

THE MEDICAL SOCIETY OF NOVA SCOTIA

NOVA SCOTIA DIVISION OF THE CANADIAN MEDICAL ASSOCIATION

MEMBERS OF EXECUTIVE COMMITTEE

OFFICERS

| | |
|------------------------------|-----------------|
| President | B. J. Steele |
| President-Elect | M. E. Churchill |
| Immediate Past President | J. F. Hamm |
| Chairman Executive Committee | M. A. Smith |
| Vice-Chairman Executive | G. H. Röss |
| Treasurer | P. D. Jackson |
| Honorary Secretary | A. J. MacLeod |
| Executive Secretary | D. D. Peacocke |

BRANCH SOCIETY REPRESENTATIVES

| | |
|------------------------|---|
| Antigonish-Guysborough | R. D. Saxton |
| Bedford-Sackville | James Fraser |
| Cape Breton | M. R. Rajani, M. A. Mian |
| Colchester-East Hants | D. G. Dewar |
| Cumberland | R. Mcl. Washburn |
| Dartmouth | J. W. MacDonald, E. C. Ross |
| Eastern Shore | P. D. Muirhead |
| Halifax | J. K. Hayes, J. W. Stewart, B. D. Byrne |
| Inverness Victoria | J. O. Belen |
| Lunenburg-Queens | M. S. McQuigge |
| Pictou County | G. C. Jollymore |
| Shelburne | J. U. MacWilliam |
| Valley | J. Kazimirski, P. Goddard |
| Western | D. M. Deveau |
| Student Member | K. B. Irving |
| Student Member | K. Orrell |
| Student Member | J. Whitlock |

OBSERVERS AND STAFF

| | |
|-----------------------------------|------------------|
| Communications Advisory Committee | A. J. MacLeod |
| Economics Committee | M. G. Shaw |
| Manager—Economics Department | A. A. Schellinck |

OBSERVERS

| | |
|--|------------------|
| Editor—The Nova Scotia Medical Bulletin | B. J. S. Grogono |
| Representative to Provincial Medical Board | H. J. Bland |
| Medical Director M.M.C. Inc | A. W. Titus |
| General Manager M.M.C. Inc | S. P. Brannan |
| C. M. A. Board of Directors | G. C. Jollymore |
| C. M. A. Council on Health Care | M. A. Smith |
| C. M. A. Council on Economics | A. H. Patterson |
| C.M.A. Council on Medical Education | J. D. A. Henshaw |
| M. D. Management Limited | L. A. Fried |

STANDING COMMITTEES

Chairman

| | |
|-------------------------------|-------------------|
| Annual Meetings | President |
| Archives | E. F. Ross |
| By-Laws | A. H. Parsons |
| Cancer | A. F. Pyesmany |
| Child Health | N. P. Kenny |
| Communications Advisory | A. J. MacLeod |
| Community Health | R. D. Stuart |
| Discipline | President |
| Drug & Alcohol Abuse | C. W. MacNeil |
| Editorial Board (Editor) | B. J. S. Grogono |
| Emergency Medical Services | D. P. Petrie |
| Ethics | R. L. Langdon |
| Finance (Treasurer) | P. D. Jackson |
| Hospitals | W. G. Dixon |
| Legislation | |
| Maternal and Perinatal Health | R. H. Lea |
| Mediation | President |
| Medical Education | M. S. McQuigge |
| Medical-Religious Liaison | W. A. P. Thompson |
| Membership Services | D. R. MacLean |
| Nutrition | C. N. Williams |
| Occupational Medicine | A. Prossin |
| Pharmacy | G. C. Jollymore |
| Physical Fitness | B. R. Wheeler |
| President's Liaison | President |
| Rehabilitation | G. J. H. Colwell |
| Society/Faculty Liaison | B. J. Steele |
| Salaried Physicians | G. H. Anderson |
| W. C. B. Liaison | P. K. Cadejan |

BRANCH SOCIETIES

President

Secretary

| | | |
|------------------------|-----------------|--------------------|
| Antigonish-Guysborough | J. E. Howard | A. R. Robertson |
| Bedford-Sackville | James Fraser | J. M. Fitzgerald |
| Cape Breton | F. B. MacDonald | D. C. Dobson |
| Colchester-East Hants | R. L. Rondeau | D. B. Langille |
| Cumberland | D. D. Forshner | D. M. Rippey |
| Dartmouth | G. C. Pace | H. P. Poulos |
| Eastern Shore | A. C. Marshall | P. D. Muirhead |
| Halifax | J. K. Hayes | A. G. Cameron |
| Inverness-Victoria | R. Stokes | C. S. Chow |
| Lunenburg-Queens | D. F. Large | Wm. H. Lenco |
| Pictou | R. A. Nicholson | R. H. T. MacGregor |
| Shelburne | W. H. Jeffrey | F. Markus |
| Valley | S. J. Katz | J. Black |
| Western | C. W. MacNeil | S. Leahey |

SECTIONS

| | | |
|----------------------------|-----------------|------------------|
| Anaesthesia | W. D. R. Writer | J. P. Donachie |
| General Practice | D. R. MacLean | |
| Internal Medicine | R. N. Anderson | T. J. Marrie |
| Internes & Residents | R. S. Silva | D. Costigan |
| Obstetrics and Gynaecology | R. H. Lea | R. H. Lea |
| Ophthalmology | G. A. Sapp | G. J. Whiston |
| Orthopaedic Surgery | R. H. Yabsley | B. J. S. Grogono |
| Otolaryngology | M. N. Wali | M. S. Sekaran |
| Paediatrics | R. S. Grant | R. S. Grant |
| Pathology | F. V. Rahman | A. J. Wort |
| Psychiatry | J. W. Barteaux | G. Gray |
| Radiology | G. R. M. Jones | J. Rees |
| Surgery | M. T. Casey | S. T. Norvell |
| Urology | W. A. Ernst | W. A. Ernst |

THE NOVA SCOTIA MEDICAL BULLETIN

EDITORIAL BOARD

Editor-in-Chief

DR. B. J. S. GROGONO

Associate Editor

DR. A. C. IRWIN

Dr. A. J. Buhr
Dr. P. C. Gordon
Dr. S. M. A. Naqvi
Dr. J. A. R. Tibbles
Dr. J. P. Welch
Dr. W. Putnam

Managing Editor

MR. D. D. PEACOCKE

Editorial Assistant

MRS. T. CLAHANE



The Year of The Child

This year has been designated as the International Year of the Child, created as we have been told many times, to promote the Rights of Children as outlined by the United Nations in 1959.

This month the Bulletin seeks to emphasize some of the less common issues that involve our responsibilities towards children. In Dr. Guttman's article, which was delivered to the annual Canadian Paediatric Society meeting in Halifax in 1979, we are again involved in the controversy epitomised by the slogans "Every child a Wanted Child" and the "Right to Life": in a perverse way the phrases themselves seem to imply that any opposition to either view means that one is dedicated either to making all children unwanted or wishing them all dead. The topic is important and we all need to look at our own personal codes of conduct and our prejudices from time to time.

Dr. John Anderson expresses a sense of outrage in his article on "The Child As Pseudocitizen", and points out many glaring inadequacies in our behaviour towards children as well as suggesting remedies. I am reminded of a recent sermon by our local minister who preached on "The Year of the Non-Child". He commented on the selfish preoccupation with their own self proclaimed "rights" to self-fulfillment by adults who care little or not at all about the results of their actions on other groups especially children. This worship of self-gratification by fulfilling adults is a contemporary danger and the reason why the rights or reasonable expectations of children need to be spelled out.

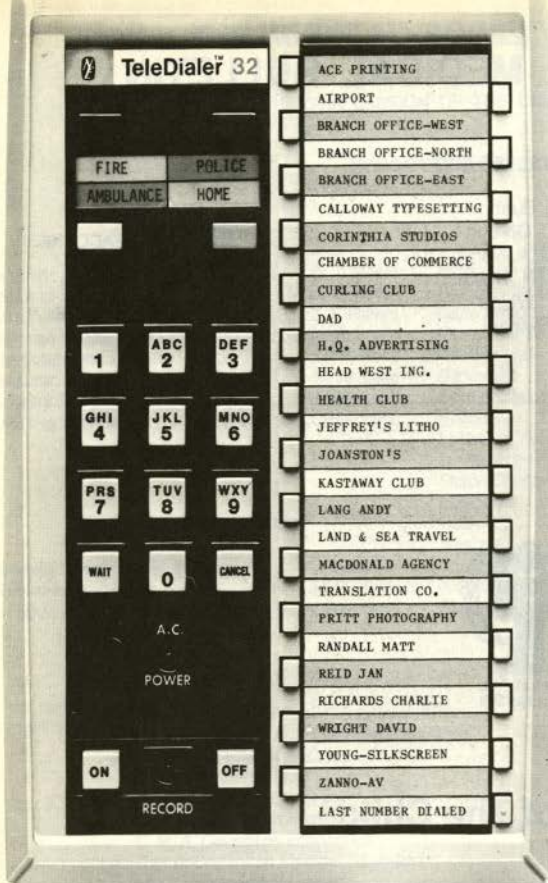
The needs of children in hospital and their parents are well expressed by Mrs. Elizabeth Crocker from her perspective as Director of the Child Life Programme at the I.W.K. Hospital. The changes in management of febrile seizures in children as a result of recent information are outlined by Dr. Peter and Dr. Carol Camfield: their advice helps one to avoid unnecessary treatment of non-disease — a salutary reminder.

When the Year of the Child has passed — What then? Will it be seen as having been a transient package of federal froth? Or will the efforts of those committed to its success have left their mark? Time will tell. Meanwhile the importance of children to the family and the nation is self-evident, for as Milton wrote:

*"The childhood shews the man
As morning shews the day."*

— Paradise Regained. □

J.A.T.



TeleDialer* 32 improves the efficiency of your most important business machine—the telephone

Now you can dial any of your 32 most called numbers at the press of a button. It's the end of many dialing and telephone frustrations . . . it's the beginning of one-button dialing to save you time on both local and long distance calls. And it's good for all people in all businesses—secretaries, shopkeepers, doctors, dentists, purchasers or presidents.

TeleDialer 32—for your office . . . or your home.

Phone our business office now, and ask about low-cost TeleDialer 32 . . . it could be the last old fashioned call you make.

CLICK!
One button
DIALING



*Trademark of American Telecommunications Corporation

The Canadian Child: Pseudocitizen

John P. Anderson*, M.D., F.R.C.P.(C),

Halifax, N.S.

This is the United Nations International Year of the Child and the 20th anniversary of the Declaration of the Rights of Children by the United Nations. Many groups are focusing on the unmet needs of all children in every country which is a member nation. The year 2000 means that babies born in 1979, the International Year of the Child, will be 21 in the year 2000. Whatever happens to babies born in this year and in the next 21 years will determine the type of adults who will lead us into the 21st century, if we are fortunate enough to be here. These young adults will also be among the planners, organizers, and decision makers for the early part of the 21st century.

There are 7 million children in Canada (one-third of our population), but they do not vote, pay taxes, or have professionals lobbying for them. Federally, provincially and municipally, children are still largely viewed as possessions, properties, or chattels of their parents, because they have no unions and no political "clout". This is wrong and was so viewed by the late U.S. President, John F. Kennedy, in his inaugural address who stated: "The most important natural resource we have is our children."

In defence of governments and professions, the improvement in medical, social, and legal care of children in Canada has been impressive in the past 30 years. Polio, rickets, scurvy, diphtheria, most tuberculosis, and some dental caries have been either eliminated or reduced by comprehensive health care plans. However, public health preventive measures, like milk pasteurization and water purification, have been even more critical in disease prevention than a wealth of antibiotics and other more flamboyant medical measures.

Against this then are the following data from the Canadian Council on Children and Youth 1978 Task Force Report: "Admittance Restricted":¹

1. Canada has an infant mortality rate of 15/1000 live births, ranking 7th of 16 developed countries in infant life expectancy.
2. Accidents and acts of violence kill more than twice as many people between the ages of 1 and 19 as do diseases.
3. One in ten Canadian children has an emotional or learning disorder.
4. Twenty-seven per cent of first admissions to public mental hospitals and public psychiatric units occur at 19 years of age or younger.
5. In 1974, 38,314 babies were born to teenagers in Canada (5,504 between the age of 12 and 16).
6. With teenage mothers, the risk of death is 60% higher than for mothers in their 20s, as teenagers deplete the nutritional resources needed by their own growing bodies.

*Director of Outpatient Services, The Izaak Walton Killam Hospital for Children, Halifax, N.S.

Let us consider the implications of these unpalatable facts in order of gestational age.

I. THE FETUS

a) Ideally, there should always be a wanted fetus with parents who have planned for the birth. Lifestyles are rapidly changing, and couples are making deliberate decisions not to have babies. This pleases me because I know of one Canadian study in which 7.1% of the parents leaving the maternity unit stated they had not planned and did not really want the baby they were taking home.²

Other couples are infertile, but infants for adoption are scarce because of the abortion rate and single mothers keeping their babies. I hope that by the year 2000 couples who do not want their babies will place them. However, consider your reaction if your neighbors had a fifth and unplanned infant but came home without the baby because they had decided to place it for adoption as they lacked the emotional and financial resources to keep an unplanned baby. You would be shocked.

- b) Is the fetus genetically sound? Mothers over 35 years of age should have amniocentesis for chromosome abnormalities, such as Down's Syndrome. However, such studies should only be done if the parents are prepared both philosophically and religiously for abortion if the fetus is chromosomally abnormal. Young Jewish couples contemplating a family can be screened for the carrier state for Tay-Sachs disease. If both parents are carriers, the risk is 1 out of 4 infants: such parents may prefer to adopt.
- c) Is the fetus well nourished via a well-balanced and nutritional maternal diet? Prenatal counselling by family physicians, nutritionists, and public health nurses at prenatal clinics or classes is essential. Far too many women go through pregnancy without dietary counselling or iron supplements, and consume fad or junk food diets. In the Well Baby Clinic at the Izaak Walton Killam Hospital for Children in Halifax, nearly 90% of the infants require iron supplements by 7-9 months of age. Their mothers have not received adequate iron intake to provide sufficient bone marrow iron stores in the 3rd trimester fetus.
- d) Is the fetus spared the effects of maternal smoking (smaller babies), drugs (e.g., thalidomide, LSD), and alcohol (mentally retarded babies with the "fetal alcohol syndrome")?
- e) Is the fetus spared congenital infection? For example, every girl should have a rubella H.I. test before she becomes pregnant and, if indicated, should receive rubella vaccine. A rubella baby can be catastrophic to the family and itself (with blindness, deafness, mental retardation, and congenital heart disease). The cost to society is close to one-half million dollars during its lifetime (not to mention the price of sorrow to the family).

Nova Scotia had the unfortunate distinction in 1974 of having a major epidemic of rubella, causing over 30 cases of congenital rubella — the result of sloppy/inadequate immunization practices.^{3,4}

- f) The next 21 years will see many ethical dilemmas confront us. Already we have seen extrauterine conception followed by the birth of a healthy infant, and it is frightening to think that the technology exists to produce babies totally outside the uterus. It would be catastrophic if clones of "superhumans" were bred in test tubes for political reasons. Scientists and research-granting agencies will require increasingly close scrutiny by ethical committees which contain members from the lay public.

II. THE NEWBORN

- a) **Delivery** — Ideally, the father should be in the labor and delivery rooms and present when the child is born. The bonding of a newborn baby with both parents may be critical in the first 72 hours.⁵ More maternity hospitals are encouraging "rooming in" so that parents and siblings may have unlimited contact with their new baby, even though this may interfere with traditional hospital routines where babies are wheeled out — 8 babies to a pushcart and given to the mother for 20 minutes, 5 times per day.

I hope that in time family oriented deliveries and newborn periods will be routine, *but* with safety — not as home deliveries. By the year 2000, maternity units will become home-like and, if the mother is healthy and relaxed, delivery could be safely conducted in the bed and not in an O.R. with the mother's legs up in stirrups. Surely the only more awkward and degrading form of delivery would be to have the mother naked and standing on her head in the case room.

Until ten years ago, the sick premature baby was moved urgently to the intensive care nursery, and then visible only through the glass of the nursery and the plastic of the incubators. Mothers went home, often feeling guilty about the premature labor, and were not encouraged to visit as they might spread infection in the nursery. Hence, the only bonding the "premie" had was a nurse on permanent 4 to 12 p.m. shift. She always demanded "Baby Smith" and if that baby should die unexpectedly, she often underwent a modified grief reaction as if she had lost a member of her own family. Now, most intensive-care newborn nurseries are enlightened and urge mothers to visit, wash their hands, well, wear a sterile gown, and put their hands in the incubator to touch, talk, and look at the baby using good eye contact. Ideally, mothers would visit daily, but, practically, this is often impossible for reasons of distance, finances, and other responsibilities.

This is where society falls down. It should provide transportation and homemaker services to ensure healthy bonding between mother and the "premie", but governments regard these services as frills. They do not realize the poor bonding may lead to child abuse, neglect and maternal deprivation — the cost of which is enormous compared to the cost of preventive services.

Selma Fraiberg⁶ in her 1977 book "Every Child's Birthright: In Defence of Mothering" states:

"This book is intended for all those radicals, like myself, who think that our survival as a human community may depend as much upon our nurture of love in infancy and childhood as upon the protection of our society from external threats.

And in particular, we have learned that the human qualities of enduring love and commitment to love are forged during the first two years of life. On this point, there is a consensus among scientists from a wide range of disciplines."

- b) **Newborn Nutrition** — One of the goals of the Canadian Paediatric Society for the International Year of the Child is to double the number of Canadian mothers who are breast feeding their infants two months after discharge from maternity units.

Teleologically, cow's milk is for calves and human breast milk is for human infants.⁷ Obviously, maternal-infant bonding is enhanced if a mother is successfully nursing her infant. In addition, it has been suggested that infantile colic, overwhelming infections, skin and lung allergies, and even "sudden infant death syndrome" are less likely to occur in the breast-fed infant.⁸

Only 25 to 40% of Canadian mothers initially breast feed and by 3 months the figure is halved. Why is this?

Many mothers are in the work force and receive only four to six weeks maternity leave after the birth of their baby. They feel that nursing for this period of time would be a nuisance. I think there should be mandatory three-month maternity leaves with pay to encourage nursing and improve bonding.

