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The NOVA SCOTIA MEDICAL BULLETIN

EDITORIAL

MORE ON TRANSITION

To the readers of this journal, the article in the October issue entitled "R For Transition" by Dr. Tom Gorman must have given much food for thought. The proposal for a formula system of remuneration for medical care is well worthy of consideration and the merit of such a plan could be the subject of much fruitful debate. When one considers the obvious faults of other schemes which are currently in effect in various parts of the world, it should not be difficult to plead a strong case for this one.

The philosophical preamble to the plan also evokes admiration. It is curious how the meaning of words has changed over the years. Charity is now a bad word but as children in Sunday School we were led to believe that St. Paul thought rather highly of it. In this day and age if a man works a little longer and a little harder than his fellow, a benevolent government presents a pistol to his head and says in effect, "If you do not hand over half to me, I will put you in prison." It then, after keeping to itself a substantial proportion "for administering" its takings, hands over the remainder to another man who for reasons, legitimate or illegitimate, does not work at all. The accepted and approved attitude on the part of the recipient is that this is good but that charity is definitely bad. In the same way capitalism with free enterprise used to be good and we as North Americans could be especially eloquent when expounding the advantages of this economic system over all others. Now we are told that it is completely bad and with pity we think of those backward peasants on the Kremlin side of the iron curtain who are showing signs of succumbing to some of its siren wiles. An American Congressman was once asked if Fascism were possible as the system of government in the United States and his reply was "Yes, but we would call it Anti fascism." When words lose their meaning, Orwell's "1984" is close indeed.

The plan itself, like all plans, will probably be controversial to a profession holding such widely divergent views as ours on this whole matter. A note of disquiet might be struck by the suggestion that the profession set up a judicial system where all grades of deviation and dereliction of duty can be judged and punishment indicated and presumably carried out. This would appear to be a pretty sweeping control indeed and one that a proud and independent profession might not accept kindly. To say that if this were done by us, there would be little need for elaborate controls by government is not necessarily significant. The actions of government are not dictated by need but rather by that which best suits political expediency at any given

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THE CANADIAN MEDICAL ASSOCIATION

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moment. On the other hand when governments attempt to impose rigid controls on us they can be fought, and with formidable weapons. We know that we alone can provide services which are in limited supply and in unlimited demand both in this province and country and, for that matter, outside them. Moreover these services are of such a nature that they can only be given at their best if they are given willingly. To use an elaborate system of tight control in a fight for freedom is to invite the danger of ending up with more control than freedom.

"B For Transition" is a well conceived and well presented proposal and it is to be hoped that it is given the careful consideration it deserves.

W. E. P.

NOTICE TO MEMBERS

At the meeting of the Executive Committee December 1st., 1962 the following resolution was carried:

"THAT notice of motion be given to the Annual Meeting of The Medical Society of Nova Scotia that practitioners resident in the province of Nova Scotia be required to be members of The Medical Society of Nova Scotia before they can be participating physicians in Maritime Medical Care, Incorporated."

BRANCH SOCIETY MEETINGS

Letter from M.M.C.

For the first time, the schedule of the ten Branch Societies' meetings prior to the Executive Meeting of December 1st was complete in all details two weeks before the first Branch Meeting. The following letter from the General Manager of M.M.C. Inc., gives evidence of the value such schedules being complete in advance of the Branch Society Meetings.

Dear Dr. Beckwith,

This is just a note to let you know we were able to benefit from the schedule of Branch Society meetings released by your office earlier this month.

The meeting of our Board of Directors had already been scheduled for November 14th, however when your schedule of meetings arrived we noted that four Branch Societies had planned to meet on that day and we were therefore able to delay our meeting one week so as not to conflict with our Directors' attendance at their Branch meetings.

We were also able for the first time to prepare a summary of events that have taken place at M.M.C. since the Medical Society's meeting in June, and we also asked our Branch representatives to obtain an expression of opinion from their fellow members concerning possible modifications to our Senior's Health Plan.

By the time our Board of Directors met on November 21st, all but one of the Branch Societies had held their district meetings and our Directors had therefore had an opportunity to report to them on recent progress. At our Board Meeting several excellent suggestions were received from Branches and it was also possible for us to obtain quickly the feelings of Branches on various matters important to the future operation of Maritime Medical Care.

I felt you would be interested in knowing how we were able to benefit from this advance information and also express the hope that the Executive will be successful in obtaining advance information of this nature for future Branch Society Meetings for as you can readily see, we were able to make good use of this information.

Yours very truly,

signed: S. P. BRANNAN, General Manager

Nov. 23, 1962. Maritime Medical Care Inc.

FROM THE BULLETIN OF 40 YEARS AGO

The Medical Society of Nova Scotia Bulletin, Dec. 1922

The Medical Profession is a great Republic. It exists for the advancement of medical science and the amelioration of human suffering. We all need one another. Particularly, as we find ourselves here a large isolated family in this Ultima Thule of Canada, as Haliburton calls it, should we aim at the exaltation of our profession and the improvement of ourselves. Let us, no matter what our College, assist the local University. It needs our encouragement, it needs our sons and daughters. It needs money. It needs books. Whatever it receives it will repay a hundredfold, in service to the profession and the community at large, in discovery, in intellectual stimulus, in scholastic attainment. Let us improve ourselves by joining our nearest Medical Society and attending its meetings; by reading our journals, and by recording our observations. If we do not achieve the highest ends, we at least will have the satisfaction of maintaining an honorable place in the procession.

BOOK REVIEW

SIGERIST ON THE SOCIOLOGY OF MEDICINE. Edited by Milton I. Roemar, M.D.

This book of some three hundred eighty pages consists of a number of lectures and essays discussing the history of medicine in relation to social change over the years. It deals particularly with the development of socialized medicine in Germany, England and France and in considerable laudatory detail describes the medical service in the U.S.S.R. up to the time of the war.

The lectures all strongly urge the development of socialized medicine, and indeed, socialism in general, for the writer was an avowed Socialist. In spite of the fact that they are now some twenty years old, they are interesting reading still, particularly since Labor's Brief to Government advocates, almost exactly, the salaried group medical service which Sigerist here recommends.

It is interesting also to note with what ease at that time (as now) the Socialists discount the many difficulties and disadvantages which we now know accrue to free medical care, and as always with these good people they make inadequate preparation for the great increase in demand for service which we know is certain to develop; build no safeguards against abuse, and establish no stern measures of discipline against malingering and dishonesty.

This book will not make you a Socialist but if you are an ardent disciple of free enterprise (?) it may make you angry. In any event it will give you an insight into medicines adjustment to changing social conditions in many countries and a glimpse into what may possibly be your future.

J.W.R.

REPORT ON THE SUPPLEMENTARY BRIEF TO THE ROYAL COMMISSION ON HEALTH SERVICES FROM THE MEDICAL SOCIETY OF NOVA SCOTIA

This supplementary brief was requested by the Commission in order to clarify certain terms used in the Brief, amplify statements made concerning some aspects of health care and to report the results of studies by The Medical Society of Nova Scotia which were incomplete at the time of presentation of the B ief. Re:

(1) Physicians services in Nova Scotia, the following figures, arrived at by survey questionnaires are of interest. The overall ratio of physicians to population is one to nine hundred sixty-one (1 – 961). The ratio for Canada is 1 to 879. To reach this Canadian ratio, Nova Scotia needs 71 doctors in addition to our present 767 giving a total of 838. To reach a proposed ideal ratio of 1 – 795 would require 160 more M.D.'s. The number of specialists in practice in Nova Scotia is 208 and this figure is included in the above ratio. Including specialists the general practitioner – population ratio is 1 – 1824. The arbitary ideal figure is 1 – 1500. To meet this one would need 87 additional general practitioners. Table Four shows the ratio of various specialists to population. Examples are Surgery 1 – 18,898, Medicine 1 – 29,480, E.E.N.T. 1 – 26,321, X-ray 1 – 30,709, Psychiatrists 1 – 32,044, Anaesthetists 1 – 43,353 etc. There are approximately eleven general practitioners, one surgeon, one internist and one E.E.N.T. for each 20,000 unit of population.

Other factors in health:

(2) Stresses, food, housing, medicine, therapists and especially hospital beds and homes for chronic and incurable disease.

(3) Voluntary agencies: This points out the need of a central co-ordinating office such as the Nova Scotia Rehabilitation Council, to correlate and give guidance, "A Council of Health Agencies" is suggested.

(4) Description of M.M.C. directorate needs no elaboration here.

