

The Medical Profession And Public Relations*

Introductory Remarks

Fred J. Barton, M.D., Moderator

Foreword. At its January meeting the Halifax Medical Society featured on its programme, a panel—The Medical Profession and its Public Relations. It was the aim of this panel to review the public relations work being carried out in other areas, specifically the United States of America, Great Britain, Canada from Quebec west along with a report on the Maritime scene. It was felt that the subject is one of general interest to the profession and that the material set forth by the panel would be sufficiently informative and provocative to stimulate discussion as to the part we should be playing in this area, in this activity, that has occupied so much of the attention of our confreres in central and western Canada, and even more so in the United States.

Following the panel the Executive of the Halifax Medical Society has critically reviewed the various aspects of public relations work, in particular the following.

1. Emergency call system. 2. Speakers' Bureau. 3. Radio-Press Relations. 4. Mediation Committee. At the March meeting of the Society the Society will report its recommendations on these matters. We will await with interest the decision of the Halifax Society.

Why a Panel on Public Relations? What is this Public Relations business all about anyway?

Our relationship with the public is a dual one—as an individual doctor, with his individual patients on the one hand, and as a profession with the public at large on the other hand. In the eyes of our medical confreres both in Canada and farther afield, who have made a particular study of the subject, the Public Relations field is a very broad one. It embraces details of the conduct of our individual practices, such as the providing of certain minimum business requirements, providing a relief doctor in emergencies, our office personnel and the atmosphere of the waiting room. It also goes further into the broader relations between groups of doctors in a community, and to their obligations to that community, such as keeping the public informed on medical matters through the media of the press, radio, television and so on. It is the view of those who have taken the subject seriously, that no group or profession is entirely without the need of revising its position insofar as these obligations are concerned, and that if we are to reclaim our alleged depreciating position in the eyes of the public, we must put our own house in order, or be prepared to awaken some fine morning to find that some other agency is doing it for us.

Briefly then, our hope this evening is to accomplish two objectives. Firstly, to bring you up to date on what is going on in the Public Relations field, both on the local and distant medical fronts, and secondly, to determine what part we should be playing in this very important field.

*A Panel Discussion at the Meeting of the Halifax Medical Society, January 19, 1955.

Some of you will, I am sure, be surprised and perhaps even disturbed to learn the extent and variety of public relations activities elsewhere, particularly in the United States, but as well in Canada, from Quebec to the West.

There are many aspects to any public relations programme, but the chief activities in operation on other fronts are: radio and television programmes, health forums, a continuous flow of newspaper articles, emergency call systems, mediation committees to iron out differences between patients and doctors, and so on. This panel cannot hope to deal in detail with all these facets of public relations work, but we do hope to bring out the salient points in these activities.

We feel that the story can be best illustrated by confining ourselves to a review of the public relations work in four main areas—in the United States, Great Britain, the Maritimes and the rest of Canada. As you will see, a review of these areas points up the situation that prevails in nearly every field of endeavour—namely that the United States is usually inclined towards the somewhat radical or revolutionary practices, Britain on the other hand is quite conservative, and Canada, as always, takes the middle road; and the Maritimes, as usual, take the right of the middle road.

The American View

Denis R. S. Howell, M.D.

Most of us are aware, I think, that in the United States, three or four years ago, the American Medical Association decided on a policy of spending large sums of money to improve relations between the profession and the public, directing their efforts in order to influence the Federal Government, large business organizations and organized labour groups, as well as towards individuals. The sums of money involved were stupendous, running into millions of dollars; the American Medical Association publications on the subject tell us that even relatively small Medical Societies, such as the County Medical Associations, which might correspond in membership to our own Provincial Medical Association, averaged something like \$50,000 annual expenditure on public relations.

However, I was rather surprised and pleased to discover, on reading these publications of the American Medical Association, that, arising out of this one big effort to suppress legislation which it was felt would be undesirable for the profession, had been created an organization to improve the ethics of the profession generally, and to encourage the individual physician to do all in his power to be worthy of the affection and respect which were once enjoyed by his father and his grandfather before him. The American Medical Association has issued detailed instructions to guide physicians in these endeavours, and I have here one folder which refers to a minimum public relations programme for County Societies, including recommendations for what are termed the basic needs for public relations. The recommendations from the American Medical Association, which they think should form a part of the activities of every Medical Society, are listed under eight headings as follows:

- (1) Provision of emergency medical care on an around-the-clock basis.

- (2) The establishment of a mediation committee to hear patients' complaints.
- (3) The development of good working relations with press, radio and television interests.
- (4) Maintenance of active speakers' bureaus supplemented by other health educational activities.
- (5) Organization and promotion of a plan to provide medical services for all who cannot pay for them.
- (6) Indoctrination programmes for new Medical Society members.
- (8) Participation in citizenship activities.

To deal with these briefly one by one: emergency medical care, on an around the clock basis, receives considerable publicity in the popular press, and the lack of such services in some areas has caused criticism of the medical profession as a whole. The provision of emergency medical care in most parts of the United States, as in Canada, is arranged largely by means of the telephone—the emergency calls systems. One point of interest here is the role played by the specialist in such call systems. The recommendations of the American groups largely are that the specialists should be prepared to play their part, acting on these occasions as doctors rather than as specialists.

An important, and in one way a rather revolutionary recommendation, is the creation of mediation committees. (These committees have various titles—mediation committee, grievance committee, board of censors, public relations committee and so on.) These committees hear complaints lodged by members of the public against individual Society members, the Society as a whole, or any physician regardless of whether or not he is a Society member. Many American Societies include one or more lay members, and this, apparently, produces a favourable reaction by the public. The individual member of the public, in approaching a doctors' group, is apt to think that the doctors are a closed and prejudiced society, and the presence of lay members on the committees is sometimes considered to be a good thing. Such lay members, however, are always nominated and appointed by the members of the Medical Society themselves.

The development of good working relations with the press, radio and television in the United States is regarded as most desirable, particularly as some of the medical news in the press is certainly not authoritative, and very often gives a garbled account of the value of new drugs and treatment procedures. Many doctors also appear on radio and television programmes.

The speakers' bureau has attracted a good deal of attention, and such bureaus exist in almost all the American states. The usual means by which they come into being is for some local newspaper or some labour group to sponsor public forums, and doctors are asked to speak in lay terms on such subjects as obesity, cancer, new drugs, high blood pressure and so on. The American publications suggest catch-penny titles for these forums, such as "Too Fat?", "Quacks and Charlatans, How Gullible Can We Get?", "Why Executives Drop Dead", "How to Live with High Blood Pressure", "Calm Those Nerves", and so on.

The organization and promotion of plans to provide medical services to all who cannot pay for them appear to occupy a fairly large part of the needs of the United States public, as expressed in these publications. I had the impression in reading these books that perhaps the United States as a whole did not have the facilities to look after the indigent sick except in the large centres, to the degree which we understand those facilities here.

Number six on the list was an indoctrination programme for new Society members. Most of the Societies which are quoted in this booklet lay great stress on the importance of impressing the doctor who first joins a Medical Society with the advantages of belonging to organized medicine, and take the opportunity, too, of impressing upon the young doctor the ethical approach to medicine. However, there are certain other advantages, in that the doctor, on joining a Medical Society, is told of the medical needs of his community, and other information is available to him, such as the days when rounds take place at the local hospital. In some societies he is even given assistance in obtaining office space, procuring a secretary and so on.

The public service projects referred to include health examination campaigns, disease detection drives, cancer detection, diabetes detection, V.D. campaigns, immunization programmes, surveys of convalescent homes, establishments of speech and hearing centres and so on. Naturally enough, in the United States as in Canada, some of these needs are covered by federally supervised organizations, and some are looked after quite adequately by voluntary organizations.

I think perhaps that most of us would not readily think of citizenship activities in relation to this question of public relations, but the point is made in the United States that the doctor is more than just a practitioner of medicine. He is a well-educated person who should be well aware of his responsibilities to the community as a whole, and it is felt desirable that doctors should make the time to join community groups and health councils, should work in close co-operation with labour groups and allied groups, and certain specific community groups such as service clubs, church and civic organizations, veterans' organizations, parent-teacher clubs and so on. The desirability of doctors submitting themselves for public office is also stressed in some instances.

The British View

L. C. Steeves, M.D.

Doctor Howell has indicated that the threat of State Medicine in the United States resulted in the development of an active programme of public relations there. Some maintain that the establishment of the National Health Service in Great Britain represents a failure of public relations activities by the British Medical Association.

The public relations policies of the British Medical Association have been revised as recently as 1953, and it is of interest to compare them, point by point, with the eight major items emphasized in the previous presentation.

- (1) Emergency medical care is a conscientiously provided service by the individual practitioner, who, whenever he is not available, provides

a substitute; since inception of National Health Service, an element of compulsion has been provided.

- (2) This element is the British equivalent of a mediation committee. In each district, the Executive Council—of mixed medical and lay membership—has, as one of its duties, the hearing of complaints by patients against doctors. The doctor has no avenue for complaint against a patient—other than dropping the patient from his panel—but can defend his actions if called before the Council by a patient.
- (3) Relationships with the press, radio and television, are bound by regulations covering advertising and canvassing in paragraph six of the Warning notice of the Medical Disciplinary Committee. Regarding "discussion in the lay press"—it may be legitimate, or even advisable—that medical practitioners should contribute. They are warned to make it a condition of publication "that laudatory editorial comments or headlines relating to the contributors professional status, or experience, shall not appear," and to avoid references "which may lead the public to expect or demand a specific line of treatment." A photograph is regarded as "a most undesirable form of publicity. In the case of radio and television, practitioners approached to appear should insist on anonymity."
- (4) The speakers' bureau exists in the form of British Medical Association officials, public health medical officers and others in similar official posts, regarding whom the regulations state "publicity is necessary—provided that it is not used for the individuals advancement."
- (5) The National Health Service effectively provides "medical service for all" with provision for a certain degree of choice, both on the part of the patient and the doctor.
- (6) Concerning indoctrination programmes for new practitioners I have no information.
- (7) Initiation of public service projects is a function of the health service.
- (8) Participation in citizenship activities is encouraged, in fact, by mention in the Warning Notice well in advance of discussion there of the previous points mentioned "it is a recognized duty of a medical man to take his share of a citizen in public life and to hold public office should he so desire, but it is essential that the holding of public office is not used as a means of advertising himself as a doctor."

In summary—the long experience of our British colleagues in the field of public relations has resulted in procedures closely paralleling American ones, but with wise precautions—such as that of anonymity, added.

The Canadian View

H. C. Still, M.D.

Having heard something of what is going on the United States and Great Britain, I propose now to give you a brief picture of the public relations scene in Canada—that is, except for the Maritimes, about which Doctor Titus will speak later. This will be factual rather than critical, but I hope it will form the basis for discussion and criticism later on. In general, it might be said that the Canadian Medical Association Executive and the Medical Societies of the Western Provinces, notably British Columbia and also Ontario have become very public relations conscious during the past few years, and have engaged themselves in a number of advertized projects, and activities in an effort to make the public feel more conscious that the medical profession is their friend and helper in time of trouble—and not just a tight union of disinterested moneymakers. Let us now see what is going on across Canada in the several aspects of public relations which the previous speakers have mentioned.

Emergency calls. Since 1949 the Canadian Medical Association has strongly recommended the establishment of local emergency call systems, through which a doctor may be obtained when the family doctor is not available. A large number of townships across Canada have done this and, I understand, they work very well and are satisfactory to both doctor and patients. The method by which this system operates varies. Perhaps the simplest and most desirable is the insertion on the front page of the telephone directory of an advertisement on the lines "EMERGENCY MEDICAL SERVICE. FIRST CALL YOUR FAMILY DOCTOR. If he is not available Telephone 1234."

Mediation Committees. All the county medical societies under the auspices of the Ontario Medical Association have official mediation committees, which consist of doctors only, for hearing complaints from patients. Though the committees rely largely on moral persuasion, they have found most doctors are sensitive to the opinions of their colleagues and readily abide by committee rulings.

The majority of cases heard so far have involved misunderstandings between doctor and patient, and have been settled amicably with either an explanation or an adjustment of fees. Extreme cases of unprofessional conduct are referred to the professional licensing authority in the province, the Ontario College of Physicians and Surgeons. Encouraged by the Canadian Medical Association mediation committees are spreading rapidly to other parts of Canada.

