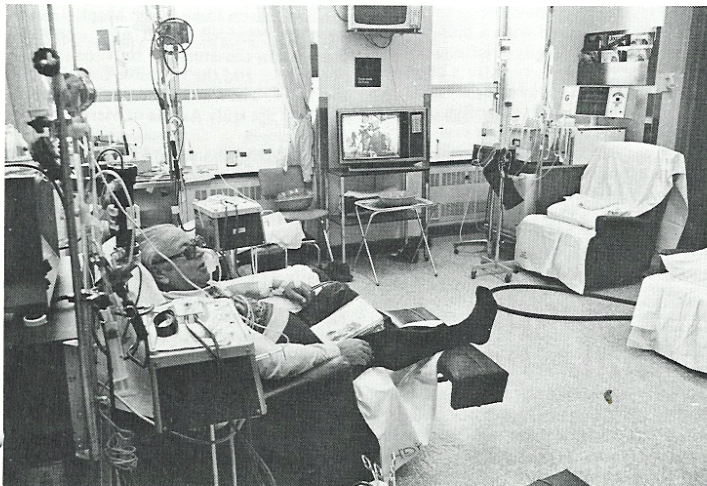
Most of the first nine residents are referrals from the Jewish General Hospital. They will be able to enjoy a family atmos-

phere, with freedom to come and go as they please, but with constant care and supervision from the house couple. This, combined with back-up from the Jewish Family Services (Social Service Centre) and the Jewish General, will provide a much needed level of confidence that they are being well cared for, while still maintaining a sense of dignity and independence.

This is only a beginning. There is an awareness of an ever increasing elderly population in Montreal. Finding shelter and care for this population is a major priority and rapidly becoming a critical one. Consideration is being given to not only more group homes, but private families in the community able to offer a room in their home and a caring, Jewish environment for someone of our older generation.

Those interested in more details or in offering help, are invited to contact Mrs. Sheila Mackay, Director, Social Services Department, at the Jewish General Hospital, tel. 342-3230.

T.V. helps time pass for patients



Dialysis patients enjoy colour television thanks to the involvement of Mr. G. Denton Clark, President of RCA Ltd.

*The following have added their names to the growing number of

Charter Research Governors Institute for Medical Research

Donald Berman
Jonah Goldstein
Jos. Guttman
Jack M. Hecht
Maurice Reznick
Harry W. Yarosky

*To March 15th, 1977

Gifts and Bequests

Received from October 1st, 1976 to December 31st, 1976.

In these columns, the Board of Directors thanks all those who, through their recent contributions, help the Hospital to fulfil its commitment to excellence in patient care, teaching, and scientific research.

GLORIA ADELMAN FUND FOR CANCER RESEARCH

DONORS	IN HONOUR OF
Mr. & Mrs. Henry Cohen	Rubin Cohen — 80th birthday
Mr. & Mrs. Rubin Cohen	Mrs. Fanny Silverman — speedy recovery
Ruth & Richard Kozlick	Mrs. Rose Cohen — continued good health
Ruth & Richard Kozlick	Rubin Cohen — 80th birthday

DONORS	IN MEMORY OF
Hy Adelman	Mrs. Emma Aronson
Hy Adelman	Sam Gershenson
Hy Adelman	Mrs. Libby Schecter
Rose & Gershon Adelman	Sam Gershenson
Dales of Montreal - \$100.00	Brian Bolger (Barhaven, Ontario)
Madeline & Gerry Ritz	Mrs. Emma Aronson
Anita & Syd Silverman	Mrs. Emma Aronson

LIONEL BAGAN MEMORIAL FUND

DONORS	IN HONOUR OF
Celia & Sam Bagan	Mrs. Harry Abramovitch — speedy recovery
Celia & Sam Bagan	Lionel Altman — speedy recovery
Celia & Sam Bagan	Mr. & Mrs. John Litwack — 50th wedding anniversary