(5) Contains a critique of commercial insurance carriers and elaborates on Maritime Medical Care's favorable position regarding exclusions for pre-existing conditions (only 0.26% of total subscribers). It describes new, more comprehensive plans to include ambulance, nurse, therapists, etc. which are under consideration. It also elaborates on methods of controlling over servicing and over utilization. It points out that insured services results in increased demand for service. Thus the Canadian Sickness Survey (1950-1951) records that for non-insured Canadians the volume of physicians services was 1511 home, office or clinic calls per 1000 population per year in comparison with 2154 such services per 1000 population where medical insurance was in effect.

In 1960 Maritime Medical Care's experiences showed 3200 services per 1000!

(6) Deals with costs: The initial brief estimated costs of additions to improve the health service at 53,653,000.00

Some additional figures are given:

(a)	To assist payment of premums	1,787,400.00
(b)	Financial assistance to Medical Students	240,000.00
(c)	Financial Assistance to Residents in Training	500,000.00
(d)	Financial Assistance to Paramedical Personnel	?
(e)	Cost of improved mental health care	1,500,000.00
		4,027,400.00

(7) Financial assistance to medical students, residents in training, etc. to cost $500,000.00 yearly.

(8) Cost of improvement in mental health care. Present expenditure in Nova Scotia $5,000,000. yearly. An immediate increase of $1,500,00. yearly would be required and from there the sky is the limit.

(9) Comprehensive medical services programme. Defines "comprehensive" as meaning complete, all inclusive medical service. Defines "universal" as meaning an insured service available to the entire population.

The Supplementary Brief states that The Medical Society of Nova Scotia believes that Universal Comprehensive Physicians' Services Insurance is a desirable and attainable objective. The Society does not believe that this requires a compulsory, tax-supported plan for the total population. Such services should be available to all residents of Nova Scotia but compulsory for none.

J.W.R.

INTRODUCING THE ONTARIO MEDICAL ASSOCIATION'S BRIEF TO THE ROYAL COMMISSION*†

Patrick Bruce-Lockhart, M.D., M.R.C.O.G.

Mr. Chairman and Members of the Royal Commission on Health Services:

The Ontario Medical Association, whom this delegation has the honour to represent, has 6,500 members, or approximately one-third of all the doctors in Canada, and they look after more than six million people.

The Commission and the Ontario Medical Association have a common interest, namely, the provision of competent health services to the people of Ontario. The Commission has this interest by reason of its terms of reference; this Association through the dedication of the lives of its members to this work.

In order to assist the Commission to a better understanding of the problems in Ontario, the O.M.A. has:

1. Studied all previous hearings, considered carefully the questions asked by the Commissioners, and noted how frequently the same questions have been asked of all doctors;
2. With the object of answering these questions, while at the same time presenting the views of the O.M.A. on what it deems to be the vital issues, it is proposed that our presentation will be in three parts.

First, I will present a broad outline of the Ontario doctors' viewpoint, in an attempt to give the Commissioners an insight into the core of our thinking and to place our brief and arguments into perspective. Secondly, Dr. Glenn Sawyer will summarize and comment on the recommendations in the brief so as to give clarity and point to our priorities.

Then this delegation would like to answer any further questions deemed relevant by the Commissioners, although we believe that our presentation will have answered most of the questions asked heretofore by the Commissioners, and that they will have learned the viewpoint and policy of the O.M.A. on these vital issues.

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†Your editors believe that this, the last Brief submitted, including as it does the experience of all previous briefs, will be of interest to Members.

This course of action will have the advantage of enabling the O.M.A. to make its presentation within the alloted time and yet give the Commissioners the opportunity to indicate those areas on which they desire further information.

In order even to begin to understand doctors, one has first to appreciate that medical care in essence is the care of the sick individual, or the potentially sick, or the well who may become sick, but always the individual.

It is essential to understand that an individual is a human being who is unique and different from all other human beings – different in his reaction to environment, in his reaction to illness, to drugs and to treatment, different in his reaction to management, and different in his reaction to other human beings, which must include doctors.

These differences of reaction are drummed into medical students, because bitter experience has taught the profession that unless a constant unrelenting awareness is maintained in this regard, constant mistakes will occur. The necessity for this has convinced doctors that medical care must be personal if it is to be efficient and safe. Further, that it must be personal if it is to be effective in dealing with the patient in relationship to his environment.

To place these personal services in perspective it should not be forgotten that home and office calls constitute the majority of all medical services rendered by doctors. The doctors providing personal services work long hours, and their whole life is one constant interruption. Yet few abandon it, and to understand doctors one must understand why.

The answer is not that they are, or think themselves, supermen – nor even that they are just a strange breed, as some would have us believe. It is just that to date there has been an intense satisfaction in their work. This satisfaction is the result of the pleasure found in becoming involved with people, of being able to help them in their need and of caring about the results, not as cases in a slot, but as human beings.

A doctor setting out in practice is usually young, enthusiastic, and in debt. He is initially delighted and somewhat thankful to answer calls night and day. Then his financial situation improves, his youth and enthusiasm diminish, but he finds that he continues to accept these calls, these interruptions to his meals, his spare time, his family occasions. Because by that time a call is not just another case, but young Johnny with his asthma, old Bill with another heart attack, or Mrs. Tessier with what sounds like an acute gall bladder. Herein, quite simply, lies the source of doctors' dedication and devotion to their calling.

This devotion to a patient's interests, this dedication to service, is a thing that only a very few lay people understand to any depth, beyond a superficial reaction typified by "that old doctor-patient relationship business". And yet if one does not understand this, how can one possibly understand our complete conviction that anything that interferes with this dedication to the individual and the job satisfaction which produces it, will ultimately and quite inevitably produce a lowering of the quality of medical care? Can one buy, or compel, devotion? Obviously not.

Now over the years, as spelled out in our brief, this dedication with its intense concern for the individual has produced a complex of medical services in this province which we believe is second to none; which is not static

but constantly changing; and has only one criterion, namely, does it meet the need of the patient?

Living in this way the profession has always been, and of course is still, acutely aware of the problems of patients – problems medical, organizational and economic. We must be; it is part of the fabric of our lives. We are constantly searching for, and finding, answers, usually initially at the individual level, and then when they have stood the test of experience, these are generally adopted. Just as we test a new drug before its general adoption in order to minimize the chance of its doing harm as well as good, so experience has taught us to shun the quick solutions to organizational problems. Our brief emphasizes the steady progress being made in solving these problems by the evolutionary process, and we are confident that given time the remainder will be solved without disturbing the essential relationship and atmosphere between doctor and patient.

However, public awareness of some of these problems – the indigent, the low-income group and the uninsurables, the cost of facilities, under-doctored areas, to mention a few – has produced the urge, very natural in the inexperienced, to correct these problems immediately. Quick action in this day and age with memories of recent wartime experience brings thoughts of a master plan, central control and government assistance with financing.

Political parties are, of course, not unaware that benefits to the public bring votes. A further factor to be taken into consideration is that if governments provide monies then they feel responsible to control their expenditure.

Thus the stage is set for the present conflict of ideas between governments and the medical profession.

In our brief we have stressed the theme "evolution, not revolution" by stating what we have done, why, why it is good, how we are tackling the problems that remain, the needs that exist and how solutions can be evolved to meet them.

To keep this clear, we have not stated directly where we stand in this conflict of ideas, and we would be failing in our duty if we did not now take this opportunity to make quite clear where the medical profession in Ontario does stand in this regard.

First, in regard to availability of medical care, we would state our opinion that in Ontario medical care is at present available to all citizens having regard to geographic circumstances.

Secondly, our profession is convinced that very few people outside the profession understand the danger of well-meaning planners seizing on a few problems in this very complex field, and producing solutions to them only to create, unwittingly and quite unintentionally, a dozen new ones.

Thirdly, we are frankly afraid of any plan, or plans, with total or major government financing because history has taught us:

a) That then the monies for medical care have to compete at the treasury level with the other needs of society, which means that political expediency dictates the allocation of money and not individual medical needs;
b) That costs rise far beyond estimates, and the easiest way to control costs is to limit facilities and services;
c) The loss of individual patient responsibility for his own care is a factor in increased costs, and further subtly alters his attitude towards his doctor. When a patient demands care instead of calling with a problem for help, then the job satisfaction of the doctor is gone.

In addition to these fears, we are flatly opposed to government ever being the sole purchaser of medical services, because quite simply we would consider this conscription. Would this situation not be vicious if the only way a man can change his employer is by leaving the country? It seems to us that it would be a new and unique position if this occurred and was acceptable, and would inevitably lead to the question: "Who is next?"