Press Relations. Press relations of a positive kind have been established in several of the Canadian Provinces and especially in British Columbia, Ontario and Manitoba. This has taken the form of a well run press room, at provincial and divisional conventions—for example, the Canadian Medical Association, Winnipeg Convention; also the appoint-

ment and close liaison of chosen doctors representing the local Medical Society and press correspondents in the locality concerned to keep the press informed of medical matters, and obtain suitable publicity in the newspapers.

Publication of newspaper articles by leading men of the profession on subjects of general medical interest to the public has been sponsored, with success, in Vancouver, Toronto and other centres. One of these articles—on obstetrics—was written by our own professor, Doctor H. B. Atlee.

Radio and Television. Radio programmes on medical subjects have been sponsored by the medical profession in British Columbia, Manitoba, Quebec and Ontario—for example, in British Columbia, they are giving a fifteen minute programme each week, during which a radio announcer interviews one or two doctors about clinical subjects, new medical developments, or the purpose and objectives of medical organizations. In Manitoba the Medical Association have sponsored a weekly radio series called "Doctors Orders." The cost is about \$52.00 per episode; some programmes already put on include, "Repair Jobs," about tonsillectomy; "Lucky Break," about fractures; "The Vampire," about anaemias; "The Book of Life," about diabetes.

Finally, Public Forums. Following their success in the United States, British Columbia started holding public forums on medical topics in 1953. These forums were sponsored and built up by the Vancouver Sun newspaper. This paper gives much space to preliminary advertising and after-the-event reporting, including many large photographs and "buildups" of the doctors taking part, and also of the subject matter of the forum. The newspaper finances the publicity and the meeting hall. In British Columbia, these forums have been well attended, averaging about two thousand at each forum. Admission, of course, is free and, I understand, there is no collection. The medical team taking part is carefully chosen for public appeal and ability to speak, and intensively rehearsed beforehand. About one hour is allotted to the forum and one hour to questions from the public. The questions are screened by the moderator before being put to the panel. In Toronto, last year, a rather similar programme of forums was sponsored by the "Telegram" and were also very highly publicized by that paper. You can see for yourselves the extent of the Toronto publicity from the newspaper cuttings displayed in this auditorium.

Such then is a very brief outline of the public relations activities sponsored by various Provincial Medical Associations across Canada. To sum up, it might be said that Canada as a whole—true to her political form—is steering a rather devious course between the Scilla of the American Medical Association's rather extreme enthusiasm and, at times, almost hysterical embrace of public relations and the Charybdis of the British Medical Association which maintains its traditional emphasis on the doctors anonymity and upholding the dignity of the profession at all costs.

The Maritimes

A. W. Titus, M.D.

Public relations in medicine, as you have heard from the other speakers, has become a very live issue all over the world. In contrast to what is being done in the United States, Great Britain and even the other provinces of Canada we in the Maritimes have done very little. More particularly, in Nova Scotia public relations is in its infancy.

A good deal could have been done but because of our own apathy or disinterest in our medical economics we have like the old expression "Let George do it," sat back hoping it would all straighten itself out. We have let insurance companies, government, the public and even our own Maritime Medical Care Incorporated sell our services without a murmur until we find that the perpetual form or forms we must fill in have become an annoyance either because they are often at rates well below our recognized minimum schedule of fees or the extra paper work has become at times ridiculous and very time consuming. This leads to many difficulties between doctor and patients that should never arise.

We often sit around doctors' rooms or in small groups to gripe amongst ourselves about this or that. Often it is the same problem year after year but we do not organize our thoughts on a systematic basis in order to do something about these difficulties when the proper time comes such as our monthly meetings or the annual Medical Society of Nova Scotia meeting. The purpose of this panel to-day is to stir up your interest in public relations and medical economics in order that we may start some sort of programme to correct this situation and regain full control of our own business and maintain our respected position in which the public holds us. It is only by such an organized effort on our own part that we can correct some of the misconceptions the public has about us and make for smoother relations and perhaps more co-operation in the future.

The need for a public relations programme in this province is urgent. You have heard what is being done elsewhere. We may not need quite as extensive a programme as they have outlined but I do feel we can at least make a start. As individuals we can begin in our own offices by being more explicit with our patients. One cry of the public is that we do not tell them anything. I know doctors who advocate tell them nothing or as little as possible. Many times I have asked a patient what this or that scar on an abdomen was for, only to be told "I don't know." We have tried to remain mysterious and aloof. In this modern age the public is inquisitive about disease and I believe that we can remove much of the fear of the doctor and get much more co-operation from our patients if we explain things to them in every-day language they understand. There are unusual circumstances where this is undesirable but even this is getting uncommon.

Another thing I find that patients appreciate is an explanation of our charges. Many places, in the United States particularly, doctors are itemiz-

ing their bills in all cases. From all reports this has been very successful and the public has been most appreciative. In most instances it has ruled out the charlatanism and the black sheep in our profession who are in it for the monetary return alone. They soon get known in a place where this itemizing is a practice. There is also much less criticism of the doctor's income in these areas. We all know that we have been listed in the press as having the third largest income in Canada, \$10,000 per year. I believe it is by these methods we can defend ourselves about our incomes and will be accepted by the public in the proper light and I think it is time we did defend ourselves instead of accepting these insults without a comeback. This could also be done by properly written and screened articles. We did a year or so ago have published a series of articles in our local press on the subjects of Health Insurance, The Cost of Medical Training, Medical Ethics and Medical Licensing. This is a start and it should be carried further. More articles should be written. More articles, not about diseases, but about our economics, especially those aspects that concern the public or government. Articles that explain the high cost of medical care such as was done in MacLean's Magazine some years ago but with a local flavour. Explain that hospital costs are the biggest bill not the doctor's fee. Explain why there is a shortage of private hospital beds. Point out to the people that there are men like those on our public ward staffs who serve many long hours and do countless costly operative procedures without any pay. Give them some idea of the amount of free work done even by private physicians who give of their time too, often in the middle of the night or on holidays, who never get paid for their work. The public or government does not appreciate the amount that is actually being done. I believe such properly run surveys and articles could do much to relieve the undue criticism levelled at us by the public and make for much better understanding on both sides.

The things I have discussed are things we can do on an individual basis. Let us now turn to the things we can do on a collective basis as a society of doctors. Doctors Howell and Steeves have listed certain ideal programmes such as is being done in the United States AND Great Britain. Lets examine what we have done here to date.

1. We have approved the appointment of a full-time secretary for our provincial society. This I feel is a big step forward and will bear much fruit in the field of public relations not only with the public but with our other provincial societies. He will act a a co-ordinator and a mouth-piece for any programme which we adopt. A central clearing house.

2. We can modify our decision of a couple of years ago in regards to supplying speakers to such deserving organizations as the Red Cross. I am sure that the committee that asked for this help during their blood donor drive two years ago were taken aback at our refusal to help in this manner. We did allow certain public officials to do this but that is not what they wanted. This service is as valuable to us as it is to the patients and I think we could have done this without violation of the Canadian Medical Association code of ethics. Radio speakers could still be anonymous although I

still do not know how television could maintain anonymity. Perhaps Doctor Steeves could answer this later. This question will arise even more prominently if open forums are to be held, and we should be prepared to give an answer.

Speakers have been provided for such groups as the Cancer Society, Diabetic Society and the Red Cross financial drive and I have myself been on a radio panel on Health Insurance. All these were done by permission of or request of our Medical Society of Nova Scotia. I might say here that if all reports received from the radio station and doctors in that broadcast area are correct we were successful in promoting a much better understanding on the part of the public of what Health Insurance would mean if brought in at the present time as advocated by certain political parties. Many letters were received from laity thanking us for clearing a picture that was before very hazy and misleading.

3. I believe we as a group can take proper steps to correct the public relations emanating from our so called Maritime Medical Care Incorporated office. In the eyes of the public this corporation is our baby and I believe we are skirting our duty in not seeing that this situation is corrected. I believe a proper committee properly publicized should be set up whereby subscribers could place their grievances to be investigated and action taken if necessary. There is one for doctors but we seldom use it. I believe public relations could improve greatly and perhaps Maritime Medical Care could enlarge if such a committee were available.

4. In regards to an emergency call system mentioned by Doctor Howell, we all remember that this problem has been investigated fully here on two occasions. Both times it was turned down. The first time because it was felt not necessary, with Telephone Answering Service practically providing this service. Some time after this some discontent developed and we investigated the possibility of operating our own medical switchboard. This was found impractical both from the cost angle and the fact that it would probably mean the end of Telephone Answering Service Ltd. It is still a problem and I feel that we will have to work it out eventually. Some of the smaller towns have a rotation system in operation for Sundays and holidays using their hospital switchboards for clearance of calls. It has worked well in some places and badly in others. Public relations were improved in some and worsened in one that I know of. In this case the doctors were at fault accusing one another of patient stealing. This system is easier to manage in a small town than in a large city such as we deal with.

5. Mediation and disciplinary committees. We have nothing so far in this field. I suppose our Provincial Medical Board partly fills this function but not very active. Also it is not a publicly known body such as is advocated where the public can take its grievances for arbitration. This is a thing to be carefully thought over before being instituted, yet it is one thing that if properly run could go far in wiping out charlatanism and improving public relations.

6. The matter of liaison between medicine and the press we have tried with some success. The New Brunswick Medical Society and to a lesser extent our own provincial conventions are reported. In New Brunswick a press representative sits in on all the meetings and his report is edited by an appointed press committee before publication. This includes business meetings and in one instance disciplinary measures against one doctor were discussed and published. The public responded favourably to this as did the Society and much was gained in making the public realize that medicine is not a closed shop and that proper supervision is given even to its own members. Also, speakers at these meetings were cognizant of the fact that they might be quoted in the press of any statement they might make. A permanent press committee could be very useful in this regard for the press would have some one definite to turn to to get straight forward reports and some one to turn to for information when necessary. It would prevent garbled reports and add a local flavour to any national article which they might like commented upon.

7. Television and public forums I am yet to be convinced about but perhaps my fellow panel members can change this. I am convinced, however, that correction of some things I have mentioned and by the institution of some others we can improve our public relations and all gain a better insight to our medical economics. Are we to start on such a programme of public relations or muddle along as we have been doing and let government and insurance agencies take us over? Are we too proud to tell the public our difficulties? With the way income tax officials are treating us, I do not think so. We must fight now and it is my firm belief that a greatly expanded and intelligent and properly organized public relations programme supplies at least part of the answer. It is up to us. What are we to do?

Age, Fat And Metabolic Weight

C. Beecher Weld, M.D.

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Most clinicians are well aware of the tendency for man to put on a bit of weight with increasing age. Even when weight is not increased, it is often apparent that the subject is laying down fat. Evidence for this is only too clear in the thickening of the shoulders and the greater waist line and if weight is not increased correspondingly it is because of a loss of non fat tissue shown by the spindle shanks and the general flabbiness.

Many an attempt has been made to evaluate this change in body make up by anthropometric studies and by more or less elaborate systems of measurements of skin fold thicknesses, but the magnitude of the changes was hardly apparent until methods were devised to study them more quantitatively.

It is felt that a brief account of the methods available and of some of the findings obtained in the last few years might be of interest. The methods are far too complicated to be applied in a routine fashion but they have now been carried out in a large enough body of human volunteers to give the results considerable interpretive significance. Apart from the anthropometric and skin fold techniques, the methods available fall into three classes, (1) Densitometry, (2) Body water partition, and (3) Fat soluble indicators.

(1) *Body Density*. In methods involving this principle, the density or specific gravity of the body is determined by weighing the subject first in air and then submerged in water. Allowance, of course, is made for the buoyancy of the air in the lungs. Let us suppose that the density of the whole body was found to be 1.065 gm/ml. (a normal value). Assuming the density of pure fat to be 0.901 and that of the fat free body to be 1.097, it can be seen that it is possible to calculate the proportion of fat in the whole body mass. A fat man may have a density of as little as 1.018, and it must be evident that his body contains a much greater proportion of low density fat than a normal young man with a density of 1.065 or a normal middle aged man with a density of 1.045.

The density of obesity tissue is a rather constant .948. It is made up of three components; 62% of pure fat with a density of .901, 24% of cellular matter with a density of 1.057 and 14% of extracellular fluid with a density of 1.002. The fat free body is made up of cellular matter with a density of 1.057, extracellular fluid with a density of 1.002 and bone mineral with a density of 3.0. In the case of normal healthy people the proportions are such that the density of the fat free body is 1.097. Unfortunately the proportions of these components are not constant in abnormal states. In the obese there is additional cellular matter and extracellular fluid as well as fat. In edema there is additional extracellular fluid. In emaciated states there is a greater proportion of extracellular fluid. All these will tend to lower the density of the fat free body and if these abnormal states are present they must be allowed for in the calculations. Thus the matter is not simple; not only are the weighings difficult, but the calculations become extremely complex. But they can be made and they do give reasonable results, that are supported and checked by other methods.