Many hospitals still discriminate against the nursing mother and do not encourage rooming in. Formula feeding using a rigid schedule is more convenient for the hospital staff. But are hospitals functioning for the needs of patients or conveniences of the staff?

Mothers need encouragement and practical advice regarding nursing, and hospitals should have volunteers or members of the La Léché League to assist them. Most male physicians cannot provide answers to the intimate details of successful nursing. It is paradoxical that many mothers feel inhibited to nurse in public, and society is prudish in its attitudes, even though we are in a very permissive society with entire bookstores full of sexually explicit and often degrading literature.

I predict that in 21 years, 90% of mothers will be breast feeding. Also, I predict that most places of employment will have day nurseries staffed by trained personnel to allow mothers to breast feed during lunch hours and coffee breaks, even up to 6 to 9 months of age.

III. THE OLDER CHILD

- a) **Immunization** — Canadian children are well below the ideal of 85% immunization against the preventable diseases. Immunization is a provincial health matter so there is a wide variation with regard to degrees of immunization. Within the last two years in Canada, there have been small but worrisome outbreaks of diphtheria and polio, and pertussis is present in most provinces all year.

In France,⁹ immunization is at the 95% level and child abuse unusual. Why? Simply that from conception

through the first five years of life, the mother attends prenatal and well baby clinics. What is the incentive? She receives her family allowance cheque only if she brings her pregnant self and later her baby to clinics. Some would argue this as being an invasion of privacy and human rights and consider the child as the chattel or possession of his parents. This, in fact, means that the child has no rights, and society should stay out of people's homes. But who speaks for the children — those who get diphtheria, get battered, get emotionally deprived, and become undiagnosed cretins. Surely the infant in our society has basic rights that should be met by the community at large if the parents fail.

- b) **Education** — We have something to be proud of in our educational programs. Progress has been made in diagnosis and treatment of learning disabilities and hyperactivity, and it is said¹⁰ that 1 in 10 Canadian children have learning disabilities (or 3 per classroom). Although resources are better in urban, middle, and upper income groups, I have encountered a great lack of resource teachers in the rural and lower income areas. Many parent-teacher groups have put pressure on provincial departments of education to provide more and better resource services. This must continue.

Day care is controversial in this country. Some regard it as a baby-sitting service for working mothers, while others see it as an extremely important form of early childhood education. In the next 21 years, we will move towards the latter type of day care. Ideally, children from 3 to 5 should be exposed to other children in a learning and playing atmosphere, under supervision of licensed, high quality, pre-school teachers.

There should be highly specialized day care for children with special needs: the blind, the deaf, the child with cerebral palsy, the mentally handicapped.

- c) **Teenage Pregnancies** — There are increasing numbers of teenage pregnancies, and the number of teenage mothers keeping their babies and living alone on provincial social assistance is alarming.

A typical situation is the 16-year old single girl who was going to place her baby for adoption. However, after holding the infant, she falls in love with her baby and decides to keep the child. Her parents disapprove and will not let her return home with the baby. There are many who would say she should be 19, 20, or 21 to keep her child (since in reality she is still emotionally a child herself).

Others, including government authorities, would say the baby is part of her, that she loves the baby and that she has every right to keep her baby at society's expense. This poses a real dilemma. If she keeps her baby, we know that the child will be at high risk for abuse or neglect. At first, the baby is fun, but the novelty wears off after about six weeks. Then the 16-year old mother is all alone in a one-room apartment with enough social assistance for food and clothing for her and the baby. No frills are provided, such as a telephone or baby-sitting money. It is Friday night, she loves her baby, but the baby is colicky, cranky, and crying non-stop for four hours. There is no one to talk with and, furthermore, she secretly wishes she were at a school dance, movie, or out bowling with friends. Something snaps inside her

and she shakes the crying baby so hard that bones are broken. Another variation is that she meets a sociopathic male who moves in on her loneliness. This "boyfriend" now has a meal ticket, a sexual partner, but the baby is a nuisance and he starts slapping the baby around until serious injuries occur.

What are the solutions?

I firmly believe that if society allows a mother to keep the baby and pays for its upkeep, then society must put in support systems to bail this girl out before she batters her child.

Many models have been tried. Just the provision of a telephone alone can be a major lifeline. Group homes for single mothers, with house mothers in charge, have been successful though expensive. There are parent counsellors (e.g., Halifax Services of Support) who are non-professional successful mothers visiting these girls as friends. These projects have been highly successful in preventing abuse and neglect, but are given low priority by governments at all levels. This is false economy. I have seen three infants who were battered under circumstances such as I have described, and who have been left with cerebral palsy and retardation. They are wards of the province and will cost 1.5 million dollars in custodial care. One could hire a lot of parent counsellors for that amount of money!!

- d) **Family Life Education** — This leads into the broader issue of family life education. Many attempts have been made to create good curricular materials about this subject, but most attempts have failed. Ideally, family life education should begin in grade primary and continue through to the end of high school. I say this as more than 50% of unwed mothers in Nova Scotia have less than grade 8 education.¹¹

Most children are going to be parents and yet we in no way prepare them for parenthood. We do not give them experiences which will help them decide if they will ever want to be a parent.

Some school boards have placed day care centres in the empty classrooms where the infants and toddlers have the legislated number of workers. However, the school children may spend several hours a month assisting in the day care and, in this way, they learn the joys and frustrations of being with small children. A generation ago, there were large families and the older children learned parenting skills by helping to raise their siblings; today, we have small nuclear families and these experiences no longer exist. Surely it is more important to learn about parenting than it is to do home economics or manual training, and these experiences should be for boys as well as girls.

Similarly, sex education, which should be only a small part of family life programs, should start in primary grades and continue through high school. Sex education should be far more than anatomical diagrams and should include values, responsibilities, moral and ethical issues.

Who should teach it? I think the regular teachers should all be trained in the teachers' colleges to teach family life and to be comfortable in discussing touchy issues frankly with students. Many teachers are at

present embarrassed and uncomfortable with many aspects of family life because their own teacher training did not prepare them for such a teaching role.

There are those who will argue that these values and responsibilities are the prerogative of the parents. This may be true in some cases, but many children do not have sound role models in their homes. Divorce, common-law relationships, and custody battles are becoming more commonplace. Teenage pregnancy is by no means related exclusively to lower socioeconomic or poorly educated families.

We live in a world of violence, and children should be free to express their concerns about violence and learn to deal with their own inner violent feelings. Educated members of school boards cannot agree on whether corporal punishment (i.e., strapping) is good or bad. When I last checked, Halifax and Dartmouth School Boards permitted strapping of children by the principal. The Halifax County School Board banned strapping. I believe strapping is banned in all of British Columbia and in Toronto, but is permitted in Ottawa. The facts may be outdated, but the point remains that the pillars of our communities are usually split as to whether strapping is good or bad. Repeated strapping of a child would tend to tell him subliminally that violence is acceptable in the adult world.

The average U.S. 18-year old will have seen something like 35,000 murders on television. Randal P. Harrison, Professor of Communications at Michigan State University, told the American Academy of Pediatrics in April 1974 that: "Again and again, even small doses of T.V. violence led to measurable increases in antisocial behavior. These effects were not limited to a few children. They can be demonstrated in children you see every day."

As parents, we should be scrupulous in knowing what programs our children are watching. In addition, we should condemn violent programs which appear on late afternoon and early evening programs.

e) **Accident Prevention** — The major cause of mortality and morbidity in Canada in children 1 to 18 years is accidents. These include motor vehicle accidents, falls, burns, drownings, and accidental poisoning. Most of these tragedies are preventable.

Ontario has mandatory seat belt legislation which has significantly reduced deaths and hospital days. Some provinces, including Nova Scotia, have not followed suit, saying it is an infringement on human rights. This is totally illogical. To drive a car is a privilege, not a right. Motorcyclists must wear helmets. Why then should seat belts not be mandatory across Canada? The savings in tax health dollars and in sorrow from death would be immense.

f) **Children's Rights**— Only in the past few years have some enlightened provinces legislated rights for infants and children. They have appointed child advocates to represent children in legal proceedings, such as custody battles between divorcing parents.

There is a general lack of respect for children as special human beings. How many times have we approached a store check-out counter and been served, along with several other adults, while a small child

waited to purchase a candy bar? We have all been party to this kind of activity and maybe it's not serious, but to me it reflects a lack of dignity for the child.

In some countries, such as Israel and China, children are not only the property of their parents, but they belong to the greater community at large. The community is the extended family which will reach out and help, even protect a child whose family is in crisis.

Most of the battered children I see come from the nuclear family in the urban high-rise sprawl. These families will never own a home and drift from district to district. There are no family ties, no friends, no church or parent-teacher affiliation. They often live, not only in economic poverty, but also in enormous spiritual poverty. Unless society provides support services, these poverties will pass from generation to generation.

Conversely, in rural Canada, the extended family of relatives and friends are tremendously supportive to the family in crisis. Putting our old people in "homes" is a very retrogressive step for they used to be a critical part of the extended family. Their potential role as foster grandparents is a huge untapped area of community resources.

Who speaks for the children? We all must because in far too many incidents they are non-citizens. Unfortunately, governments at all levels speak only partly for the children. Since elections occur every four or five years, planning and promises by governments are short term.

It is up to us, in whatever job or organization we work, to speak for the children. When the politician asks for your vote, ask him what he is prepared to do for children in his constituency. The bottom line rests in the political world, the treasury boards, and the municipal budgets of our country.

In conclusion, every year must become the International Year of the Child, and we must all, even in our tiny splinter groups, speak out for children's rights so that collectively our voices will make the eardrums of our elected representatives ache with noisy clatter. □

Acknowledgement

The author wishes to thank Dr. J. A. R. Tibbles for his helpful comments.

References

1. Canadian Council on Children and Youth: Admittance restricted: the child as citizen in Canada. 1978.
2. Stone SH and Scott KE: The unwanted pregnancy. *Can. Med. Assoc. J.* 111:1093-1097, 1974.
3. Tibbles JAR, Donaldson J, Gibson EJ, et al: Congenital rubella in the maritimes: clinical features. Paper presented at the 53rd annual meeting of the Canadian Pediatric Society, Vancouver, B.C., June 30, 1976.
4. Faulkner RS and Gough DA: Rubella 1974 and its aftermath, congenital rubella syndrome. *Can. Med. Assoc. J.* 114:115-119, 1976.
5. Klaus MH and Kennell JH: *Maternal-infant bonding*. Saint Louis, The C.V. Mosby Company, 1976.
6. Fraiberg S: Every child's birthright: in defence of mothering. New York, Basic Books Inc., 1977.

7. Committee on Nutrition, American Academy of Pediatrics: Breast feeding: a commentary in celebration of the international year of the child. *Pediatrics*. 62:591-601, 1978.
8. Committee on Nutrition, American Academy of Pediatrics: Breast feeding: a commentary in celebration of the international year of the child. *Pediatrics*. 62:591-601, 1978.
9. **Wynn M and Wynn A:** The right of every child to health care. Occasional papers on child welfare, No. 2. London, Council for Children's Welfare, 1974.
10. Crainford L for the Commission on Emotional and Learning Disorders in Canada (CELDIC Report): One million children: a national study of Canadian children with emotional and learning disorders. 1970.
11. Department of Social Services, Province of Nova Scotia, 1977 Statistics.


C

REALTY LTD.

MEMBER
N.S. Real Estate Assoc.

BUS: 423-3002
RES: 477-5706

2979 OXFORD ST.
HALIFAX, N.S.



V. F. Clahane

PRESIDENT

PHYSICIANS

Growth Opportunities in Alberta

We have been asked to assist in locating a number of specialists who may wish to develop and head a buoyant practice in a new 300 bed hospital which is one of the most modern in Western Canada located in a community of 30,000 serving Alberta's rich tar sands.

Department heads are required in the following specialty areas:

- Pediatrics
- General Surgery
- Radiology
- Orthopedic Surgery
- Psychiatry
- Internal Medicine
- Pathology

In addition, the community requires sound General Practitioners.

Our client is offering a generous relocation program, an excellent guaranteed income package and the opportunity to establish and develop a private practice with access to the most modern equipment and facilities for all specialty areas.

If you have the professional credentials and are seeking an autonomous working environment coupled with the advantages of small city living in the centre of one of Canada's most buoyant economic regions, then we would be pleased to hear from you in the strictest confidence. Please write or phone A. J. Martin, in our Toronto office or A. R. Kasper, Hickling-Johnston Limited, 10020-101A Avenue, Suite 800, Edmonton, Alberta, T5J 3G2, telephone (403) 426-4941.

Executive Search Division

Hickling-Johnston

Hickling-Johnston Limited, Management Consultants
415 Yonge Street, Toronto M5B 2E7
Telephone (416) 356-2811

TORONTO
MONTREAL
OTTAWA
EDMONTON



Member of the Canadian Association of Management Consultants



Each new generation's traditions depend
on the quality of the last generation's standards.

◇ **Donnatal**[®]

After almost two generations, still the most widely
prescribed antispasmodic/sedative in Canada.

Full prescribing information available on request.

Management of Febrile Seizures

Peter R. Camfield*, M.D., F.R.C.P.(C) and Carol S. Camfield, M.D., F.R.C.P.(C),
Halifax, N.S.

INTRODUCTION

Febrile seizures are such a common problem that few physicians dealing with children can escape involvement in their management. Since this subject was last reviewed in the *Nova Scotia Medical Bulletin* in 1973,¹ there has been considerable information about the epidemiology of febrile seizures which has led to changes in their management.

EPIDEMIOLOGY OF FEBRILE SEIZURES

Approximately one child out of 25 or 4% of all children will have a febrile seizure.² We estimate that approximately 400 children per year in Nova Scotia will have their first febrile seizure. The recurrence rate following a first febrile seizure is approximately 40%; however, unfavourable outcomes, namely epilepsy or brain damage, are extremely rare. Of all children with febrile seizures, only 3-6% will develop recurrent febrile seizures or epilepsy.^{2,3} Even though this is three times greater than the incidence in the rest of the population, it represents a very small risk.

Certain features enable the physician to predict a little more precisely which children will become epileptic following a first febrile seizure. Children who are delayed developmentally or have focal neurologic signs prior to the febrile seizure are at much higher risk for epilepsy, but even here it does appear to exceed 10%. Other features including a prolonged febrile seizure (> 20 minutes), focal febrile seizures, repeated febrile seizures within the same illness and a family history of epilepsy, also increase the risk of subsequent epilepsy but, again, not to a very large degree. Each of these complicating features is additive and, therefore, the child who is developmentally delayed and who has prolonged focal febrile seizure has 18 times the risk of developing epilepsy over the child who has a short generalized febrile seizure and who is neurologically and developmentally normal.

The risk of brain damage from a brief febrile seizure appears to be exceedingly small. A large well-controlled study showed no effect on school achievement and intelligence from febrile seizures at age 7.⁴ Nonetheless, very prolonged febrile seizures occasionally lead to devastating neurologic disease including mental retardation, hemiparesis, and temporal lobe epilepsy. Unfortunately, of all prolonged febrile seizures, the majority are the initial febrile seizure for that child and, therefore, could not be anticipated.

ACUTE MANAGEMENT

Should the child arrive at the hospital or physician's office still convulsing, it is urgent to stop the seizure. As emphasized above a brief febrile seizure appears benign,

while a prolonged febrile seizure may, on occasion, cause severe damage. We recommend Valium 0.25 mg/kg be given intravenously as quickly as possible. Valium intramuscularly does not appear to be very effective. Rectal Valium has shown some promise as an alternate route of administration; however, the data at present are still too preliminary to encourage its routine use.

Since 10% of patients with an initial febrile seizure will have a second one within 24 hours, an intramuscular dose of 5 mg/kg of phenobarbital should be given once the initial seizure is stopped, whether or not the child arrives still convulsing. This single dose of phenobarbital is probably sufficient to prevent most recurrences during that particular illness.

TABLE I

SUGGESTED INITIAL MANAGEMENT OF FEBRILE SEIZURES:

| |
|--|
| Stop convulsion with diazepam intravenously |
| Give phenobarbital 5/mg/kg I.M. |
| Careful history and physical examination |
| CBC |
| Lumbar puncture if less than 1 yr of age, obtunded, or neurologic signs. |
| Follow-up visit |

All children who have had a febrile seizure should be examined promptly. Since electrolytes, calcium, glucose, and skull x-rays practically never yield additional information, they are not recommended after an initial febrile seizure. However, a white count is often helpful and if elevated should usually be followed by a blood culture. On rare occasions, meningitis may present as a febrile seizure but this extremely unusual in an otherwise well-appearing child. We recommend that lumbar puncture be included in the initial evaluation for most children under one year of age, and for all children who appear obtunded, who have neurologic signs or unreliable parents.

Most children with a febrile seizure need not be hospitalized but because of the fright of the seizure, a few hours of observation often seems appropriate. Many parents believe their child was dying during the febrile seizure and reassurance is extremely important. A follow-up visit a few days later is extremely valuable, to review the situation with the family once they are less upset, and to try to prevent such problems as a child sleeping in the parents' room or the parents extreme reluctance to leave the child with a baby-sitter.

An EEG is usually not helpful in deciding either acute or long-term management. Performed within a few days of the seizure it almost always shows significant postictal changes, and an abnormal EEG at a later date does not accurately ensure either a good or a poor prognosis. Therefore, the EEG should be reserved for children at especially high risk for epilepsy or those with more than 2 or 3 uncomplicated febrile seizures.

*Assistant Professor, Department of Pediatrics, I.W. Killam Hospital for Children, Dalhousie University, Halifax, N.S.

**Lecturer, Department of Pediatrics, I.W. Killam Hospital for Children, Dalhousie University, Halifax, N.S.

Mailing address: Dr. Peter R. Camfield, P.O. Box 3070, I.W. Killam Hospital for Children, Halifax, N.S. B3J 3G9

LONG-TERM MANAGEMENT

The major emphasis in long-term management of children with febrile seizures is an attempt to decrease the parental anxiety by pointing out to them the benign nature of the seizures. Unfortunately, there is no simple way to prevent recurrences. "Intermittent therapy", meaning anticonvulsants given only at the time of the febrile illness, is ineffective for two major reasons. First, in 25-30% of cases the recurrent febrile seizure is the first indication of the fever. Secondly, even when the fever is recognized, parents are often away from home and medication, or the child is at daycare or with a baby-sitter.

