

ity and delusional ideation. He was paranoid, grandiose and hallucinated in the auditory field. Because of episodes of unpredictable rage, 1200 mg. chlorpromazine daily was prescribed, to be given orally in divided doses. On the fourth day, because of torticollis and trismus he was also given benztropine 2 mg. parentally and 2 mg. twice daily. On the fifth day of hospitalization he was noted to be confused and disorientated and had ataxia. No atropine-like symptoms were noted. He had visual hallucinations of snakes hanging from the wall and cats running all over the hall. At this juncture all medications were discontinued.

Within 24 hours of drug withdrawal the visual hallucinations had stopped, but the patient remained disorientated for another 24 hours. Upon disappearance of toxic manifestations, chlorpromazine therapy was reinstated, 400 mg. daily in divided doses. In addition trihexyphenidyl, 2 mg. twice daily was given. There was no recurrence of toxic manifestations and the patient gradually improved on this treatment regimen.

Since this patient developed the toxic psychosis while receiving a high dose of chlorpromazine (1200 mg. daily) when he was also receiving benztropine, one must consider the possibility that the psychosis was due to the latter agent alone or to its combination with chlorpromazine. Nevertheless, from the absence of atropine-like symptoms we inferred that the toxic manifestations were primarily due to chlorpromazine. Moreover, repeated administration of trihexyphenidyl 4 mg. daily did not produce any toxic symptoms, nor did the resumption of chlorpromazine therapy at a lower dosage (400 mg. daily) lead to a recurrence. It is reasonable to conclude that the initial high-level dosage of chlorpromazine was most likely the cause of the toxic psychosis.

A. Beszterczey, M.D. and
J. C. Pecknold, M.D.

Douglas Hospital,
6875 LaSalle Blvd.,
Verdun, Quebec.

More efficient use of hospital beds

To the Editor:

Bed shortage is by no means an unfamiliar situation. The co-operative efforts of the hospital medical staff to obtain optimal bed utilization have not always been a reality.

Since April 1970, the "Maui System" of instant bed review has been initiated and operated by the Medical Staff at St. Joseph's Hospital, Victoria, B.C., in an endeavour to derive the greatest advantage from the hospital facilities already existent. The work of the Utilization Committee appointed by the medical staff has resulted in faster turnover of beds, with reduction in both medical and surgi-

cal waiting lists and more efficient booking of time in the operating room. It goes without saying that co-operation, enthusiasm and good humour on the part of all concerned are essential.

For some 200 diagnoses the projected length of stay was decided. For every admission the attending physician is notified on a special grey sheet attached to the patient's chart of the number of days allotted to the particular condition diagnosed. Should the diagnosis change, the physician supplies that information and the revised discharge date on this same form.

A pink card is also prepared for each patient and these are cross-filed under the predicted discharge date. The cards for patients who are in hospital beyond the date assigned are reviewed first thing each morning by a designated member of the medical staff who obtains the explanation for the postponement of discharge from the clinical record, the nursing staff or the doctor concerned. The reviewer forms his own opinion and assigns a new discharge date which will again be cross-filed and duly reviewed. By having a roster of reviewers composed not only of members of the Utilization Committee but including doctors on the Active and Associate Staffs of the hospital, the work involved for any one individual is limited to one hour a day for one week in the year.

This instant review system works as an excellent quality-control mechanism. It also demonstrates the shortcomings of current methods of hospital financing, where a fixed *per diem* rate does not compensate for the increased amount of work performed. Under this system the hospital includes more patients with a more serious degree of illness and who are therefore more costly to care for.

The following figures bear out the claims:

Available beds: 428

Bassinets: 48

Additional patients admitted compared to 1969-70:

April 6—December 31, 1970: 673

January 1—March 22, 1971: 400

Surgical waiting list:

March 1970 1313

March 1971 900

Medical waiting list:

March 1970 80

March 1971 25

Further details of the working of this system are available on request.

W. Billung-Meyer, B.A., M.D.,
Chairman, Utilization Committee
Elsa Stephens, R.N.,
Admitting Supervisor

St. Joseph's Hospital,
Victoria, B.C.