(2) *Body water.* The methods using this principle involve the following assumptions, (a) that the body cells (non fat) consist of 70% water and 30% solids, and (b) that the bone minerals make up 7% of the body weight.

The body weight is made up of the body fat + total body water + cell solids + bone minerals. Or, transposing, Fat = Body Weight - body water - cell solids + bone mineral. Each of these components may be determined as follows,—

Total body water. This is done by injecting a substance known to diffuse evenly throughout all the body fluids and determining the degree of dilution. Urea or antipyrine or heavy water are the substances most commonly used. Antipyrine is perhaps the most satisfactory and the antipyrine space is determined.

Cell Solids. By determining the total body water and subtracting from it the extracellular water, we obtain the cell water and the cell solids are assumed to be 30/70 of this. The extracellular water is determined by injecting a substance that diffuses readily into the tissue spaces but does not enter the cells. Inulin or sodium thiocyanate are the ones used. The latter is most commonly used because of its technical simplicity; it gives results that are consistently too high, the extracellular water being .68 of the thiocyanate (TCN) space.

Bone minerals 7% of body weight in normal adults. This figure is lower (perhaps 4 or 5%) in obese or grossly edematous people and higher (perhaps 8 or 9%) in emaciated individuals.

To sum up in equation form, the body fat is calculated as follows —

Fat = Body weight - Antipyrine space - $\frac{3}{7}$ (Antipyrine space - .68 TCN space) - 7% body weight.

It is evident that there must be a considerable error in each of these measurements even under the best of conditions and that the error will be greater under such conditions as excessive obesity, edema states or emaciation. Nevertheless the method does give us a reasonable estimate of the body fat and the results check surprisingly well with those obtained by the other methods.

(3) *Fat soluble indicators.* Nitrogen is about five times as soluble in body fat as in water and cyclopropane shows an even greater solubility in fat. By collecting the nitrogen washed out of the body by breathing oxygen for a number of hours calculations of body fat have been made. Similarly, in animals the amount of cyclopropane absorbed after several hours of breathing 20% cyclopropane has been measured and used to calculate the body fat. These methods give results that are of the same order of magnitude as the other methods.

These then are our methods; they are crude and subject to considerable error but they do allow us to get a reasonably quantitative measure of the fat of the body. Furthermore, at the same time we gain insight as to the proportions of other body constituents such as the fat free cell mass, or 'lean body mass' and the extracellular fluid. Another useful conception is the 'active

cell mass' by which we mean the gross weight minus the estimated extracellular fluid, fat and bone mineral. This conception is particularly valuable in considering problems of metabolic rate. The findings, perhaps do not provide us with many new clinical concepts but they do give us a more precise and definitive understanding of several clinical conditions. A few such applications may be briefly mentioned below.

The Fat Load.

Normal young men are found to have 7-22% fat in their bodies, normal young women showing figures in the 13-29% range. Obese people may contain up to 50-60% fat. In terms of pounds of fat to carry around a lean young man might have (10% 150) 15 pounds, a big middle aged non obese man might have (20% 200) 40 pounds, and a very obese person might have (50% 300) 150 pounds. Even a 40 pound pack is quite a load when carried far, especially uphill.

Weight change and diet.

When weight is lost or gained by a normal person simply as a result of changed caloric intake, so long as the change is not excessive it is probably true that it represents a change in adipose tissue chiefly. However adipose tissue does not consist of 80-90% fat as is commonly believed but it is made up of 62% fat, 24% cell matter and 14% extracellular fluid. Measurements of these components during minor weight changes show these figures to be substantially correct. However in more extreme conditions such as semistarvation or emaciation these proportions are grossly altered.

With more severe forms of calorie deficit the loss of cellular tissue becomes progressively larger as starvation proceeds. The absolute extracellular fluid volume does not change until emaciation is severe when it shows an increase. Of course the relative proportion of extracellular fluid to body weight is steadily increasing.

In extreme starvation there is almost complete depletion of the fat depots and any further famine causes great cell loss though the weight change may be offset by development of edema.

In the emaciated person who gains weight on an abundant diet, the sequence of events is interesting. For several weeks there is an increase in fat and in cellular matter though the fat accumulation is in excess. Not until later is the extracellular space reduced to normal values. When body weight and extracellular fluids have been restored to normal there is still a considerable excess of fat and it may take several more weeks for the post-starvation excess of fat to become replaced with cellular matter.

Age Changes in Fat.

Many adults as they grow older, put on a bit of weight or even become frankly fat. It requires no particular study to know that these are depositing an excessive amount of fat. Most people, however, pass through many years of adult life with very little weight change, but as has been stated in the first paragraph of this paper there is a change in the distribution of tissues. Fat

replaces active cell tissue (chiefly muscle); there are many reports of this in the literature but most are largely either mere qualitative reports or very crude quantitative estimates. The densitometry and water distribution methods described cannot be considered very precise but as compared to the older estimates they are models of accuracy. The following table is compiled from several reports from workers using these methods and standardized methods of calculation. The figures represent the averages of groups of healthy men or women of the stated age, volunteers, selected because they happened to be the exact normal weight - height ratio for their age according to standard tables. In other words they would be considered to be normal people, neither fat nor thin.

	Age (years)	20	25	35	45	55
Men,	% fat	10	14	17	22	26
Women	„	—	26	31	35	39

Skin fold measurements were also made on these people and on the average, in all the age groups those of women were about 50% higher than of men. Measurements were made at many sites and averaged, but it was noted that the chest fold most consistently fitted the average.

Physical Activity.

The same workers from whose papers the above table was compiled, have also shown that the steady replacement of cellular tissue with fat as age advances is largely the result of physical inactivity. They compared a group of "physically active and of inactive individuals drawn from a larger sample of healthy middle-aged (52 years) business and professional men." The active men continued to participate in recreational activities involving physical exertion, the inactive group did not. Matched for age and height the active group were slightly heavier and by comparison with standard tables would be considered slightly overweight but their fat content was lower, the extra weight being due to a considerably larger lean body mass. There was little of the disuse atrophy characteristic of 'normal' aging.

Basal Metabolism.

It is a time honoured custom to report the basal metabolic rate in terms of % normal and to compute the normal in terms of Cal/sq M/hour for the appropriate sex and age group, and it is not likely that this will be changed. However this method of reporting is not entirely satisfactory; the emphasis on the surface area is hardly justified. It is true that if we compare the metabolic activity of a series of animals ranging in size from mouse to elephant the caloric output is more closely related to the surface area than to body weight but when comparing two animals not very different in size it matters little which unit is used. Fat tissue has a much lower metabolic activity than lean body and differences in body build may more than outway the advantages of using the complicated surface area system instead of the simpler body weight.

Throughout adult life the standard caloric output per square meter of body surface is less for women than for men and it declines in both sexes with advancing years. However if the caloric output is calculated on the lean body mass these differences and changes disappear and it would seem that the sex and age differences in metabolic rate are merely a reflection of the differences in body build. If one could assume an individual to be euthyroid, the lean body mass might be estimated from the basal metabolism.

This relationship, however, is altered in young growing individuals, in individuals recovering from some wasting disease and developing new tissue, and even in normal people actively putting on weight. For some reason the newly added active tissue has a basal metabolic activity nearly twice that of normal tissue and it is for this reason that juveniles and convalescents ordinarily show a higher metabolic rate than normal constant weight adults.

These phenomena are important in interpreting the metabolic rate of the obese individual. When expressed in the usual way his BMR is low but if it is calculated on the basis of what the caloric output should be for a person of his height of normal weight, his B.M.R. is high. This discrepancy is due to the fact that obesity tissue consists of about 24% cellular material, which is metabolically active, and contains only 75% of metabolically inactive material. His total metabolic activity, therefore, is high but not as high as his increase in weight or surface area would lead one to expect. If he is in the stage of actively putting on weight, however, the extra metabolic activity of the newly formed tissue will make his B.M.R. higher than it will be when his weight becomes established. An obese person of constant weight will show the same B.M.R. as anyone else if it is expressed in terms of Calories per pound of lean body mass.

Other applications.

The conception of lean body mass instead of total weight may lead to a better conception of other body constants as well. For example, the cardiac output and plasma volume measurements correspond more closely to the fat free mass than to the total body weight. Furthermore in the calculation of doses of certain drugs it is important to know whether they are primarily fat soluble or water soluble and to adjust the dose on the basis of the degree of adiposity rather than on total weight.

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Management of Bronchial Asthma in Children

A New and Successful Method*

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SOLUTION of the problem of asthma in a child is not simple. In many cases inciting causes are multiple and there is by no means agreement among allergists as to methods of diagnosis or of treatment. Meanwhile we are all seeing these youthful patients and their distressed parents. Both voluntary societies and government agencies are doing something for the assistance of children who are crippled by skeletal and muscle defects, but to date no such agency seems to be too much interested in the child who is seriously crippled by bronchial asthma. It is up to the individual physician (general practitioner, paediatrician, or allergist) to take a special interest in such patients and endeavour to remove this handicap from the asthmatic child. This paper presents a method of management of such cases which in the author's experience has been extremely efficient and economical. A theory is also presented which is consistent with our present knowledge, and which would seem to explain the excellent results obtained.

A very careful history of the circumstances preceding and attending the onset of the first attack is extremely important. It is also important to get an accurate history of the child's normal living conditions and conditions preceding or accompanying isolated attacks; as well as the type of treatment, if any, which has been given to date, and the patient's reaction thereto. Sometimes in the taking of such history the author finds it is very necessary to spend some time in educating the parents so that they can give a useful history. All too frequently, although they are aware in a general way of the fact that bronchial asthma is probably due to an allergic reaction to something, they have entirely erroneous ideas of the nature of allergy. Quite often they are thinking in terms of large amounts of offending substances, and will assure one that the child is not exposed to some potent allergen when, as a matter of fact, the child does have some occasional exposures which are quite sufficient to incite attacks of asthma. On this account the taking of a history must include much more than the asking of a routine set of questions from a printed list. A considerable period of time spent in quiet conversation with the parents answering *their* questions and explaining as far as possible the kind of thing one is looking for is frequently very rewarding. Valuable information can be obtained in this way which is impossible to get by any routine procedure. Of course if and when this history taking gives some definite clues as to probable sensitizers it is then necessary to arrange that the patient will not be exposed to the suspected allergen. If it is not something which can be avoided and particularly if it is an inhalant it may be possible to hyposensitize.

In the case of a considerable number of common allergens it seems to the writer that *avoidance of contacts* is an extremely important procedure, whether or nor there is a definite cause in the history for suspecting these allergens, and

whether or not the child is skin sensitive to these allergens. In other words there does not seem to be any point at this particular stage to skin testing a small child to such common sensitizers as feathers and animal danders. Whether or not such test is positive or negative, it is not absolute proof that the test substance is or is not causing the clinical symptom. Moreover even if one of these substances is not causing asthmatic attacks at the time of observation it is quite possible that with continued exposure the patient could become clinically allergic to it in the next month or two. It is so easy to cover feather pillows with plastic or use sponge rubber and to avoid contact with pet animals, that this should be done any way for at least a time. This is not to advocate that pets should be destroyed, since the emotional disturbance caused in a child who loses his pet in this manner may be such a potent aggravator that he would become worse rather than better. Placing the animal in an animal home or with friends for a few weeks will serve the purpose quite as well. In their excellent article on asthma in children Rackemann and Edwards⁴ reported animals to be the original cause of asthma in 25.8% of 449 children. Therefore the above procedure should serve to separate the patient from one of his most potent sensitizers in one out of every four cases. This will give such a patient a chance to be some better, and give the doctor time to study him from other angles.

Avoidance of allergens which are suspected because of the history, and of feathers and pets and other common sensitizers, will prove of great help in relieving a small percentage of patients. One should also realize that it is important to avoid exposure to inert dusts as well as those which are allergenic. For example, inhalation of road dusts can bring on or aggravate an attack of asthma, although it is highly improbable that the silicates act as allergens. It is more probable that they mechanically irritate, and have much the same effect on the mucous membranes as rubbing and scratching have on an area of eczema.