Intensive antipyretic measures, including aspirin, acetaminophen, or sponging, do not appear to reduce the recurrence rate significantly, although antipyretics are indicated to make the child more comfortable during a febrile illness. The only clearly effective measure of preventing recurrent febrile seizures is daily phenobarbital,⁵ given as 4-5 mg/kg/day in a single daily dose. The half-life of phenobarbital in toddlers is > 36 hours and, therefore, a single daily dose will produce adequate blood levels throughout the day and be less difficult for families to remember. Most febrile seizures are benign and because phenobarbital may have significant effects on the child's behaviour and cognitive abilities, it should only be used in a few patients.⁶ The major motivation for using it should be the prevention of prolonged febrile seizures.

TABLE II

INDICATIONS FOR DAILY PHENOBARBITAL:

Developmental or neurologic abnormality
Prolonged febrile seizure
2 or 3 brief febrile seizures
Limited access to medical care
Overly anxious family

We, therefore, recommend daily phenobarbital be used following an initial febrile seizure in children with developmental or neurologic abnormalities; those with an initial prolonged febrile seizure; or those with 2 or 3 brief febrile seizures; and those with no immediate access to medical care. Compliance with long term phenobarbital is not very good and, therefore, these patients need continuous encouragement to give medication regularly. In addition, since cognitive side-effects appear to be related to serum level, it is desirable that phenobarbital serum level be monitored once every 6 to 8 months. The recommended level is approximately 1.5 mg/dl. At this level, if side effects such as change in personality or disturbance in sleep with nighttime awakening occur, it is worthwhile to decrease the dose to the range of 2-3 mg/kg/day, since these side effects may be dose related. If they persist at a lower dose, then phenobarbital should be discontinued. If it is still felt necessary to give an anticonvulsant, possible alternative medications include dilantin, carbamazepine, or valproic acid.

When daily phenobarbital is used over the long-term, it should be continued until the child reaches approximately 3 years of age. If the child's third birthday falls in the middle of the infectious disease season, it seems most reasonable to carry on until the next spring. Although recurrent febrile seizures are seen after age 3, they are quite uncommon.

SUMMARY

Febrile seizures are extremely common, as are recurrences. The risk of epilepsy or brain damage following a febrile seizure is very low. The first priority in the initial management of a child with febrile seizures should be to stop any ongoing convulsion, followed by a careful history and a physical examination, and often a lumbar puncture. The long-term management should include reassurance since parents are very upset by the febrile seizure and, for a few selected patients, daily phenobarbital. □

References

1. **Tibbles JAR:** Febrile Convulsions in Children *N.S. Med. Bull* 52:162-163, 1973.
2. **Nelson K, Ellenberg J:** Predictors of Epilepsy in Children who have Experienced Febrile Seizures. *New. Eng. J. Med.* 295:1030-1033, 1976.
3. **Annegers T, Hauser W, Elveback L et al:** The Risk of Epilepsy Following Febrile Convulsions. *Neurology.* 29:279-303, 1979.
4. **Ellenberg J, Nelson K:** Febrile Seizures and Later Intellectual Performance. *Arch. Neurol.* 35:17-21, 1978.
5. **Wolf S M, Carr A, Davis D et al:** The Value of Phenobarbital in the Child who has had a Single Febrile Seizure: A Controlled Prospective Study. *Pediatrics.* 59:378-385, 1977.
6. **Camfield C, Chaplin S, Doyle A et al:** Side Effects of Phenobarbital in Toddlers; Behavioural and Cognitive Effects. *J. Pediatr.* 95:361-365, 1979.



PETER R. ARNOLD, CLU.
Consultant

Introducing . . .

TOTAL FINANCIAL PLANNING for persons
in the Health Professions:

- Insurance Planning
- Investment Planning
- Money Management
- Tax Shelters
- Estate Planning

A. G. ANDERSON & ASSOCIATES LIMITED

Insurance and Financial Consultants

2624 Windsor St., Halifax, N.S. B3K 5C8

(902) 454-7338

Parents Have Needs, Too. . .

Elizabeth J. Crocker,*

Halifax, N.S.

When a child has an appointment to see a doctor, it is probably rare for the child to go alone, but rather that mother or father go also. Consequently, dealing with children in a medical context usually means dealing with parents. Parents often look to doctors for answers, reassurance, and guidance. Their questions, concerns and anxieties must be recognized and dealt with; to focus only on the child is not enough. Parents need accurate information about development, health and illness, so that they can clarify children's misconceptions and be informal teachers with their children. In addition, if parents' anxieties are not resolved, children will pick them up and mirror them back . . . anxiety and stress are contagious and children often end up being the barometer of family moods. Doctors can be powerful influences in terms of health teaching and in terms of instilling or removing parental anxiety; much depends on how parents are handled by medical professionals. What follows are some recommendations of situations to avoid when dealing with parents.

1. Do not set up situations where parents can dwell on the unknown. Think of the following situation . . . a child has had some blood tests in an attempt to discover why he seems so tired . . . the results come back and nothing serious shows up — there is simply evidence of mild anemia and you want to discuss the child's diet with the mother . . . you have your secretary phone the mother to make an appointment for her to come in and see you . . . but it is late Friday afternoon, you have left town, the secretary does not know the details, and the mother cannot get in touch with you until Tuesday morning when the appointment has been scheduled! What happens to the mother is this . . . not knowing that the blood tests showed nothing serious but only that the doctor wants to see her, the mother begins to imagine the worst . . . a serious blood disease that is at least life-threatening if not fatal . . . she becomes "edgy," the rest of the family becomes edgy, the child in question becomes frightened because he can feel the tension, and the weekend is unpleasant for everyone. What is unknown is usually worse than what is known; in the absence of information, people tend to imagine the worst. Share with parents as much as you know as soon as you know.

2. Do not presume that parents (and parents-to-be) have thought about things or know how to handle certain situations. What about breastfeeding? What about circumcision? When should babies be weaned? What are some good pointers for toilet training? Should you bundle up a child with a fever to make him "sweat it out" like our parents did with us? When is constipation a problem? In our society, people receive no training to be parents and often have not considered some of the issues involved, let alone what to do about them. For many of these questions, there are no right or wrong answers, but for others there are. While it may take extra time to discuss and teach at the outset, it invariably

saves time eventually and parents have some bases for decisions to be made and actions to be taken. Doctors who give parents an instruction sheet or brochure, outlining common questions and answers, are to be commended for their efforts.

3. Do not presume that parents know or understand. Surprising though it may seem, there are adults who still think a tonsil is what you see hanging down from the back of your mouth! There are parents who do not know how to give suppositories or what is normal, developmentally, for a four-year-old. If inaccurate information is conveyed to children, problems can be compounded. Always check to determine what parents understand and hear from what you say to them. Just as the unknown can be frightening, misconceptions about anatomy and physiology or only half-heard explanations can also be devastating.

4. Do not presume that because you think something is a minor problem parents will, too! Doctors see patients with a wide variety of complaints, ranging from very serious illnesses and injuries to mild viruses and aches and, therefore, have a broad perspective about what is serious and what is not. Parents may, on an objective level, be able to say their child with a bad cough and fever is relatively well-off when compared with a child in a coma following a car accident; but on a subjective level, their anxiety level can still be very high. Parents do not always have the breadth of experience that would reassure them that things will be all right. Simply telling parents that they are over-anxious may not help. They need to be understood, told that their anxiety is a normal reaction, and given reassurance that things are under control.

5. Do not underestimate parents concerns and observations. Too many stories exist of parents who took their child back to their doctor repeatedly because they felt something was wrong, only to be told continually, "He'll grow out of it", when, in fact, eventually a diagnosis of something like a hearing impairment, learning disability, or chronic disease was reached. While it is true that some parents are over-anxious or over-protective about their children and look too closely at things, the fact remains that parents are observing their children all the time and over a period of time which is a perspective no doctor has. Moreover, parents know the moods and quirks of their children best and can often tell when things are "out of sorts". If, on examination, it is found that their observations or concerns really are unfounded, give them as much of an explanation as they need to be convinced.

6. Do not presume, in the case of a child being hospitalized, that parents no longer have an active role to play in caring for their child. Hospitalization is often viewed as a traumatic experience for a child, especially a young one, but, in fact, it may be more traumatic for parents. The obvious parental concerns about the welfare of their

*Director, Child Life Department, Izaak Walton Killam Hospital for Children, Halifax, N.S.

child are heightened by a hospitalization, but these are often coupled with a feeling of helplessness and/or guilt. What did I do to cause this? Why can't I make my child better? Can't I do anything to help? Parents can assist in hospitals; in many cases, they can help feed and bathe their children, play with them and keep them occupied, provide a familiar link between home and hospital, and, in the words of one mother, "I'm no doctor but as comforter, I'm the best!" Sometimes, hospital staff may view a parent as being overly anxious and feel he or she is not helping the child. The solution is *not* simply to send the parent home, but rather to try to understand where the parent is coming from and, to provide the parent with more information and support.

Regrettably, most Nova Scotia hospitals have very limited visiting hours for parents; only a few have unrestricted visiting. All hospitals should recognize that parents are not visitors but parents, and, as such, should be encouraged to be with their children as much as possible. Although the following letter did not originate in Nova Scotia, it could have; it is one parent's expression of frustration towards a system and rules that tried to interfere with her attempts to meet her child's needs:

"My two year old daughter Rachel was a croup patient in Happy Haven Hospital for 4½ days. She was examined in the emergency room and soon after admitted. While discussing her admission with the doctor, I asked if I would be allowed to stay with my daughter and was told there were no rules against it.

Soon after arriving on the ward, the night nurse came in to my daughter's room and demanded that I leave immediately. I briefly explained the necessity of my staying and the doctor taking my daughter's medical history said I had a right to stay. The nurse reluctantly agreed but remained hostile.

Two mornings later, the day nurse in charge informed me I would no longer be allowed to stay except during regular visiting hours. I then asked the staff doctor in charge of my daughter's case for permission to stay; he was curt and impolite and told me I was breaking hospital rules and he could not give me permission to stay.

Although by then I was extremely shaken and crying, I persisted in my efforts to convince this doctor that my child's needs should be considered. I told him that:

1. Our first baby had died at the hospital and that before her death she had been dusky around the eyes and mouth, just as Rachel had been the preceding two nights.
2. Rachel had been in this hospital at birth, having had seizures, which caused us long term anxiety about her.
3. Our family doctor (who was out of town) who cared for Rachel since her birth, and who knew our complete history had told me that I could stay with her and that she should be kept calm and quiet.
4. My being with Rachel helped her to settle easier and to get her breathing better rather than worse, which is what the hospital is supposed to be for.

The staff doctor repeated that I was breaking rules and stated that he had no authority to give me permission to stay. When I asked him who had such authority, he told


me that only the Administrator of the hospital could do so. He asked if I wished him to make me an appointment with the Administrator and I stated that I did.

Approximately two hours later, having received no message concerning an appointment, I asked to speak to the day nurse in charge and asked her to make the appointment as the staff doctor had not done so. The nurse then asked to speak to me privately. She questioned me on the events surrounding my first child's death. She then cheerfully informed me that it would not be necessary for me to speak to the Administrator — that parents of babies who have died at the hospital are given special consideration, and that I would be allowed to stay with my child. She added that she was sure the staff doctor and the night nurse in charge would agree with her decision. She then explained that she had based her initial decision on the wards not being "set up" for parents to stay overnight. But, as the nurse agreed, I had not asked, nor expected, special accommodation, and I had not interfered in any way with hospital routine. Furthermore, the nurse admitted that my reasons for wanting to stay with my child were good ones, but stated, "If I had let you stay, then everyone would want to stay".

In conclusion I want to say that I object to the "no parents allowed" rule (restricted visiting hours). The "no parent" rule forces a busy staff to allow young children to lie crying in their cribs, gasping frantically for breath. This rule also encourages nurses to tie toddlers down under mist tents, rather than allow parents to stay and soothe them. I do not think a parent should have to fight so hard to be with her child.

Signed: A concerned mother

Parenting is a major responsibility. It provides joys and sorrows, excitement and struggles, moments of pride and frustration. It is both time-consuming and emotion-absorbing. Research has shown, though, that most people grow and their characters are enhanced when they master stress or frustration, and that support is a significant aid in mastering such experiences. When a child needs a doctor, it is usually because of some problem and parents are likely to feel stress and anxiety. By remembering to offer parents support at these times, doctors can help them to cope and to grow. In treating a child, it must be remembered to treat parents, too! □



ALFRED J.
BELL & GRANT Limited
INSURANCE SPECIALISTS

bank of montreal tower, george street, (p.o. box 8)
halifax, nova scotia (902) 429-4150, telex 019-21713

"INSURANCE — THAT'S ALL!"

Ethical Problems Facing the Pediatrician, Neonatologist and Pediatric Surgeon:*

A REPLY TO DR. E. C. KOOP**

Frank M. Guttman,† M.D., F.R.C.S.(C),

Montreal, Quebec

Pediatricians, neonatologists and pediatric surgeons often confront ethical problems. They must provide guidance to parents of infants born with multiple congenital anomalies, and as it may be difficult to know the prognosis, the question of withholding treatment may be agonizing.

Eckstein, Hatcher and Slatter have divided these infants into 4 groups.¹ (I) Infants with surgically correctable anomalies who will die unless treated, e.g. intestinal atresia. (II) Infants with lethal anomalies that are not correctable, e.g. anencephaly. (III) Abnormalities which are surgically correctable but otherwise fatal and allow an abnormal child to live, e.g. meconium ileus in cystic fibrosis; duodenal atresia and Down's syndrome. (IV) The abnormality is not necessarily fatal, but untreated will be more severely handicapped, e.g. meningomyelocele.

In 1976, Dr. Everett Koop spoke of his concern about the sanctity of human life and condemned "the widespread infanticide being practiced in the U.S. by the medical profession",² in an address to the American Academy of Pediatrics. Dr. Koop carried out a psycho-social evaluation 15-25 years later, among 25 families where a child had been born with an imperforate anus. He found that every family referred to the experience of raising a defective child, as a positive one and that many were better families than they would have been without such adversity.

This differs from our own experience and that of others.³ (1) For example, Duff and Campbell refer to an infant, Baby 'S', born with a high lumbar meningomyelocele, hydrocephalus, paralysis and deformities of her legs. Her mother, a social worker, and father refused to sign consent for operation permitting closure of the spinal defect. The hospital staff therefore obtained a court order for a series of operations. Complications were numerous and the child's brain was damaged. The infant was discharged home but, as complications arose, was returned to hospital frequently for further treatment. Each time the parents faced a hostile staff and when the baby died at 10 months of age, both physicians and the police questioned whether they had deliberately delayed seeking treatment.

Subsequently, two healthy children were born, but the mother had to work to help pay the debt incurred in the care of the first baby. This led to the other children being neglected and developing behavioural disorders. Ultimately the mother was hospitalized for treatment of severe

depression and later reported that "It was just more than I could take". The parents felt that their first baby should have been "helped to die", and considered that much of the suffering by their baby, themselves and their children was senseless and destructive. They doubted that the family would ever fully recover from the court ordered treatment of their first child.³

The following might answer Dr. Koop's statement "I hate the term death with dignity because there is no dignity to death."

(2) A premature infant³ was believed to have a hopeless prognosis. The parents, medical and nursing staff decided to stop all "heroics". The parents were asked whether they preferred — to leave, to be beside the baby's incubator; or to have the baby, all his tubes and apparatus removed, brought to them in a private room. They chose the last and in the company of the doctor, they held their infant for 55 minutes while he died. During this time, they wept, talked to their son or about him, or were silent. The mother cradled the baby to her bosom most of the time while the father stroked his wife and baby. The father stated that the scene was one of sublime beauty despite its occurrence in the midst of tragedy. The mother said, "We had to say hello to him before we could say goodbye." They came to think of this experience as a fitting funeral from which they gained greater strength for living.

(3) Madame Van de Put, a Belgian,⁴ took eleven thalidomide pills during her pregnancy. The infant, Corinne, had a typical severe thalidomide syndrome with flipper-like rudimentary limbs, an imperforate anus, and an abnormal facial appearance. The family decided an active euthanasia. The mother, after asking her family to leave, picked up the infant in her arms, rocked her and fed her a bottle containing milk, honey and barbiturates. She was charged with murder and her husband, mother, sister, and family doctor were arraigned as accessories. At the trial, Madame Van de Put said, "I just thought you could not let a baby like that live. I thought it could never be happy in its whole life." To the question why she had not institutionalized the infant, as had been recommended, she replied, "I do not want it. Absolutely not. For me, as an egoist, I could have been rid of her. But it wouldn't have given her arms." To the comment that the child was mentally normal she observed, "That was only worse. If she had grown up to realize the state she was in, she would never have forgiven me in her whole life for letting her live."⁴

When a verdict of not guilty was announced, wild applause burst out in the crowded court room.

In *The Right to Life*, St. John Stevas writes that "if there is a right to life, Corinne Van de Put possessed it as much as anyone else. Corinne was never consulted."⁵ This is true.

*Annual Canadian Association of Pediatric Surgeons, Lecture to the Canadian Pediatric Society, Halifax, N.S. — June 1978.

**Paediatric Surgeon, Direct Patient Care, 1 Children Centre, Philadelphia, P.A.

†Paediatric, Surgeon-in-Chief, Jewish General Hospital; Staff-Surg., Ste-Justine & Montreal Children's Hospital, Assoc. Prof. Research & Assoc. Prof. Dept. Surg., McGill Univ., Montreal, P.Q.

Newborn infants never can be consulted. Responsible parents must make decisions for them in an effort to serve their best interests. In the case of seriously defective children, it would seem to those close to them that their right to a peaceful death is much more important than the right to life.

In considering the above problems, it is relevant that most people in society and medicine judge an act by its consequences. Duff and Campbell, and Fletcher, consider that there are two possible philosophies in determining the care of severely handicapped or dying persons. The first is disease-oriented in which death is placed in the extreme negative position, of lacking dignity. They note that the unbridled application of this philosophy commonly aggravates suffering and dehumanises patients. The second philosophy is person-oriented and regards some kinds of severely compromised life as worse than death. This second position allows for the protection of patients from the indignity and suffering of pointless treatment and the cruelty of hopeless disease, and may be a wise choice.⁷

Fundamental to Dr. Koop's condemnation of what he perceives as widespread infanticide seems to be the concept that suffering is good for the soul. He quotes his own aphorism, "nothing makes a woman out of a girl faster than a colostomy in her child." This view that disease is a punishment from God and good for the soul was elemental to early Judeo-Christian religious thought, and Ivan Illich's nihilistic approach to education and medicine, updates the philosophy. The Greeks and Romans had a rational approach to disease. Socrates and Plato justified the elimination of maimed children and contended that no elaborate attempt should be made to keep alive invalids for whom there was no hope of recovery. In Aristotle's ideal state, defective children were not allowed to survive, and Epicetetus endorsed the right of every person to an easy death.

