## Science meets politics at the National Forum

Kudos to Michael Kramer[1] for articulating a major problem in the relationship between health policy and research evidence. Several years ago I was invited to write a National Forum on Health position paper on the prevention of adverse pregnancy outcomes. In terms of incidence and economic and social impact, preterm birth is the main adverse pregnancy outcome in North America. After a critical appraisal of evidence regarding the effectiveness of programs to prevent preterm birth, I concluded that the Canada Prenatal Nutrition Program should be discontinued.

Although I knew that my conclusion would be unpopular, I had no idea that I would be caught in a maelstrom of invective, rhetoric, and personal attacks from National Forum reviewers. Their comments reflected the tension between health promoters and epidemiologists, to which Kramer referred. More disturbing than the personal attacks was the evidence that the reviewers had little skill in critical appraisal of research evidence. In an attempt to correct the latter problem, my next version of the position paper included a section on the main sources of bias in epidemiologic research designs and how these biases led to faulty conclusions about the effectiveness of the Women, Infants, and Children Program in the US, and about similar programs in Canada.

After many months of rebuttal and debate, and struggles to rewrite without compromising my professional integrity, I decided I had wasted enough time and refused to participate any further. Subsequently I was told that my conclusions could not be refuted but were too controversial and that someone would be assigned to rewrite the paper. This position paper went unpublished — in any form. Perhaps nonpublication conveys the same message my paper did: although we know little about how to prevent preterm birth or most other adverse pregnancy outcomes, we do know that our current health promotion programs are ineffective.

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**Reference**

1. Kramer MS. Maternal nutrition, pregnancy outcome and public health policy. *CMAJ* 1998;159(6):663-5.

## Doctors within Borders?

I recently received a letter from Médecins sans Frontières (MSF) /Doctors without Borders. It asked for money, of course, and I was quite happy to donate $100, knowing full well that $100 spent in Africa will do far more good than $1000 spent here. I knew this because I spent the early part of my career there. Indeed, 2 of my children were born in a rural hospital on the Uganda/Kenya border. My experiences in Africa have proved important during my subsequent career as a rural GP in British Columbia.

The MSF letter was accompanied by a list of physicians currently working in Africa and other parts of the world, and it was interesting to learn that they all came from Canadian cities. Why are these physicians so willing to work overseas and so unwilling to work in rural areas in their own country, where they are so badly needed? Twenty-five years ago the town I live in had 7 Canadian graduates working full time; today it has one. Why? Are young Canadian graduates not suitably trained? Are they afraid of the lawyers and the colleges? Are they afraid of working too hard?

Thank God for South Africa. May it continue to supply MSF services in Canada, even as doctors from Toronto, Montreal and Vancouver provide them outside our borders.

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## Defining futility

The paper by Charles Weijer and colleagues on dealing with demands for inappropriate treatment[1] did a good job of clarifying this difficult area of clinical care, but the case example involving cardiopulmonary resuscitation (CPR) is out of touch with clinical reality. In fact, it missed what I think is the central cause of

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patient–doctor conflicts over CPR.

There is general agreement among physicians that CPR after cardiopulmonary arrest in a nonmonitored area is futile in all but a few cases. Futility would seem to be absolute for patients who, before their cardiopulmonary arrest, had poor functional status combined with advanced organ disease or certain other conditions that clinicians easily recognize. In my experience, conflict most often arises when patients do not understand this and instead regard the physician's decision to refrain from CPR as a withdrawal of care.

In the case of the patient with advanced cancer who wants to survive a little longer to see a relative who is due to arrive soon, Weijer and colleagues recommend a time-limited order to attempt resuscitation. But if such a patient were to experience a cardiac or respiratory arrest, CPR would be rendered no less futile by the anticipated arrival of a relative. The authors contradict the literature they cite by accepting the false, and conflict-engendering, notion that CPR can be an appropriate treatment option for a patient like this. The reason for refraining from CPR is precisely because it is not.

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**Reference**

1. Weijer C, Singer PA, Dickens BM, Workman S. Bioethics for clinicians: 16. Dealing with demands for inappropriate treatment. *CMAJ* 1998;159(7):817-21.

## Temporary henna tattoo with permanent scarification

With the advent of the contemporary pop group the Spice Girls, many children and teenagers are ornamenting themselves with temporary tattoos. A popular dye for such tattoos is henna.

Last summer, a henna tattoo was applied to the left arm of a 4-year-old white boy with a history of sensitive skin. Within hours, the tattooed area became itchy and inflamed, a reaction that lasted well over a week, until the dye disappeared. In the area where the dye had been applied and where the inflammatory response occurred, marked keloid scarification resulted. The scarification took the form of the tattoo design and was still prominent 8 weeks after the tattoo was applied (Fig. 1).

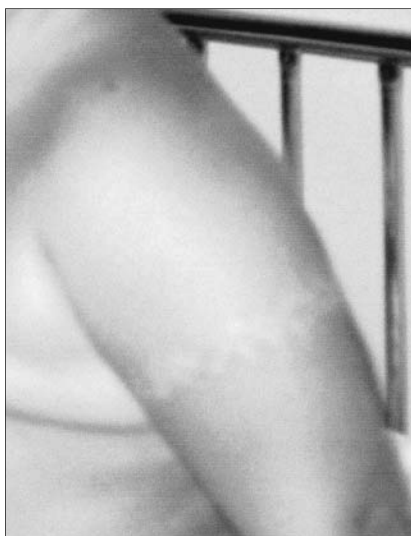

**Fig. 1: Geometric keloid scars on left arm in pattern of temporary henna tattoo.**

Henna is a dark reddish vegetable dye whose active agent is a hydroxynaphthoquinone. It is obtained from the dried leaves of the *Lawsonia* tree, which is native to North Africa and Asia. This compound has been used for thousands of years in Egypt and India and is still widely used for the colouring of hair and the ritualistic staining of the skin in Arab countries, India and Pakistan. Henna is relatively safe, and only one case of contact dermatitis has been reported.[1] This is the first reported case of acute contact dermatitis with keloid scarring associated with henna. It suggests that on rare occasions temporary tattoos may become permanent.

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**Reference**

1. Cronin E. Immediate type hypersensitivity to henna. *Contact Dermatitis* 1979;5:198.

## Remember residency's good times too

I am sorry that Dr. Robert Patterson recalls so many negative experiences from his residency years and so few positive ones.[1] My experience was the opposite.

Certainly the work was hard. I had 57 medical patients to look after in my first residency, the hours were long, and the deaths — especially those of young women my own age who died of tuberculosis — were traumatic. Occasionally I was bullied, especially by senior registrars.

But there were so many positive things to offset the hardships. Unlike Patterson, I never fell asleep while driving, for on £100 ($540) a year plus keep I could not afford a car. And even if I could have afforded one, there were few to be had in post-war Britain.

I still recall insignificant things: the thrill of locating the head of a tapeworm, the birth of "my" first baby (in a miserable Glasgow slum), the "plop" of a dislocated shoulder being returned to its socket, the 48 split scalps sutured on hogmanay revellers, the clandestine radiography performed at night to save the radiologist from being called in. From the start I was given responsibility, and nothing but the best was accepted. I