DONORS	IN MEMORY OF
Celia & Sam Bagan	Mrs. Bess Burman
Celia & Sam Bagan	Harry Yaphe
Ann & Jack Brotman	Mrs. Bella Saxe
Mrs. Ruth Drimer	Mrs. Bella Saxe

MARY BESSNER MEMORIAL FUND FOR CANCER RESEARCH

DONORS	IN HONOUR OF
Elaine & Leo Guttman & daughters	Mrs. Freda Frohlich — speedy recovery
Elaine & Leo Guttman & daughters	E. Kantor — speedy recovery
Elaine & Leo Guttman & daughters	Mr. & Mrs. Martin Nadler — wedding anniversary
Elaine & Leo Guttman & daughters	Mrs. Eddy Levine — speedy recovery
Elaine & Leo Guttman & daughters	Mr. & Mrs. H. Whittenoff — 30th wedding anniversary
Elaine & Leo Guttman & daughters	Mr. & Mrs. William Pinsky — birth of grand-daughter
Elaine & Leo Guttman & daughters	Mrs. Sam Tessler — birth of great grand-daughter

DONORS	IN MEMORY OF
Jack Bessner	Mrs. Bella Saxe
Mr. & Mrs. Morton Bessner	Mrs. Eva Ashmele
Mr. & Mrs. Morton Bessner	Mrs. Esther Sepinwall
Morton & Lois Bessner	Mrs. Lyla Klein
Morton & Lois Bessner	Mrs. Bella Saxe
Elaine & Leo Guttman	Mrs. Bella Saxe
Elaine & Leo Guttman & daughters	Joseph Fellows
Mr. & Mrs. Max Stein	Mrs. Mary Bessner

DAVID BETTER MEMORIAL FUND FOR DISEASES OF THE COLON AND RECTUM

DONORS	IN HONOUR OF
Mrs. David Better - \$100.00	Dr. M.A. Gold — in appreciation
Mrs. David Better - \$100.00	Dr. Israel Shragovitch — in appreciation
Dr. & Mrs. Ned Better	Sol Berger — 50th birthday

DONORS	IN MEMORY OF
Mrs. David Better	David Better
Mrs. David Better	Mrs. Sarah Hertz
Dr. & Mrs. Ned Better	Mrs. Sarah Hertz

JULIUS AND DOROTHY BLOCK MEMORIAL FUND

DONORS	IN HONOUR OF
Mr. & Mrs. William Abrams	Nathan Cummings (New York, N.Y.) — birthday
Mr. & Mrs. Sam Kaplan	Nathan Cummings (New York, N.Y.) — birthday

MYER BLOCK SCHOLARSHIP FUND IN CARDIOLOGY

DONORS	IN HONOUR OF
Ethel, Rose and Jennie Block	Mr. & Mrs. Joe Lefcoe — wedding anniversary
Shirley & Carl Goldenberg	Mr. & Mrs. Joe Lefcoe — wedding anniversary
Gus & Mabel Gray	Miss Jennie Block — in gratitude for recovery
Mrs. Rose Hartt	Misses Rose and Jennie Block
Mrs. Isaac Kert	Misses Rose and Jennie Block

DONORS	IN MEMORY OF
Miss S. Biehlman	Myer Block — Yahrzeit
Rose, Jennie & Ethel Block	Myer Block

LYNDA BLOOM MEMORIAL FUND FOR CANCER RESEARCH

DONORS	IN HONOUR OF
Mr. & Mrs. Maurice Lakin (Braintree, Mass.)	birth of great-grandson, Lawrence David Sternthal
Mr. & Mrs. Murray P. Reiser (Milton, Mass.)	birth of grandson, Lawrence David Sternthal
Dr. & Mrs. Elliot Sternthal	birth of son, Lawrence David Sternthal

DONORS	IN MEMORY OF
Rhona & Manny Bloom	Max Dickman
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Bulletin Board

SPEAKERS

Drs. A. Papageorgiou and M.F. Desgranges from the Department of Neonatology presented a paper on "Continuous Distending Airway Pressure in the Management of Cardio-Respiratory Failure Due to Patent Ductus Arteriosus" at the Annual Meeting of the Royal College of Physicians and Surgeons of Canada, held in Toronto, January 26th - 29th, 1977.