Dr. Koop also stated the legalization of abortion led to the cheapening of human life. To quote, "who knows what happiness is for another person? What about the rewards and satisfactions of life to those who worked with and succeed in the rehabilitation of other than perfect children? Stronger character, compassion, deeper understanding of another's burden, creativity and deeper family bonds all result from the so-called social burden of raising a child with a congenital defect repaired but less than perfect."

Sometimes this is correct and we all know of families that have adapted well to such adversity. In contrast we all know families and individuals who have completely broken down from such a trial.

This approach is supported by Dunphy, who has stated that "we cannot destroy life, we cannot regard the hydrocephalic child as a nonperson and accept the responsibility for disposing of it like a sick animal".⁸ Yet he also tells how he withheld surgery even when it was indicated in his 85 year old former professor, because of his filial attachment, and describes the relief and happiness that this choice caused in the man, who died a day later.⁹

Dr. Koop has also stated: "I have many times withheld extraordinary measures from the care of my patients who were terminal. I have felt that I was doing the moral and just thing." I question the circumstances under which they decide that the patient is terminal. For what reason do they withhold treatment? Do they discuss the matter with the family or

priest? After drawing the line against any small step leading to Auschwitz, Dr. Koop seems to be more flexible than he implied.

The most serious problem raised by Dr. Koop related to the thin edge of the wedge,¹⁰ or, as Dr. Koop calls it, "the slippery slide to Auschwitz". In 1939, all state institutions in Germany were required to report patients who had been ill for five years or more and who were unable to work. A decision regarding which patients should be killed was made on the basis of race, marital status, nationality, next of kin, social contact, and financial responsibility. The decisions were mostly made by German university psychiatrists, who never saw the patient. William L. Shirer reported in his *Berlin Diary*: "Since last fall the Gestapo, has been systematically putting to death the Reich's mentally deficient Families were never called to their loved one before death came. Many received a warning not to demand explanations or spread false rumors".¹¹

Alexander feels that this deplorable practice started with the acceptance of an attitude that there is such a thing as a life not worthy to be lived, which is basic to the euthanasia movement. In using the 'wedge argument', Alexander and Koop and Russell¹² fail to note the fundamental difference in motive and method between the Nazi program and the compassion and openness of those who advocate the right to choose euthanasia in accordance with legal safeguards that would protect their right to live as well as their right to die. The danger lies not in the belief that life sometimes becomes intolerable, but in the idea that secret agents of the state-doctors or others should decide whose lives are unwanted and terminate them.

Similarly, Bertrand Russell, commenting on a similar approach stated that he "had not argued against the principle of putting the incurable to death, but had merely demonstrated the need for safeguards."

Again, Williams¹³ in the Sanctity of Life and the Criminal Law states: "the wedge argument" against euthanasia could be used against any desired action because "there is no human conduct from which evil cannot be imagined to follow if it is persisted in when some of the circumstances are changed."¹³

Duff and Campbell³ also find little reason to defend their policy against the wedge argument. They find the danger is greatest when leaders of governments or the medical profession alone decide, but consider that those decisions could only be made by those who care most for the patient and who must bear the consequences. The agony and the suffering which invariably must be endured by those who decide provide effective safeguards against abuse with rare exceptions.

Historically, Sigerist has pointed out that the sick, crippled and the aged are killed in some tribes from respect and compassion.¹⁴ As a corollary, it also happens that some sick and infirm commit suicide, as among Polynesians, Siberians, Inuit, Americans, and some others.

In a survey of the North American scene, in 1973, Duff and Campbell reported that 43 of 299 neonatal deaths were related to withholding treatment at the Yale New Haven Hospital.¹⁵

In addition, Shaw has reviewed the attitudes of pediatricians and pediatric surgeons in response to these ethical questions.¹⁶ Among the questions asked, the first was "Do

you believe that the life of each and every newborn infant should be saved if it is in our ability to do so?" 83% of surgeons believed that not every child should be saved and the Catholic surgeons were the most conservative group. The pediatricians responded similarly with Jewish pediatricians being the most conservative.

Most surgeons and pediatricians follow the desires of the parents. Only 3.4% of pediatric surgeons and 16% of pediatricians would obtain a court order overriding the parents refusal for surgery in newborns under certain situations.

A similar study was carried out in Massachusetts¹⁷ by Todres *et al.* and revealed similar attitudes. An analysis of religion, sex, and religious activity showed that more males, Catholics and religiously active people recommend surgery. To the question "Of those recommending surgery, would you obtain a court order to operate over the parents' refusal", 40% said 'yes' which is very close to the figure in the previous study.

I feel it is important that we know how widespread are these attitudes which Dr. Koop condemns as inhumane and unconcerned with the sanctity of human life. It is obvious that the majority of people working in these fields do not feel an absolute requirement to save every human life under all circumstances at all times.

An early advocate of euthanasia, Sir Thomas More, canonized four centuries later, presented his ideal of a model society in "Utopia", published in 1551.¹⁸

"Them that be sick of incurable diseases they comfort with sitting by them . . . if the disease be not only incurable, but also full of continual pain and anguish; then the priests and magistrates exhort the man, that he will determine with himself no longer to cherish that pestilent and painful disease.

. . . . either dispatch himself out of the painful life, as out of a prison . . . or else suffer himself willingly to be rid of it by others . . . But they cause none such to die against his will, nor they use no less diligence and attendance about him, believing this to be an honourable death."

Legalization and legal terminology certainly have finality; but they may not have consistency with the practice of the community. Perhaps the trust between doctor and patient and his family is not enhanced by the arbitrary possibility of withholding treatment. Terminal patients can by law now refuse medical treatment in eight states in the U.S.A. In Canada in 1979, the Canadian Medical Association approved of withholding treatment and of brain death. "An ethical physician will allow death to occur with dignity and comfort, when death of the body appears inevitable." It stated also that he need not prolong life by unusual or heroic means when clinical death of the mind has occurred." The Canadian Association of Pediatric Surgeons in 1976 unanimously passed a resolution favoring withholding treatment under some circumstances.

Active euthanasia is another problem as illustrated in the Van de Put case. However, a study of jurisprudence shows that trials have rarely resulted in anything but acquittal, either of doctors, or relatives carrying out active euthanasia. In other words, judgement by society has resulted in tacit approval of active euthanasia under some circumstances.

Dr. Joseph Fletcher stated: "The dimensions of our moral responsibility expand of necessity with the advances made in medical science and medical technology. The ethics of medical care have to change, to grow, and to engage constantly in self correction. We are, by some strange habit of mind and heart, willing to impose death (in war) but not to permit it; we will justify humanly contrived death when it violates the human integrity of its victims but we condemn it when it is an intelligent voluntary decision."¹⁹

In an address to the Italian Society of Anesthesiology in 1958, Pope Pius XII answered questions that had been submitted to him. They included, "Can narcotics be used even if the lessening of pain will probably be accompanied by the shortening of Life?" The Pontiff replied: "The answer is 'Yes' . . . Christian heroism does not require the refusal of narcotics, everything depends on the particular circumstances. The most perfect and most heroic decision can be present as fully in acceptance as in refusal."

This is very similar to Talmudic interpretation. In the Talmud it is written: "if one removes the pillow from a dying patient in order to hasten his death that is murder. However if one removes the pillow in order to make the patient more comfortable and at the same time that hastens his death it is permitted."

In *Jewish Medical Ethics*, Rabbi Immanuel Jakobovits stated "Any form of active euthanasia is strictly prohibited. At the same time Jewish law sanctions, and perhaps even demands the withdrawal of any factor whether extraneous to the patient himself or not — which may artificially delay his demise in the final phase."²⁰

The Protestant churches have also addressed themselves to these problems, The Church of England, the Episcopal Church, The United Methodist Church, the United Church of Christ have all passed resolutions at their general councils approving withholding treatment under certain circumstances.

It seems to me that we no longer live in a tribal unit where all moral values, judgements and practices are uniform. We come from various backgrounds, with a subtle and complex interpretation of what is moral. Morality is the sum total of what society upholds in practice as part of its heritage and need for self preservation. In Quebec over the past few years we have had the spectacle and mockery of an unenforceable law, where the Crown prosecuted Dr. Henry Morgentaler three times for abortion carried out clearly and openly in an illegal manner, (i.e. not in hospital) with television coverage and a CMAJ paper on his lack of complications, and yet 36 Montrealers acquitted Dr. Morgentaler of guilt. I do not believe that society can prevent abortion, infanticide, or euthanasia. The question is whether we induce respect for the laws that govern our society. I extend this to other issues because I believe that withholding treatment in an abnormal child where there is a correctible lesion is infanticide, or mercy killing, and we do it.

As Joseph Fletcher has pointed out "The plain hard logic of it is that the end or purpose of both negative and positive euthanasia is exactly the same: to contrive or bring about the patient's death. . . . It is naive and superficial to suppose that because we don't do anything positively to hasten a patient's death we have thereby avoided complicity in his death. Not doing anything is decision to act every bit as much as deciding for any other deed."¹⁹

War is also murder and we condone it. Capital punishment, another euphemism, is murder by the state and, we are told, most Canadians condone it. I feel that it is time to consider whether under certain conditions with certain safeguards, we should be able to carry out objectionable acts legally for the ultimate benefit and good of the persons and of the families which request these actions.

I recommend discussion as to whether we should not encourage our legislators to deal with this issue. You all know what happened to the C.M.A. resolution on withholding treatment and on orders not to resuscitate. The legal counsellors of the association were upset by these resolutions. We leave ourselves uncovered by law especially in the light of the new child abuse laws.

A good law would protect a person's right to live, because there would be no mandatory nature to a diagnosis of incurability, the law would not necessitate euthanasia. Termination of life contrary to the patient's wish would still be murder and punishable as such.

The use of the terms infanticide, wedge, and Auschwitz arouse an emotional response instead of a reasoned one. The shock and horror of the Nazi crimes are still so vivid that everyone rightly wants to avoid any possibility of such terrible action, but to argue that the enactment of good legislation would lead to police state action is fallacious. What the Nazis did was not 'mercy killing' but merciless killing done secretly and in violation of German law.

As Leon Eisenberg has written, "Because science is incomplete, reason imperfect, and both can be put to damaging uses, some would abandon science and reason in favor of mysticism, hermeneutics, and transcendental rapture. It is not knowledge but ignorance that assures misery. It is not science but its employment for inhuman purposes that threatens our survival."²¹

A good law would give more protection from unscrupulous, scheming relatives, or doctors than one has now when secrecy of action by a single doctor is being encouraged by those who say "Don't legalize euthanasia; just leave the matter to the doctor."

Although awareness of these ethical problems among the general public has increased, the majority of doctors who do not want legal definition are not facing reality. There is a great interest in these problems over the past decade among the medical profession, but not enough stimulation of discussion among our legal confreres. Society no longer wants to leave it up to the doctor but has not yet agreed to face the issue squarely and to debate it openly. □



Bibliography

1. **Eckstein H B, Hatcher G, Slater E:** New Horizons in Medical Ethics. Severely Malformed Children. *B. Med. J.* 2:284, 1973.
2. **Koop C E:** Address given to the American Academy of Pediatrics on Presentation of the William Ladd Medal. Chicago, 1976.
3. **Duff R S, Campbell A G M:** On Deciding the Care of the Severely Handicapped or Dying Persons with Particular Reference to Infants. *Ped.* 57:487-493, 1976.
4. **Russell O R:** *Freedom to Die.* Moral and Legal Aspects of Euthanasia. Human Science Press pg. 176, 1975.
5. **St. John-Stevas:** *The Right to Life* N.Y. Holt, Rinehart and Winston. 1964.

6. **Fletcher J:** Ethics and Euthanasia. *Am. J. Nursing.* 4:670-675, 1973.
7. **Smith H:** Suicide and Euthanasia. *Br. Med. J.* 2:591, 1971.
8. **Dunphy J E:** Annual Discourse — "On Caring for the Patient With Cancer" *N. Eng. J. Med.* 295:113, 1976.
9. **Dunphy J E:** Ethics in Surgery: Going Beyond Good Science *Am. Coll. Surg. Bull.* 63:8-12, 1978.
10. **Alexander L:** Medical Science Under Dictatorship. *N. Eng. J. Med.* 241:39-47, 1949.
11. **Shirer W L:** Mercy Deaths in Germany. *Readers Digest.* 38:55-58 June, 1941.
12. **Russell O R:** *ibid*, Pg. 93
13. **Williams G:** *The Sanctity of Life and the Criminal Law*, N.Y. Knopf, 1957.
14. **Sigerist H:** *A History of Medicine.* Vol. 11. Oxford Univ. Press, pg. 299, 1961.
15. **Duff R S, Campbell, A G M:** Moral and Ethical Dilemmas in the Special Care Nursery. *New Eng. J. Med.* 289:890, 1973.
16. **Shaw A:** Ethical Issues in Pediatric Surgery. A National Survey of Pediatricians and Pediatric Surgeons *Ped.* 60:588-599, 197.
17. **Todres I, Crane, D., Howell, M., Shannon, D.:** Pediatricians Attitudes Affecting Decision-Making in Defective Newborns *Ped.* 60:197-201, 1977.
18. **More T:** Utopia 1551. cited in Russell, O.R. Freedom to Die More and Legal Aspects of Euthanasia. Human Science Press pg. 54-56, 1975.
19. **Fletcher J:** *Morals and Medicine* Boston: Beacon Press 1960.
20. **Jakovovits I:** *Jewish Medical Ethics.* Bloch Publ. Company N.Y. 1959, 123-124.
21. **Eisenberg L:** The Social Imperatives of Medical Research. *Science* 198:1105-1110, 1977.

When you're ready to set up practice, we're ready to help.

Bank of Montreal We've been helping doctors and dentists longer than any other Canadian bank. We've got plans designed to meet your particular needs. Operating funds, term loans and mortgages (business or personal). We can also arrange your car or equipment leasing. We mean it when we say

Just look for the shingle.  The First Canadian Bank 

Bank of Montreal

There is now a Mercedes-Benz station wagon. Come. See it.



ISNOR MOTORS LTD.

2487 Maynard Street,
Halifax, N.S.
429-2300



Engineering begets performance:

The new Fiat Strada



Combined mileage rating 62 km/gal*

Standard features: front wheel drive • five-speed transmission • electronic ignition • extractable AM/FM radio • cloth upholstery • rear window washer-wiper • tinted glass all around.

Test drive before you decide!

ISNOR MOTORS LTD.

2487 Maynard Street,
Halifax, N.S.
429-2300

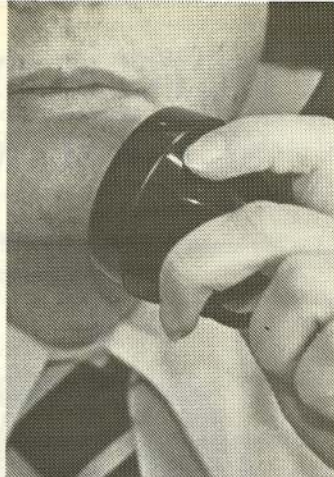
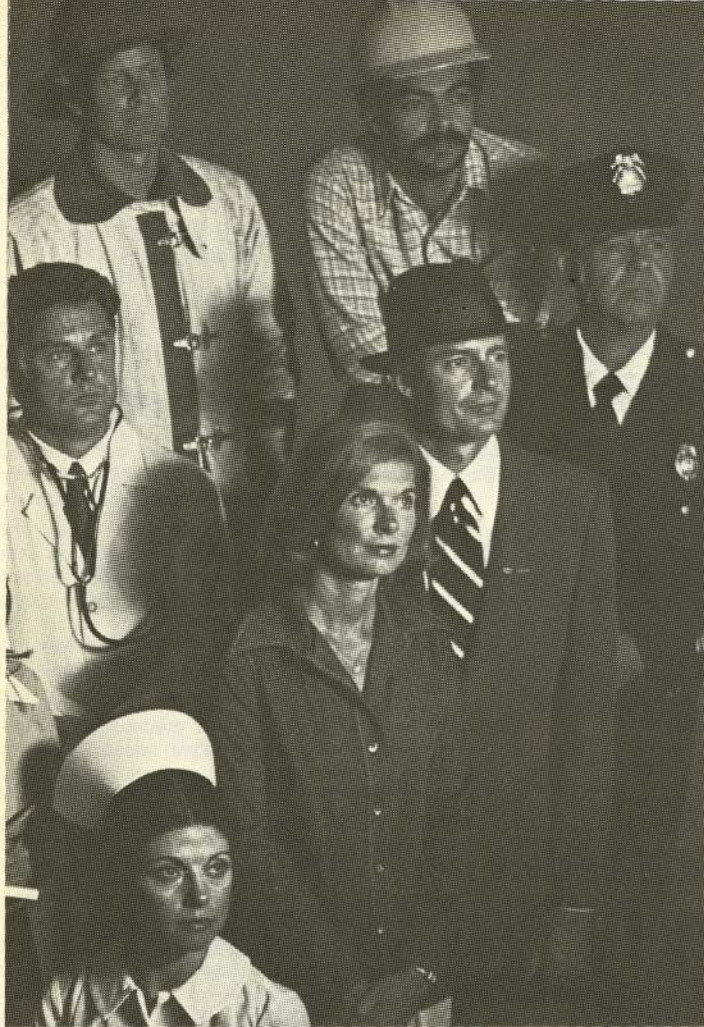
**Fiat is the only import
that offers both:**

- a 2 year/40,000 km power train warranty
- a 3 year/120,000 km corrosion performance warranty

*Based on laboratory tests using Transport Canada test methods. Actual consumption may vary. Urban winter consumption will be significantly greater. Fiat and Strada are trademarks of Fiat S.p.A.

FIAT

© Fiat S.p.A.



A lot of people depend on AIR-PAGE[®]

... to help them keep in touch.

