Portraits from Memory

6—Charge nurse Cecilia Scott, Belvidere Fever Hospital, Glasgow

JAMES HOWIE

In early 1933, acting on the advice of my good friend and mentor Dr (later Professor) Robert Cruickshank, I sought and secured a clinical post as a medical officer at Belvidere Fever Hospital, in the east end of Glasgow.

"You must see the clinical side of microbial diseases if you're to be any help to clinicians as a microbiologist," said Robert—and how right he was—"and if you get into Belvidere you'll be sent as the newest junior to ward 20—the baby pneumonia ward. There you'll see everything because baby pneumonia has been made locally notifiable; and the doctors can always find or suspect a bit of respiratory infection in any sick Glasgow child they need to get in to hospital. And," added Robert, who had served there himself, "you'll learn a lot from nurse Cecilia Scott who runs that remarkable baby pneumonia ward." How right he was again.

In my time at Belvidere—May 1933 to September 1934—we were still without sulphonamides, let alone antibiotics. Nursing was the only effective treatment apart from antimeningococcal serum injected intraspinally, for treatment of cerebrospinal meningitis, and the injection of diphtheria antitoxin. So the life of medical officers was not arduous: a half day's work except when on receiving duty. There was even time for tennis for those on receiving duty and golf for those who were not. I spent much of my spare time in the laboratory; there was a technician in charge but no medical microbiologist as such. I planned to return to laboratory work, and so I kept my hand in by doing postmortem examinations on dead children and checking for carriers of diphtheria bacilli and streptococci among candidates for discharge from hospital.

The ghost goes home

One regular attender at all my postmortem examinations was nurse Cecilia Scott, who expressed approval that anybody should take the trouble to show her the lungs of children whom she had failed to nurse back to health.

"Now I really know what we're up against," she said. "Do you think there will ever be a cure?" I didn't know. What I did know was that if I had a sick baby in my family I'd want it nursed by Cecilia or one of her pupils. Over the bed of every seriously ill child sat Cecilia or one of her senior nurses, hour after hour, with a cup of glucose and brandy, ready to spoon in as much of the fluid as possible without making the child cough or be sick. Intravenous rehydration was not then in general use.

Incredible recoveries often followed. One particular child—"the ghost"—spent six months with us from October 1933 to March

1934. Cecilia could hardly bear to part with this child, who had at last emerged laughing and talking from a nearly dead body of skin and bones. One day, after he had at last been returned to his "dirty old mother," Cecilia found mother and child in a cinema queue in Bridgeton—James Maxton's deprived constituency. She got out of the car in which she was travelling and ordered the mother to take the child home at once. She was obeyed.

Keeping out the mizzles

I ceased to be the most junior but Cecilia ordered me to refuse to give up the ward.

"We need these post mortems to be done," she said, "and this will be a mizzles year [=measles epidemic year] and I'm going to show you how to spot the mizzles early."

One day I was indeed advised by the medical superintendent that the measles epidemic had begun and that we might as well close ward 20 now because it would soon be cross infected by someone or other of the duty officers passing for admission a child incubating measles.

"Nothing of the sort!" ordered Cecilia. "I have already given orders to the ambulance men that any child labelled 'baby pneumonia' is not to be passed for admission to ward 20 unless it has been seen by me or by you. I've taught you how to spot the mizzles; and when you're out I'll be in; and when I'm out you'll be in." So it went, well into February—"Still not crossed?" asked the medical superintendent daily. Then one day I received a summons to come straight to ward 20. Cecilia was refusing admission to a child in an ambulance although I had passed it for admission.

"That's the mizzles," said Cecilia, "and it's not coming in here." I re-examined the child but found no Koplik's spots.

"We'd better send for McRorie," I said. He was the senior medical officer and he knew the mizzles, as even Cecilia agreed. McRorie duly examined the child and agreed that he could find no diagnostic signs of measles.

"But," he said, "if Cecilia isn't happy, I'll take the child in to the isolation ward." Two days later, the Koplik's spots appeared.

"What did you see that we missed?" I asked Cecilia.

"Och, he had a watery eye on just one side; and you could see he'd soon have the spots—just by the look of him." A reliable expert discounts Cecilia's "watery eye on just one side" but upholds her "just by the look of him"—a dejected, hanging, sad expression and a dull matt appearance of the buccal mucosa.

