



long-term outcome studies, prognostic indicators and information about concomitant conditions have been thoroughly reviewed. All of these factors should be taken into consideration in deciding an applicant's suitability for the armed forces.

A few significant points to consider:

- ADD is not diagnosed only in individuals under 12 years of age. It is a life-long disorder, the manifestations of which change with age.
- Treatment of ADD in the form of medication, counselling and structured programs allows many affected individuals to do well.
- There is a genetic predisposition to the development of ADD, and the disorder is 4 times more common in males than in females.⁹
- Continuation of treatment such as pharmacotherapy and psychotherapy would help these individuals function efficiently within the armed forces.

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Cervical cancer screening

The article "Review of the screening history of Alberta women with invasive cervical cancer" (*Can Med Assoc J* 1997;157[5]:513-9), by Dr. Gavin C.E. Stuart and associates, is a useful addition to the now-extensive literature on this subject. However, Stuart states that "[n]one of the previous Canadian studies included a detailed cytology review."

A recent paper from the British Columbia Cancer Agency,¹ not referenced in the article by Stuart and associates, reviewed the demographic characteristics and screening histories in 437 cases of invasive cervical cancer seen in British Columbia over the 4-year period from 1985 through 1988. Our results were similar to those of Stuart and associates and provide further evidence, if such were required, of the need for implementing the recommendations of the National Workshop on Cervical Cancer Screening.²

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Bias in the CMAJ?

A review of the articles relating to ethical issues published by *CMAJ* over the last year indicates a definite bias against pro-life advocates. For example, the following statements appeared in articles with blatant bias:

- "The term 'maternal' suggests the existence of parental obligation toward the fetus, whereas the woman is *yet to become* a mother to the fetus she is carrying"¹ (italics in original).
- "To encourage physicians to perform abortions . . . consideration should be given to providing financial compensation to cover staffing, supplies and equipment."²
- ". . . the neurologist's decision [to stop IV and intubation] was both humane and correct. . . ."³

There are other examples. It is a general journalistic principle that people are named according to how they name themselves. Groups who endeavour to protect unborn children are and call themselves "pro-life."

The media can create false impressions, which can determine attitudes, which may change behaviour. It appears from reading the *CMAJ* that there is nothing to be said for the pro-life stance, yet there exist reasonable observations and cogent arguments that lead to conclusions different from those usually expressed in the *CMAJ*. These are never heard, and because they are not heard, it is assumed that they do not exist.

I would like to see evidence, if not in the past then in the future, that the journal is both in policy and in practice unbiased on major ethical issues.

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The many faces of pheochromocytoma

I am now an ophthalmologist active in medical research and teaching, but the article "Pheochromocytoma manifesting with shock presents a clinical paradox: a case report" (*Can Med Assoc J* 1997;157[7]:923-5), by Jason Ford and associates, reminded me of a similar case, the first I ever researched in detail and wrote up for publication.¹ I credit a good part of my success as an investigator to learning from that experience that physicians, when treating relatively common problems, must always be aware of the existence and characteristics of rare disorders that may mimic common problems. A perusal of my now reasonably lengthy CV indicates a disproportionate interest in "esoteric" disorders, perhaps as a consequence of once saving a man who surely would have died if not for

unusual curiosity on the part of his doctors (as far as I know, he's still alive and well).

As a direct consequence of my own experience, I have serious concerns about reformed medical curricula, which teach medical students about common problems, and tell them to look up the others. We never know who is going to walk into our offices next, and it is the responsibility of all physicians to be curious and knowledgeable about rare as well as common problems. I thank Ford, Rosenberg and Chan for reminding a new generation of Canadian physicians not to relax until *all* parts of the puzzle fit, and for pointing out that rare things are a lot more common when you look for them.

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Why?

Dr. Robert Krell's article, "Confronting despair: the Holocaust survivor's struggle with ordinary life

and ordinary death" (*Can Med Assoc J* 1997;157[6]:741-4), is outstandingly important, both to professionals and fellow children of Holocaust survivors. I am both, and I carry a similar legacy.

I used to joke that as other kids grew up on fairy tales, I was told stories from the camps. Now, as I struggle in mid-life with the lingering impact of such psychological trauma, I know that it is no joke. It is not only that I was exposed to death at too young an age but also that stories of extreme horror were told and retold, always in a rote, unemotional style. The result is profound confusion: I swing like a pendulum between excessive compassion and almost cold, grim determination.

After I grew up, I left home and closed the door, happy not to have to listen to the grim stories any more. Now, "unfinished business" that was buried for 20 years has come to the forefront.

Our trauma seems minor, sometimes even to professionals. We are our own worst enemies: we become overachievers to overcompensate, discounting the serious difficulties resulting from our early insecure attachment¹ to seriously damaged parents and survivor guilt. Although I know many children of survivors, the

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