Maritime owned and operated, AIR-PAGE understands the communication needs of local businesses and professionals. Poor communications can often result in a waste of time and money. AIR-PAGE is fully experienced in solving these problems in the most cost effective way.

With the addition of a **Direct Dial* Voice Paging** service to the already accepted operator assisted voice paging and tone only paging, AIR-PAGE is again

leading the way. Only with AIR-PAGE can you choose from three different ways to page.

Direct Dial* Voice Paging allows the person receiving your message to hear it directly from you, in your own voice. Each pager has it's own number which you can give out to the people who need to reach you. All they do is dial the number and in a matter of seconds they give you their message privately. This service is available with all models of voice pagers presently in use.

Operator Assisted Voice Paging is designed for those who need a timed message holding service. If you should miss a message or inadvertently have your pager turned off you simply call the AIR-PAGE operator who has kept a written record of all your messages.

For those who don't require a spoken message we have a wide selection of **Tone Pagers**.

For further information on how AIR-PAGE can help you keep in touch call us at 453-2640.

*Operates via human interface

Herpes Simplex Virus: Ubiquitous Opportunist from Womb to Tomb

P. A. M. Anderson*, B.Sc. and J. A. Embil**, M.D., Ph.D., F.R.C.P.(C),
Halifax, N.S.

Herpes Simplex Virus (HSV), also called *Herpesvirus hominis*, belongs to the herpesvirus family of morphologically similar DNA-containing, enveloped viruses. Man is a natural host to four members of this family: HSV, Cytomegalovirus, Varicella-zoster virus and Epstein-Barr virus; in addition, man can be infected with the B virus of monkeys. All of these viruses can become latent after a primary infection, only to be reactivated at a later date. A recent review by Andrewes et al¹ discusses this family of viruses in more detail.

Structurally, HSV is 100 nm in diameter, with a DNA core and a capsid surrounded by a lipid envelope with short projections. HSV infections are among the most common in man.² Although about 90% of HSV infections are subclinical, they can be very severe in newborns, malnourished children or adults, and the immunosuppressed. The virus is the most common cause of genital lesions in women and second only to syphilitic infections in males.² Genital and other HSV infections in pregnant women pose serious threats to the fetus and newborn infant. Based on the prevalence of maternal infections, the risk of neonatal HSV disease has been estimated at between 1 in 30,000 and 1 in 3,500 deliveries.³

HSV actually consists of two antigenically distinct types which have about 40% common sequences in their DNA¹ and cross-react serologically (Table 1). It was once thought

that HSV 1 was involved only in nongenital infections and HSV 2 only in genital lesions. In fact HSV 1 and HSV 2 show predilections for nongenital and genital sites, respectively, but both can infect any area of the body.

ETIOLOGY

Man is the only host to and reservoir of HSV; consequently, transmission is by human contact. The prevalence of infection is highest among lower socioeconomic groups, presumably because of crowded living conditions with their greater opportunity for viral spread. HSV 1, the causative agent of "cold sores" and "fever blisters", primarily affects children. By the age of fourteen, 70% of children show serologic evidence of HSV 1 exposure.⁴ Since HSV 2 is spread primarily by sexual contact, evidence of infection increases after age fourteen or the onset of sexual activity. By fifty, over 90% of some populations have had either HSV 1 or HSV 2 infections at some time in their lives.

Asymptomatic shedding of HSV is of great epidemiologic importance. Following the primary oral infection, a significant number of asymptomatic individuals intermittently excrete the virus in saliva, unwittingly providing a mode of transmission for the disease.⁴ Cases of asymptomatic cervicovaginal shedding of HSV after acute infections have also been described.⁵

TABLE 1
DIFFERENCES BETWEEN HSV 1 AND HSV 2*

| Characteristic | HSV 1 | HSV 2 |
|--|--|--|
| Site of Infection | usually nongenital | usually genital |
| Transmission | primarily nongenital route | primarily genital route (sexual or mother-to-newborn) |
| Heat lability at 40°C | no | yes |
| Heparin sensitivity | yes | no |
| Growth characteristics chick embryo membrane mice (<i>in vivo</i>) | small pocks less neurotropic | large pocks more neurotropic |
| DNA guanine + cytosine (moles %) | 67 | 69 |
| composition | types have about 40% homology in DNA | |
| Immunology | types can be differentiated by a number of immunological methods | |

*modified from Nahmias and Visintine.³

*Second year medical student, Faculty of Medicine, Dalhousie University, Halifax, N.S.

**Associate Professor, Microbiology and Assistant Professor, Pediatrics, Dalhousie University, Halifax, N.S.

Mailing Address: Dr. J. A. Embil, Infectious Diseases Research Unit, Izaak Walton Killam Hospital for Children Halifax, N.S. B3J 3G6.

At delivery, 0.05-0.50% of pregnant women have active genital HSV infections but about half of these are not detected.⁶ These women will pass the infection to about 40% of their infants,² and 85% of these babies will be symptomatic. Between 70 and 80% of neonatal HSV infections are caused by type 2, as a result of its greater prevalence in the genital tract.

Transmission of HSV infections in adults is usually sexual. Oral infections, which are usually type 1, can be transmitted by kissing, sharing contaminated eating utensils, etc. The overall prevalence of HSV 1 genital infections is 15% in contrast to the majority that are HSV 2. In patients 15-24 years old, HSV 1 accounts for 30% of herpetic genital infections, the higher incidence being attributed to orogenital sex in this age group.⁴ Autoinoculation from one body site to another also occurs.

Most neonatal infections are acquired during passage through an infected birth canal. The trauma of forceps delivery often provides an inoculation site for the virus on the infant's scalp. When the membranes rupture more than four hours before delivery, the route of transmission can be ascent from the cervix to the fetus. The greatest danger of intrapartum infection occurs when the mother is infected within two weeks of delivery. Transplacental transmission has been reported in rare cases, with resultant dissemination of the virus with or without anomalies such as microcephaly, microphthalmia, intracranial calcifications and skin lesions.^{2,7} The rate of abortion among women with genital herpes infections is higher than that in the general pregnant population, suggesting that infection *in utero* is not compatible with continued life in some cases.³ Presumably maternal viremia is a prerequisite for transplacental transmission.²

The neonate may be infected after birth through contact with people, including the mother and health personnel. Infants can also acquire the infection from infected breast milk;⁸ furthermore an infected infant can infect the mother's milk,⁹ thereby endangering the next baby. A fatal neonatal infection following maternal intercourse 24 hours before delivery with a man who had active penile lesions has been reported.¹⁰ Figure 1 summarizes the possible modes of transmission to the neonate.

CLINICAL MANIFESTATIONS

Acute Gingivostomatitis

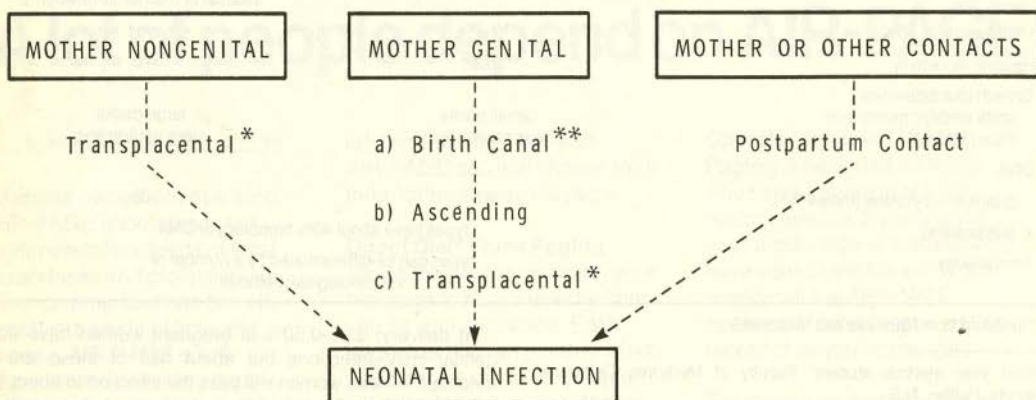
HSV primary infection usually attacks children from age one to three years, and HSV 1 is almost always the causative agent. In about 90% of the children, the illness is subclinical and passes unnoticed among other childhood infections. However, some cases manifest themselves as acute gingivostomatitis with accompanying fever and malaise. The incubation period for primary HSV infections is 2-12 days. Fever is usually the first symptom, followed by the formation of vesicles which rupture to form painful ulcers on the tongue, palate or buccal mucosa. Loss of appetite is a consequence of both the painful oral sores and the fever, and may be severe enough to cause dehydration. The vesicles occur in groups which coalesce to form larger lesions with uneven borders. The distribution and shape of the resultant ulcers is characteristic of the disease, as is a generalized erythema of the surrounding gingiva. Halitosis and enlarged lymph nodes on both sides of the neck are also common in the acute phase of this disease, which usually runs its course in 10-14 days. The lesions heal completely without scarring.

Herpes Labialis

Following primary infection, the disease passes into a latent phase; some people never show evidence of clinical disease again, although they may asymptotically shed the virus from time to time. However, those less fortunate suffer recurrent lesions or "cold sores" on the lip; this affliction, herpes labialis, is one of man's most common diseases, affecting about one-third of the population.¹¹ It can be triggered by any stress such as infection, fever, excessive sunlight, menstruation or immunosuppressive therapy. Although the exact mechanism of reactivation of the virus is unknown, it is also believed that during the latent periods

FIGURE 1

POSSIBLE MODES OF TRANSMISSION TO THE NEONATE



* Very Rare

** Most Common

HSV resides in the trigeminal ganglion.¹¹ When stimulated by any of the above factors, the virus passes down the nerve to the skin, usually causing a recurrence at or near the site of the primary infection. An intense itching is felt a few hours before small red papules appear on the lip. These lesions develop on an erythematous base and contain fluid. Crusting occurs within 2-3 days and complete resolution without scarring by 2 weeks. The presence of high levels of antibody against HSV does not prevent recurring attacks.¹¹

Central Nervous System

Most non-neonatal HSV infections are subclinical, although they do lead to encephalitis or meningitis occasionally. Meningitis is extremely rare; usually it is not serious and does not require vigorous therapy. Encephalitis, however, may have the highest mortality rate of all viral encephalitides — 70% in some situations.¹² HSV 1 is more commonly involved than HSV 2. Severe headaches and malaise are the first symptoms, followed by fever, personality changes, confusion, convulsions and finally coma. Characteristic electroencephalographic (EEG) changes are seen, including periodic discharges at 1 to 2s intervals and a slow delta-type rhythm of 2 to 3 Hz.¹³ The EEG in herpes encephalitis is never normal and for this reason is important in diagnosis. One-fourth of the minority that survive the disease have serious neurological sequelae.

Eye

HSV 1 is the most common cause of herpetic infection of the eye.⁴ The classic primary infection affects only one eye. Vesicles appear on the eyelids and/or margins, with accompanying edema of the lids and enlargement of regional lymph nodes. Conjunctivitis may or may not be accompanied by keratitis which can lead to blindness.⁴ The corneal lesions develop in branch-like (dendritic) patterns which are often diagnostic in appearance. The patient presents with pain, sensitivity to light, tearing and a mucoid discharge from the infected eye. The lid lesions heal in the same manner described for other skin lesions (see herpes labialis). Corneal lesions require 3 to 4 weeks to heal and the conjunctivitis runs its course in 2 to 3 weeks. Recurrences are generally less severe than the primary infection. When chorioretinitis is present, it is usually in association with neonatal encephalitis or in the immunocompromised adult as part of the disseminated disease.

Traumatic Herpes

Areas of the skin that have been cut or scraped provide a portal of entry for traumatic herpes infection, especially in wrestlers and in rugby players.⁴ Inoculation of virus into damaged skin around the nail fold causes herpetic whitlow in dentists, doctors, nurses and other health personnel involved in oral hygiene.⁴ HSV 2 is more commonly involved than HSV 1. This disease characteristically presents as painful vesicular-pustular lesions around the nail folds which heal spontaneously within two weeks of their appearance.

Immunocompromised Hosts

Individuals with defects in cellular immunity are prone to serious and/or unusual forms of HSV infections. This population includes transplant recipients, the severely malnourished, burn patients, recipients of steroids and cytotoxic agents and persons with certain skin conditions.

For example, those with chronic eczema are subject to a particular form of HSV infection, eczema herpeticum, in which vesicles appear over much of the body surface and are accompanied by fever. This is usually a primary infection and has on occasion been reported to be fatal; consequently, eczemic patients should be protected from exposure to HSV.⁴ Other conditions include chronic, large ulcerated lesions (herpes phagedena), pneumonitis and esophagitis.

Herpes Genitalis

Most genital herpes infections are caused by HSV 2 and are sexually transmitted. They can present as penile lesions or vulvovaginitis. The diagnosis is often missed in women, however, because the most common site of infection is the cervix and the disease is often asymptomatic.⁴ Only one-third of patients show the characteristic vesicular or ulcerative lesions.² In males these lesions can occur anywhere on the glans, prepuce or shaft of the penis. In rare cases, herpetic urethritis occurs in males. When the infection involves the vulva and vagina in the female, painful ulcers develop associated with inguinal adenopathy and fever. Primary infections are generally more severe than recurrent ones in both sexes.

Anorectal herpes presents with anal vesicles and may involve the rectal mucosa.¹⁴ It is usually associated with a history of anal intercourse.

Carcinogenicity

Evidence for an association of HSV (particularly HSV 2) with cervical cancer is circumstantial but persuasive.⁴ Women with histories of HSV 2 infections have an increased incidence of dysplasia, carcinoma *in situ* and invasive carcinoma of the cervix.¹⁵ In recent years there has been extensive research in this area, but the etiologic role of HSV in cervical cancer remains a mystery.¹⁶ Nevertheless, the link between cancer and HSV is strong enough to warrant frequent Papanicolaou smear tests for women with previous herpetic infections.^{7, 15}

HSV has also been implicated as a causative agent in multiple sclerosis, but definite evidence is lacking at present.¹⁷

Neonatal Disease

Neonatal infections are usually symptomatic, although typical skin or mucosal lesions may not be present. About two-thirds of infected infants have disseminated disease; the others have localized lesions only. The severity of the disseminated form is underscored by a mortality rate of 75%, compared with 5% when the disease remains localized.⁷

When the infection is acquired during the birth process, the incubation period from birth to disease is 2-12 days. The disease due to HSV 1 is clinically indistinguishable from that due to type 2 and only virologic typing will make the differentiation. About half the infants infected at birth develop a papulovesicular rash; this can appear anywhere on the body, but is usually seen on the scalp in vertex presentation deliveries and the perianal region in breech presentation, since these areas receive greatest exposure to the infected birth canal. Recurrence of skin lesions at the same site or nearby may continue to five years of age, despite high antibody levels against the virus. About 20% of HSV-infected infants have eye manifestations; conjunctivitis followed by keratitis may be the first abnormality noted.

The neonatal disease may remain localized or lead to dissemination with a wide variety of possible clinical patterns, including respiratory distress, cyanosis, hepatomegaly, jaundice, bleeding abnormalities and CNS signs such as lethargy and seizures.² Sometimes the signs of disseminated disease appear before or in the complete absence of any rash.² The combined mortality rate of disseminated and localized infections is over 50% and at least one third of survivors show CNS or ocular sequelae in later years.³ Predictions of normal development after neonatal HSV infections must, therefore, be made with caution.

These high rates of morbidity and mortality do not take into account the unknown number of subclinical infections which lead to minor or no sequelae and are not brought to the physician's attention. However, it may be shown eventually that, as in congenital rubella and CMV infections, neurological sequelae develop even in asymptomatic patients.²

PATHOLOGY

The pathological changes in primary and recurrent HSV infections are similar. The affected skin shows vesicles with ballooning epidermal cells, multinucleated giant cells and intranuclear acidophilic inclusions. Some inflammatory cells (mostly mononuclear cells) are present in the dermis. Intranuclear inclusions may be seen in the glial cells and the neurons of the CNS. Once the infection becomes disseminated, the virus is probably blood-borne (viremia).¹⁸ Consequently, the liver and adrenals are almost always infected, showing focal coagulative necrosis; frequently various other organs are also involved. Nuclear changes such as margination of chromatin are similar to those caused by other members of the herpesvirus family. The intranuclear inclusions which develop are not as large as those in CMV-infected cells but are indistinguishable from varicella-zoster.²

DIAGNOSIS

Diagnostic tests must be interpreted in the light of the patient's history. Since HSV infections are so common and the virus is isolated from so many asymptomatic mouths and genitals, mere isolation of the virus does not prove that HSV is responsible for a particular infection. Clinically, the presence of characteristic vesicular skin lesions is an aid to diagnosis, but only half of the afflicted patients present with any cutaneous manifestations. In the case of neonatal infections, the appearance of typical vesicular lesions in the first week of life along with a maternal history of herpetic infection is often diagnostic by itself.² Laboratory tests can be grouped into three categories: demonstration of morphologic changes in infected cells, cultivation of the virus and serology.

Demonstration of Morphologic Changes

The Tzanck smear test of skin lesions shows characteristic giant cells. Typical intranuclear inclusion bodies are seen in the Papanicolaou stain. However, these methods do not differentiate between acute and chronic infections or between HSV 1 and HSV 2,⁴ and the results are similar to those in cases of varicella-zoster infections. Also, not all cells show the morphologic changes such as inclusion bodies.¹³ Electron microscopy has also been used in diagnosis. The vesicular fluid of HSV lesions is a good source of identifiable HSV particles,² but problems with this method stem from

difficulties in locating these particles and the fact that all members of the herpes family are morphologically similar.

Cultivation of Virus

HSV is one of the most readily cultivated viruses, the best source of inoculum being an unruptured vesicle. Isolation in cell culture is the most sensitive and commonly used method of diagnosing HSV infections.³ Characteristic cytopathic changes are produced within 24 to 48 hours, allowing a provisional diagnosis to be made within a day of inoculation. Identification and typing of the cultivated virus can be accomplished by neutralizing the virus with specific HSV antiserum.¹⁹

Serology

Techniques for detecting and quantitating antibodies include the neutralization, passive hemagglutination, immunofluorescence, radio-immunoassay and peroxidase tests. Measurement of antibodies has a practical limitation, however, because the common prevalence of antibodies to HSV in the general population means that their mere presence is not indicative of active infection. Serial measurements are needed to establish an increase in antibody titre. As a further complication, recurrences are usually not associated with antibody rise.⁴

When the typical vesicular rash is present, diagnosis is not difficult. The patient's history, or the maternal history in the case of newborns, and virus isolation and typing are the preferred diagnostic methods when the cutaneous manifestations are absent.