Cardiac arrest remembered

To the Editor:

A 68-year-old man who previously had suffered no symptoms of coronary artery disease awoke with aching pain in the left arm. Squeezing retrosternal pain developed several hours later and persisted until his admission to hospital in the late afternoon. He was transferred without delay to the coronary unit, where his general condition was found to be satisfactory. Blood pressure was 126/78, heart sounds were normal and there were no signs of cardiac failure. A 12-lead electrocardiogram was normal. The heart rhythm was monitored continuously and only an occasional ventricular premature beat was seen that followed the T wave by a comfortable distance. Ten hours after admission the chest pain became worse and the patient was given 50 mg. of meperidine. Suddenly a ventricular premature beat fell on a T wave, causing ventricular fibrillation. One of the coronary unit nurses recognized the cardiac arrest and immediately defibrillated the patient. After this there were no further serious arrhythmias, and convalescence was uneventful apart from an episode of pulmonary infarction. The ECG was normal the morning after defibrillation, and it was not until the 10th day that changes of anterior subendocardial infarction became evident. Changes in SGOT and CPK levels, however, were diagnostic of recent myocardial infarction from the first day in hospital. The patient remembered in detail the events surrounding his cardiac arrest, and the following account is his own vivid description of his experience. (The right leg mentioned was badly scarred from osteomyelitis suffered in childhood.)

"As I promised, I am setting down my experiences as I remember them when I had the cardiac arrest last May.

"I find it hard to describe certain parts—I do not have words to express how vivid the experience was. The main thing that stands out is the clarity of my thoughts during the episode. They were almost exactly as I have written them and in retrospect it seems that they are fixed in my memory—more so than other things that have happened to me. It seemed at times that I was having a 'dual' sensation—actually experiencing certain things yet at the same time 'seeing' myself during these experiences.

CORRESPONDENCE

"I had been admitted into the Intensive Care ward in the early evening. I remember looking at my wrist watch and it appeared to be a few minutes before 4 a.m. I was lying flat on my back because of the intravenous tubes and the wires to the recording machine. Just then I gave a very, very deep sigh and my head flopped over to the right. I thought 'Why did my head flop over?—I didn't move it—I must be going to sleep.' This was apparently my last conscious thought.

"Then I am looking at my own body from the waist up, face to face (as though through a mirror in which I appear to be in the lower left corner). Almost immediately I saw myself leave my body, coming out through my head and shoulders (I did not see my lower limbs). The 'body' leaving me was not exactly in vapour form, yet it seemed to expand very slightly once it was clear of me. It was somewhat transparent, for I could see my other 'body' through it. Watching this I thought 'So this is what happens when you die' (although no thought of being dead presented itself to me).

"Suddenly I am sitting on a very small object travelling at great speed, out and up into a dull blue-grey sky, at a 45-degree angle. I thought 'It's lonely out here.—Where am I going to end up?—This is one journey I must take alone.'

"Down below to my left I saw a pure white cloud-like substance also moving up on a line that would intersect my course. Somehow I was able to go down and take a look at it. It was perfectly rectangular in shape (about the same proportions as a regular building brick), but full of holes (like a sponge). Two thoughts came to me: 'What will happen to me when it engulfs me?' and 'You don't have to worry; it has all happened before and everything will be taken care of.' I have no recollection of the shape catching up with me.

"My next sensation was of floating in a bright, pale yellow light—a very delightful feeling. Although I was not conscious of having any lower limbs, I felt something being torn off the scars of my right leg, as if a large piece of adhesive tape had been taken off. I thought 'They have always said your body is made whole out here. I wonder if my scars are gone,' but though I tried I could not seem to locate my legs. I continued to float, enjoying the most beautiful tranquil sensation. I had never experienced such a delightful sensation and have no words to describe it.

"Then there were sledge-hammer blows to my left side. They created no actual pain, but jarred me so much that I had difficulty in retaining my balance (on whatever I was sitting). After a number of these blows, I began to count them and when I got to six I said (aloud I think), 'What the . . . are you doing to me?' and opened my eyes.

"Immediately I was in control of all my faculties and recognized the doctors and nurses around me. I asked the head nurse at the foot of my bed, 'What's happening?' and she replied that I'd had a bad turn. I then asked who had been kicking me, and a doctor pointed to a nurse on my left, remarking that she really had to 'thump' me hard and that I would be black and blue on my left side the next day (I don't think I was).

"Just a few comments as I think over what happened to me. I wonder if the bright yellow surroundings could have been caused by someone looking into my eyes with a bright light?