Drs. H.H. Sigman, N. Goldberg, P.H. Niloff, and C. Lachance presented a paper to the American College of Gastroenterology on the "Use of Biliary Drainage in Diagnosis of Biliary Tract Disease" in Montreal on October 26, 1976.

Dr. Leonard Pinsky of the Lady Davis Institute gave several lectures in December. These took place at the Genetics Symposium of the Faculty of Medicine, University of Manitoba, the Department of Endocrinology and Metabolism, Montreal Children's Hospital, and the Department of Pediatrics, University of British Columbia. His titles were: "How Genes Work", "Making Sense of Male Sexual Maldevelopment", and "Congenital Androgen Insensitivity: the Present and the Prospect".

Dr. Marvin L. Kwitko, Ophthalmologist, delivered the following speeches: Santa Monica Medical Center (U.C.L.A.) October 11 and 12, 1976. "Recent Advances in Cataract Surgery" California.

University of Maryland, Mercy Hospital, Baltimore, December 4-11, 1976, guest lecturer "Intraocular Lens Symposium", Barbados.

Contact Lens Association of Ophthalmologists, Jan. 14-16, 1977 guest lecturer, "Symposium on Contact Lenses", Las Vegas.

Fifth-Biennial Cataract Surgical Congress, guest lecturer, "Recent Advances in Cataract Surgery", Feb. 5-9, 1977. Miami.

Dr. G. Shyamala, Ph.D. of the Lady Davis Institute spoke on February 2, 1977 at the Department of Biochemistry, Queens University, Kingston, Ontario. Title: Hormone-Receptor Interactions and Stimulation of Murine Mammary Tumor Virus.

Dr. A. Kahlenberg, Ph.D. of the Lady Davis Institute spoke on March 13-14, 1977 at the Workshop on "Reconstitution of Transport Systems" under the auspices of the ICN-UCLA Symposium on "Molecular Aspects of Membrane Transport". Held in Keystone, Colorado, title: Reconstitution of D-Glucose Transport in Vesicles Composed of Lipids and Intrinsic Protein (Zone 4.5) of the Human Erythrocyte Membrane.

Dr. Morton Kapusta, Rheumatologist, spoke on "Modern Medicine and the Book of Job" at the Beth Zion Men's Club, March 20, 1977.

GRANTS

Lady Davis Institute for Medical Research, research grants received:

Mark A. Wainberg, Ph.D., National Cancer Institute of Canada. Project - Immunological Aspects of the Host-Tumor Relationship in Chickens bearing Tumors induced by Rous Sarcoma Virus. \$45,000 per year for two years.

Medical Research Council of Canada, Project - Immunotherapy of Cancer in Primary and Metastatic Disease. \$20,000 per year for two years.

Leonard Pinsky, M.D., Ph.D., Medical Research Council of Canada, Project - Genetics of Androgen Responsiveness and Metabolism in Human Cell Culture. \$77,946.00 per year for a period of three years.

James F. Perdue, Ph.D., National Cancer Institute of Canada, Project - Control of Cell Replication by Mitogen Receptors. \$30,000.00 per year for two years.

APPOINTMENTS

Dr. Papageorgiou, Neonatologist in Chief, was recently appointed to the Board of Examiners of the Province of Quebec, for the specialty in Pediatrics.

PUBLICATIONS

Dr. Marvin L. Kwitko, Ophthalmologist: Eohlers - Danlos Syndrome, XXII Concilium Ophthalmologicum, Paris 1974 Vol pp 661, Masson Paris.

AWARDS

Dr. Marvin L. Kwitko received the following: AMA Accreditation; (Category 2) for Lens Implantation Surgical Course.