recall the great camaraderie among residents, and our patient and understanding chiefs, and I have the fondest memories of the nurses. We did not have time to get into mischief, but there were occasional dances and the famous weekly Wednesday afternoon nurses-versus-residents grass hockey game. And can I ever forget that glorious bathtub, deep enough to sit in and with the warm water right to my chin? I relaxed at leisure, tired and worn out.

Perhaps I was just lucky, or maybe Patterson was unlucky, but I am sure he must have had many positive times too.

Allan S. Arneil, MD
Glasgow University Class of 1947
Victoria, BC

Reference

1. Patterson R. "You're the worst goddamn resident I've ever had." *CMAJ* 1998;159 (7):823-5.

Chiropractors here to stay

I read with some dismay that the Alberta Society of Radiologists is recommending that radiologists refuse to perform diagnostic x-rays on children when they are ordered by a chiropractor.[1] The report claimed there is "growing concern over health and safety issues surrounding chiropractic."

The resolution is extreme and confrontational, and I believe this approach is inappropriate and unbecoming of the medical profession. Chiropractors are trained as primary care professionals. Although most do not practise that way, it is within their scope to do a physical exam, make a provisional differential diagnosis and order appropriate investigations. This is true even if the condition they are evaluating is not treatable by chiropractic.

On the basis of appropriate evaluation, chiropractors are perfectly capable of deciding whether the presenting condition is treatable by them or whether it should be referred to a family physician or specialist. An appropriate investigation includes ordering radiographs to rule out a fractured ankle, or spinal radiographs when appropriate (and they rarely are).

Some chiropractors order radiographs inappropriately, but some physicians do as well. Because many more medical doctors order radiographs in Alberta than do chiropractors, they may pose a bigger problem in this area. Until a comparison study is performed, it seems inappropriate to single out a profession in this antagonistic fashion.

All the society's recommendation will do is further open the wound in the relationship between our professions, which many of us have tried to heal. There is a place for chiropractic in the health care system, and the sooner medical doctors get used to this relationship the better things will be for everyone — especially our patients.

Ron Cridland, MD
Canadian Sleep Institute
Calgary, Alta.

Reference

1. Alberta radiologists target chiropractors. *CMAJ* 1998;159(10):1237.

Violence in the FP's office

Barbara Sibbald's recent article gives an excellent overview of the ways physicians can protect themselves against potentially violent patients.[1] It recommends that violent patients be dismissed from a practice in writing.

Handing a potentially violent patient a dismissal letter in a community-based family practice is never a pleasant undertaking. Recently, I was confronted with this problem and greatly feared that handing a dismissal letter would prompt a violent response. Because this patient did not have a fixed address, I would be forced to hand the letter to him instead of using registered mail. A standard dismissal letter was, nevertheless, drafted.

This patient rarely kept appointments. In an earlier visit I had raised the issue, and he agreed to a verbal and written contract. It stated that if he ever missed or was late for an appointment and did not give due notice, he could be dismissed from the practice. After several violations and consultation with office staff, it was decided to enforce the contract.

It was with great trepidation that I awaited the scheduled appointment to dismiss him. When he showed up 2 hours late expecting to be seen, he was reminded of the contract and was asked to honour it and leave the practice. He objected and called back the next day to appeal the ruling. We refused to do this.

This is one way to handle, proactively, potentially violent patients.

Howard Cohen, MD
Ottawa, Ont.

Reference

1. Sibbald B. Physician, protect thyself. *CMAJ* 1998;159(8):987-9.

Cause and effect

Comparing research physicians who support the use of calcium-channel blockers (CCBs) and those who do not, Dr. Allan Detsky notes a positive correlation between physicians who receive research funds from companies that manufacture CCBs and physicians who favour these drugs.[1] From this correlation he concludes a cause-and-effect relationship.

This is quite incorrect. One thing stressed even in elementary statistics classes is that a correlation does not prove cause and effect. All it shows is that variable A can cause variable B,

or variable B causes variable A, or A and B are both caused by C or, finally, that the whole thing is a coincidence.

Marc A. Baltzan, MD
Saskatoon, Sask.

