

of their government in their own language." The Bilingual and Bicultural Commission was set up, spent a vast amount of money, went too far and too fast, and fanned the prejudices of anti-Quebec backlash, especially in the west. Politicians and commentators in the media, always the trouble-makers, exploited the issue. The front lash, with Trudeau in Ottawa and dominating the federal bureaucracy, committed further excesses in their determination to make bilingualism and biculturalism a reality. Many Canadians began to say, "Let Quebec go, it costs us too much anyway." Quebec has now voted to do just that.

Canada needs Quebec

The situation is absurd. Canadians need Quebec. Our French inheritance is our greatest bulwark against the overwhelming influence of American culture or lack of culture. Without Quebec nothing would hold British Columbia and Alberta, naturally rich provinces, in the same bed where Ontario insists on hogging all the bed-clothes. The language issue is hopefully temporary in any case and must be played down. Time, travel,

and television will ultimately solve the world's communication problems by developing a universal polyglossary of communication. Nationalism based on language is narrowing, short-sighted, and retrogressive, especially when the language is fanned into prominence solely for that end (Welsh and Scottish Nationalists please note).

The real issue is one of provincial versus federal spending of tax money and that is no reason to destroy the country. All of us in Canada have good, respected, and well-loved friends in Quebec. Let us acknowledge them as the asset they are and continue to meet and talk with them in La Belle Province over the best food and wine in Canada. Let us continue to give them every advantage to keep them in Canada, even if it costs us precious money and resources. I, for one, am looking forward to the Canadian Medical Association Meeting in 1977 that is to be held in Quebec City; surely one of the most lovely cities in all the world.

The best thing that could happen for Canada at the present time would be for all the inflammatory politicians and all the trouble-making commentators and columnists to be put on to a large ship and sailed into the middle of Lake Superior and sunk. The Great Lakes are polluted already.

Personal Paper

Multiple sclerosis: a doctor's personal experience

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I am a 32-year-old doctor and have had multiple sclerosis for 11 years. The diagnosis was not confirmed until four years after my first symptoms, which were pain in the left eye followed by blurring of vision.

Onset

The disease started when I was 20, while I was in my second year as a medical student. I saw the doctor responsible for students' health, and my first suspicions were aroused when he gave me a full neurological examination. Afterwards I read up "optic neuritis" in the textbooks, with the result that I became intensely anxious. I was unable to accept the possibility that I might develop MS, and I remember almost persuading myself that the symptoms were due to sinusitis. I was referred to a consultant neurologist, who examined me with great care. He listened to my anxious questions and theories but said nothing to reassure me. I felt shocked, frightened, and very alone at this time. I now realise that the neurologist was in an awkward position since he could not have been expected to predict whether or not I would go on to develop MS.

My vision improved but remained slightly impaired, and I

did not see a doctor again for four years. During this time I had numerous minor symptoms such as numbness in both hands and occasional unsteadiness. I found it hard to keep up with the pace of student life, and I tended to opt out of physical activities.

Trying to work normally

After qualifying as a doctor and while working as a resident I developed further symptoms. On one occasion I had attacks of vertigo. These were associated with nystagmus, observed by my wife and experienced by me as involuntary jumping movements of my eyes. The attacks came on only if I was lying down and suddenly moved my head. They stopped after a couple of days, and I tried to believe that they were the side effects of an antibiotic I was taking at the time.

There was also a problem in the operating theatre, where I spent long hours as a neurosurgical houseman holding delicate instruments. Sometimes my unsteadiness was commented on by the surgeons, and looking back I now realise that I ought not to have done that particular job. I still denied the possibility of MS with one part of my mind, however, while the other part knew deep down that I had the disease.

I was determined to gain full registration but was scared that if I mentioned my symptoms MS might be diagnosed and so interfere with my progress. I became depressed at times, especially when tired, and also when looking after patients with MS who were severely disabled. Whenever I was tired my symptoms would be accentuated and to make matters worse I found that I was becoming tired more and more easily.

I was working as a casualty officer about a year later when I gradually lost the use of my right hand and arm. My writing became illegible, and I persuaded the nurses to write my notes

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for me. Suturing cuts became difficult and slow and so I also delegated this to the nurses whenever possible. I often dropped my car keys, and I spilt hot coffee over myself because I had lost sensation in my fingers and position sense in my right arm. I had to seek help on this occasion and saw another neurologist as I had come to live in a different area. He told me squarely that I had MS and said that I should give up my job as a casualty officer.

MS confirmed

Knowing that I did have the disease was a great relief, but despite this I could not really believe it for some years to come. Other people could see nothing wrong with me, and I feared that they regarded me as a malingerer. I had further episodes of blurred vision, pins and needles in my legs, and another attack of vertigo but none of this showed outwardly to my relatives or colleagues.