Before going to the trouble of skin testing a child with asthma the author considers it is wiser to treat the patient as though he were allergic to the products of bacteria. The reasons for this will be discussed in a later paragraph. It should suffice to point out here that in actual practice a procedure which will be described has produced very good results and seems to control the asthmatic tendency in the vast majority of patients. As a matter of fact the control or "cure" of the asthma is usually so good that in only a few cases is it necessary for the patient to take anything of a palliative nature at occasional intervals. The method will be described in detail at the end of this article.

Bacteria might well be described as *the universal source* of allergenic material. Their presence can be demonstrated in the air of rooms in which people live, and consequently in the dust which precipitates in those rooms. It is probable that bacterial products constitute the one group of potential sensitizers which is common to all "house dusts," but this is not proven. All patients carry around with them a plentiful supply of common bacteria on and in their mucous membranes. It seems to the author that in dealing with this subject there is a problem of semantics which first needs to be cleared up. The expressions "infectious asthma", "asthmatic bronchitis", and "bacterial

allergy" are often used with widely different interpretations by different workers. A little clear thinking based upon our present knowledge should prove helpful. The reaction of the body or its tissues may be either one of two types, or a combination of both; the immunity reaction, and the sensitivity reaction. It seems to have been originally intended that both should be included under the term "allergy" (the changed capacity to react). However there has been a tendency on the part of many writers to confine the word to the sensitivity reaction. This helps to add to the confusion. It has been suggested⁶ that sensitivity of particular tissues is related not only to the presence of antibodies at the site of reaction, but to the presence of the wrong kind of antibodies. These are bivalent or sensitizing as contrasted with univalent, immunizing, or blocking antibodies. The tendency for the body to react in the immunity manner to the presence of bacteria has been known for a long time and is what we mean by "infection." The fact that various bodily tissues could react in the sensitivity manner to the presence of bacteria or their products has not been recognized until quite recently. As a matter of fact up to about ten years ago the possibility of such a sensitivity phenomenon was denied, chiefly because it had not been possible to get clear-cut wheal reactions on the skin by testing with bacterial vaccines. However positive skin reactions have been demonstrated³ and the fact that bacteria are often concerned in the production of sensitivity reactions is being more and more accepted. However, as stated by Rackemann and Edwards "more knowledge of 'bacterial allergy' is needed." Such expressions as "focus of infection", "infective asthma", etc., seem to be still having an undue influence on the thinking of the profession, so that it seems to be assumed by many writers that bacteria can stimulate the sensitivity reaction only when they are at the same time stimulating an immunity reaction at their particular location in the body. The idea that there can be a sensitivity reaction *without* an immunity reaction (infection) anywhere does not seem to be popularly accepted as yet. However just as in certain seasons practically everyone is inhaling certain pollens, but only a few react in their mucous membranes in the form of hay fever or asthma, so it seems reasonable to suppose that everyone is absorbing some of the products of the bacteria which ordinarily inhabit our mucous membranes even in health. What could be more reasonable than that a few have developed bivalent antibodies in certain tissues, and have not a sufficient supply of univalent antibodies in their blood stream to block the bacterial products from reaching the sensitized tissue? If the sensitized tissue happens to be mucous membrane this does not preclude sensitivity reaction from the products of bacteria located there, as well as those which reach it after being absorbed from some other area and carried by the blood stream. Here then is a potent source of sensitizing substances to which everyone is exposed and which *could* play a part in the causation of asthma in the vast majority of cases along with other sensitizers such as inhalants, food, etc. It seems reasonable therefore to attempt to raise the univalent antibody content of the blood stream of every asthmatic patient so that his bronchial tubes will be protected from exposure to possible allergens which he may be absorbing from his sinuses, throat, intestines,—or even from bacteria which are located in the bronchia themselves and are possibly

stimulating the immunity reaction of bronchitis at the same time. Can such a procedure be carried out?

Whether or not the theory just stated is the actual explanation it does seem that the use of large doses of bacterial antigen plus antibody given according to the method to be described will clear up a majority of cases of bronchial asthma. Even in many cases where certain inhalants are known and proven to be able to set off an asthmatic attack the child seems to become less sensitive to such an allergen after raising the immunity to the type of bacteria which frequently inhabit the respiratory tract. The explanation of this *may* be that one of several allergens is minimized as a cause, or that there is a certain amount of non-specific hyposensitization (immunization) following the procedure. Some of the studies by Wright⁷ would favour the latter.

The careful history taking previously suggested frequently indicates that bacteria have played a part in initiating the child's asthma.

(1) One frequently learns that a child's first attack of asthma was during or shortly after an acute respiratory condition such as whooping cough, measles, bronchial pneumonia, or even just a severe cold. Many of these children still have some evidence of chronic sinus trouble such as nasal congestion, excess lymphoid tissue in the pharynx, postnasal drip, lack of voice resonance, a history of otitis, or mastoiditis, and quite often a history of tonsillectomy and adenoidectomy. In such cases the sinusitis would seem to be the chief source of the asthma. At least clearing up the sinusitis usually results in long periods of relief from asthma,—even in children who are known to be sensitive to other respiratory allergens. Clearing up of the sinusitis by the method of bacterial immunization which will be described has been previously reported by the writer¹.

(2) Some children develop asthma every time they get a "cold". In their excellent discussion previously referred to Rackemann and Edwards⁴ suggest that "colds in asthmatic children cause attacks of wheezing because, in theory, they lower the threshold to make a slight degree of allergy become clinically manifest. If wheezing occurs with colds, it means that the child is still in contact with some foreign dust substance." The writer cannot agree with this statement. Rackemann and Edwards seem to differentiate between asthma which is due to "allergy" and asthma which is due to "infection", but admit that in spite of their difficulties with the expression "bacterial asthma", "it is possible that allergy to infection, caused by bacteria or viruses, may really exist. . . ." The theory of sensitivity to the products of bacteria which has just been presented is simpler than one which distinguishes between "infectious asthma" and "allergic asthma." In the world of science it is an accepted principle that, other things being equal, the simpler explanation of phenomena is more likely to approach the truth. Moreover the idea that the asthma which accompanies the common cold is actually due to the bacteria concerned rather than an increased sensitivity to something else in the presence of the cold, is entirely consistent with the observations of Stokes⁵ and associates in the matter of a number of types of skin eruptions. They investigated and discussed what they termed the virus-pyogen sequence or flare which

frequently follows an upper respiratory tract infection and which they attribute to the bacteria rather than the virus. They call it "an allergic or sensitivity affair". In the case of the skin it would of course be more difficult to conjecture that an area of skin was made more sensitive to non-bacterial contactants by a common cold than in the case of a respiratory allergy like asthma.

The incidence of the common cold is greatly reduced and frequently entirely eliminated by adequate treatment with bacterial antigen plus antibody even in children who have no asthma.² Bacterial sequelae such as otitis media do not occur. Moreover the individual actually seems to be less susceptible to the initial "virus cold." This process takes some time and often a fair number of repeat doses of the larger inoculations, but even before reaching the point where he has no colds a child's parents frequently call attention to the fact that for the first time the child has had a cold which was not accompanied by an asthmatic attack.

(3) There are a few children where one cannot get any evidence from the history which suggests the association of asthma with upper respiratory infection. Even in these cases one frequently gets a history or observes signs such as have been mentioned above as being evidence of some degree of chronic sinus trouble and these children's asthma usually improves very greatly under treatment with bacterial antigen plus antibody.

(4) Among the children who do not fall into one of the previous three groups a few will nevertheless respond to the treatment under discussion but a much smaller percentage than in the first three groups. The majority of this group and the small minority of the first three groups who are not very greatly relieved (one hesitates to use the word "cured") can still be investigated by such more complicated methods as skin testing, food diaries, and elimination diets. However, if the methods described in this paper are thoroughly carried out it is the experience of the writer that the number requiring the more complicated studies will be an extremely small percentage of the whole.

Immunization (hyposensitization) against bacteria and their products:

Product: H. influenzae 'Serobacterin' Vaccine Mixed (No. 4750) (Sharp & Dohme).

Give subcutaneously at intervals of three to seven days,—not over one month. Divide doses over 1.0 cc giving half in each of two places.

Local reaction is usually a pink and slightly tender area one or two inches in diameter. If excessively large, or much muscle soreness occurs, repeat that dose before giving larger ones.

General reaction, though rare, are sometimes of benefit, and should be followed by same or a smaller dose.

The doses and their increases which the writer has been using for many years are so much larger than those ordinarily employed with other stock respiratory vaccines that any experience with the latter will be of very little help in using this method. The writer knows of a good many cases where workers have been afraid to use these doses and have given much smaller ones with very little benefit and frequently with considerably more reaction than is desirable. This reaction was sometimes of a sensitivity nature and aggravated the asthma. The explanation of this paradoxical effect may well be found in the statement by Wiener,⁶ "the reason for this may be that small doses generally elicit the formation of bivalent antibodies, whereas larger doses are more likely to induce production of univalent antibodies." The following doses are ordinarily well tolerated by children. The author has frequently given them to very small infants.

0.2 cc; 0.4 cc; 0.8 cc; 1.2 cc; 1.8 cc; 2.5 cc

The 2.5 cc dose should usually be repeated several times at intervals of one to three weeks. In a few intractable cases good results are obtained only by giving doses of 3.0 cc.

SUMMARY

The author presents his method of management of asthma in children. In the case of allergens definitely proven by history, avoidance or hyposensitization are indicated. The avoidance of contacts with **common** allergenic inhalants is urged, even if there is no proof that they are causing the asthma. After this and before using skin tests, food diaries, or elimination diets, the author suggests that all children with asthma should be treated as though they had a sensitivity to products of bacteria, by his method of inoculations of large doses of mixed bacterial antigen plus antibody. In his experience a large percentage of child asthmatics are so completely relieved that more complicated and time consuming investigation or treatment is unnecessary. The method of treatment is described, and involves rapidly increasing doses up to 15 or 20,000 million killed bacteria.

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The Child Guidance Clinic*

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TO present this topic to this convention, we feel we should first tell you of the philosophy of treatment and then present a typical case to illustrate how the investigation and treatment actually proceed.

Figure I illustrates the classical attitude towards the patient. He is looked upon in three separate distinct spheres, the physical, the emotional and intellectual.

THE PATIENT

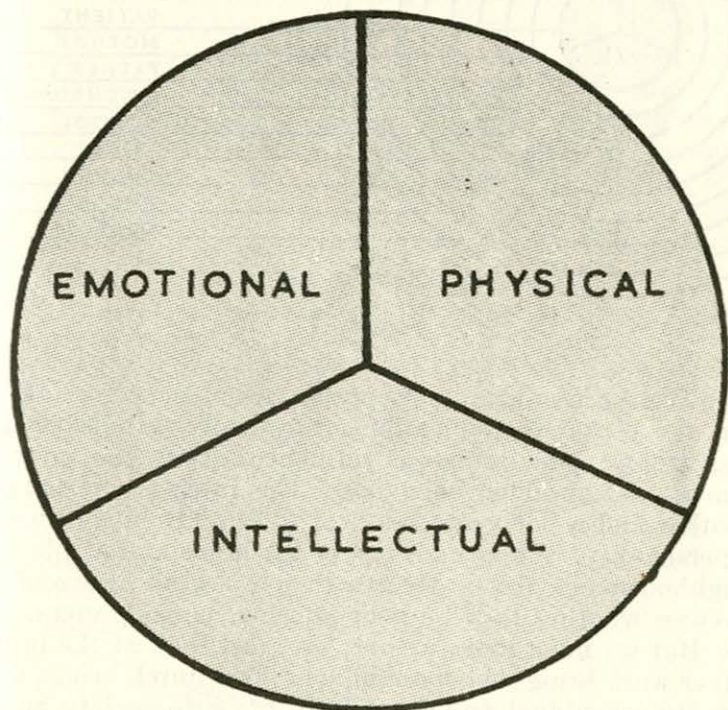


Figure I

Most of this audience have been exposed to a philosophy in medical education that emphasized the physical. From our earliest introductions to people by means of anatomy and histology, it has frequently been forgotten how a person functions as a total organism in a total field.

*Presentation-Canadian Public Health Association Meeting.—Sydney, September 10th, 1954.

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On the other hand there has been a danger among psychiatrists to over-emphasize the emotional aspects of a patient and education has had a tendency to over-emphasize intellectual functions. In the study of the patient and in particular the child patient, a total integration of all these aspects must be undertaken.