Reference

1. Harrison P. Conflict-of-interest issues face increasing scrutiny. *CMAJ* 1998;159(10): 1290.

Give it and they will spend

I am concerned about arguments put forward by both Michael Gordon and colleagues[1] and Steven Lewis[2] on a proposal to treat health care as a taxable benefit.

What do citizens covered by medicare want? They want to remain healthy and never use the system. Thus, if anyone is to pay an extra tax on the health care system it should be those who don't use it and who thus get what they want.

Steven Lewis is glib to state that Canada has been able to resist US-style medical economics despite our close economic ties with that country. For many years our ties were not that close — Canada was protected by trade tariffs that no longer exist. The only thing protecting us from US-style health economics is the spectacular and well-documented failure of that system, not anything we are doing to protect ourselves from American encroachment.

Another problem, one that the authors of both articles failed to discuss, is that it does not matter where money comes from: it will be used up if it is there — a form of Parkinson's Law applied to health care. For instance, we could provide more money for health care by taxing lottery winnings but it would soon be swallowed up by new technologies or public demand for more services.

Do I have a solution for all this? Of course not. The great thing about being an outraged critic is that one is not expected to have solutions. However, I suspect that part of a solution will eventually lie in deciding what are and are not core essential services. This would be analogous to the Oregon system, though I'd be the first to admit that those of us who crow most loudly about that system don't know the first thing about it.

Morton S. Rapp, MD
North York, Ont.

References

1. Gordon M, Mintz J, Chen D. Funding Canada's health care system: a tax-based alternative to privatization. *CMAJ* 1998;159(5):493-6.
2. Lewis S. Still here, still flawed, still wrong: the case against the case for taxing the sick. *CMAJ* 1998;159(5):497-9.

Norwood reconstruction

The article about the Winnipeg inquest into the deaths of 12 young heart patients[1] includes the following editorial statement: "[Norwood reconstruction], used to treat infants with hypoplastic left-heart syndrome, is considered a palliative procedure, since transplants are considered the treatment of choice for this condition. The operation has a very high mortality rate."

This statement is inaccurate. There is a paucity of suitable donors in Canada, neonatal heart transplantation is available in only a few centres, and excellent results have been achieved for the Norwood procedure in this country, so the treatment of choice for most variants of hypoplastic left-heart syndrome is in fact the Norwood procedure. The procedure is done at the Hospital for Sick Children in Toronto, the University of Alberta Hospitals in Edmonton, British Columbia's Children's Hospital in Vancouver and the Montreal Children's Hospital.

The operation is complex, and the mortality rate, which is substantial, varies from one centre to another. One might certainly question why an inexperienced surgeon would attempt such a procedure. One might also question the source of the referral. Surgions do not recruit patients directly, but receive referrals from cardiologists.

Robert J. Adderley, MD
Pediatric Intensive Care Unit
British Columbia's Children's Hospital
Vancouver, BC

Reference

1. Sibbald B. Twelve deaths in Winnipeg: judge must ponder 48 000 pages of inquest testimony. *CMAJ* 1998;159(10):1285-7.

Drinking in moderation

As a participant in the discussion, I will not comment on the substance of the Royal College debate on whether physicians should promote moderate consumption of alcohol,[1] beyond noting that the Canadian health care system should certainly not count on the $5 billion net savings projected to result from people drinking more. I have 2 elaborations on the reporting, though. First, the "large majority of delegates" was in fact 12 of the 14 who turned up for the debate, which was held on a Sunday morning. Second, current Canadian low-risk drinking guidelines, endorsed by the Canadian College of Family Physicians for communication to the general population, specify not only up to 9 drinks per week for a woman and 14 drinks for a man, but also no more than 2 on any day. In terms of risks of harm from drinking, how one's drinks are spaced is at least as important as the total number per week.

Robin Room, PhD
Visiting Scientist
National Institute for Alcohol and Drug Research
Oslo, Norway

Reference

1. Harrison P. Royal College debates whether MDs should promote moderate consumption of alcohol. *CMAJ* 1998;159 (10):1289-90.