The real end of that particular story, however, came 17 years later. I had newly taken up duties as professor of bacteriology at the University and Western Infirmary of Glasgow. I was invited to the eye department to take specimens for virology from "an interesting child with unilateral conjunctivitis." I approached the bed and looked at the child. Suddenly something rang inside my head and I was back again at the ambulance held up outside ward 20 in Belvidere. I knew what I was seeing for the second time "just by the look of him." I asked if I might have a spatula to look inside the mouth. Not only was it ready and waiting but it was presented to me

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with a beaming, knowing smile by a ward sister whom I recognised as having been one of Cecilia's favourite pupils. This time the Koplik's spots were there.

Single but not slighted

Cecilia was graded "nurse in charge," never "sister." Why? She had never sat any examinations—she was "too busy for that sort of nonsense"—but they could not upgrade her to sister—or so it seemed—without the examinations. Not for the first or last time various of her admirers petitioned the matron and superintendent and begged them to find a way round the regulations.

"There's no ward like ward 20," I argued. "I go in there at night to do my final ward round and every child is asleep. Where else in this hospital is that true?"

"Ah!" said the matron, "but have you ever really examined how much brandy you sign for?" Cecilia was never made "sister" but she was designated "nurse in charge" of various wards where nursing of babies was specially important. She had health problems but they were never allowed to hinder her work. I recall our farewell.

"You never married," I said to Cecilia.

"No," she answered, "I never had the notion or the time. I will go single to the grave; but you might like to know: I have not been neglected."

Prescribing in Pregnancy

Treatment of cardiovascular diseases

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Drugs required in pregnancy for cardiovascular disorders fall into two major categories: antiarrhythmic and antihypertensive agents. Antihypertensive agents have been widely used, and both controlled and uncontrolled trials have been performed with these drugs in pregnancy. Experience of their use in the first trimester is limited, however, so the absence of reports of malformation cannot be equated with safety. The rarity of cardiac arrhythmias during pregnancy means that most information is anecdotal or retrospective. Further information on the use of drugs for cardiovascular disorders during pregnancy is contained in recent detailed reviews.¹⁻⁶

Antiarrhythmic drugs

The indications for starting antiarrhythmic treatment in pregnancy are the same as in non-obstetric practice. Most experience has been gained with digoxin, quinidine, and the β blockers.

DIGOXIN

There have been no reports of digoxin causing malformation. Digoxin crosses the human placenta, and toxic maternal concentrations can be fatal to the fetus. At therapeutic concentrations, however, digoxin does not appear to have an adverse effect on the fetus. There is some evidence that digoxin increases myometrial tone,⁷ resulting in shorter pregnancy and labour.⁸ Digoxin is found in human breast milk in concentrations similar to those in maternal

serum. Thus the daily dose to a breast fed infant may be about 1-2 μ g; one report showed no detectable digoxin in the infant's blood during breast feeding.⁹ Digoxin is safe to use throughout pregnancy and the puerperium provided that maternal serum concentrations do not rise above the therapeutic range. Digoxin clearance by the kidney increases during pregnancy. If the dosage remains unchanged, by the end of pregnancy the serum concentration will have fallen to about half the value before pregnancy. It is therefore important to measure the digoxin concentration at intervals during and after pregnancy.

Digoxin is the drug of choice for control of atrial fibrillation, atrial flutter, and paroxysmal supraventricular tachycardia in pregnancy. Like all antiarrhythmic drugs it is indicated as a prophylactic agent only when the arrhythmia to be treated has been shown to be recurrent, sustained, and poorly tolerated.

QUINIDINE

Teratogenesis has not been reported with quinidine. At therapeutic concentrations it appears to be safe, and the drug has only mild oxytocic activity.¹⁰ Some quinidine is found in human breast milk but at concentrations below those of maternal plasma. Quinidine is normally 80% protein bound. Changes in plasma protein concentrations during pregnancy cause total plasma quinidine concentrations to fall and free concentrations to be underestimated. This must be taken into account when interpreting drug monitoring data. After delivery total concentrations of quinidine increase by half.

Quinidine is the drug of choice for the treatment during pregnancy of premature extrasystoles, Wolff-Parkinson-White syndrome, and ventricular arrhythmias and for treatment after cardioversion of supraventricular tachycardia.

PROCAINAMIDE

Procainamide has not been associated with teratogenesis. The drug crosses the placenta but does not appear to have any adverse

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