In theory, a government could own an insurance plan, solve some of the economic problems of the populace and not interfere with the individual patient and his doctor. Here we would like to be careful of words. An insurance plan for medical care is a concept of people buying insurance to spread the risk. Such plans are at present available, and the problem of enabling everyone to buy insurance is discussed in our brief. However, when one talks of government insurance we believe this implies control beyond this insurance principle, because experience has taught us this. Government insurance to us means just a government-run medical plan under another name.

We are convinced that a government-run plan of medical care will mean central control; that central control produces a mediocrity of care because it is geared to the masses and not to the individual and his needs. Further, a government-controlled plan would work on an averaging principle, and we do not believe it possible to deal in norms and averages and retain complete individual patient consideration and attention.

Also, we are completely opposed to compulsion, direct or indirect, because one cannot have compulsion and choice. We believe that choice of doctor, choice of type of service, choice of type of prepayment mechanisms, are productive of flexible selective progress geared to individual needs.

We are certain that in the long run government interference in the practice of medicine – directly, or indirectly through financial control – however well intended, will affect the dedication of the doctors by diminishing their satisfaction in giving service. It will also increase the problem of finding adequate personnel. What serious student contemplating a medical career would not prefer infinitely the opportunities for freedom in service in the state to the south of us rather than a bureaucracy at home?

Mr. Chairman, we have explained as best we might our fundamental concept of medical care. We have stated our views on government intervention in medical care. We would like to complete the picture by stating that we believe that good medical care is the concern of all of us; that to produce it the profession needs co-operation from government and voluntary agencies; that we each have our place in this field and that we have views on the proper role of government. We would like to emphasize very briefly these views, which are the result of a study by one of our committees and were approved by the profession in the Council of the Association three years ago.

The report reads:

"Our concept of the responsibility of government with regard to the health of the public is to insure, in co-operation with, and on the advice of, the medical profession as a whole, that a high standard of medical care is available to everyone. With these thoughts in mind, we should consider the proper role of government in the field of medicine.

"Central government has three advantages over any other section of the community, namely:

i) Central view and authority;
ii) The power to legislate;
iii) The provincial treasury.

"It seems logical that these aspects of medicine which fundamentally require any of these things are properly the concern of government.

"A. Aspects of medicine requiring essential province-wide view:
- i) Sanitation, preventive medicine, and venereal and infectious disease control;
- ii) Civil defence and disaster planning;
- iii) The education of the public in health and hygiene matters.

"B. Aspects requiring the authority of legislation:
- i) Legislative jurisdiction with respect to the licensing of doctors to practice medicine;
- ii) Legislative jurisdiction over hospitals;
- iii) Legislative standards for food and its handling, housing, drugs, and safety precautions in homes and factories, institutions, etc.

"C. Aspects requiring assistance from the provincial treasury:
- i) In situations where the individual is incapable of providing for himself because of (a) indigency; (b) chronic or permanent mental or physical disability;
- ii) In situations where a particular community would otherwise shoulder the financial load for a project beneficial to the whole province:
  - a) Medical education;
  - b) Medical research;
  - c) Facilities which are expensive or located in small number of centres, e.g. radiotherapy by Cobalt Bomb, etc.;
  - d) Subsidizing hospital building and operating costs."

PSYCHOPHARMACOLOGICAL AGENTS IN GENERAL PRACTICE

*J. D. McLean, M D.

In recent years a wide range of drugs for the treatment of emotional illness has appeared on the market.

These drugs are continuing to appear with such frequency that it is impossible for the busy General Practitioner to keep abreast of the field.

This discussion is a review of those agents most effective in the treatment of emotional illness, in the belief that with a small but carefully selected list of drugs, a wide range of therapeutic effects can be obtained. If one wishes to consult a review of a wider range of drugs than is given here, it is suggested that the following articles would be of value:

(1) *Revised Survey of Selected Psychopharmacological Agents*—Cattell and Malitz-American Journal of Psychiatry 117-5 (Nov. '60).

(2) *New Drugs in Psychiatric Therapy*—H. E. Lehmann—Canadian Medical Association Journal 85-21 (Nov. 18/61).

It must be remembered that in most cases the main treatment of emotional illness is to take a genuine interest in the patient's emotional difficultes, and to give the patient opportunity to discuss his difficulties.

The use of drugs, therefore, usually should be considered to be a measure second in importance. In most circumstances the use of drugs is a temporary measure.

It should be remembered also that no drug is effective in 100% of patients with any given syndrome, and one may have to try several drugs before finding the most suitable one for a particular patient.

The selection of the drug to be given to a patient with an emotional illness is best made on a basis of symptomatology, rather than on the basis of the diagnostic classification of the illness. This is the approach used in the discussion following.

In the discussion to follow each drug is mentioned first by its pharmacological name, and thereafter by the Brand Name by which it is most widely known.

The first group of symptoms to be considered is the following:—Delusions, hallucinations, aggressiveness, severe overactivity, severe agitation or fear. The drug of choice for these symptoms is chlorpromazine (Largactil).

Largactil orally is used from 25 to 1200 mg. per day, in divided doses, though doses of over 600 mg. per day are not often used outside of hospital. It is recommended that one start with small doses, and increase the dose daily until control is achieved or until side effects appear.

The side effects to watch for are as follows:—

(a) Dizziness and drowsiness—these are frequent side effects. If the dosage at which they appear is reduced slightly, they usually disappear.

*Resident in Psychiatry, Camp Hill Hospital, Halifax, N. S.

Occasionally, however, they are persistent, and severe enough to force discontinuation.

(b) Extra-pyramidal symptoms—to be discussed later.

(c) Marrow depression and agranulocytosis—a rare but serious side effect, necessitating discontinuation.

This possibility should be considered in any patient receiving Largactil who has frequent infections or develops a sore throat. If possible, white counts should be done at convenient intervals on patients receiving long-term treatment with Largactil.

(d) Jaundice is occasionally seen as a side effect of Largactil, and the drug should be avoided when patients have a history of jaundice. It is an indication for discontinuation of the drug. It is most common in the second to eighth weeks of treatment, and is of cholestatic origin. It responds well to the usual regime for cholestatic jaundice, and is almost never followed by permanent liver damage.

(e) Photosensitivity with danger of severe sunburn is a frequent side effect.

(f) Less serious but still annoying side effects, which occasionally may force discontinuation, are rash, blurred vision, constipation, tachycardia, hypotension and dryness of the mouth.

If discontinuation of Largactil is necessary in a patient on high doses, it should be done gradually over a period of several days, if possible. The reason for this is that sudden discontinuation of high doses of Largactil sometimes causes convulsions.

If Largactil is discontinued, it may be replaced by thioridazine (Mellaril). This drug is less effective than Largactil. It is given in doses of 20 - 800 mg. per day, though the higher doses are not often used. Though Mellaril is less effective than Largactil, many physicians will find Mellaril a more useful drug because of its lower incidence of side effects.

The side effects of Mellaril are in general the same as those given for Largactil, though extra-pyramidal syndromes are extremely rare. One unusual side effect sometimes seen is that the patient, during intercourse, may experience orgasm without ejaculation.

Recently there has appeared on the market a drug known as chlorprothixin (Tarasan). This drug has not been in use long enough to be well evaluated, but it seems to be similar in effect to Largactil. It is reported to have some anti-depressant effect as well.

Tarasan is used from 30 - 400 mg. per day in divided doses. Side effects are dryness of the mouth, diarrhoea fatigue, and drowsiness. Side effects, however, are infrequent.

The second group of symptoms is the following:—Withdrawal, fatigue, lethargy, apathy, etc. These patients may respond to the drugs just described, but are more likely to respond to trifluoperazine (Stelazine). Stelazine in turn is sometimes effective in the group of patients that has just been discussed.

Stelazine is used in a dosage range of 4 - 120 mg. per day in divided doses, though doses of over 20 mg. per day should not be used outside of hospital, because of the high incidence of side effects. Stelazine should be started at 4 - 6 mg. per day, and increases should be gradual.

The lesser side effects seen are dizziness, dry mouth, rash, blurred vision, and fatigue. These are not serious, and often disappear after a few days of continued treatment.

The more serious side effects are extra-pyramidal symptoms. They occur at any dosage level, but are more common in the higher ranges.

The extra-pyramidal symptoms are subdivided into three types; more than one type may be seen at once.

(a) Motor restlessness (akathisia) usually occurs early in the course of treatment. It may vary from minimal restlessness to severe agitation and inability to relax or to maintain prolonged effort.

(b) Dyskinetic syndromes also usually occur early in treatment, and vary in degree. One may see perioral spasms, involuntary tongue movements, oculogyric syndromes, torticollis, hyper-extension of the neck and spine, and myoclonic twitches.