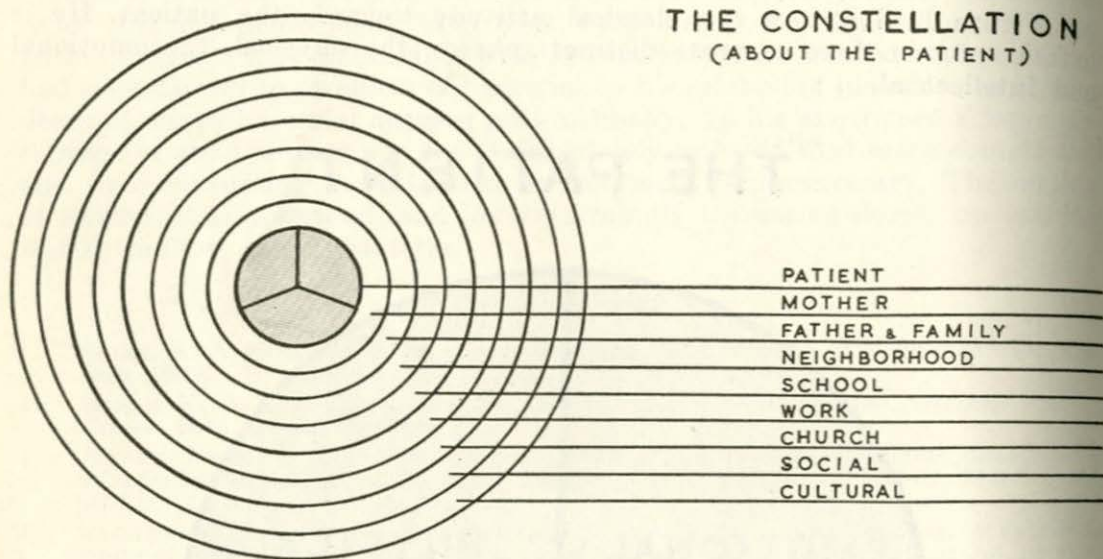


Figure II

In Figure II we present for your consideration, the complete Patient Constellation. In the center is the patient (physically, intellectually and emotionally) and around him numerous influences. It is the interaction of all these influences that produce behaviour. The interactions between the patient and mother and a few years later, of the family unit do most to shape the child's personality. When he is out of the home and at play, he interacts with the neighbourhood. Public Health People are all aware of the environmental influences whether they be poor housing, poor finances, poor diet, infections, etc. But we must look further; we must look at the influence of the school, whether work brings satisfaction, whether church brings solace or more conflict, how the individual and the family fits into society and the culture in which he grows up. Though it has been said that man is born free and equal, this is not so. The person who comes from the "wrong" family, from the "wrong side of the tracks," doesn't belong to the "right" church, has a different pigment in his skin or a different slant of his eyes, has a difficult time making a healthful adjustment.

In our clinic, it is our function to look into all these factors and we have the help and close working with many agents and agencies.

Our liaison mental health teacher in Halifax, is very valuable not only in recognizing emotional difficulties but works with the parents, school teach-

ers, and principals in our treatment procedures and helps explain our work.
(Figure III)

LIAISON

- | | |
|----------------------------------|-----------------------------|
| 1. LIAISON MENTAL HEALTH TEACHER | 5. HOME PHYSICIAN |
| 2. AUXILIARY CLASS TEACHER | 6. CLERGY |
| 3. SCHOOL STAFFS | 7. OTHER COMMUNITY AGENCIES |
| 4. PUBLIC HEALTH NURSE | |

Figure III

The auxiliary class teachers work with us and help the children who are retarded emotionally or intellectually to the degree that the school adjustment is poor. Both of these agencies work closely with school staffs, principals and teachers and we receive tremendous support from them.

The Public Health Nurse is becoming increasingly valuable to us and we hope that we are to them. In regions with less organized school systems it usually falls to the Health Nurse to do the work of the liaison teacher with parents, teachers, principals and doctors.

The home physician is recognizing emotional difficulties earlier and more accurately and I have nothing but praise for our relationships with them which improves steadily, especially as treatment of their referred cases comes to a successful conclusion.

To date, our work with the clergy has not been expanded to its ultimate goal but we are very pleased with the progress that we are making. I would emphasize that it is not our role to give spiritual guidance nor do we feel that child psychiatry can usurp the proper role of the church. Man is a social and spiritual being and our job is to strengthen and not weaken these social and spiritual ties.

Lastly, we have good relationship with other community agencies such as welfare and childrens aid societies. We feel it is impossible to have an adequate child guidance clinic when other community agencies are not well organized.

STAFF FUNCTIONS

1. PSYCHIATRIST (PHYSICIAN — SPECIALTY)
(PHYSICAL & EMOTIONAL FACTORS & SUPERVISION)
2. PSYCHIATRIC SOCIAL WORKER
(SOCIAL FACTORS)
3. PSYCHOLOGIST
(TESTING, TREATING, RESEARCH)

Figure IV

In Figure IV we have attempted to portray staff functions. The psychiatrist as a physician and as a specialist is responsible for assessment and diagnosis of the physical and emotional factors, supervision and consultation with other members of the staff. The psychiatric social worker deals with social factors about the patient especially helping the parents. Our psychologist is responsible for testing not only of intelligence but also by special techniques to understand the underlying emotional factors that contribute to the child's disturbance. Under supervision too, our psychologist carries out treatment and heads the most important role of research with a constant evaluation of our treatment methods and re-evaluation of our understanding of dynamics in emotional illness.

OVERLAP (“TEAM” APPROACH)

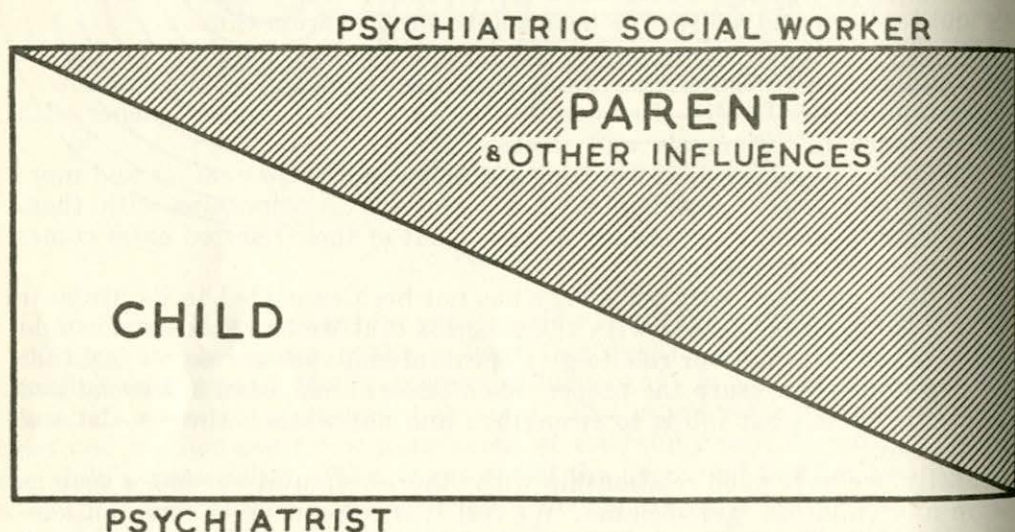


Figure V

In Figure V we attempt to illustrate the overlap in the team approach. The psychiatrist is usually concerned most with the child but also has contact with the parent and other influences. To the same degree, the psychiatric social worker works mostly with the parent and social influences but at any given point works in co-operation with the psychiatrist and the roles at times switch over. There can be no artificial line-drawing or petty jealousies in a total team approach.

In an attempt to illustrate our philosophy of treatment, we have chosen a case. We could not pick a case that would indicate disturbance in all the spheres about the patient because it would take too long and be too complicated due to time limits, so we have had to cut down some of our presentation

but we feel that it illustrates closely the interreactions between the patient, the mother, the father and the other adults in the family that contributed to disturbed behaviour in this child. In this case the neighbourhood, the school and the social and cultural influences did not seem to contribute too much to the disturbance but it was within the family and particularly the psychological disturbances within members of the family, especially mother, that were of greatest importance in etiology and therefore required most of our attention as therapy proceeded.

I first saw Shirley in consultation. The mother brought in a great number of complaints that she had all written out. But all these complaints were in contrast to my own impression of the youngster. I found her a slightly overactive and bright girl who talked freely and I felt that she had the usual interest and ambitions of her age.

I saw her several times in the playroom. I will first attempt to tell you about the playroom. We have found that it is the closest to natural setting in which to observe and treat children. Here the child can express herself quite freely with toys, and with small life-like dolls that we have available children often tell us their hopes and fears and ambitions. They feel and act differently than in a physician's office, where often they are subjected to a "third degree" of leading questions. As the youngsters play they are able to release a lot of their feelings, too. In the playroom they find what they are permitted to do, learn to become more sure of themselves and they have an example of how they might get along with an adult who handles them differently than their parents do. This form of treatment is called play therapy and we use it very extensively and very successfully. Concurrently we help the parents to change and finally parents and child make a good reconciliation and we let them go on their merrier way.

By comparison to normal and disturbed children that I have worked with, Shirley proved to play fairly normally, and freely on her age level. However, she was a little puritan. In one interview she picked up the dolls to represent her family and one of them was always bad. Shirley showed no forgiveness for him—even when I tried to prompt her that maybe the little boy was unhappy and that's why he acts bad. The mother doll was always punishing and scolding and finally the little boy ran away. On the other hand, the little girl was always good and did everything mother told her. Incidentally father was seldom mentioned. This picture of "always good" and the contrast with "always bad" was more marked than usual even in little conscientious Nova Scotians that I've worked with and correlated closely with what the psychiatric social worker learned from the mother.

Background:

Shirley, the elder of two children was born to fairly well-to-do young healthy parents seven years ago. She was three weeks premature at birth, five pounds and two ounces. It was a normal pregnancy and delivery. Mother was very anxious for a family and Shirley came after one year of marriage. As an example of the mother's attitude and overconcern, she listed that Shirley was lethargic about eating; "from two weeks to nine months she was colicky and we had an awful job with feeding her, I couldn't feed her without help." Housing and financial problems were absent throughout Shirley's development.

From the first, mother said that she noticed things. "She always tensed up with sleeping," but then mother went on to say that she used to try to move Shirley into what mother decided were more comfortable positions. Mother further said that Shirley suffered from spastic constipation and would never relax for naps since the age of one year. Shirley however, has always been healthy and the various physicians that mother has dragged her to have never found a thing physically wrong with her.

Mother's attitude towards school is very interesting. She didn't believe what the teachers told her about her daughter's social adjustment but then went on to say how well Shirley gets along with strangers, how they like her and how she likes them, how she loves to dance and how well-behaved she is in town and on trips.

From the first contact, I was struck by the mother's list of complaints, her determinations, preconceptions, standards and goals and my original impressions were definitely born out by future contacts with our social worker.

Shirley was seen about three times in the playroom and our psychiatric social worker saw the mother and father a total of seven times. Our psychologist performed psychological testing on the youngster.

Our Social Worker will now present the results of her contact and attempt to fill in the social factors whose influence produced Shirley's disturbed behaviour.

Social Work Presentation

P. Ahern, M.S.W.

Mother was seen by me on six occasions and father was seen once. Mother is 39 years of age, of better than average intelligence and is a graduate nurse. She is a pleasant person to speak to but her manner is without enthusiasm, rather blank with occasional inappropriate laughter.

During the first interview she made a strong effort to control the situation, endeavouring to put the whole blame on Shirley and not wanting to look at her own part in the situation at all. Her attitude appeared to be "we've done the wrong things—now you tell us what to do about it." She was somewhat annoyed when I pointed out that we could not give her rules and regulations, but rather, we wanted to help her to understand Shirley and herself a little better so she could handle things more easily.

Intellectually she was very accepting of the fact that Shirley needs help and that the parents have played a part in making her the way she is, but emotionally she is very resistive and puts up a great many defences. As long as the focus was kept on Shirley, progress was smooth but if the discussion turned to the mother's own feelings and attitudes there would be an apparent change to "neutral" subjects.

As soon as she arrived at my office mother seemed to be presenting a case against Shirley. She described the particular problem as follows: "Shirley is a very negative child, she does the opposite of everything that is asked, she has to be told a thousand times, she does not play with children her own age—her best friend is Joanne, aged 3. She never hurries and always has to be pushed, at first we thought she might be defective but now we think she may have the ability and does not use it. She is always cranky and irritable and often nasty. You never know if she understands you or even hears you."