There are four steps in the laboratory diagnosis of herpes encephalitis.²⁰ (1) CSF examination. Isolation of the virus is very rare, but increased lymphocytes, protein elevation and the presence of red blood cells are commonly found. (2) Radiographic localization. Temporal lobe localization is the common finding, since this is by far the most typical site for HSV involvement. Computed tomography scanning and technetium scanning can be used for this purpose. (3) Electroencephalography showing a pattern of paroxysmal spiking periodic discharges limited to one or both temporal lobes, which changes over the course of a few days, is highly suggestive of the diagnosis. (4) Brain biopsy. This remains the definitive step in diagnosis. Edema and hemorrhagic necrosis are seen on gross examination; microscopically typical cytopathic effects and the isolation of virus in cell culture confirm the diagnosis.

TREATMENT AND PREVENTION

The treatment of HSV infections remains largely symptomatic. No treatment has proved effective against cutaneous herpes, although drying agents such as alcohol and ether do cause the vesicles to dry up faster.⁴ Vital dyes applied with light therapy and inactivated vaccines are not recommended because of the suspected oncogenic properties of inactivated HSV.⁷ Fortunately, most cutaneous lesions are localized and heal spontaneously within 1-2 weeks. It has been noted that the placebo effect from any therapy in this disease approaches 50% or greater,²¹ and consequently the use of saline solution has had reasonable success. Recently the use of ice packs applied to cold sores lesions was reported to limit the outbreak of vesicles.²² No therapy can eliminate recurrences.

There has been some success in treating herpes encephalitis with systemic adenosine arabinoside (ara-A). When administered early, this drug significantly reduces the mortality rate.⁴ In the case of neonatal encephalitis, ara-A appears to improve the chances of normal post-infection mental development by about five times.¹⁸ Ara-A exerts its effects by interfering with viral DNA synthesis and, therefore, must be used with caution because it also affects host DNA and may be immunosuppressive.⁷

Topically-applied ara-A, deoxyuridine (IDU), cytosine arabinoside (ara-C) and trifluorothymidine have also been used successfully to treat ocular HSV. However, all of these drugs are toxic because they affect both host and viral DNA. Recently, AIU, the 5' amino analogue of IDU, was used successfully to treat herpes keratitis in rabbits.¹⁹ The advantage of this drug lies in its inability to be metabolized by normal cells; it selectively enters into viral DNA and makes the genome nonfunctional without being toxic to normal cells. These drugs often cause prompt reduction of the clinical manifestations of ocular herpes, but they do not affect the ability of the virus to cause recurrence.

Since HSV is ubiquitous in the general population, prevention of contact is very difficult. In the case of genital infections, however, it has been found that certain contraceptive foams are virucidal and the use of condoms protects against infection and impedes its spread.⁴

Cesarean sections are recommended when maternal genital infection is present at or near term to avoid exposure of infants to the virus.^{2,4} However, this is only advisable if the membranes rupture less than four hours before the operation; after this time it is assumed that the virus has ascended through the birth canal to the infant *in utero* and a cesarean section would have no value.²

Unfortunately, due to the large number of asymptomatic HSV infections, maternal disease is not always detected in time to perform a cesarean section. This problem can only be solved by looking specifically for evidence of HSV infections in susceptible pregnant women. The disease is most prevalent in lower socioeconomic groups and in women with a history of multiple sexual partners.

In the rare cases where transplacental transmission occurs (Figure 1), a cesarean section would obviously be of no therapeutic value.

Neonatal HSV has been treated with gamma globulin before symptoms developed or early in the disease in the hope of neutralizing any cell-free virus with the antibodies present in pooled globulin.¹⁸ However, this must still be considered an experimental procedure.

Another new approach to HSV infections involves the use of levamisole which is believed to enhance macrophage function and hence stimulate host defense.²¹ Its effectiveness is controversial, however.^{20,23} As yet there is no proven, reliable and safe protection against primary and recurrent herpetic disease. □

References

1. **Andrewes C H, Pereira H G, and Wildy P:** Herpetoviridae. In: *Viruses of Vertebrates*, 4th ed. London, Cassell and Co. Ltd., 1978, pp. 312-355.

2. **Hanshaw J B and Dudgeon J A:** Herpes simplex infection of the fetus and newborn. *Major Probl. Clin. Pediatr.* 17:153-181, 1978.
3. **Nahmias A J and Visintine A M:** Herpes simplex. In: *Infectious Diseases of the Fetus and Newborn Infant*, ed. by J. S. Remington and J. O. Klein. Philadelphia, Saunders, 1976, pp. 156-190.
4. **Felman Y M and Sonnabend J A:** Herpes simplex virus infections. *N.Y. State J. Med.* 79:179-185, 1979.
5. **Ekwo E, Wong Y W and Myers M:** Asymptomatic cervicovaginal shedding of herpes simplex virus. *Am. J. Obstet. Gynecol.* 134:102-103, 1979.
6. **Baker D A and Plotkin S A:** Genital herpes simplex virus (HSV) isolation during pregnancy. *Obstet. Gynecol.* 53:9S-12S, 1979.
7. **Hayes K:** Cytomegalovirus and herpes simplex virus: wolves in sheep's clothing. *Aust. Fam. Physician* 7:552-569, 1978.
8. **Dunkle L M, Schmidt R R and O'Connor D M:** Neonatal herpes simplex infection possibly acquired via maternal breast milk. *Pediatrics* 63:250-251, 1979.
9. **Quinn P T and Lofberg J V:** Maternal herpetic breast infection: another hazard of neonatal herpes simplex. *Med. J. Aust.* 2:411-412, 1978.
10. **Spence M R:** Inapparent sexual transmission of herpes simplex virus type II infection with subsequent neonatal death: case report. *Am. J. Obstet. Gynecol.* 130:590-591, 1978.
11. **Bader C, Crumacker C S, Schnipper L E, et al:** The natural history of recurrent facial infection with herpes simplex virus. *J. Infect. Dis.* 138:897-905, 1978.
12. **Haynes R E:** The spectrum of herpes simplex virus infections in children. *South. Med. J.* 69:1069-1078, 1976.
13. **Longson M and Bailey A S:** Herpes encephalitis. *Recent Advances in Clinical Virology* 1:1-19, 1977.
14. **Curry J P, Embil J A, Williams C N, et al:** Proctitis associated with *Herpesvirus hominis* type 2 infection. *Can. Med. Assoc. J.* 119:485-486, 1978.
15. **Belsey E M and Adler M W:** Current approaches to the diagnosis of herpes genitalis. *Br. J. Vener. Dis.* 54:115-120, 1978.
16. **Rawls W E, Bacchetti S and Graham F L:** Relation of herpes simplex viruses to human malignancies. *Curr. Top. Microbiol. Immunol.* 77:71-95, 1977.
17. **Koprowski H and Warren K G:** Can a defective herpes simplex virus cause multiple sclerosis? *Perspect. Biol. Med.* 22:10-18, 1978.
18. **Plotkin S A:** Perinatally acquired viral infections. *Curr. Top. Microbiol. Immunol.* 78:111-120, 1977.
19. **Jawetz E, Melnick J L and Adelberg E A:** *Review of Medical Microbiology*, 13th ed. Los Altos, California, Lange Medical Publications, 1978, pp. 445-449.
20. **Hirsch M S, Cheeseman S H and Hammer S M:** Human herpesvirus infections: pathogenesis and clinical implications. *Seminars in Infectious Diseases* 2:217-264, 1979.
21. **Nuss D D and Aeling J L:** Herpes simplex: treatment today. *Cutis* 20:237-241, 1977.
22. **Danziger, S.** Ice-packs for cold-sores. *Lancet* 1:102, 1978.
23. **Kaplan B K, Cardarelli C and Pinnell S R:** Doubleblind study of levamisole in aphthous stomatitis. *J. Oral Pathol.* 7:400-404, 1978.

A case for Vanceril

NOW AVAILABLE AT
NEW REDUCED PRICE



VANCERIL (beclomethasone dipropionate) from Schering is the aerosol corticosteroid that has changed medical opinion about steroids in chronic asthma. VANCERIL offers these patient advantages:

- Metered dose inhaler delivers effective asthma control *directly* to the bronchial mucosa.
- Provides selective, potent, *topical* anti-inflammatory activity and *virtual freedom from side effects* at recommended dosage.
- Is indicated for patients whose chronic asthma is inadequately controlled by non-steroid medication such as bronchodilators and/or sodium cromoglycate.
- May replace oral corticosteroids with a programme of gradual patient withdrawal from systemic medication.

VANCERIL offers packaging designed for maximum patient convenience and co-operation.

- 1 "Dosage reminder" canister.
- 2 Convenient plastic carrying case.
- 3 Instruction sheet in four languages.
- 4 Identity card advising that patient is asthmatic using corticosteroid therapy.

Vanceril Oral Inhaler

(Beclomethasone Dipropionate Inhaler)

Vanceril Oral Inhaler

(Beclomethasone Dipropionate Inhaler)

THERAPEUTIC OR PHARMACOLOGICAL CLASSIFICATION

Corticosteroid Aerosol for the treatment of asthma.

Indications

Treatment of steroid-responsive asthma.

1. In asthmatic patients who do not respond adequately to conventional therapy.

2. In steroid-dependent asthmatics where a reduction of systemic steroids is desirable.

Contraindications

1. In status asthmaticus or in patients with moderate to severe bronchiectasis.
2. Active or quiescent untreated pulmonary tuberculosis.
3. Untreated fungal, bacterial or viral infections of the respiratory system.
4. In children under the age of 6 years.

Warnings

1. Glucocorticoids may mask some signs of infection and new infections may appear during its use.

2. "THE DEVELOPMENT OF PHARYNGEAL AND LARYNGEAL CANDIDIASIS IS CAUSE FOR CONCERN BECAUSE THE EXTENT OF ITS PENETRATION OF THE RESPIRATORY TRACT IS UNKNOWN. IF CANDIDIASIS DEVELOPS VANCERIL SHOULD BE DISCONTINUED AND APPROPRIATE THERAPY INSTITUTED."

3. In patients previously on high doses of systemic steroids, transfer to Vanceril Inhaler may cause withdrawal symptoms: tiredness, aches and pains, and depression. In severe cases, acute adrenal insufficiency may occur necessitating the temporary resumption of systemic steroids.

4. The safety of Vanceril in pregnancy has not been established. If used, the expected benefits should be weighed against the potential hazards to the fetus, particularly during the first trimester of pregnancy.

Precautions

1. The transfer of a patient from systemic steroid to Vanceril Inhaler has to be very gradual and carefully supervised by the physician. The guidelines under Dosage and Administration should be followed.

2. A decreased resistance to localized infection has been observed during corticosteroid therapy.

3. During long-term therapy, pituitary adrenal function and haematological status should be periodically assessed.

4. Fluorocarbon propellants may be hazardous if they are deliberately abused. Inhalation of high concentrations of aerosol sprays has brought about cardiovascular toxic effects and even death, especially under conditions of hypoxia. However, evidence attests to the relative safety of aerosols when used properly and with adequate ventilation.

5. It is essential that the patient be instructed that Vanceril Inhaler is a preventative agent which must be taken at regular intervals, and is not to be used during an asthmatic attack.

6. There is an enhanced effect of corticosteroids on patients with hypothyroidism and in those with cirrhosis.

7. Acetylsalicylic acid should be used cautiously in conjunction with corticosteroids in hypoprothrombemia.

8. Patients should be advised to inform subsequent physicians of the prior use of corticosteroids.

Adverse Reactions

No major side effects attributable to the use of recommended doses of Vanceril Inhaler have been reported. No significant systemic effects have been observed when the daily dose was below 1 mg (twenty inhalations). Above this dose, reduction of plasma cortisol, indicating adrenal cortical suppression, may occur. Therapeutic doses may cause the appearance of *Candida albicans* in the mouth and throat. In some patients the appearance of hoarseness or pharyngeal irritation has been observed, occasionally necessitating withdrawal of treatment. The replacement of systemic steroids with Vanceril Inhaler may unmask symptoms of allergies, which were previously suppressed by the systemic drug. Conditions such as allergic rhinitis and eczema may thus become apparent during Vanceril therapy after the withdrawal of systemic corticosteroids and should be treated appropriately.

Symptoms and treatment of overdose

Overdose may cause systemic steroid effects resulting in symptoms of hypercorticism and/or adrenal suppression. Decreasing the dose will abolish some of these side effects, when due to excessive dosage. Adrenal suppression should be treated symptomatically.

Dosage and Administration

Optimum doses vary, but the total daily dose should not exceed 1 mg of beclomethasone dipropionate (10 inhalations), and should not be initiated until the severe attack has been controlled with systemic corticosteroids.

Adults: Two inhalations reach 50 µg three to four times/day is the usual maintenance dose. In severe cases it is advisable to control the symptoms with systemic corticosteroids before starting treatment with beclomethasone dipropionate inhaler.

Children: Insufficient information is available to warrant the safe use in children under age 6. For children over 6 years of age one inhalation (50 µg) up to four times daily.

MAXIMUM DAILY DOSE SHOULD NOT EXCEED 20 INHALATIONS FOR ADULTS AND 10 INHALATIONS FOR CHILDREN UNDER 12 YEARS OF AGE.

Since the effect of Vanceril Inhaler depends on its regular use and on the proper inhalation technique, patients must be instructed to take inhalations at regular intervals. They should also be instructed in the correct method: to exhale completely, lips to be placed tightly around the mouth-piece and actuate the aerosol in the next inspiratory period. In the presence of excess mucus secretion, severe attacks of asthma, and/or infection or high atmospheric concentrations of appropriate antigens, the drug may fail to reach the bronchioles. Therefore, if an obvious response is not obtained after 7 days, appropriate therapy including a short course of systemic corticosteroids should be instituted before returning to the use of inhaler, as well as the concomitant use of a broncho-dilator aerosol.

Careful attention must be given to patients previously treated for prolonged periods with systemic corticosteroids when transferring them to beclomethasone. Initially, Vanceril and the systemic steroid must be given concomitantly for 10-14 days, followed by a gradual withdrawal of the systemic steroids. Dose reductions should be the equivalent of 1.0 mg every 10-14 days if close continuous medical supervision is not feasible. It may be possible to withdraw systemic corticosteroids more rapidly if the initial dosage was 7.5 mg daily of prednisone (or equivalent) or less, or if the patient is under close continuous medical supervision. Some patients may not be able to completely discontinue the use of systemic steroids. In such cases a minimum maintenance dose should be continued in addition to Vanceril Inhaler.

Dosage Form

Vanceril Inhaler is a metered-dose aerosol, delivering 50 µg per inhalation. Each canister provides 200 metered sprays.

Full information is published in the Compendium of Pharmaceuticals and Specialties and available on request from Schering Canada Inc., Pointe Claire, Quebec H9R 1B4.

*Reg. T.M.

PAAB

MEMBER

PMAC

SCHERING

A PRIVATE PSYCHIATRIC HOSPITAL

... for the diagnosis and treatment of all types of psychiatric disorders including alcohol and drug dependence - over ninety years continuous experience. A high ratio of psychiatrists to patients enables our staff to individualize treatment. All types of modern therapy are available through the skills of a modern, professional psychiatric team.

The Sanitarium is set in the midst of 55 acres of wooded parkland in the City of Guelph, which is located 50 miles south-west of Toronto, a 50 minute drive from Toronto International Airport.

All of the buildings and units have been modernized and are well planned and therapeutic in their design. The facilities provide excellent recreational areas. There is a modern Physiotherapy Department with a large whirlpool, active Horticultural Therapy Program and a large activity therapy program.

The semi-private rate is \$90.90 per day for active treatment units and \$83.25 per day for long-term care. The only additional charges are for medical and psychiatric services in accordance with the Ontario Medical Association fee schedule. Insurance benefits applicable depend on the nature of the illness and on the terms of the insurance policy.

For further information, write or telephone Mrs. Marion Glazier, Director of Admissions at The Homewood Sanitarium, 150 Delhi St., Guelph, Ont. N1E 6K9
Phone 1-519-824-1010.

ESTABLISHED 1883
ACCREDITED BY C.C.H.A.



**M. O. Vincent, B.A., M.D., C.M., D.A.B.I.M.,
F.R.C.P.(C.),
EXECUTIVE DIRECTOR.**

**J. A. Watt, M.B., ChB., D.P.M., M.R.C. PSYCH.,
F.R.C.P.(C.),
MEDICAL DIRECTOR**

HOMEWOOD SANITARIUM

OF GUELPH, ONTARIO, LIMITED

Computer-Generated MSI Claims Documentation

In the past two or three years, there has been increasing interest, in North America, in the use of computers to assist physicians in the administration of their practices. Initially, developments in this field were concerned with large group practices. However, with the advent of relatively powerful but inexpensive micro- and minicomputers, recent developments have been concentrated on systems for small group practices or even solo practitioners.

One of the more significant administrative functions, in any practice, is the preparation of claim documentation, for government insurance agencies — in this Province, MSI.

A recent MSI Physicians' Bulletin (Volume XI, #2, dated February 28, 1979), indicated that the Health Services and Insurance Commission and Maritime Medical Care Inc., as administrators of the Plan, has recognized that physicians, within the Province, may wish to take advantage of the new technological developments. They recognize that the current claim card may not be the most suitable document, for use with computer systems. Accordingly, the Health Services and Insurance Commission has approved the use of other forms of claim input — notably, magnetic tape. It is anticipated that,

in the near future, input, by means of diskette or "floppy disk", will be acceptable.

As indicated in the MSI bulletin, the Health Services and Insurance Commission has also set out the procedures which must be followed by any physician who wishes to use any form of claim documentation, other than the standard MSI claim card. This is known as the "Accreditation" process.

Both the standards governing the type of claim documentation acceptable e.g., tape specifications and the Accreditation procedures, are set out in a manual, *MSI Claims Preparation and Submission Standards and Specifications*. Copies are available from Maritime Medical Care Inc.

It should be noted, however, that this manual does not attempt to make any recommendations or suggestions, as to available computer hardware or software. Such information can be obtained through individual computer hardware or software. Such information can be obtained through individual computer companies or the Canadian Medical Association, who have been very active in encouraging the use of computers in physicians' offices. □



Four of Halifax's best restaurants are hidden in this picture.