The commonest dyskinetic manifestation is a combination of perioral spasm, tongue movements, oculogyria and torticollis, with or without myoclonic jerks. The patient suddenly develops the syndrome, and is seen to have his eyes rolled up to one side, with the head tilted to that side, and the shoulder on that side elevated. He has speech difficulty, and difficulty in movement of the arm on the effected side.

This syndrome is alarming to the family, the hospital staff, and to the physician seeing it for the first time. The patient also is usually alarmed. Some patients, however, seem to be unconcerned by the syndrome.

(c) Parkinsonian tremor is the third extra-pyramidal syndrome seen. It usually occurs early in treatment, but may occur anytime in the first three months.

The management of these extra-pyramidal symptoms depends on the severity.

The mild ones respond to treatment with an anti-parkinson drug. Sometimes reduction or discontinuation of the Stelazine is necessary as well.

If discontinuation is necessary, reinstatement after several days may be attempted, starting at low doses, and increasing the dosage slowly.

If the extra-pyramidal syndrome is severe enough to require urgent treatment, it can usually be best treated by one of the following drugs—

(a) Caffeine sodium benzoate - 7.5 grains i. v.

(b) Cogentin - 2 mg. i. v.

(c) Sodium Amytal - $3\frac{3}{4}$ - $7\frac{1}{2}$ grains i. v.

At the same time the patient should be placed on an oral anti-parkinson drug, and the Stelazine should be omitted for a few days.

The most commonly used anti-parkinson drugs are trihexyphenidyl (Artane); methanesulfonate (Cogentin); and procyclidine (Kemadrin). These drugs are all given orally and Cogentin is also available for injection.

Artane and Kemadrin are given at doses of 3 - 12 mg. per day in divided doses. Cogentin is given from 0.6 - 6 mg. per day in divided doses.

Artane seems to be less popular than the other two.

Before leaving these first two groups of symptoms, some of the other drugs sometimes used should be named. All of these are, like Largactil, phenothiazine derivatives, and have an action similar to Largactil. As some of them have specific contra-indications they should not be used without consulting detailed literature on them. They are promazine (Sparine), perphenazine (Trilafon), levomepromazine (Nozinan), proclorperazine (Stemetil), trifluopromazine (Vesprin), thiopropazate (Dartal), Fluphenazine (prolixin), and mepazine (Pacatal).

The next general group of symptoms to be considered is the depressions, ranging from mild depression and lethargy through to severe psychotic depression.

The drugs used to treat depression are divided into two broad groups:—

(a) Mono-amine oxidase inhibitors:

Ipronizid (Marsilid), nialamide (Niamid), phenelzine (Nardil), isocarboxaoid (Marplan) and tranylcypromine (Parnate).

(b) Non-MAO inhibitors:

Imapramine (Tofranil), amitriptyline (Elavil), deanol (Deaner), methylphenidate (Ritalin) and piperadol (Meratran).

A patient should not be given two MAO inhibitors at once, and because of untoward side effects, drugs from the two groups should not be combined.

Because MAO inhibitors have a prolonged effect, they should not be replaced by a drug from the other group until the MAO inhibitor has been discontinued for at least two weeks.

The reverse, however, does not apply, and one may replace a drug of the second group with an MAO inhibitor after a period of 1 - 2 days.

For mild depression the most useful drugs are phenelazine (Nardil) and tranylcypromine (Parnate).

Nardil is usually started at 45 mg. per day, in divided doses, with gradual reduction of dosage after maximum benefit appears, to discontinuation after 3 or 4 months of treatment. Improvement is usually seen within one week, but maximum effects may take up to a month to appear.

Side effects of Nardil are widely varied, but infrequent. The commonest are:—dizziness, dry mouth, constipation, tachycardia, and hypotension.

Parnate, alone or with Stelazine, is frequently effective in treating the less severe depressions. Combined preparations are available, with 10 mg. Parnate to 1 or 2 mg. Stelazine (Parstelin and Parstelin S-2).

Parnate is usually started at 20 mg. per day, in divided doses, and increased up to 60 mg. per day if necessary. Side effects are frequent but not severe—they include dizziness, headache, hypotension and insomnia.

Parnate is the most rapid acting of the anti-depressant medications. The first signs of lifting of the patient's depression will appear within 48 hours, or not at all.

As with Nardil, once maximum benefit is obtained, the dosage should be gradually reduced to discontinuation after three or four months.

For more severe depressions the drug of choice is imipramine (Tofranil). Parnate and Nardil occasionally produce some improvement in severe depressions, but not often.

Tofranil is used from 50 - 300 mg. per day in divided doses, though doses over 150 mg. per day are not often used outside of hospital.

Improvement is usually seen within two weeks, but may not be maximal until the fourth week. Once improvement is seen Tofranil should be continued at the effective level for *at least* 3 months, with gradual reduction of dosage to discontinuation after another three months.

The incidence of side effects is high, particularly in patients over the age of 65, but serious side effects are extremely infrequent. The commonest side effects are dizziness, tremors, dry mouth and G.I. upsets An infrequent but

uncomfortable side effect of Tofranil is difficulty in micturition. This almost always responds to discontinuation of Tofranil and the administration of Carbacol, but it has been known to last for several weeks or more, especially if Tofranil is not discontinued.

A recent drug marketed for the treatment of depressions is amitriptyline (Elavil). Reports in the literature have been very favourable, and it may prove to be as effective as Tofranil. In addition to its anti-depressant effect, Elavil also has some sedative effect. The dosage and duration of treatment are the same as for Tofranil. Side effects are infrequent and well tolerated, and include drowsiness, dizziness and weakness.

Before leaving the topic of depressions it should be stressed that because of the high incidence of liver damage, the use of iproniazid (Marsilid) is no longer recommended.

The next group of emotional disorders to be considered is the group showing overt anxiety, hypochondriasis, obsessions, tension, etc. The most effective drug for these symptoms is meprobamate (Miltown, Equanil). The dosage range is 800 - 1600 mg. per day, in divided doses. A wide variety of side effects have been reported. The more serious (though infrequent) ones are hypersensitivity reactions, fainting spells, bronchial spasm, and acute non-thrombocytopenic purpera. MEPROBAMATE IS A VERY ADDICTING DRUG, and should be dispensed accordingly. Sudden withdrawal of meprobamate may cause convulsions.

Less effective, though equally popular, is phenobarbital, given in doses of ½ - 1 grain per day, in divided doses. It is popular because of its low cost, and because though it is less effective than meprobamate, the difference is minimal. For these reasons it is felt that phenobarbital should be given preference to meprobamate. The addicting properties of phenobarbital, however, makes this drug useful only on a short time basis. The major side effect of phenobarbital is drowsiness.

Small doses of Largactil (50 mg. per day) or Mellaril (60 - 75 mg. per day) are often used for the patients under discussion.

Librium is also popular for the treatment of these patients, and is the drug of choice for severe panic-like states. It is also effective in helping to control impulsive behaviour, such as impulsive outbursts of aggression. The dosage range is 15 - 80 mg. per day, in divided doses. Side effect are mild and infrequent.

Other drugs that are sometimes used for these patients are:—Prochlorperazine (Stemetil), adiphenine with phenobarbital (Neuro-Transentin), hydroxyzine (Atarax), and thioproprazate (Dartal).

Next to be considered is the management of the alcoholic.

With the exception of Tempasil and Antabuse, drugs are of little value in helping an alcoholic to stop drinking. Many psychiatrists do, however, give small to moderate doses of Largactil. Though this rarely, if ever, affects the drinking it does help to relieve the anxiety and tension these patients experience.

The use of Antabuse and Tempasil is not recommended unless the patient is being seen regularly at a psychiatric clinic.

The drug of choice for the treatment of delirium tremens is Largactil, given either orally or inter-muscularly, up to 1200 mg. per day. This is contra-indicated when serious infection or cardiac disease is co-existent. Other seda-

tion, particularly barbiturates and opiates, should be avoided, except paraldehyde, which is often useful.

Acute alcoholic intoxication rarely needs treatment with a sedative. If such is needed, *small* doses of Largactil may be used.

Finally, mention must be made of the acutely disturbed patient, awaiting admission to hospital.

For patients only moderately disturbed, 100 mg. Largactil I.M., 8 - 16 c.c. of paraldehyde I.M., or $3\frac{3}{4}$ - $7\frac{1}{2}$ grains of sodium amytal I.M., usually produces the desired sedation. This may be repeated every two hours as needed.

For violent patients, when immediate and complete control is urgent, the most effective drug is Sparine, given intravenously. The dose is 50 - 300 mg. depending on the size of the patient. One hundred-fifty mg. is the usual dose.