She went on to tell me that she wants Shirley to be a nice little girl—a little lady—but this does not seem possible. When asked how she handled these problems mentioned above mother put a great deal of emphasis on good and bad, and right and wrong. Much is expected of Shirley and if she does not do what is thought to be "good" and "right" she is prodded and urged by the mother to do what "nice girls do" or what "good little children do", mother having read in books what is "right" for a certain age and observed from her friends' children with whom she constantly compares Shirley.

In the remaining interviews with the mother, I was able to get a better picture of her own personality; of her family, its standards and attitudes, of her relationship to her husband, and of her real feeling towards Shirley.

Mother described her husband as a hard working, driving, ambitious person, who like herself is at a loss to understand Shirley. When I met him, I saw a rather apprehensive, pleasant chap, aged 37. He appeared to have a better understanding of Shirley than her mother, and as the interview progressed he "warmed up" and spoke more freely. He said that he felt that his wife puts too much stress on little things and that neither of them relax enough. He was more ready to accept the fact that we could not lay down rules for bringing up children and that the type of help that we give takes place over a period of time.

During the following interviews mother spoke of her own family. She described both of her parents as very intelligent persons, they had attended university and always led their classes. Her father was a driving, ambitious man, working hard for whatever he got. The children always thought that the father was more intelligent but now as they look back they feel that the mother was just as clever but much more easy going, taking things in her stride. Shirley's two aunts were like their mother and her mother is like her grandfather, although she says he is a dictator.

Once when Shirley was visiting him for three months, she said in her prayers one night—"Dear God you don't have to make me a good little girl because granddaddy already has." During this three month visit Shirley behaved better than at any other time, but when they returned home and the same type of discipline was tried, it brought on a family squabble and was dropped.

Mother said that she was always an ambitious person herself and constantly made her mother very unhappy by aiming for goals that seemed too high, but with a struggle were usually reached. She was overseas with the army during the war, says that she was most independent, nothing fazed her—she could go anywhere on her own, but after Shirley was born she seemed to become completely dependant. Her husband took her to Ontario to visit her family when Shirley was six months old, planning for her to return alone, but she was so afraid that her father had to come all the way with her. She was so tense and ner-

vous that she was unable to drive the car, and says for a long time it was hard for her to believe that Shirley really was her own and that nothing was going to happen to her.

With respect to Shirley's development they had trouble with her feeding and after six months was changed from breast to bottle feeding. She had a great deal of difficulty with colic, starting at two weeks until nine months. Mother worried about this. Shirley was a fussy baby and the parents noticed that if they even tried to change her to a more comfortable position she became tense and irritable. From about this time on feeding time was battle time and it would take two people to hold her while she was being fed. From the interviews it would appear that the mother was tense while nursing.

Toilet training brought another battle and she was not properly trained until she was four years old. Shirley then went to nursery school—there were no children her own age in the neighbourhood and she was presenting such a problem at home, e.g. bedwetting, temper, feeding, etc., that her parents thought this might help.

The teacher said that Shirley got along fairly well, but mother said that she does not feel this was so. She went on to Kindergarten and then to grade 1 at the age of six. Both teachers said that Shirley was not presenting any difficulty, but the parents drove about the school grounds on several occasions and saw Shirley standing by herself at recess.

When Shirley was 5/ her brother Stanley was born. Between the two children mother had four miscarriages. She blames these on the Rh factor in her blood or on Shirley—saying to me in firm tones—"I told my husband that if I didn't stop having miscarriages we would have to put Shirley in a Home"—talking on about this and showing a great deal of hostility to Shirley.

During the first three months of pregnancy with Stanley mother was in bed. When he was born there was much rejoicing, for he was the first boy in the family for 25 years. Stanley is described by his mother as "sweet and lovable, a sunny disposition—always happy, etc."—just the opposite of Shirley. She says that it is hard to understand how they can be so different. Stanley is so "good and nice" and Shirley can be so "hateful," but going on to say that Shirley loves Stanley and there is no jealousy or rivalry, although whenever Stanley tries to be friendly towards Shirley she pushes him away.

Thus we can see how it is important for the parents to be seen at the clinic, and not just the disturbed child. With the parents it was essential to help mother with her own feelings before Shirley would change and be a happy little girl. We noticed that the mother's attitudes started to change during our contact. Both parents are eager to continue and we feel that the prognosis is very favourable.

Our psychologist will now present the results of his contacts. (M. Hirsch, B.Sc., B.Ed., M.A.)

Psychological Testing of Shirley

Tests Used—Stanford Binet Form L, Blacky Pictures, Children's Apperception Test.

My first session with Shirley was spent giving her the Stanford Binet intelligence test. Shirley, at first, was rather nervous and she giggled inappropriately, however she soon warmed up during the testing and one of the things I noticed with her was that she was extremely responsive to any signs of affection displayed towards her. When I put my arm around her she cuddled up to me very closely and most of the testing was done with Shirley sitting on my knee.

The intelligence test results indicate that Shirley is of *normal average intelligence*. However, whenever she didn't know the answer to a question she would say "I don't know." Questions which she knew the correct answer—were answered with a great deal of giggling and laughter. She appeared throughout to be rather tense, nervous and not sure of herself. The most important things that came out of this were (1) she is of average intelligence (2) she responds actively and positively to any outward signs of affection that might be shown towards her.

The next session was spent giving her the projective tests. The tests I used were the Blacky Pictures, which is a series of ten cards about a little dog called Blacky, a sibling called Tippy and the mother and father dog, and the Children's Apperception test which consists of a series of cards depicting various situations among animals such as chickens, monkeys, family consisting of a mother bear, a father bear and baby bear, a few bunny rabbits, etc.

From these projective tests it may be said that Shirley does not appear to be too emotionally disturbed. Her sense of good and bad is slightly mixed up. The word "bad" was used a great deal. To her a child is bad if she disobeys the mother. The child is bad if she dirties her clothes, the child is bad if she steals. An important thing was that Shirley probably feels that if the child is bad the parents will want to get rid of her in some way, to keep the love of her parents the child must be continually good. Now we know for a fact that children quite often get into a lot of mischief and sometimes become quite frightened of the

consequences. In this case I would say that Shirley would be very much afraid of doing anything that might gain the disapproval of her mother. The standards which have been set in the home appear to be fairly high and rigid, and Shirley is continually striving to meet these standards. At this time I don't think she is able to and as such she has become very tense, very nervous, very anxious and also very unsure of herself. In a great number of responses from these projective tests with Shirley she would never come out with a definite statement but always ask me "Is that right?" or "What do you think?" She is afraid to take a definite stand and is always looking for adult approval. Anything that does not meet the approval of the adult she would consider. She is afraid to take a definite stand and is always looking for adult approval. Anything that does not meet the approval of the adult would consider bad and would feel that the adult does not love her.

As such, Shirley is continuing to try to win the love of her mother by making sure that everything that she does is good and not bad. I would say that she is also a very selfish little girl, does not have too many friends. I don't think she is the type of child who would give freely to her friends, and she probably likes to keep things to herself, again not being sure how her mother would react.

Very little mention was made of the father and it would seem that the father, up until now, has played a minor role in Shirley's personality development.

Regarding the younger brother there is an average amount of sibling rivalry, however I think that Shirley feels that if her brother does anything bad he doesn't know any better and as such is not to be blamed for it. Her reaction to the brother is that he is a cute and funny little baby but I don't think she feels too hostile towards him.

The final session was spent partly in my office and partly in the play room. The first thing she said when she walked in my office was that she had eaten all her egg up today and she was quite proud of this. Another thing that came up that I think might be worth while mentioning was that she had told me once she had rolled down the hill during the winter and hurt herself. I asked her if she hurt her "bum"—at the mention of that word she became very excited, put her hands up to her ears and said rather loudly "don't say that word, it's not nice and you're not supposed to say it, it's bad, bad, bad." She then said the word should be "seat." Later she danced and jumped around and just couldn't seem to sit still—and appeared a very happy little child. I asked her what her mother would say if she saw her dancing, she hesitated for a minute, screwed her face up and said "mummy wouldn't say anything." I somehow had the feeling that mother would disapprove of Shirley being as lively as she was.

We then went into the playroom where she played with the comic books, put them on the floor, went to the playhouse and played house for a while—all her play is that of a normal child in a situation where she could do almost anything she pleased. Again she would quite often ask me "Can I play with this?" "Would it be all right to do that?" As soon as I gave her approval she seemed to enjoy herself immensely.

In summary I would say that Shirley is a child of average intelligence who is very responsive to any signs of affection displayed towards her—will react positively to these signs. She is very unsure of herself, a very tense and anxious little girl who is always trying to win her mother's approval by doing things that are always good. To do something bad would as she put it, "be awful, awful, awful", and only by being a good little girl can she win her mother's approval. Standards which the mother has set for her are very high, and which she is continuing to strive to attain. She is having difficulty attaining these standards and as such feels very badly about them.

Summary of the Case

We have here a seven year old youngster who shows a variety of symptoms which however, seem greatly exaggerated and over-emphasized by the mother. This picture is found very commonly in our cultural pattern where we set up such standards for our children that the virtues in themselves are over-emphasized and imposed much too young for the youngster's understanding.

Shirley is basically a healthy girl of average intelligence with at least a moderately good social adjustment but is in a home where ambition and standards, cultural, moral and financial are very high, probably so high that they contributed to her mother's anxiety state. The mother's experience and background has developed a perfectionist who covers many feelings and disguises others.

The handling of these cases is very difficult because the basic factors are tied up in the mother's attitudes and these cannot be changed by any simple rules or by telling what she must do or by referring her to a book. Only through patient handling can we bring her to insight into her own basic personality structure, and especially the way this affects Shirley. Sometimes the parents need psychiatric treatment themselves and are best treated in our adult psychiatric clinic, or by private psychiatrists, to the point of improvement where we can help to broaden their outlook into helping their children.

We would emphasize that *WE DO NOT BLAME*; that in our contact with relatives we emphasize the corrective measures that can be taken and enlist their co-operation. Blame or pointing out to this mother too quickly her defects or drawbacks in her handling of her youngster would either destroy all confidence in herself and lead to a marked increase in nervousness, or on the other hand too much pushing would arouse her hostility and resentment and in the long run—in either case—Shirley would suffer.

We would emphasize that our approach to such a case is a team approach. Our functions over-lap, i.e., the psychiatrist's contact would over-lap with both that of the social worker and with the psychologist. It is only by constant discussion and a co-operative approach in which the group works as a whole and there are not arguments and bickerings about narrow functions that such cases can be approached.

Such cases as we have presented may be dealt with by public health officers and public health nurses or other agencies in the community when there are not better organized treatment facilities available. But the treatment of the type of case presented this morning requires, for its best outcome, trained and skilled people who can work together in a team approach.

A Coronary Attack

A. F. Weir, M.D.
Hebron, N. S.

THIS is not a learned scientific article, but a simple account of an illness from the viewpoint of the patient. I have never seen any writings in medical journals that approached the subject in that manner and I thought that some of your readers might be interested to know just what goes on in the mind of a patient during a serious illness. If anything I should say appears to be at all critical I wish it to be distinctly understood that it is because I have not presented the facts properly, for I believe I received the best possible treatment from everyone with whom I came in contact.

Until early in June, 1953, I enjoyed what I considered very good health. Then one day, while I was following a power mower around my lawn, I noticed that every time I walked up a little grade I felt a pain in the region of my sternum. As soon as I walked on the level the pain left. Like many another foolish patient I ignored the warning and finished the lawn. A few days later I was called to a house and found a man dead on his front lawn. There was no one else there except his widow and another man, cars were passing up and down the road, so I thought we had better get him into the house as quickly as possible. The other man took one end of the body, I took the other and we carried it across the lawn, up several steps and into the house. By the time the job was done I really had pain, but it passed off after I sat down for a minute. I thought afterwards of what a situation it would have been if I had passed out then too. Shortly after that I had a call to a confinement at the hospital in Yarmouth, which is about three miles from here. I had to drive along Lake Milo, where they were having boat races. There was a large number of cars parked along the road and they seemed to all be in my way. Then the pain came back again. When I got to the hospital I had to climb two flights of stairs. I kept a poker face and sat down. In about a minute the pain was gone. A few days after that I was called out about five miles to attend a woman, and, when I got there, I found that she was almost dead from heart failure. So I had to help carry her to a couch. This time I had no pain. The reason I have for telling of these things is that I wish to show how stupid and foolish a person can be in ignoring warnings, because I believe that if I had heeded all these warnings, I would have avoided the catastrophe that befell me later.