Up under the roof, there's the Noon Watch and Night Watch — with superb food and a breathtaking view by day or night.

Right next to it, an intimate little lounge specializes in aperitifs. Off the lobby there's Sam Slick's, where Halifax meets to raise a friendly glass or enjoy a business lunch. And deep inside, the Crown Coffee House serves good old-fashioned meals all day long.

Of course it's all done with traditional CP Hotels' service and expertise.

CP Hotels  **Chateau Halifax**

MARDAN BUSINESS SYSTEMS LTD.

Specializing in Practice Management Aids for the Professions

- **Filing Information Systems** (color coded)
- **Accounting:** (one write systems)
Receivable & Payable
- **Audio Visual:** Patient Education Systems (Medfact Cassettes)

Exclusively

Distributed in Atlantic Canada by:

A.C. Systems Limited
184 Shore Drive
SS# 1, Site #2, Comp. 31
Bedford, N.S. B0N 1B0

Telephone: 835-2129
835-8934

FOR FURTHER INFORMATION
Clip and Mail to the address above:

| | |
|--------------------|---------------------------------------|
| Name | Interested in: |
| Address | <input type="checkbox"/> Filing* |
| | <input type="checkbox"/> Accounting |
| Phone Number | <input type="checkbox"/> Audio Visual |

Division of Continuing Medical Education Request to Physicians

WE NEED TO HEAR FROM YOU

Lynn Curry*, Ph.D., and R. Wayne Putnam**, M.D.,

Halifax, N.S.

YOU HAVE RECEIVED A CONFIDENTIAL QUESTIONNAIRE FROM DAL. C.M.E. PLEASE TAKE 20 MINUTES AND TELL US HOW YOU LEARN BEST. WE NEED TO PLAN C.M.E. TO MATCH THAT STYLE. THE UTILITY OF OUR PROGRAMMES DEPENDS ON THE BREADTH OF INFORMATION WE RECEIVE. EACH PERSON'S RESPONSE IS CRUCIAL.

When we were younger, our better teachers took trouble to find the way each student learned best and then provided that learning mechanism. If we learned by manipulating real things, there were physical models to work with; if visual or auditory memory was best, there would be slides, films or audio tapes and records. The principle is well established in education: seek individual differences in learning habits and match instruction to suit strengths. Does this principle become invalid in adult learners? No, but we seem to act as if it did.

Continuing medical education, in particular, has been overly reliant on the model of mini-lectures and passive learners. With constant and conflicting demands on their time, physicians should be able to choose the CME method most compatible with their own learning style and needs, for the most effective and efficient learning to occur. Properly matched, CME becomes an ongoing, continual and individually focused process rather than a pot-luck selection of refresher courses.

This approach to individual choice in CME does not mean the end of formal refresher courses. A sizable minority of individuals prefer the lecture presentation on a topic of personal interest and need. However, we must identify, legitimize and make accountable the range of other approaches to effective CME.

The first step is to ascertain what learning methods are preferred, used and effective, in changing the patient management of physicians in practice. There has been little comprehensive work in this area, even though recent reviews of CME call for "major efforts to develop and demonstrate more effective methodologies" (Richards, 1978). American surveys of specialist groups by Standar (1978) and Murray-Lyon (1977) found that journal reading was the most practised form of CME and was preferred to formal lectures and symposia. However, Whitney and Caplan (1977) found that medical school courses were the most preferred method. All three studies reported that the other CME modes — group activities, regional/national programs and textbooks — were used by significant sections of their sample populations.

This CME Planning study is supported financially by the Provincial Medical Board of Nova Scotia, the New Brunswick Medical Society, and the Medical Council of Prince Edward Island.

*Assistant Director for Research, Division of Continuing Medical Education, Dalhousie University.

**Assistant Dean and Director, Division of Continuing Medical Education, Dalhousie University, Halifax, N.S.

A Canadian survey by Buchanan and Laxdal (1971) and an unpublished Saskatchewan report by Laxdal (1976), showed a similar emphasis of journals and other methods (textbooks, informal discussions, hospital teaching rounds and consultations with specialists), and low reliance on formal CME courses. An unpublished survey conducted in the Maritimes by Clark (1972) noted that among those responding, more time was spent in self-generated CME activities than in any of the formally organized CME activities.

These surveys provide insufficient information for a number of reasons. In most, the return rate was less than a third and conclusions drawn from these responses are very likely inaccurate for the larger group. Surveys designed for a particular group of specialists may not extrapolate, particularly from the American milieu. In none of them was there any follow up work to substantiate the findings, or planning to utilize the information.

The Division of Continuing Medical Education is currently planning the CME program for the coming decade. IN ORDER TO MAKE THOSE PLANS MOST USEFUL WE NEED TO KNOW WHAT YOU DO NOW TO CONTINUE YOUR LEARNING, WHAT YOU WOULD PREFER TO DO AND WHAT YOU PERCEIVE AS EFFECTIVE IN MOTIVATING POSITIVE CHANGES IN YOUR PATIENT MANAGEMENT. FOR ACCURATE AND APPLICABLE INFORMATION, A FULL SCALE SURVEY OF MARITIME PHYSICIANS IS NEEDED. We will undertake further analysis and follow up work with individuals choosing to participate in specific pilot projects. The nature and direction of these projects will emerge from the questionnaire responses.

In October, we mailed the questionnaire to every physician licensed to practice in Nova Scotia, New Brunswick and Prince Edward Island. It was developed last spring and "pilot tested" three times to remove final ambiguities and insure that the questions are understood as intended. H. R. Doane and Company have been retained to insure anonymity of all responses.

Two areas are pursued in the questionnaire. The first focuses on the learning formats used to update knowledge and skills, formats preferred and sources of information involved in altering patient management. The second elicits a range of demographic information: age, sex, type and amount of practice, size of community, year of graduation. Analysis will enable us to describe the kinds of learning regularly undertaken by Maritime physicians, what they prefer to do and what kinds of information change their

patient management. Based on these results, the Division of Continuing Medical Education will begin developing approaches to help physicians learn more efficiently by the methods they themselves have identified.

By developing these alternative CME patterns, we hope to avoid mandatory collection of credit hours and thereby avoid the negative consequences experienced in the United States (Chouinard, 1979) as a result of too hasty adoption of mandatory CME. We in Canada must carefully analyse and evaluate all effective modes of continuing medical education before endorsing similar policies. The proposed analysis will identify a choice of legitimate means to ensure continual renewal in the medical profession.

If you have not returned the questionnaire, please take 20 minutes now to do so. **THE ACCURACY OF THE SURVEY DEPENDS ON GETTING RESPONSES FROM ALMOST ALL PHYSICIANS PRACTICING IN THE MARITIMES.** □

This project enjoys the encouragement and support of:

The Medical Society and Provincial Medical Board of Nova Scotia
The New Brunswick Medical Society and Medical Council
The Prince Edward Island Medical Society and Medical Council.

References

- Buchanan K, Laxdal O E:** Continuing education habits of Saskatchewan general practitioners. *Can. Med. Assoc. J.* **105:** 1328-1333, 1971.
- Chouinard J L:** *Mandatory CME: A discussion document.* Prepared for the Council on Medical Education of the Canadian Medical Association. January, 1979.
- Clark M R:** *How Maritime physicians keep up with new advances in medicine and retain old skills.* Unpublished report of Maritime Physician Study, Division of Continuing Medical Education, Dalhousie University, 1972.
- Laxdal O E:** *Involvement of Saskatchewan physicians in continuing medical education — a survey.* Internal report, Continuing Medical Education, College of Medicine, University of Saskatchewan, 1976.
- Murray-Lyon N:** Communication in medicine: A study of how family doctors obtain information on recent advances in the treatment of rheumatic diseases. *Medical Education* **11:**95-102, 1977.
- Richards R K:** Continuing medical education: *Perspectives, problems, prognosis.* New Haven: Yale University Press, 1978.
- Stander R W:** Executive desk. *American College of Gynecology Newsletter,* June, 1978.
- Whitney M A, Caplan R M:** Learning style and instructional preferences of family physicians. *Annual Conference of Research in Medical Education* **16:**194-199, 1977.

ATLANTIC CHRISTIAN TRAINING CENTRE

A rich resource for those in the helping professions exists at A.C.T.C. in Tatamagouche, N.S. The Centre is an educational, residential establishment, partially funded by the United Church, and is open to all persons, groups or organizations who wish to use its facilities and/or leadership. Your name can be placed on the mailing list by writing:

The Registrar
Atlantic Christian Training Centre
Tatamagouche, N.S.

Some of the Programs for this fall include:

Creative Grieving — November 16-18

Skills for the Developing Family —
November 23-25

Team Building — November 30-December 2

PLEASE SEE THE INSIDE BACK COVER
FOR **NOTICE** REGARDING THE
MEDICAL SOCIETY INSURANCE PROGRAM.

EMPLOYMENT OPPORTUNITIES

The Central Newfoundland Regional Health Center is now receiving applications for:

Canadian Certified (or certification eligible — Fall 1979) Specialists in:

**Ophthalmology
Internal Medicine
Paediatrics**

The successful applications will work in an established Acute Care Treatment Hospital of 208 beds.

Interested persons reply to:

Administrator
Central Newfoundland Regional Health Center
Grand Falls, Newfoundland
A2A 2E1

Correspondence

To the Editor:

In the last week or two someone brought to my attention the fact that the Nova Scotia Medical Society had publicly endorsed the construction of the new \$80,000,000 Camp Hill project. If this is true, then I suspect the Medical Society has failed to do its homework in soliciting opinions from its membership. If it is not true, the Medical Society of Nova Scotia should hasten publicly to announce that they do not support and endorse the construction of the new Camp Hill complex.

While on this topic, I would like to add a few thoughts of my own. I am concerned that such a vast amount of money is being spent in Halifax while the rest of the Province goes begging. New facilities may indeed be necessary in the Halifax area but I seriously question whether the Halifax area needs the enormous project being scheduled for the Camp Hill area. Nova Scotia already has one tertiary care institution in the Victoria General Hospital. I submit it doesn't need a second tertiary care institution. I also submit that the \$80,000,000 figure is ridiculously low. If I would hazard to guess, the institution when completed will probably be three times that figure and I will go on record as predicting that the figure will probably be closer to \$200,000,000 by the time it is completed.

How do I think these funds could be better spent? Well, let's get my obvious vested interest on record. The Dartmouth General Hospital could use 100 additional medical/surgical beds and as well could use a 100 bed obstetrical unit. It is time that the provincial government used foresight and planning in putting obstetrical beds where the deliveries are occurring. The vast population growth in the Dartmouth-Cole Harbour area already contributes a significant percentage of deliveries done in the Grace Maternity Hospital. Why not put the obstetrical unit where the patients are?

The other area of enormous explosive growth is the Sackville/Bedford area. This area and its population deserves its own Hospital. Finally, the Spryfield area of Halifax should have its own Hospital.

I beg to suggest that all three hospitals could be constructed at a price far less than the \$80,000,000 tip of the iceberg we are having unveiled for us in the Camp Hill Hospital complex.

I am expressing my concerns through you, and hopefully through the Journal, to physicians and other interested parties in this Province. We, as physicians, should identify and clarify the following areas.

1. Do we as physicians see the necessity of a second tertiary care institution in South-End Halifax?
2. Does the Medical Society of Nova Scotia support and endorse the formation of such an institution?
3. If the Medical Society indeed does endorse such an institution on what basis do they endorse it? Have they surveyed the medical population to solicit opinions?
4. How does the Medical Society stand on the institution of Health Care facilities in the other areas of the province such as the three critical areas that I have outlined?

5. We should seek to have explained through proper channels why the government is prepared to spend \$80,000,000 (\$200,000,000?) in south-end Halifax while the rest of the metropolitan area has no health care facilities to speak of.

I thank you for the opportunity to present my biased point of view.

Kindest personal regards,

E. G. Nurse, M.D.
110 Woodlawn Rd.
Dartmouth, N.S. B2W 2S8

□

To the Editor:

Thank you for the opportunity of replying to Dr. Nurse's letter on the subject of Rationalization of Hospital Services in Halifax. Dr. Nurse asks a number of important questions which may well be in the minds of many other members. I apologize now for the length of this letter, but it is essential that this important matter be discussed with all the facts in the open.

The following are extracts from a memo received from the Department of Health on August 3, 1979.

"This proposal (Rationalization of Halifax Hospital Services) was introduced in order to capitalize on the availability of Federal funds for construction at Camp Hill and to seize an opportunity to make good use of the Halifax Infirmary buildings if the Infirmary is relocated at Camp Hill.

"The Department is convinced that hospital services would be improved and economies of operation effected by this rationalization. New facilities can be made available for little more capital outlay than will be required to upgrade and refurbish existing hospital facilities at the Halifax Infirmary, Camp Hill Hospital and the Grace Maternity Hospital.

"Camp Hill would be the site for a 500-bed acute general hospital to replace the Halifax Infirmary and the acute care portion of Camp Hill; a 200-bed geriatric centre with priority for veterans as required in the 1978 Federal-Provincial Agreement; and a 150-bed obstetrical hospital to replace the present Grace Maternity Hospital. The Abbie J. Lane Hospital would form part of the complex and provide all psychiatry services. These sections would in effect be separate institutions, but would utilize common services in dietary, x-ray, laboratory, stores, maintenance, etc., thus avoiding costly duplication of equipment, staff and supplies.

"Under the Federal-Provincial Agreement on Camp Hill, Nova Scotia holds a credit of 22.6 million in 1977 dollars for construction of a new 200-bed geriatric unit with priority for veterans with an acute care backup, and also construction of a 35-bed unit for veterans in Cape Breton (several thousand dollars). This money is indexed for six years according to the construction index. The Department of Health estimates that after constructing the 35 beds in Cape Breton there will be 22 million in 1979 dollars available to be spent at Camp Hill.

"**Camp Hill Hospital** — We must build 200 beds for geriatric veterans with an acute care backup on the Camp Hill site. Renovation of the main Robie Street building for the backup would cost in excess of 10 million dollars and would still be an old building; a new structure would cost little or no

more and would be modern; 200 geriatric beds would cost about 6.5 million. The present building could be used for non-patient care functions; i.e. — offices, research, teaching, detox centre, etc.

"Halifax Infirmary — An old building with a limited site requiring an estimated 25 million for upgrading, renovation and additions in the next 5 to 10 years, about 1/3 of this cost is to meet Fire Marshal's requirements for hospitals. The Infirmary buildings are suitable for and desired by Nova Scotia Technical College without renovations, thus reducing the need for more funds for Tech to meet new commitments for expanded programs recently approved. Tech wants possession of the entire complex in five years.

"Grace Maternity Hospital — An old building (1922) requires extensive renovation. If renovation takes place on site, it is almost impossible logistically to operate the hospital (costs — renovation 19.6 million; new separate building 22-25 million plus land; new building sharing services at Camp Hill 17.3 million). The present Grace could be disposed of, the proceeds invested and the interest paid to the Province by the Salvation Army for the privilege of operating the obstetrical wing of the new complex.

"Halifax Civic Hospital — does not enter into this as the building was condemned in 1972 and will be closed as soon as arrangements agreeable to the City of Halifax are completed, certainly within the next year.

"Victoria General Hospital — will remain the Provincial referral hospital and will not be affected except where the planners may adjust the numbers of beds in the various services; i.e., all female surgery may go to the new facility and beds thus vacated in the V.G.H. will be available for other services, such as neurosurgery, orthopedics, cardiac surgery, etc.

"Relevant factors:

- 1) Camp Hill site must be used if we are to make use of Federal money;
- 2) Camp Hill site is large enough, is centrally located for a teaching hospital and the Power Plant can handle the entire complex without renovations;
- 3) The Infirmary and the Grace Maternity would continue to exist, but as modern facilities on a new site;
- 4) The number of beds in the City would remain relatively constant, but more would be available for long-term care as D.V.A. will not likely require more than 150 beds and less as years go by;
- 5) The Department of Health feels that it would be better to spend the same money on new buildings rather than on renovation of existing buildings; and also there is a possibility of saving up to five million a year (1979 dollars) in operating costs by combining to share facilities.
- 6) The cost of rationalization is 80 million including equipment, but much equipment can be saved from the existing buildings which reduces this amount to some extent; and
- 7) There would be increased preferred accommodation, thus providing more income for the hospital."

I wish now to comment on some of Dr. Nurse's points.

The Camp Hill project is not a second tertiary care institution. It is a relocation of the Grace and Infirmary together with an upgrading of the physical Camp Hill plant as agreed to with the Federal Government.

The Medical Society does support the proposal and the following are relevant paragraphs from my letter of August 23, 1979 to Dr. Sheehy.

"Your proposal makes sense in both economic and practical terms, provided of course that your intent to maintain, at the very least, the current level and quality of services available in Halifax to all Nova Scotians is not lost along the line toward implementation.

"Your determination to retain the identity of the units comprising the complex is most important. It will be a principal factor in gaining and retaining the full co-operation of these units in the design and building of the complex.

"The Society is pleased that the complex will include provision for bed access by general practitioners. This is also important from both the patient and physician point of view.

"An aspect on which we are not entirely clear at the moment relates to psychiatric care. Great progress has been made in the last decade through the integration of psychiatric care with other routine hospital services. Nova Scotia psychiatric care is the envy of many provinces and has been of considerable benefit to residents of this Province. We expect to be communicating with you further relative to this point.

"A point about which little has been paid is the extent to which the complex will benefit all of Nova Scotia residents and not just those in Metro. It might be appropriate for you to consider making this aspect more public, perhaps by publicizing the extent to which Metro facilities are utilized by "out-of-towners".

The foregoing letter was circulated to all members of the Executive Committee prior to its meeting at Digby and no objections were presented. In mid-July in a statement to the press I indicated Society support provided certain principles were retained (e.g. no reduction of level of service in Metro, family doctor access to beds assured) and no members indicated disagreement. Before presuming to speak for the Society, I consulted with many of my colleagues both in Metro and other parts of Nova Scotia and received expressions of support. The Halifax Medical Society has also expressed its support of the project to Dr. Sheehy.

The figure of \$80 million seems to be a reasonable figure. We understand it results from quite detailed calculations. Dr. Nurse's estimate of \$200 million may well turn out to be closer but only time will tell. Of course, we hope he is wrong.