Intravenous Sparine is absolutely contra-indicated in anyone who is known to have cardio-vascular disease, or who is in the age group where cardio-vascular disease is common.

The reason for this is that in these persons it may precipitate a prolonged and severe drop in blood pressure. Even in healthy persons some drop in blood pressure may occur, and must be watched for.

Less effective, though far safer than Sparine, is intravenous sodium amytal. The dosage varies from $3\frac{3}{4}$ - 15 or more grains, depending on the size of the patient.

In giving either sodium amytal or Sparine intravensouly, the drug should be diluted to 20 c.c., and given slowly over a period of 5 or more minutes. In this way it is possible to judge by the patient's actions when he has had an effective yet safe dose. The dilution also serves to prevent irritation to the vein.

Before closing a few general points of caution should be given:—

First—Most of the drugs discussed can sometimes cause dizziness and drowsiness—patients should be warned to avoid driving an auto, and any other activity where dizziness or drowsiness would be unwelcome.

Second—Many of these drugs potentiate alcohol and the patient should be warned of this effect.

Third—Many of these drugs potentiate opiates, and this must be kept in mind when prescribing opiates.

Fourth—Some of the medications which have been discussed, particularly some of the anti-depressants, can be lethal if overdose is taken. The possibility of accidental or intentional overdose must always be remembered, and it may at times be wise to prescribe frequent small lots, or to have the medications made the responsibility of the patient's family, rather than of the patient himself.

Fifth—One cannot expect medications to cure every patient, and the necessity for hospitalization of some patients must not be forgotten. This will apply particularly to the severely depressed patient.

Finally—Because extra-pyramidal symptoms can be frightening to all concerned, drugs which frequently produce these effects should be used with caution in the treatment of patients who live a great distance from the physician.

SUMMARY OF TARGET SYMPTOMS

For symptoms of:

Anxiety, tension, phobias, agitation, the drugs preferred are:
Phenobarbital, Librium, small amounts of Largactil or Mellaril, Meprobamate

For symptoms of:

Severe anxiety, tension or agitation; aggressive behaviour, the drugs preferred are:
Largactil, Mellaril, Tarasan.

For symptoms of:

Withdrawal, retardation, severe apathy, the drug preferred is:
Stelazine.

For symptoms of:

Mild depression (lassitude, apathy, tiredness, loss of initiative), the drugs preferred are
Parnate, Nardil.

For symptoms of:

Severe depression (delusions of guilt, crying spells, suicide thoughts, early morning awakening), the drugs preferred are:
Tofranil, Elavil.

For the alcoholic the drugs preferred are:
Largactil, Paraldehyde.

For violence the drugs preferred are:
Sodium Amytal, Sparine, Paraldehyde.

For details of dosage, side effects and precautions refer to the main article.

THE POWER TO MOVE*

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Once upon a time this chance to address doctors would have been looked upon less in the light of the honor it is than as an opportunity to attack what some suppose to be one of the last citadels of privilege

But Time tempers ardor, a fact of which the physician is more aware than anyone – unless it be the psychiatrist Hence, if an oral assault had been desired, as experts in such matters, the staff would have chosen one upon whom Time, the tranquilizer, had not yet taken hold The only conclusion, then, is that the result would be happier if excesses of language were avoided and the "soft sell" employed

There may even be room for reminiscence For instance, I knew and was lucky enough to be treated by a doctor who studied with Lister and lived among the early users of chloroform and many other 19th Century English and Scottish innovators

This doctor lodged in the same house with deQuincy and, like him, became an "opium eater," surviving to use it for more than 60 years He told of the Rosettis and Tennyson and Dickens and Pater, whom he knew, and, second-hand through deQuincy, of Coleridge and Wordsworth and Southey.

That went back a century and a half in years, but many many times as far in terms of medical progress – a hundred hundred years perhaps.

In that doctor's day, Halifax had a pest-house where the sick usually died and a bedlam where the mad were hidden. Then, a hospital was a place of last resort for the doomed; and the mentally ill, always shunned, were seldom so much as acknowledged.

Today, the hospital where mental illness is being conquered has taken the place of bedlam and major centres of other healing tower over the community, symbols of new attitudes.

Institutions, training, skills and, as vital as anything else, public viewpoints have changed. Only doctors themselves can say what has happened to the physician, his outlook, his rewards and his influence. To explain that last term a little incident may serve.

Not so many days ago at a social function where, as usual, doctors and doctoring were being gossiped about, the conversation for a moment took on a serious note when a woman said:

"When you are despondent and suffering so much you wish all would end – if that happens to be the only way to get relief – you turn your eyes and there is the doctor. . . . . He walks toward you and you know that he has come to help you bear what had seemed unbearable, it is as if a god had come. .You worship him, unquestioningly accept his advice, and you obey him.

"Looking back, it seems far-fetched," this woman said, "but what I have said was true. There, I think, lies the power of the doctor."

And not one of those who heard this and who had known such spiritual and physical testing took exception to what she had said.

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*Address given to the Victoria General Hospital Medical Staff, at their Annual Dinner Meeting, Nov. 29, 1962.

*Executive Editor, Halifax Herald.

DeQuincy, who has been mentioned as a doctor's friend, had something to say about such power, though he was speaking of writers. He distinguished between the "literature of knowledge", whose function was to teach, and the "literature of power", whose "purpose was to move". He said the meanest of authors who moves has pre-eminence over all who merely teach, that "the literature of knowledge" must perish while "the literature of power is triumphant forever – so long as the language in which it is written exists".

Substitute the words for healing for deQuincy's literature and the result is interesting. There is the physician who heals; there is the one who, in addition, uses his power to begin great movements. Scar tissue left by the first appendectomy long since has become dust. On the other hand, attitudes fostered by Lister and his like will prevail, to apply deQuincy's thought, so long as the practice of medicine exists – because those men used their power to "move" as well as their knowledge of how to cure.

In this god-like influence, the power to move of which that woman spoke, the medical profession today not only has the weapon with which to meet the attacks to which it is being subjected, it can forestall such assaults. It can render absurd, for example, the claim that, to concoct a panacea, doctors be state-ified – as if state operation, of itself, ever mended a major fault!

To be precise about this exercise of the power to move, perhaps local situations and problems where the medical man's power might be exhibited – such things as housing and hospitals, medical training facilities, to name only three of these which have received some attention of late can be cited.

The doctor knows the squalor of the slums; he saves lives there. He could do even more by using the power which is his, based on knowledge, to seek out and induce the elimination of the cause of that squalor, of slums, of moral as well as physical illness, of the poverty which turns out bandy-legged boys because there is so little and so wrong food or, alternatively, so so much simple ignorance.

The medical man's power to move can be usefully applied in still another area. All know how nearly scandalous were the conditions in the old hospital, yet it took a generation to get a new VG – and doctors did not supply the driving force. Now there is need for even larger space and the years of delay which already have accumulated may be succeeded by other years before construction is complete. If doctors would use their influence, gained in dealings with their patients, to guide the public, their patients who ask no more than guidance, the responsible authorities would be enabled to undertake buildings. If the public throughout Nova Scotia thoroughly understood the urgency of the need for a more complete medical treatment and training centre, political people would be as able as they are anxious to act. It is much easier to till already broken ground than it is to have to start from the stump lot. There is, then, an opportunity for the exercise of power to encourage an accelerated program and an acknowledgement on the part of the public that they must pay for it.

Were this a time of war, emergency accommodation for expected casualties would be ready within weeks. People and governments would be moved to swift action.

This is a time of peace. There is no movement, even though there is no need to wait for expected patients; illness is already here, needing hospital space available only after a lingering wait.

(Incidentally, there even could be temporary accommodation of a war-

time nature, not costly, but certainly sufficient to bridge the gap between now and the provision of permanent hospital beds. . . .But there is no such space.)

Doctors, particularly in Halifax, are to be congratulated upon the efforts they have made, but even they are likely to admit they have not been as forceful as if the matter of new space had been of immediate, personal consideration.

In any event, the public, aware of the shortage and lacking leadership, strikes at the most familiar health figure, the medical practitioner. It demands that he be regimented, not because he has failed to put his medical knowledge to work for the individual but because health and hospital conditions at a community level are considered unsatisfactory.

There are precedents for the layman's viewpoint. To stem a flood, an engineer is engaged, to manage money an economist is called in. It seems logical, then, to employ doctors' full knowledge to deal with health in the broad sense when the need demands it.

The profession, in the beginning, said that to do this would be completely at variance with its duty. It inferred, or so the public understood it, that all was well with medical protection or service. Then, it negated its own claim by saying that complete protection could not be provided because there were not enough doctors to go around.