About eight o'clock in the morning of June 14, 1953 I started to get out of bed when I had an attack of sudden intense pain all over the front of my chest. It did not go down either of my arms. This time I knew something had to be done, because the pain was unbearable. I went downstairs and got some nitroglycerin tablets and put two of them under my tongue. All they did was give me a headache. My wife called Dr. D. F. Macdonald in Yarmouth and he came right away. The odd thing is that, although I know he could not possibly have got to my place in less than half an hour, it seemed to me that he walked in the door almost immediately after my wife had hung up the phone. I did not lose consciousness either. He gave me a whole grain of morphine before the pain stopped, half of it I.V. and the other half S.C. Then I felt fine.

When the ambulance came I felt as if I could get up and walk. Some time in August I went back to the hospital and looked up my history. The nurse's notes on the first day contained one interesting item, "Patient very blue. Respirations 6."

At the hospital I had to stay in an oxygen tent for about a week. I received the usual treatment of anticoagulants. One peculiar thing I noticed was that I was very sensitive to pain. Before that and since I never minded pain very much and could go through all kinds of dental work without "battling an eye." But after a few days in the hospital those needles almost killed me. It was agony every time a nurse gave me an alcohol rub. I don't know why.

About the third day I had a sudden pain in my chest, about the anterior end of the seventh right rib. I would cough for half an hour before bringing up a mass of bloody mucus. After a short time I would repeat the process. I never did ask Dr. Macdonald what the trouble was, but I presume I had a pulmonary embolus. He put me on one of the oral antibiotics which cleared the thing up, but brought on a terrific diarrhoea about which I will have more to say later on.

About the sixth day the oxygen tent was removed and I was certainly glad to see it go. Probably it saved my life. However, the Yarmouth Hospital air smelled much sweeter to me than the mixture I got in that tent.

At the beginning of the fourth week two orderlies came once a day, lifted me out of the bed and placed me in a chair. I can still see the queer looks they gave me as they carried me to the chair. I think they half-expected me to pass out on them. Each day I was allowed up a little longer and on the fifth week I went home in the ambulance. The man who runs the ambulance is also the local undertaker and, after they had deposited me in my bed, he said, "Well, I'll see you later." I said to myself, "Old boy, you're going to have a long wait if I have my way!"

I was certainly glad to get home. There had been a fire in the Children's Ward of the Hospital shortly before I was admitted and they had to use a room across the hall from me for the children. Every night there would be at least one T. & A. hollering his head off and the nurse had to give me sedatives so that I could get some sleep. I was just a victim of circumstances.

Although there was a "No Visitors" sign hanging on my door I had plenty while I was in Hospital. I was glad to see them all, but the visit I got the most pleasure out of was when Dr. Siddall came in to see me. He sat and talked for about an hour and he spoke my language. I was sorry to see him go. I have come to the conclusion that visitors can be of great help to a patient.

About the first of August I was getting out of bed on a pair of very rubbery legs. At about the same time I found that I had a frozen right shoulder and peri-arthritis in both hands, but far worse in the right one. Maybe I am wrong in this, but it seemed to me that my shoulder became frozen because I laid on my right side for about six weeks, for when I rested on my left side my heart made a very disturbing noise that kept me from sleeping. Exercises cleared

up the shoulder condition, but my knuckles are still a bit sore. When I first got back to work the thing that bothered me most was squeezing the bulb when taking blood pressures.

About the middle of August I began to go downstairs. I have never noticed that climbing stairs was any different from walking on the level. I have no doubt that a person with a failing heart might notice a difference. I have come to the conclusion that it does more harm than good to put too many restrictions on a person who has had a coronary attack. It only makes the patient excessively conscious of his condition and makes him neurotic. Believe me, when one has survived one of these attacks and has spent several weeks with the knowledge that all those about him were watching for him to drop dead, he does not need anything else to upset his nerves. For my part, I would much prefer to forget that I have a heart to coddle. By this time I have made up my mind that I am just as apt to keep on living as anyone else. I have a bit of scar tissue in my heart where there used to be muscle, so what?

Early on the morning of December 2 I awoke with a pain in my right chest and it was definitely pleuritic in character. I had a severe chill and later on in the day I began to cough up bloody mucus again. I remembered my former experience with an oral antibiotic, so this time I got my wife to give me a shot of penicillin. Also, it was Wednesday and I thought I had imposed on Dr. Macdonald enough without calling him out on a holiday. That afternoon I felt much better, but the pain started up again in the night. So Dr. Macdonald had to come out to see me on the 3rd. This time he decided to try a different antibiotic and everything was fine until December 10, when I got a sort of "delayed action" result. I awoke that morning with my abdomen swollen up like a balloon and the diarrhoea I had had in the hospital was nothing compared to what I had now.

Previous to this I had made an appointment to see Dr. Holland in Halifax on the 15th. I was quite satisfied with the care Dr. Macdonald had been giving me, but we talked the matter over and decided there would be no harm in having a second opinion. At the time I had made the appointment I had not foreseen what I was going to be like on the 14th, the day I had set to go to Halifax. When the 14th came I was no better and had not eaten anything since the 9th, so I was not feeling very strong. However, I started to drive to Halifax. I visited every rest room between Hebron and Hantsport. When I got to Hantsport the car got stuck in high gear, so I left it in Windsor to be repaired and went on by train. Instead of getting to Halifax at five o'clock I got there about eight. After I got to the hotel I had a severe chill and began to have colicky pain all over my abdomen. I had another ambulance ride, this time to the Victoria General Hospital. During the night I had a hypodermic of morphine and two of demerol. I awoke early in the morning and the pain was still there. However, I decided that I was going to ask for no more hypos. About eight o'clock I felt a gurgle somewhere in my abdomen and the pain was gone. This was when I found out what a bed shortage means to a patient, because everything was filled at the Victoria General except one of the so-called quiet rooms attached to the public ward. About the third day I got a room up on

the eleventh floor and it was so pleasant that I felt as though I could stay there forever. Meanwhile Dr. Holland had cleared up the diarrhoea with a few doses of paregoric and some amphogel. If I ever have to take an antibiotic again I hope I do not have to take it by mouth.

Dr. Holland found my condition to be much as Dr. Macdonald had found it and gave me about the same advice. At first I took their advice very much to heart, but I found some of it a bit hard to follow, such as climbing stairs very deliberately. I do find the cold weather is a handicap. Last year I spent about six weeks of the winter in Florida and I used to walk about four miles every day without minding it in the least. I only have to walk a quarter of a mile in the cold here to get a little feeling of constriction in my chest. I don't know whether it is due to the heavier clothing I have to drag around up here nor do I know for sure that the sensation is caused by my heart or is just in my chest muscles. One thing I have found out by my own experience, and that is that it is better for me to eat slowly. I had very bad eating habits and could put away a whole dinner from soup to dessert in about five minutes. Now I take my time. It was not very easy to make the change. I had to count forty chews to every bite to break myself of my old habit. For years I had been telling others to rest before and after eating. Now I take some of my own advice.

One red letter day was the first time I went to church. It was in December, 1953. I never realized before what a darned neurotic I had become. A dozen times I felt as though I were going to faint and when we had to stand up to sing those hymns I had to hold onto the back of the seat in front of me. It was then I envied the Catholic who could get down on his knees.

By now I think I have my life pretty well regulated. I work and enjoy my work, but I take my time about it. I have resigned from the Eager Beaver Club. It used to be that I was driven into doing all sorts of things by what must have been my conscience. I took every call that came and always felt that I had to take in every public meeting that I could get to. Now I let things slide. If I don't feel inclined toward doing a thing, I just don't do it. I realize now that, for a good many years of my life I was wound up as tight as an E string. It did not pay. From now on I am going to be just as lazy as I please. Often in the past I have told others to "take it easy." By that I meant that they should do almost nothing. I now realize that was poor advice. For the sake of his morale a patient should have enough to do so that he feels that he is a useful member of society. To just putter around or to do nothing at all would be a "fate worse than death."

SUMMARY—For those who had not the patience to read through all I have said and also to clear up any points that may not be clear, I would like to say that I have, as a patient, learned the following lessons from my experience:—

1. I should have heeded the warning I received when I had that first little pain in my chest.
2. Peaceful and quiet surroundings are a great help to one recovering from a coronary attack.

3. An oral antibiotic is very much a two-edged sword. So is penicillin too, for that matter.
4. One should rest before and after eating and one should eat slowly.
5. While the patient is confined to bed visitors can be great morale boosters, but they should be carefully screened.
6. In my opinion, after one has recovered from a coronary thrombosis, his troubles are about 95% neurotic and it is important that his family and friends should not aggravate this condition by constantly cautioning him to "go easy."

There is a post script that I would like to add to all I have said.

While I was *hors de combat* I had a lot of time to think and one of the things I thought about was the fact that, in Canada and the United States among humans, females live longer than males. In some other parts of the world men live longer than women. The female heart beats about 11% faster than the male and almost every woman has been subjected to at least one major operation and has probably been through the hands of the hysterectomy specialist, so it would seem that women have two strikes against them. In spite of these things they outlive men. Why?

Well, I think I know of one good reason why women live longer than men, and I think I know of one good reason why men live shorter lives than women.

Women are far more health-conscious than men. They are constantly thinking of their weight and any doctor knows that women consult him far more than men do. A man can have all sorts of creaks in his anatomy, but he ignores them. Not so the woman. She wants the answer quickly and, if she does not get it from one doctor, she keeps on trying until she does get the answer. So, since she takes more thought of her health, it seems only natural that a woman should live longer than a man.

We all know about the life insurance salesman who wants to load us up with insurance. We are just pikers if we have less than \$50,000 insurance. Three per cent of that would only be \$1,500 and no widow and orphans could live on that for a year. So the applicant loads himself up with so much insurance that he spends the next twenty years jumping from one insurance premium to another. I think the Twenty-Pay-Life policy has killed more men than our wars have. If I had my life to live over again I would get some straight life insurance and carry it until I was fairly well established. Then I would drop it and take my loss. Life insurance agents talk so glibly of building up an Estate and how well-off one will be at age 65. But where is the applicant at age 65? Ten to one he has spent several years underground in the cemetery. Women do not have these premiums to keep up and worry about. So it only seems natural that men should live shorter lives than women.

Society Meeting

The Antigonish-Guysborough Medical Society

The semi-annual meeting of The Antigonish-Guysborough Branch of The Medical Society of Nova Scotia was held in the Board Room at St. Martha's Hospital on Sunday, March 27th, 1955, at 2.30 p.m., with the following members present: Doctors J. A. MacCormick, T. B. Murphy, C. N. MacIntosh, T. W. Gorman, R. L. Sers, R. C. Griffin, O. C. MacIntosh, J. J. Carroll, S. L. Speller, R. H. Fraser, F. N. Chisholm and S. Donigiewicz.

The minutes of the last meeting were read and adopted.

There was no unfinished business from the previous meeting.

A letter was received from Mrs. H. G. Grant thanking the Society for flowers sent at the time of the Dean's death.

A letter was read from Doctor A. W. Titus on suggestive tariff changes and the executive member from this Branch was nominated as representative to the Tariff Committee.

A letter from the Halifax Medical Society enclosing a copy of their resolution to be presented at the annual meeting of The Medical Society of Nova Scotia was discussed.

A letter from the Secretary of The Medical Society of Nova Scotia asking for a Branch Committee to study the Stewart Report on Health Facilities and Service of Nova Scotia was read and after discussion the President was authorized to appoint this committee.

A letter from the Secretary of The Medical Society of Nova Scotia asking for an appointment to the Editorial Board of the Bulletin was discussed and Doctor Rolf Sers of Goldborough was nominated for the position.

Following this meeting Doctor W. D. Stevenson of Halifax presented an excellent paper on "Head Injuries." This paper covered very concisely and thoroughly the diagnosis and treatment of head injuries and was followed by a very exhaustive discussion.

The thanks of the Branch were tendered to Doctor Stevenson and the Dalhousie Post-Graduate Faculty for this extremely practical presentation.

Following the paper, dinner was served at St. Martha's Hospital and a vote of thanks was tendered to the Superintendent of the Hospital.

The date of the Annual Meeting was tentatively fixed for the last week in June and an effort will be made to attain another speaker from the Dalhousie Post-Graduate Faculty for this meeting. There being no further business, the meeting adjourned.

J. J. CARROLL, M.D.,
Secretary, Antigonish-Guysborough Branch,
The Medical Society of Nova Scotia.

ANNUAL MEETING

The Annual Meeting of The Medical Society of Nova Scotia will be held at the Fort Cumberland Hotel, Amherst, N. S., on September 6th, 7th, 8th and 9th.