With respect to health care, particularly hospital, facilities outside Halifax, the record seems to indicate that to this date, the record is not bad. In the past five years for example \$75 million has been spent outside Metro and \$24 million in Metro, including Dartmouth. Unfortunately, I cannot be specific but can say that the next decade will see extensive upgrading of hospital facilities throughout Nova Scotia, including the areas mentioned by Dr. Nurse. The Society is aware of the needs of other parts of Metro and has been assured that provision of appropriate facilities will proceed alongside of the Halifax-Camp Hill Project. For starters of course, we will see the opening of a diagnostic facility in Bedford/Sackville by Spring 1980.

I am in no position to comment on the specific bed requirement for the Dartmouth General Hospital. Perhaps Dr. Nurse might see fit to arrange for the Society to review their proposals for expansion thereby putting us in the position of adding Society support.

Dr. Nurse need not apologize for expressing what he refers to as his biases. It is a credit to him that he is prepared to speak out for what he feels is right.

In conclusion, I note in particular Dr. Nurse's reference to consultation with the membership. On this point I will rest the case with the Executive Committee at its next meeting. This appeared to be one of those occasions when the elected leader had to bite the bullet.

Yours very truly,

B. J. Steele, M.D.
President,
The Medical Society of Nova Scotia.

□

Medical Estate Planning Services

Donald R. Cox

Suite 1110
Duke Street Tower
Scotia Square

Phone: 422-6314

Estate Planning Directed to the Medical Profession



Manuge Galleries Limited

- We specialize in Canadian paintings of the 19th & 20th centuries.
- Our collection includes work by the Group of Seven, Robert Pilot, Goodridge Roberts, Alan Collier, Tom Roberts, Tom Forrester, John Little and many others.
- Most paintings purchased as a wall decoration can be depreciated and many professionals in Canada are selecting high quality original art for their offices. This may be done on a lease-purchase basis.
- We have more than 600 paintings in inventory.

MANUGE GALLERIES LIMITED
1674 Hollis Street
(adjacent to the Halifax Club)
Halifax, N. S.
Telephone: Halifax 902-423-6315

Medical Director Victoria General Hospital Halifax, Nova Scotia

The Victoria General Hospital, Halifax, Nova Scotia invites inquiries for the position of a Medical Director. This position provides an opportunity for someone with clinical and administrative experience to undertake the coordination and direction of medical services in an 800 bed hospital. This is essentially a tertiary care teaching hospital and is the principal adult Dalhousie University teaching hospital.

There are Royal College of Canada accredited programs in the general and subspecialty medical and surgical fields, a School of Nursing and other Allied Health Training Programs.

The individual should be a University graduate in Medicine, registered or eligible for registration in the Province of Nova Scotia with several years clinical experience.

Desirable qualifications also include demonstrated administrative ability and post graduate training in hospital or health services administration.

Further information may be obtained by communication with the Secretary of the Search Committee for a Medical Director, Doctor M. A. MacAulay, Victoria General Hospital, Halifax, Nova Scotia B3H 2Y9.

Unstuffy "shrink" Retires

Barbara Hinds*,

Halifax, N.S.

Actor, surgeon, distiller, psychiatrist, ocean yachtsman, father confessor to a regiment, quasi-priest, and gourmet cook are some of the roles brim-filled by Dr. J. Fraser Nicholson, 66, who retired from his post of assistant dean of admissions, in the Faculty of Medicine at Dalhousie University.

For the past 28 years, Dr. Nicholson has taught psychiatry to every medical student, and lent a broad shoulder to those who needed it, as they worked through medical school. His lectures are renowned for their humanity and humor. The least stuffy of men, he calls himself a shrink.

"I always believed in a little humor. I remember Dr. Atlee. (The late H. B. Atlee, a professor of obstetrics with a pungent wit). There are things he said I still remember, more than 40 years ago.

"A lecture usually has a short half life . . . I have to punctuate mine with incidents and anecdotes. That's what students remember."

Students know and will remember Dr. Nicholson for other qualities, and each year, they have shown their high regard at the annual auction held for charity by second-year students.

Teachers and friends provide the auctioneer's items. Dr. Nicholson and his wife Shirley simply offer hospitality. A dinner at the sociable Nicholson's house on the shore of William's Lake always draws the highest bids of the charity auction.

The students' affection and respect were formally acknowledged when they made him professor of the year in 1971, also, the annual med. school stage show, Euphoria '79 was dedicated to him and at graduation ceremonies in May this year, the class of 1979 made Dr. Nicholson an honorary member.

"I want to go to their 25th annual reunion party," he said. The ambition is typically optimistic of the man. He has had surgery seven times for seven pacemakers in seven years. The most recent is supposed to be good for 14 years. "I reckon it's my second last one. I'll get to that reunion if my next pacemaker holds out," he said.

His own graduation was in 1937, and with fresh diploma, he went to a general practice in Sherbrooke as a locum tenens for the incumbent studying surgery in Hungary.

Fresh out of college, he did his own surgery and obstetrics, and in the fashion of the day, he removed tonsils from children, chloroformed on the office table on Saturday mornings.

He did "a whole bunch of home deliveries," never lost a mother, but lost a baby or two. One of them was a premature infant born into a Roman Catholic family. Dr. Nicholson baptized the infant in the absence of a priest and assured the grieving parents it was valid.

In fact, a forsaken vocation had been the Church. He had thought seriously of becoming a minister when he was young. With that intention, he studied Greek while doing grade XII in Glace Bay, where his father was superintendent of mines, but young Fraser forsook the cloth for the stethoscope.

In rural areas amongst stoic countryfolk, emergencies were often of crisis proportions in days before Medicare. Dr. Nicholson recalls vividly being called to a patient on a pitch dark night in driving rain to the last house at the end of a long unpaved road.

The patient was a woman. "She was just about bled out from an incomplete spontaneous abortion. A neighbour was there. We laid the woman crossways on the bed. The neighbour held the lamp. I had to sit on the floor to operate. I prepared the patient, then the neighbour went to the head and gave the patient chloroform while I cleaned and packed the patient's uterus.

"I bandaged her legs to help her blood pressure and promised to return soon. When I went back, I removed the packing, she had no infection and she said she felt fine."

The next year, newly-wed Dr. Nicholson went to England to do post-graduate training in surgery, pediatrics and medicine, from September, 1938 to August, 1939, the eve of World War II.

He was unable to book berths home on the passenger liner Athenia, so he and his wife returned a little earlier aboard the Duchess of Bedford. The Athenia was the first passenger ship to be torpedoed in World War II, with great loss of life, a few days after he landed in Montreal.

The way home to Cape Breton was aboard a coal boat. "She was filthy. The food was terrible. Inedible. We brought back an English bulldog named George and we had dog biscuits and hamburger to feed him for the trip. The best-fed fellow on board was George.

"We were so broke, we hadn't got the fare to pay the captain and had to wait in Sydney for my father to come and pay our fare on the coal boat."

In October 1939 he set up medical practice in Sydney. It was a rough time getting started. The only patients he got were the emergencies, on evenings when the GPs of the town were at the hockey games.

By May 1940 Dr. Nicholson had joined the Army and lived out of a kitbag for the next several years, never staying more than six weeks in any one spot. He was "shrink" to the commanding officer, sanitary officer and father confessor to the regiment.

In 1941 he arrived in England and carried on moving around until he went in troopship convoy to North Africa in 1943 to be strafed by 50 Stuka dive bombers as the regiment prepared to land at Philipville in Algeria.

The next stop was Italy, and he got into action around Christmastime at Ortona — "A sticky wicket". The front line

*Consultant, Public Relations, Faculty of Medicine, Dalhousie University, Halifax, N.S.

was bogged down for winter in a shell-pocked landscape, and he lived in a medical outpost in the cellar of a wrecked farmhouse at Ortona crossroads.

The doctor turned distiller in the cellar. Surrounded by huge vats of sour, undrinkable Italian wine, the resourceful Nova Scotian rigged up a still.

Outside the rubble which had been the farmhouse was a shattered German Panther tank. He personally wrestled the copper fuel line from the wreck, heated it gently and coiled it around a tin of beef stew. With other basic essentials, he used the copper coil to distill the sour wine. He ran it through three times, flavored it with quinine, colored it with gentian violet and called it foot lotion to stop the troops from taking it.

When the line moved forward, he ran the booze through the still once more to remove the junk. "Then we had a fantastic party," he said.

He served with several field ambulance units, was "boss" of a convalescence depot, and then went to Germany to become officer commanding a field dressing station until the European war ended.

"I wanted to get home, so I volunteered for the Pacific Force, and in July 1945, I got back. Then V-J Day ended the war. Shiril was serving with the Red Cross. She came home from overseas. We met again in Baddeck."

After a quick post-war course in modern medicine in New York, Dr. Nicholson took over a practice in Glace Bay for three years and was very busy doing his own surgery. He had 500 obstetric cases in three years. Psychiatry appealed, so he went back to study in New York and in July '51 returned to Halifax to practise psychiatry and to teach in the medical school.

"As an older person, I can do psychiatry much more easily than I used to," he said. "I can pick up clues of what people are really worrying about. I've done thousands and thousands of interviews . . .

"My special interest was in psychotherapy of schizophrenic people. I've treated seriously-ill schizos with, to me, surprising success. That was the biggest thing I did.

"The treatment of schizophrenia now is with anti-psychotic drugs. But the treatment of people is psychotherapy. You cannot hand out drugs and expect people to get well."

Dr. Nicholson will continue teaching psychiatry to second-year students and he will give care to patients in the Victoria General Hospital and to out-patients at the Abbey J. Lane Memorial Hospital.

His leisure will be spent sailing as a joint owner of the yacht Tsubame and tending his large garden. A former active player with Halifax Theatre Arts Guild, he is a keen theatregoer and seldom misses a play. He swims regularly, for his health's sake. When you've had a coronary, you have to look after yourself," and walks three lively Scottish terriers every day.

He leaves his post as assistant dean of admissions, with sincere regret. "The happiest years of my career," but his happy student contact will continue as he teaches psychiatry to second-year medical students. □

Why have a Disabled Individuals' Alliance?

Often times when you are disabled, you feel alone. Many accident victims see themselves as being isolated in a hostile world, and it seems to them that their obstacles are insurmountable. There are, however, many concerned therapists, specialists, and social workers who do their utmost to assist the individual to adapt to his new life.

The disabled person is now a part of that group labelled "handicapped", and he must learn how to deal with the environment on his terms. He must learn how to swallow his pride, when help is needed; to fend off the pity of others, and through it all, believe in himself. Whether or not he ever becomes truly adapted to his disability, is a question which will be debated until the sun ceases to shine. Nevertheless, if enough time and patience is given him, he should come to accept his new lot in life. The burden can often be made lighter if there is someone there to talk to, someone who has already been through the ropes. Initially, this was why the Disabled Individuals' Alliance was formed.

In the Fall of 1977, several members of the Canadian Paraplegics Association, who were either paraplegic or quadraplegics began meeting as a small group to exchange information through discussion. Even some social workers were participating, and it soon became evident that there was more under the ice, than just water. Despite the fact that these people had various disabilities, which posed, in itself unique problems, they discovered to their amazement that they all had many problems in common. This then, was the time to expand so that the Disabled Individuals' Alliance could include many other disabilities, as well as interested able-bodied persons.

The Disabled Individuals' Alliance, (DIAL), is pressing for major changes in the policies of government, in such areas as employment, education, Human Rights legislation, social assistance, and transportation. In the field of Provincial Human Rights for example, we are demanding that the disabled be covered in all jurisdictions; we are presently just barely covered under employment.

By advocating change, DIAL seeks to inform both the handicapped, and the general population that the disabled are people, who like very other citizen group, deserve equal rights and opportunities in our society.

Physicians and therapists must provide the patient with a clear understanding of their situation. They could be using groups, such as DIAL, for a means of providing patients with an invaluable resource of comradeship and understanding. The newly disabled individual must come to realize that he is not alone and that there are others with similar problems. Participation in groups such as DIAL, provide patients with persons who can truly empathize with their situation. They are then given an opportunity to help bring about much needed changes in social attitudes; changes which have been far too long in coming. After all, the more people we have who are willing to work together, the sooner our goals and aspirations will be realized. □

Barry Abbott*

*Public Relations, DIAL, Halifax, N.S.



The Medical Society of Nova Scotia

APPLICATION FOR MEMBERSHIP

NAME
Surname Given names

ADDRESS
.....POSTAL CODE.....

TELEPHONE NUMBER: Home Office SOCIAL SECURITY NUMBER

PLACE OF BIRTH DATE OF BIRTH

MEDICAL SCHOOL DATE OF GRADUATION

ARE YOU LICENSED IN N.S.? DATE ISSUED NUMBER

OTHER DEGREES

POST GRADUATE TRAINING

PRESENT TYPE OF PRACTICE

SECTIONS: Membership in the Society entitles you to make application for membership in the Section(s) of your choice. Please mark (Section(s) you may be interested in.

- | | | |
|--|--|-------------------------------------|
| <input type="checkbox"/> Anaesthesia | <input type="checkbox"/> Ophthalmology | <input type="checkbox"/> Psychiatry |
| <input type="checkbox"/> General Practice | <input type="checkbox"/> Orthopaedic Surgery | <input type="checkbox"/> Radiology |
| <input type="checkbox"/> Internal Medicine | <input type="checkbox"/> Otolaryngology | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Internes and Residents | <input type="checkbox"/> Paediatrics | <input type="checkbox"/> Urology |
| <input type="checkbox"/> Obstetrics and Gynecology | <input type="checkbox"/> Pathology | |

ARE YOU A MEMBER OF
A BRANCH SOCIETY? WHICH BRANCH SOCIETY?

REMITTANCE ENCLOSED \$

DATESIGNATURE

Personal Interest Notes

Recognition of the exemplary contribution made by the Medical Society of Nova Scotia to the field of adult non formal education was made by Saint Francis Xavier University in July in a certificate of commendation.

Dr. Ford Doolittle, associate professor of biochemistry in the faculty of medicine, Dalhousie University, attended the third international symposium on photosynthetic prokaryotes held at Oxford University, England. He was invited there to present a scientific paper and to make two poster presentations about his work with blue-green algae. Dr. Doolittle was winner of the Atlantic Provinces Inter-University Committee on the Sciences annual Young Scientist Award in 1978.

Dr. Les. E. Bailey, professor of pharmacology in the faculty of medicine, Dalhousie University, made a four-day trip to the University of Hawaii in August to present his latest research in an animal model with muscular dystrophy. He has been able to prevent degeneration of heart muscle in hamsters with a form of muscular dystrophy by supplementing their diet with orotic acid during the critical 30-day period when the virulent stage of the disease would occur. Hamsters which did not receive the diet supplement were sickly, had poor coats and developed heart failure. The treated animals are surviving and are apparently healthy adults. Dr. Bailey's next step is to conduct trials, feeding orotic acid to pregnant female hamsters. His work has been supported by The Muscular Dystrophy Association of Canada, The Nova Scotia Heart Foundation and the Medical Research Council of Canada.

Dr. Byron Reid has been appointed assistant dean, admissions and student affairs, a part-time position in the faculty of medicine, Dalhousie University, with a third responsibility as representative on the provincial advisory committee on physician manpower. He will maintain his private practice in The Professional Centre in Halifax. Dr. Reid has been a family physician for the past 18 years.

Cape Breton has a new specialist in lung diseases. **Dr. Rick Lemoine**, Director of the Beckwith Lung Unit at the Victoria General Hospital, Halifax, until late September, returns to his native Sydney Mines area to practise. He will be associated with the pulmonary function test laboratory for coal workers, scheduled to be opened by the year's end.

Dr. Lemoine was an assistant professor in the department of medicine, Dalhousie University, and as director of the pulmonary function laboratories. He was in charge of the Victoria General's respiratory intensive care unit and research investigator. Prior to his departure from Halifax, he helped to make a video tape on the management of patients with cystic fibrosis which will be available to service

organizations through the inter-library loan service of the medical faculty's Kellogg library.

Dr. Martha Laurence has been named general conference chairman for the 8th Scientific and Educational Meeting of the Canadian Association on Gerontology, to be held in Halifax Nov. 1-4.

Dr. David Shires was appointed general secretary of the International Medical Informatics Association at its 11th Annual Conference in Paris.

The familiar figure of **Dr. Fraser Nicholson** will not be seen in the Sir Charles Tupper Medical Building so frequently in future. He retired as assistant dean, admissions and student affairs, after six and a half years in the post. However, he will continue to teach psychiatry to second year medical students and to treat patients in the Victoria General and Abbie J. Lane Memorial hospitals.

Dr. Nicholson has been one of the most respected faculty members, regarded with affection by medical students during a teaching career which goes back 28 years. In 1971, he was Professor of the Year, and at convocation ceremonies in May this year, he was made an honorary member of the class of '79. With typical optimism, he said he wants to attend the class's 25th reunion. □

HRDoane and Company

Chartered Accountants

| | | | |
|---------------|--------------|-------------|-----------------|
| Halifax | Amherst | Fredericton | Port Hawkesbury |
| St. John's | Antigonish | Grand Falls | St. Stephen |
| Saint John | Bathurst | Hamilton | Summerside |
| Charlottetown | Bridgewater | Kentville | Sydney |
| Montreal | Campbellton | Marytown | Truro |
| Toronto | Corner Brook | Moncton | Windsor |
| Vancouver | Dartmouth | Newcastle | Woodstock |
| | Digby | New Glasgow | Yarmouth |

ADVERTISERS' INDEX

| | |
|-------------------------------------|----------|
| Air Page Communications Limited | 130 |
| Anderson, A.G., and Associates Ltd. | 122 |
| Bank of Montreal | 128 |
| Bell and Grant Limited | 124 |
| C. Realty Limited | 119 |
| Chateau Halifax | 138 |
| Citadel Auto Leasing Limited | O.B.C. |
| Doane, H.R., and Company | 147 |
| Hickling/Johnson Limited | 119 |
| Homewood Sanitarium of Guelph | 137 |
| Isnor Motors Limited | 129 |
| Manuage Galleries | 143 |
| Marcil Realty Service Limited | I.F.C. |
| Mardan Business Systems Limited | 138 |
| Maritime Tel & Tel | 114 |
| Medical Estate Planning Services | 143 |
| Medical Society Insurance Program | I.B.C. |
| Robins, A.H., Canada Limited | 120 |
| Schering Canada Inc. | 136 |
| Classified | 140, 143 |