As if a universal system would cause a sudden surge of illness. True, it might induce a sudden rush of patients who have been suffering it out, afraid of medical costs, but it could scarcely cause an epidemic!

Eventually at a national level the profession, to clear the air, agreed that improvements could be made and suggested ways to bring them about on a nation-wide scale. Unfortunately, as experience in one province recently showed, the explanation was insufficient and unemphatic. There was a clash of interests and a breakdown in public relations.

Fortunately, by exercising the power which is theirs, doctors can alter the public attitudes which created that western crisis. They can continue to heal – they also can institute or strengthen greater movements, social undertakings even though some are designed, among other things, to make the medical man's services less necessary.

This effort calls for sacrifice, but most laymen believe in their doctors and the dedication which is the foundation of their profession. They will accept their ideas if they are positively, humanly put forward so that any can understand. They do not want a faith founded on generations of service erased by ultra-radicalism or sicklied over by extreme conservatism.

To be frank, the public looks for leadership mainly in order to get maximum protection; moreover, it seems willing to assume the cost of some form of medical insurance; that does not mean, necessarily, that it wants state intervention. Frustrated, though, citizens may be swayed by the demagogue when they should have guidance from the doctor. There are signs this has happened in some places.

Told that he cannot have full service because doctors are too few – and a thousand could be employed in Canada before the patient-load is down even to the unsatisfactory British level – the citizen wants to know how he can help overcome the shortage. If it is of plant and equipment, he will help see they are provided; if the shortage is of training staff, he can assist in assembling it. If measures are needed to ensure that the medical economy

is not destroyed and medical men allowed ample rewards, the citizen can see that such laws are enacted. The public is eager to know, not because it wants to revolutionize or replace the known system but because it wants the best and to see that medical men are enabled to provide it.

Again, therefore, the power of which deQuincy wrote – the power to move, the power to influence, undoubtedly possessed by the doctor, should be exercised. The suggestion that this be done seems abhorrent to many because it goes contrary to all medical dicta – as well it should.

A few generations ago, communications were rudimentary and the population largely illiterate; the purveyor of snake oil consequently prospered.

Today what is done now is known around the world tomorrow and at least partly understood by a population steadily growing in knowledge and ability to weigh evidence. Both still may be defective but they are infinitely greater than they were when most medical taboos began. Therefore, the robes of the alchemist and the attitudes of the all-knowing high priest of healing no longer serve in this informed, inquisitive world.

The profession should recognize this change and should use its power to influence by sharing with the public its knowledge, not of intricacies of private practice, but of the broader aspects of medicine and of the associated community needs of which its members are necessarily conscious.

The medical profession today seems to be the sickest of all professions, suffering from illness which may destroy it as we have known it. At least, no one has come forward with a sound reason for believing Canadian doctors will escape the fate of their fellows elsewhere. Consequently they should be concerned to find a cure.

Even now, with this country already an addict of state-ism, some physicians defend themselves only by declaring that sacred relationships and freedom of action must be preserved. Such "stand-pat" may be sound, but the public, rightly or wrongly, knowing no different, has begun to think otherwise.

The unionized, industrialized, assembly-line worker knows nothing of the freedom of which doctors speak and have enjoyed. Such freedom has to be explained to the ordinary man who is the product of compulsory birth registration, compulsory schooling, compulsory vaccination, compulsory registration for his first employment. He knows little of freedom in doctors' terms. Even if he did, human nature being what it is, "we all have strength enough to endure the misfortunes of others" – even doctors.

That other term, "sacred relationship," deserves examination, too, because it is so often heard. It still seems so meaningful to doctors though they know and the public knows they already are bound by law to disclose to third parties many, intimate things about their patients.

Here it might be helpful to recall another sacred relationship, that which once existed between monarch and subject. The king ruled by divine right and to ignore it, he said, was to invite the executioner, to overcome it would bring anarchy. Everyone, royal, semi-royal and plebeian, believed that, because it was the rule of fear based on ignorance. The day came when there was no compromise in a certain king of whom all have heard. He lost his head on a chopping block. No one except himself was struck dead that day – and chaos did not come on the morrow. Instead, in time, there was a new arrangement and kings ruled again – but by consent. They sat comfortably on their thrones serving usefully the needs of the state as directed by the

state. They presided again over nations because democracy had replaced demagoguery but their ability to initiate was gone forever.

There may be a lesson in that. Change takes place inevitably, either by discussion and agreement or by force – and force already has been tried in the medical world. Incidentally, a single victory does not mean a war finally won; it could mean merely that both sides are bolstering their forces for a fight in which all, without exception, will suffer.

Doctors label as a fool the man who ignores treatment and damns the expert who prescribes it. In what way does a profession differ from the individual when it chooses to battle public skepticism about sacred relationships and absolute freedoms by retreating into its shell in stubborn silence?

Counsel has been given by experts; their prescription is not new and contains at least two ingredients, one of which is the importance of leadership. The other involves telling the profession's story in terms all can understand.

Hands will be flung up in horror at the thought – "that means headlines for cases – advertising". It might even mean mention of an individual! Medical men can be assured that, after the first flush, they won't even get space, much less headlines, because what they have to say will have to fight for space and time against other newsier news.

Like everybody else, publishers are human, and so are editors and reporters and broadcasters. They are interested primarily in their own health, that of their families and their neighbors; secondary, are headlines and breathless bulletins if they endanger the public welfare. All want a system that will ensure the best possible health protection, only that.

Doctors are in the key position to tell them what the system is and what can be done to make it more effective. However, it is folly for them to believe they can hold their position by merely reiterating shibboleths or by crying socialism or even communism. They can do it by causing concrete achievements to be recorded in human, everyday terms.

They themselves probably can do most to improve their system by citing its needs and exercising power to influence the public to affect the change before someone else, with destructive intent, does so. Doctors might even step aside for the moment, as the Samaritan did to tend to what seemed to be someone else's business but actually was his own. Such acts in the community field, as observed from the standpoint of medicine, would give weight to doctors' words with respect to their professional sphere.

The medicine man was listened to once because he painted his face, wore a necklace of human teeth and waved a thigh bone over a smoky fire. That sort of thing does not work today nor do their cultivated, modern counterparts. Just as the priest has had to come down from his pulpit to prove his words by good works, so must the gray-flannelled or white-gowned physician cease muttering protests behind his facade of assumed disinterest in anything except magic philters. The sooner he does this, the better for him and all Canadians because – and few question this – Canada has evolved its own medical system, excellent for its time, and that system became what it is through change and change must inevitably continue.

So, it is suggested – and many phrases could be used – "Come out of your caves but do it before the attack starts". "Get down off your horses and into action before the beasts bolt". "Better kill a sacred cow or two than have

the entire profession starve in state stanchions." The doctor should place his case before the public by relating accomplishments, not statistics, but human achievements. That is the suggested cure for present troubles. It may taste sour to many practitioners. If so, they should reach for the soda or scalpel, not for the ether, find relief in action, not sleep.

After all, Canadians, doctors and lay, would like a continuation of the system designed to "protect the health and lives of the people of this Dominion from the unskilled treatment of incompetent men".

Those were the first words of the first president at the first Canadian Medical Association meeting in 1867. A Nova Scotian, he was Sir Charles Tupper, a father of confederation, a Canadian Prime Minister, and here Sir William Osler, most distinguished doctor, is quoted: Tupper was a "politician first and a physician only when stranded by the exigencies of party".

If that, as a note to end on, seems partisan, only some of the doctors will forgive it. But in some way the two arts Tupper practiced should be merged. Perhaps the doctor will serve as the catalyst. Better that than have an emulsion useful only if shaken from time to time by the public.

SUSCEPTIBILITY AND IMMUNITY TO COMMON UPPER RESPIRATORY VIRAL INFECTIONS—THE COMMON COLD*

Studies with volunteers show that many viruses are found in the nasal secretions of people suffering from the common cold and that physiologic and psychologic factors influence the symptoms Infection causes immunity, but immunologic control may be difficult.

Common upper respiratory viral infections, despite their frequency, have been something of an enigma to physicians and scientists in general. Little has been known about their specific etiology and the factors that influence susceptibility or resistance to infection. A prevalent view, even within recent years, has been that there is a common cold virus to which only man is susceptible and which causes recurrent symptomatic infections without establishing immunity of the host. This concept now appears to be far too simple.

The present report gives results of experimental challenge of volunteer subjects with one of the common cold agents under controlled conditions.

Donors with naturally acquired typical common colds in the months from September to May have contributed specimens of nasal secretion. The secretions have been filtered free of bacteria and cells and stored at minus 90°F.