It is expected that Doctor T. C. Routley, President of The Canadian Medical Association, and Doctor A. D. Kelly, General Secretary of The Canadian Medical Association, as well as two visiting speakers comprising the "C.M.A. Team" will be attending.

Reservations for accommodation should be made immediately. Address communications to Doctor J. A. Langille, M.L.A., Chairman of the Housing Committee, 107 Church Street, Amherst, N. S.

NOTICE

Applications are invited for the post of full-time secretary for the Nova Scotia Division of The Canadian Medical Association. Those interested should address communications, stating qualifications and experience, to -

The Chairman,
Secretary Selection Committee,
The Medical Society of Nova Scotia,
Dalhousie Public Health Clinic,
University Avenue,
Halifax, N. S.

Committee on Nursing

At the suggestion of the Canadian Commission on Nursing, which committee is composed of representatives of The Canadian Medical Association, the Canadian Hospital Association and the Canadian Nurses' Association, each provincial division of the three national organizations were asked to form Provincial Committees on Nursing.

The Nova Scotia Committee on Nursing is composed of the following persons:

(1) Representing The Medical Society of Nova Scotia are Doctor A. E. Blackett, New Glasgow, Doctor J. B. Tompkins, Dominion, Doctor C. J. W. Beckwith, Halifax.

(2) Representing the Registered Nurses' Association are Sister Catherine Gerard, Halifax, Miss Nancy Watson, R.N., Halifax, Sister Hugh Teresina, Sydney, N. S.

(3) Representing the Nova Scotia Section of the Maritime Hospital Association are Mr. Frank Silversides, Halifax, Sister Clarissa, Sydney and Doctor O. C. MacIntosh, Antigonish, N. S.

The first meeting of the Committee was held at the Halifax Infirmary, Halifax, N. S. March 29, 1955. The meeting was opened by Doctor D. M. Cochrane, President of The Medical Society of Nova Scotia. Sister Catherine Gerard was appointed Chairlady of the Committee and Miss Nancy Watson was appointed Secretary. Doctor M. R. Macdonald, Secretary of The Medical Society of Nova Scotia, was also present.

The purpose of the Committee is to study all problems relating to nursing in an attempt to improve the situation in so far as supplying nursing care to fulfil adequately this portion of Canada's health needs, and more particularly as it applies in Nova Scotia.

Dalhousie Post-Graduate Programme

Week in Obstetrics, Gynaecology and Paediatrics

May 16th - 20th, 1955

Monday, May 16th, 1955

Grace Maternity Hospital

8.45 Assemble in Front Hall of Grace Maternity Hospital on University Ave. Accommodation arrangements and facilities explained.

9.00-10.00 "How to Conduct Labour"—Dr. H. B. Atlee.

10.00-11.30 "How the X-Ray Helps in Obstetrics"—Dr. I. A. Perlin.

11.30- 1.00 Symposium: "Toxaemias of Pregnancy."

(a) Diagnosis and Prevention—Dr. J. McD. Corston.

(b) Treatment—Dr. K. M. Grant.

Victoria General Hospital—Third Floor.

2.00- 4.00 "Gynaecological Procedures in Office Practice."—Dr. I. A. Perlin.

4.00- 5.00 Film —Dr. P. Pugh.

Tuesday, May 17th, 1955

Children's Hospital

2nd Floor Lecture Room

9.00-11.00 Case Presentations—

Moderator: Dr. N. B. Coward.

11.00-12.00 Fluid Balance.

Demonstration of Paediatric Procedures—Dr. J. M. Crosby,
Dr. R. S. Grant.

Dalhousie Public Health Clinic—University Ave.

2.00- 3.00 Training for Childbirth.

(a) Talk by nurses—on dietaphone.

(b) Short talk by Staff man

—Dr. W. R. C. Tupper.

3.00- 4.00 "Discussion of Prenatal Problems"—Dr. W. R. C. Tupper.

4.00- 5.00 "Handling of Abnormal Obstetrics"—Dr. W. G. Colwell.

5.00- 6.00 Presentation of Gynaecological and Obstetrical Problem Cases.
—Ob. - Gyn. Staff.

Wednesday, May 18th, 1955.

5th Floor West

Victoria General Hospital

9.00-10.00 Ward Walk—Dr. J. McD. Corston.

10.00-12.00 Demonstrations in Operating Room of Minor Procedures:

Cauterization

Conization

Biopsy of Cervix

Insertion of Pessary

Removal of Bartholin's Cyst

D and C.

Emptying incomplete abortion—Ob. - Gyn. Staff.

12.00- 1.00 Round Table:—"Psychiatric Problems in Pregnancy."

Moderator: Dr. H. B. Atlee. Dr. R. J. Weil, Dr. S. Hurst.

Children's Hospital—2nd Floor Lecture Room.

- 2.00- 3.30 "Paediatric X-Ray Problems"—Dr. R. L. Smith.
 3.30- 4.30 "Behaviour Problems in Childhood"—Dr. F. A. Dunsworth.
 4.30- 5.30 Surgical Ward Rounds—Surgical Staff.

Thursday, May 19th, 1955.

Grace Maternity Hospital

- 9.00- 9.50 Post-Partum Complications—Ward Presentation—Dr. W. R. C. Tupper.
 10.00-11.00 1. Demonstration of Pelvic Examination
 2. Talk on Birth Control with Demonstrations
 Dr. W. G. Colwell.
 11.00- 1.00 Symposium:
 1. Care of the Baby in the First Ten Minutes of Life.—
 Dr. H. B. Atlee.
 2. The Rh Factor in Pregnancy—Dr. W. R. C. Tupper.
 3. Ante Partum Bleeding—Dr. K. M. Grant.
 Children's Hospital—2nd Floor Lecture Room.
 2.00- 3.00 Paediatric Problems—illustrated by Kodachrome Slides.—
 Dr. R. S. Grant.
 3.00- 5.00 Symposium: "Recent Advances in Paediatrics."
 (a) Diagnosis of C.N.S. Disease.
 (b) Indications for Endocrine Therapy.
 (c) Poisoning and Dangers of Therapy—Medical Staff.

Friday, May 20th, 1955.Children's Hospital
2nd Floor Lecture Room

- 9.00-10.00 "Paediatric Dermatology"—Dr. D. R. S. Howell.
 10.00-12.00 Weekly Medical Ward Rounds.
 Moderator: Dr. G. B. Wiswell.
 Victoria General Hospital—5th Floor Clinic Room.
 2.00- 3.00 "The Ichy Perineum"—Dr. I. A. Perlin.
 3.00- 5.00 Symposium:
 (a) Post-Partum Bleeding—Dr. K. M. Grant.
 (b) Complications of Pregnancy.
 (1) Cardiacs—Dr. P. Pugh.
 (2) Diabetes—Dr. G. E. Flight.
 (3) Virus Infection (Measles)—Dr. E. Fry.
 (c) Post-Partum Breast—Dr. J. McD. Corston.
 5.00- 6.00 V.G.H. Staff Meeting: (1) Surgery of Ca of the Cervix.
 (2) Presentation of Case.

Your enquiries or applications may be addressed to the Executive Officer,
 Post-Graduate Committee, Victoria General Hospital, Halifax, N. S.

Registration fee of twenty-five dollars is payable on your arrival in
 Halifax.

Maritime Medical Care Incorporated

It was at first our intention to discuss to-day the plan for National Uniform Coverage which will be put into effect in June by T.C.M.P., but as this plan will affect only nation wide Corporations we will leave that until a later date and give some attention to our present "Individual Plan."

The Individual Plan was brought out in order to cover those individuals and small groups who were not eligible for the more comprehensive standard group contract. It is being utilized principally by small business employers and employees where the staff is not in sufficient numbers to form a group, i.e. less than ten employees. As it is as yet unknown what the utilization of this plan will be, it was considered necessary to place certain restrictions upon its use; therefore, the Individual Plan does not offer the relatively complete coverage provided by the Standard Group Contract.

Chief among these restrictions is the exclusion of pre-existing conditions. On application, each prospective subscriber must complete a medical history form; any disease or condition which appears in this history and which might require considerable subsequent treatment will be excluded by a rider on the contract when issued. This rider will also appear on the Identification Card, for attending doctors information. Conditions which are not mentioned by the applicant in his medical history, but are pre-existing, are also excluded, even though no rider to this effect may appear on the Contract or Identification.

The benefits obtained under the Individual Contract are essentially the same as those under the Standard Contract, with the exception of the following items: viz: refractions, diagnostic procedures in hospital, sterility investigations or treatment, physiotherapy, short wave and diathermy and treatment of psychiatric conditions. X-ray services for fractures and dislocations only are allowed, and then when done by a participating physician.

Waiting periods under the Individual Plan are as follows: Obstetrical: ten months. Surgery for gall stones or urinary stones: 12 months. T. & A's: twelve months. Prostatic conditions: two years. Reparative gynaecological operations: two years. A yearly limit of \$500.00 is placed on medical and surgical services.

As thus presented, this Contract appears stringent, but as more subscribers enroll, and as our statistics of utilization become more accurate, benefits may be extended, or present rates to subscribers lowered. If the coverage is used wisely, this result will undoubtedly come about in time, as the plan is not subject to the continual abuse from which the Standard Group Contract appears to suffer.

G. B. Shaw, M.D.,
Medical Director.

Personal Interest Notes

A meeting was held at Digby the end of March for the purpose of forming a branch of the Canadian Mental Association. Guest speaker was Doctor R. O. Jones of Halifax, president of the Nova Scotia Mental Health Association, who traced the work of mental health groups and told of the great and increasing need for work in this field both by professional and lay groups.

Doctor H. B. Atlee of Halifax has been awarded a \$2,200 federal government health grant to conduct a study on the effects of post-mature birth on mothers and infants.

Doctor and Mrs. L. R. Meech of North Sydney and Doctor and Mrs. A. C. Gouthro of Bras d'Or recently enjoyed a vacation in Florida.

The Bulletin extends congratulations to Doctor and Mrs. C. C. Giffin of Inverness on the birth of a daughter, Gaye Elizabeth, on February 19th, and to Doctor and Mrs. H. I. MacGregor of Halifax on the birth of a daughter on April 10th.

Members of the medical profession recently in hospital were Doctor W. H. Robbins of Wolfville, Doctor F. E. Walsh of Springhill, and Doctors H. W. Schwartz and R. J. Weil of Halifax.

The staff of the Western Division of the Nova Scotia Department of Public Health held a conference at the Roseway Hospital in Shelburne late in March, followed by a nurses meeting. One of the guest speakers was Doctor W. H. Jeffrey who gave a review of the role of the family doctor in the infant programme.

Doctor D. K. Murray of Halifax attended the yearly meeting of the Wilmer Eye Institute of Johns Hopkins University in Baltimore early in April.

Doctor E. F. Ross of Halifax has been appointed a member of the Board of Governors of the American College of Surgeons as a representative of the Royal College of Surgeons of Canada for the period 1954 to 1957.

FOR SALE

- (1) Office Equipment, Office Furniture, Medical Equipment and Apparatus.
- (2) Dwelling and Offices.

The above located at Liverpool, Nova Scotia, and formerly occupied by the late Dr. E. Dudley Dickie.

Anyone interested or requiring further information, please contact E. J. Theriault, Barrister, P.O. Drawer 140, Digby, N. S., Solicitor for the Estate.

Obituary

Doctor William James Egan

Doctor W. J. Egan of Sydney died at St. Rita's Hospital there on March 27, 1955. He was born at Sydney Mines on September 3, 1877, the son of John Egan and Charlotte Stevens Egan. After attending the local schools and Sydney Academy, he went to St. Francis Xavier University, and later to McGill where he graduated in medicine in 1901. He engaged in general practice in Sydney and Reserve Mines for fourteen years, after which he proceeded to London for post-graduate work at the Royal London Ophthalmic Hospital and Greys Inn Nose and Throat Hospital. On his return to Nova Scotia he was engaged in this special field in Sydney until his retirement several years ago. When the Government of Premier E. N. Rhodes came into power in 1925 he took a prominent part in amending the Workmen's Compensation Act of Nova Scotia.

At one time or another Doctor Egan was Vice-President of the Cape Breton Historical Society and President of the Kiwanis Club, Sydney. He was a good writer and capable speaker and took part in many community activities.

In 1903 he married Mary J. Livingstone of Low Point, Cape Breton, who died some nine years ago. He is survived by two daughters.

To them and to all other members of his family the Bulletin extends its sincere sympathy.