"I have read about heart transplants where it is claimed the brain dies before the heart stops. In my case, my brain must have been working after my heart stopped beating for me to experience these sensations.

"If death comes to a heart patient in this manner, no one has cause to worry about it. I

felt no pain (other than what I had when I entered hospital), and while it was a peculiar experience it was not unpleasant. The floating part of my sensation was so strangely beautiful that I said to a doctor later that night, 'If I go out again, don't bring me back—it's so beautiful out there,' and at that time I meant it."

It is unusual for patients to remember the events surrounding cardiac arrest. More often there is a period of amnesia of several hours' duration before and after the event. This description is extremely interesting. The patient saw himself leaving his body and was able to observe it "face to face". This could be the concept of the soul leaving the body which is found in many religions. The delightful feeling of floating in space and the tranquillity, the yellow light, the rectangular shape with holes in it, associated with the wish of not wanting to be brought back again, may provide comfort and reassurance to patients suffering from coronary artery disease as well as to their relatives.

R. L. MacMillan, M.D., F.R.C.P.[C] and
K. W. G. Brown, M.D., F.R.C.P.[C]

Coronary Unit,
Toronto General Hospital,
Toronto 2.

Abortion

To the Editor:

I would like to congratulate Dr. H. A. Gibson for his interesting observations on abortion, a subject generally of paramount interest only to the young (*Canad Med Ass J* 104: 535, 1971).

Dr. Gibson correctly points out that the world would have lost a great deal if certain pregnancies had been interrupted for some reason. Perhaps men like Laurier, Macdonald, Osler, etc. would never have existed.

This is undoubtedly true, but it is equally true that the world would have been an infinitely better place in which to live if such scourges of mankind as Hitler, Stalin and Torquemada had been destroyed in embryo.

These seemingly logical arguments, pro and con, however, are beside the point. What we must consider is not whether the embryo will grow into a Beethoven or an Attila, for we cannot determine this in advance, but whether the poor, hapless girl carrying within her the results of momentary bliss, or often not even that, should be made to suffer through all eternity for her indiscretion.

It is for this principle that the Women's Liberation Movement is fighting and may God bless its members! Let them shout and clout. Eventually, I have no doubt the walls of Jericho will come tumbling down.

Philip Eibel, M.D.

5845 Côte des Neiges,
Montreal, Que.

Dalacin C

Indications: Dalacin C is indicated in infections caused by organisms susceptible to its action, particularly Streptococci, Pneumococci, and Staphylococci. As with all antibiotics, *in-vitro* susceptibility studies should be performed.

Dosage and Administration

Adults — Mild to moderately severe infections: 150 mg. (one capsule) every six hours. Severe infections: 300 mg. (two capsules) or more every six hours. **Children** (over one month of age) — Average infections: 10 mg./kg./day (5 mg./lb./day) divided into three or four equal doses. Severe infections: 16 mg./kg./day or more if indicated by the clinical situation (8 mg./lb./day or more) divided into three or four equal doses.

Dalacin C may be taken with meals since its absorption is not appreciably modified by ingestion of food.

Note: With β -haemolytic streptococcal infections, treatment should continue for at least 10 days to diminish the likelihood of subsequent rheumatic fever or glomerulonephritis.

Cautions

Generally well tolerated. Usual antibiotic side effects — abdominal discomfort, loose stools or diarrhoea, nausea, vomiting. Transient neutropenia, (leukopenia), or abnormalities in liver function tests have been observed in a few instances. Mild hypersensitivity reactions (skin rash and urticaria) have been observed on rare occasions.

Use with caution in patients with a history of asthma and other allergies. As with other antibiotics, periodic liver function tests and blood counts should be performed during prolonged therapy.

Not indicated in the newborn or in patients who have demonstrated sensitivity to lincomycin. Safety for use in pregnancy not established.

Availability

Adults: 150 mg. Capsules — Each capsule contains clindamycin hydrochloride hydrate equivalent to 150 mg. clindamycin base. Supplied in bottles of 16 and 100.

Children: 75 mg. Pædiatric Capsules — Each capsule contains clindamycin hydrochloride hydrate equivalent to 75 mg. clindamycin base. Supplied in bottles of 16 and 100.

Detailed information available upon request.

Upjohn

CE-6052.1

MEMBER

PMAC