Students ranging in age from 18 to 48 have been challenged with a nasal secretion, usually diluted 100 times; a virus grown in tissue culture, or a salt solution. Symptoms were recorded for each day of the following week.

Nasal discharge was the symptom most uniformly recorded. It was the only symptom that was rated as severe. Sore throat, malaise, postnasal discharge, headache, cough, and sputum were frequent symptoms of moderate severity. Feverishness and chilliness were reported infrequently.

Bacteria Cultured

Bacteriologic cultures of the nasal specimens before and on the fourth, seventh, and ninth days after challenge were made for the detection of pathogenic microorganisms in the respiratory secretions. Some of the volunteers harbored staphylococci, hemolytic streptococci, or pneumococci in their prechallenge specimens. There was no apparent relationship between the presence of these microorganisms and the development of clinical symptoms.

Among a control group of volunteers who received uninfected buffer solution, there was a direct and statistically significant relationship between the usual number of colds per year reported by the subject and the likelihood of his developing symptoms of a cold in the experiment. Thus, among 23 subjects who reported five or more colds per year and who received the noninfectious control inoculum, 26 per cent developed a cold according to the criteria used in the experiments. Among the subjects who reported fewer natural colds and received uninfected material, there was a proportionately smaller number of experimental colds.

Attitudes exhibited before challenge showed that cold symptoms would be less likely to be reported by individuals who (1) did not believe they would develop a cold, (2) thought that emotional status did not influence physical status, and (3) reported feeling no concern or worry over anything going on in their lives at the time of experimental challenge. A positive response to these three attitudes made it more likely that cold symptoms would be reported by the individual.

In regard to the effect of chilling on the common cold, the data show two important features: (1) among uninfected subjects, chilling did not activate

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George Gee Jackson, M.D.; Harry F. Dowling, M.D.; Truman O. Anderson, M.D.; Louise Riff, B.S.; Jack Saporta, M.S.; and Marvin Turck, M.D., *Annals of Internal Medicine*, October, 1960.

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latent viruses with the production of a clinical cold; (2) among subjects who received a uniform challenge, chilling did not increase the susceptibility to clinical infection.

Previous tonsillectomy had no influence on susceptibility or symptoms, nor did the smoking history of the person.

Discussion

The causative agents of the common cold appear to be several, perhaps many, different viruses. These viruses produce both clinical and subclinical infections in man. Each of the viruses can produce a variety of clinical syndromes, commonly classified under categories of common cold, undifferentiated upper respiratory infection, and "flu." The common cold viruses cause afebrile, acute coryza in the great majority of persons. With a few exceptions, these viruses have not been isolated, named, or well characterized.

The common cold viruses are present in infectious form in both the cells and the fluid of nasal secretions; the titer is sufficient to suggest that droplet spray could be an effective means of communicating infection. Person-to-person transfer, presumably by droplet spray, was observed to cause clinical illness in approximately 10 per cent of persons exposed under experimental conditions and in 17 to 55 per cent among family members. The viruses in the community at different times, however, appear to be immunologically different, and some seem to cause sharp waves of epidemic illness, whereas others are more endemic.

The strong positive correlation between the usual number of colds per year by history and symptomatic reaction to an innocuous instillation appears to establish a wide range of difference in the proneness of persons to develop rhinorrhea or coryza. The data do not permit a conclusion as to whether physiologic or psychologic facts are dominant. On either basis, it is surprising that among the subjects who were hyperreactors to an uninfected solution, there was not greater susceptibility to clinical illness from a secretion containing an infectious agent.

For centuries men have associated the common cold with environmental chilling. The present data seem adequate to conclude that the basis of the association is not the direct activation of latent viruses by physical cold or physiologic reaction to chilling, since these factors did not produce colds without infection.

Immunity

Previous epidemiologic and experimental observations that show insignificant immunity to the common cold have failed to recognize the number of specific viruses involved. Neutralizing antibody has been demonstrated in the serum and nasal secretion, and immunity to a specific rechallenge is as complete as that observed for influenza under natural conditions of infection. The duration of immunity is not known, but it appears to remain through at least one respiratory disease season.

These observations require the postulate that each viral upper respiratory illness is a specific infection, and thus that the number of viruses responsible for these infections is very great. Under the concept that the common cold is caused by many specific agents, each of which elicits an adequate immune response, the likelihood of discovering a predominant common cold virus that maintains this role for a long time is quite unlikely. If this is the case, the logistics for immunologic control of the common cold may be very difficult.

LETTERS TO THE EDITOR

To the Editor – The Nova Scotia Medical Bulletin

December 18, 1962

Sir:

With regard to the editorial in your November 1962 edition entitled "Another Crack in the Mirror" the Department of Public Health is in agreement with the writer (J.W.R.); however, we would like to draw to the attention of J.W.R. and others the reason for not consulting the Society when the program was postponed.

When a program such as the Sabin vaccine program is being considered by the Department, it is our practice to bring such programs before the Society. In some cases it is not possible, because of timing, to bring matters before the Annual Meeting – in such cases the Executive is consulted. In addition, such matters are brought to Branch Societies. On many occasions our officers or myself appear at such meetings to give information, answer questions, et cetera. When important issues are at stake we do our best to have an informative article in the Bulletin.

Like the writer of your editorial, we are frequently surprised at the apparent lack of interest as shown by the paucity of questions – possibly because the profession has complete faith in the Department – if so, their attitude is appreciated by all members of the Department.

The decision to recommend the postponement of the Oral Sabin vaccine program was made by the Technical Advisory Committee in Ottawa on September 12 – the Department was advised of this decision on Thursday, September 13. The Nova Scotia program was to start on Monday, September 17, 1962, – it is clear that there was not sufficient time for discussions with the Society – we had barely enough time to notify our own personnel throughout the Province.

The Department of Public Health are most appreciative of the co-operation of the medical profession in public programs. The profession can be assured that, except under unusual circumstances such as the above, the Department will always confer with the Society before any program affecting the profession is put into effect or cancelled.

Yours truly,

J. S. ROBERTSON, M.D., D.P.H.,
Deputy Minister.

To the Editor – The Nova Scotia Medical Bulletin

Nov. 20, 1962.

Sir:

It has recently been drawn to my attention that a patient for whom paraffin wax baths had been prescribed for the hands and wrists, was employing undiluted Parowax for the purpose. Considerable trouble was experienced as the preparation was too hot at melting point and difficult to remove after use.

As there is an element of likelihood of burns in this situation, I should like to draw to the attention of your readers, through your pages, the fact that instructions for the use of paraffin wax baths in the home are available from the Nova Scotia Division Office of the Canadian Arthritis and Rheumatism Society, 353 Bayers Road, Halifax. These can be supplied in the form of a single sheet of paper with mimeographed directions. Precise directions also appear in "Osteoarthritis – A Handbook for Patients" and "Rheumatoid Arthritis – a Handbook for Patients" and these pamphlets are also available from the Division Office.

For patients who wish to avoid mixing the proper proportions of Parowax and mineral oil, the Society has on hand a supply of low melting point wax designed for this particular use and we will be pleased to supply it to patients at cost on the recommendation of their physician. A copy of the instructions is attached and might, perhaps, be added as an addendum.

Yours very truly,

JOHN F. L. WOODBURY, M.D.,
Medical Director.

THE CANADIAN ARTHRITIS AND RHEUMATISM SOCIETY
NOVA SCOTIA DIVISION

353 Bayers Road, Halifax – Telephone 455-5133

Instructions for use of Low-Melting-Point Wax

(as prescribed by the family Physician)

CONTAINER:

The wax should always be melted in a water bath, such as a double-boiler or a container immersed in hot water. A 48-ounce juice tin with the rim clean cut is very suitable for immersion of the hand. For an ankle a large double-boiler would suffice.

The wax should be heated until it melts. As soon as the wax melts it is at satisfactory temperature for use, and the heat should be turned off or container removed. Test the temperature of the wax with one finger before proceeding. While the bottom of the container is hot it should not be touched with the fingers.

METHOD OF USE:

(1) Immerse hand or foot in the wax, then immediately lift out, keeping fingers or toes still so that the wax does not crack.
(2) Repeat, dipping the hand or foot in and out until fifteen coats have been applied.
(3) Wrap the hand or foot in waxed paper and a towel and allow to remain in the warm wax for fifteen to twenty minutes.
(4) After that the wax can be peeled off like a glove or sock and replaced in the container to be reused many times.

Editors Note:

If Parowax only is available it should be used at temperatures of 110° 120° by thermometric control. The household candy or fat thermometer is adequate.