I was given corticotrophin injections, which were quickly effective for optic neuritis but did not relieve other symptoms. This may have been because the benefit of corticotrophin is in reducing oedema at the site of the lesion, and the optic nerve has to pass through a narrow and rigid canal. Corticotrophin was always associated with unpleasant side effects. These included irritability, phases of intense activity and elation followed by physical exhaustion and depression, and palpitations. I also experienced periods of diuresis when I had to visit the lavatory many times in the night to pass water. This also happened during the day, causing embarrassment and interfering with my work.

I received much help from senior colleagues once the diagnosis had been made. They suggested that I worked in an area where physical stress would be at a minimum. I did not wish to do radiology or pathology, as they recommended, but decided to become a psychiatrist. I had wished to enter this specialty anyway but had originally hoped to gain more general medical experience first.

It was during my postgraduate psychiatric training that I became seriously depressed myself. I began to wonder whether I did in fact have MS or whether my symptoms had psychological origins. I wondered if other people thought that I was inadequate and neurotic, and this caused more distress. I did not see another doctor but put myself on a course of antidepressant medication. This worked rapidly and was surprisingly effective. It was not long before I started to see things in better perspective, and at times I almost forgot about the disease. As a psychiatrist I have always prescribed drugs sparingly, if at all, and have preferred to use psychotherapeutic or social methods. I have not changed my emphasis, but this experience has helped me to become more aware of the need for a broad and eclectic approach in psychiatry.

Four years ago I passed my MRCPsych examination and was working as a senior registrar when I developed increasing urinary frequency and hesitancy. This has remained and has been associated with weakness in both legs, unsteadiness, and difficulty in walking. This became worse about a year ago, and I have used a stick ever since. I can now walk slowly with my stick for quite long distances provided I have occasional rests. Physiotherapy improved my co-ordination, and I now take as much exercise as I can without exhausting myself. At first I did not like being seen with a stick but I have now grown used to it. As well as helping me to balance it reminds me and other people of my limitations, and so I am less inclined to be unrealistic.

Accepting the disease

I have now accepted the disease to a greater extent and no longer feel either depressed or angry about it. It has been like a long drawn-out bereavement, and I have had to come to terms with loss of health and ability and also to establish a new identity.

I eat a diet high in polyunsaturated fatty acids and take six capsules of gammalinolenic acid (Naudicelle) daily. I have decided that the evidence so far supports this course of action but I realise that the research is far from complete. I also take regular vitamin supplements prescribed for me by my general practitioner. He is frank about my health, and I value his objective opinion when I am uncertain and in need of advice. I drive a car with automatic transmission, which I find less wearing and much safer. I also have a disabled persons (orange) badge to allow me to park as near as possible to my destination.

I have joined Action for Research into Multiple Sclerosis, a pressure group for MS sufferers and others who wish to speed up research into the disease and tell people generally about the nature and effects of MS. I also support my local branch of the Multiple Sclerosis Society and have become involved in setting up a self-help group for younger, often less disabled, MS sufferers. This movement within the Multiple Sclerosis Society nationally is called "CRACK."

I work part-time for three days a week as a clinical assistant in child psychiatry. This gives me plenty of job satisfaction and the important feeling of being useful in the community. It has been said that a major problem in coping with MS is how to avoid over-tiredness and yet not opt out. This has certainly been difficult, but I have been well supported by relatives and friends, including fellow MS sufferers.

I married a fellow medical student nine years ago. She now works part-time as a school doctor, and she also helps me with voluntary work. She knew that I might develop MS when we married, but like me she has often had difficulty in accepting the disease. We have no children so far, through chance rather than choice, and have come to terms with this.

Positive aspects

There have been positive aspects to this disease. It has helped me to understand myself and to establish my priorities in life. I have chosen not to climb up the medical career ladder but rather to live simply, near my relatives on the family farm. The disease has helped me to develop an increased sensitivity to other people's needs, and I hope that this has made me a better doctor.

My experiences both as a patient with MS and as a doctor have given me insights and responsibilities of a special kind. I believe that patients with MS should be told the truth as soon as the diagnosis has been confirmed. How this is done will depend on the individuals concerned, but it is essential that all patients receive adequate emotional and social support at a major crisis in their lives. The support given should include close relatives and must be prolonged for it is in the first few years that fundamental psychological adjustments are made. The self-help groups that now exist in many parts of the country can provide much of this support, but it may take several years before a new patient can come to terms with the disease enough to accept help from other sufferers without feeling too threatened.

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Is there any hazard in using galvanised iron sheeting to contain compost or manure that will subsequently be used in a vegetable garden?

The Ministry of Agriculture gives advice about the maximum permissible concentration of heavy metals—the "zinc equivalent"—in sewage slush, which is based on a dubious formula and is not directly relevant. Galvanised iron sheeting cannot be regarded as the ideal material to contain a compost heap owing to the inevitable corrosion and lack of aeration needed for bacterial activity. It cannot, however, be considered to constitute a hazard, as only a small proportion of the compost would be directly in contact with the sheeting. Moreover, corrosion would be slow and any metal contamination would be well diluted in normal use.