PERSONAL INTEREST NOTES

Cumberland Medical Society

The regular meeting of the Society was held in the Fort Cumberland Hotel on November 14th. On Dec. 5th a meeting of the Committee of Post Graduate Studies was held with Dr. Lea Steeves to arrange a Regional course in Cumberland Co. On Dec 12 a special General Meeting to discuss Fee Schedules was held.

We extend CONGRATULATIONS to Dr. and Mrs. Carson Murray, Springhill, who celebrated their Twenty-fifth Wedding Anniversary on November 25, 1962.

Halifax Medical Society

Dr. Frank Dunsworth has resigned from the Active Staff of the Childrens' Hospital. He remains on the Courtesy Staff of the hospital.

Dr. C. M. Harlow, Director of Laboratories at Camp Hill Hospital used "Lovely Lady Nellie" to show where Cancer and other diseases might strike the human body, when he made two addresses recently to the pupils of St. Patrick's High School on "Cancer and General Health" under the auspices of the Canadian Cancer Society.

On Nov. 28, the Medical Staff of the Victorial General Hospital held a reception, dinner and dance at Lord Nelson Hotel. Mr. F. W. Doyle, Executive Editor of the Mail-Star was guest speaker.

Copy from Mail-Star. "Halifax's real life Dr. Casey – Dr. M. Thomas Casey who not only resembles the TV idol but is the same age has arrived in Emekuku, Eastern Nigeria to begin a year's study as a staff member of the Holy Rosary Hospital. He is a native of Glace Bay and graduated from Dalhousie in 1953. Since then he has spent four years in postgraduate training in General Surgery Bellevue Medical Centre, N.Y.C. He received his F.R.C.S. (C), and was on the staff of the Victoria General Hospital and Dalhousie University as a Lecturer in Surgery. A year ago he returned to New York for further study in Thoracic Surgery and completed his residency in this field before going to Nigeria. While in that country he will continue his work as a surgeon and also instruct internes. His service with the hospital was arranged by the Catholic Medical Missions Inc. of New York".

Congratulations

We extend congratulations to Dr. P. M. Sigsworth, Halifax, on being elected a Fellow of the American Academy of Paediatrics at it sannual meeting in Chicago in November.

We also congratulate Dr. W. A. Condy, Halifax, and Surgeon-Captain Charles M. Harlow, Halifax on their admission to the Rank of Serving Brothers in the Order of St. John of Jerusalem. An Investiture was held recently at

Government House. A Priory Vote of Thanks was given to Dr. Graham Pace, Dartmouth, and to Dr. John J. Quinlan, Kentville.

Further indication that doctors are Community workers – and players. Dr. Anne Hammerling has been elected Ladies' Chairman for the Annual Israel Bond Drive and Dr. Howard Goldberg was a member of the winning team of the first annual mixed team of four champion tournament of the Halifax Bridge Club.

Cape Breton Medical Society

The Secretary of the Cape Breton Medical Society Dr. E. W. Christ and his wife Dr. Elly Christ have left Cape Breton and have taken up practice in Central Butte, Saskatchewan. We wish them every success in their new surroundings.

Western Counties

"On Tuesday, November 27th we had a mock disaster exercise at the Yarmouth Hospital. Everyone was satisfied with the performance and felt that this was quite successful.

Dr. D. F. Macdonald, as President of The N. S. Medical Society is busy visiting all the other Branch Societies. He has already named his Committee Chairmen and they have met officially and are starting to organize the coming Annual meeting.

We extend our congratulations to Dr. A. F. C. Scott on his election to the Presidency of the Western N. S. Medical Society for 1963.

Our good wishes go to Dr. P. E. Belliveau in his convalescence from his recent surgery.

Dr. L. M. Morton has once again left us for the sunny weather in Florida for the winter months."

N. S. Society of Ophthalmology and Otolaryngology; Nov. 19, 1962–

The Annual combined Meeting of the Nova Scotia and New Brunswick Societies of Ophthalmology and Otolaryngology was held at the outpatient department of the Victoria General Hospital for case presentations, which was followed by a luncheon meeting at the Lord Nelson Hotel. The luncheon was followed by a paper on Orbital Tumors by Dr. C. F. Keays (commenting on a recent meeting at Houston, Texas,), and impressions of the recent meeting of the American Academy of Ophthalmology and Otolaryngology at Las Vegas, Nevada, by Dr. H. J. Davidson. This was followed by three films; Haemostasis: The Effect of Estrogens, "Lamellar Keratoplasty and Recurrent Pterygium" and "Cataract Extraction using Mechanical Eresiphake and Alphachymotrypsin". Business meetings were held during both morning and afternoon sessions.

Officers elected for the coming year were: Drs. J. S. Hammerling, President; D. M. MacRae, Halifax, Vice-President; J. H. Quigley, Halifax, Secre-

tary-Treasurer, and in addition the Executive for the year will include Drs. R. F. Hand, Halifax, H. F. Sutherland, Sydney, R. H. Fraser, Antigonish and J. K. G. Grieves, New Glasgow.

Births

To Dr. and Mrs. J. R. Buchanan (née Jacqueline Singleton), Rockland State Hospital, N. Y. a son, Keith Singleton, on Dec. 5, 1962.

To Dr. and Mrs. Neville Elwood a son, Thomas, at the Halifax Infirmary on Nov. 30, 1962.

To Dr. and Mrs. Dennis Johnston (née Dr. Lalia Dauphinee) a son, Dennis Walter at King's College Hospital, London, England on Dec. 11, 1962.

To Dr. and Mrs. Lester Wiseman, a son, Christopher James, on Dec. 14 1962, at the Grace Maternity Hospital.

Another new arrival is the son, Kevin Michael, born at the Grace Maternity Hospital, on Dec. 18, 1962, to Mr. James Smith (4th year Medical student) and Mrs. Smith (neé Frances O'Brien), (second year Medical student).

Obituaries

Dr. Hugh Robert Peel physician and surgeon and one of Truro's most prominent citizens died on Dec. 15 after an illness of five years at the age of 57 years. He graduated in Arts from Whittier College, California and in Medicine from Edinburgh in 1931. He practised in Edinburgh and London before settling in Truro. Later he went to Scotland and studied surgery at Glasgow. Dr. Peel was always interested in the problems of the Colchester County Hospital and held various positions on its staff, as well as in the Colchester-Hants Medical Society. He was a keen hunter and fisherman and was long a member of the Masonic Order and of the Kiwanis Club.

Dr. W. H. Robbins, a prominent retired New Glasgow physician and surgeon and a veteran of World War I died at Wolfville recently, at the age of 90 years. A native of Digby Co. he graduated from Dalhousie and later took postgraduate work in London, Edinburgh and Glasgow. In 1914 he received the F.R.C.S. (Edinburgh.) Having served with both the British and Canadian Forces he began practice in New Glasgow. He served three terms on the New Glasgow Town Council and was an elder of Westminster Presbyterian Church until his death. He was an Honorary member of the C.M.A.

Dr. A. J. MacNeil, died in Mabou, Cape Breton at the age of 95 years on Nov. 20. He was one of the oldest living graduates of St. Francis Xavier University (1894). He graduated in Medicine from the College of Physicians and Surgeons Baltimore in 1904 and later did post graduate work at Johns' Hopkins. He then practised in Iona-Grand Narrows area, then Margaree and finally in Mabou until a broken hip in 1956 made him reluctantly give up practice.

Sympathy

We extend our sympathy to Dr. H. W. Schwartz on the death of his wife on November 29, after a short illness.

And also to Dr. Roy A. Morash of Berwick on the death of his brother E. W. Morash of Spryfield, Chief of the Spryfield Fire department on Nov. 22.

COMING MEETINGS

Clinical Meetings

Regular Clinical Presentations will be given by the Staff of the Victoria General Hospital at 5 p.m. on Wednesdays (except the 4th Wednesday in each month). The first meeting will be on February the 6th, 1963.

A program has been arranged which will be of interest to all of the Profession, and a cordial welcome is extended to all Doctors in the Province.

Program details will be published in advance in The Nova Scotia Medical Bulletin and copies will be sent to every Hospital in Nova Scotia.

It is intended that these meetings shall be a rebirth of the regular sessions which were so well attended for many years in the past. Suggestions for this clinical program will be welcome and should be sent to the Program Committee of the Victoria General Hospital.

Selected papers from these presentations will be considered for publication in the Bulletin.

Program

The first of these presentations are:

6th February: Minor Menstrual abnormalities (including the use of drugs such as Envoid).
13th February: Some less well-known techniques in X-ray diagnosis.
20th February: Perfusion techniques in cancer therapy.

A five day Postgraduate Course in the Medical Care of Adolescents will be given at the Adolescent Unit at the Children's Hospital Medical Center in Boston from April 29 through May 3, 1963.