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.

L. John Hoffer, MD, PhD
Associate Professor of Medicine
McGill University
Lady Davis Institute for Medical Research
Montreal, Que.

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).

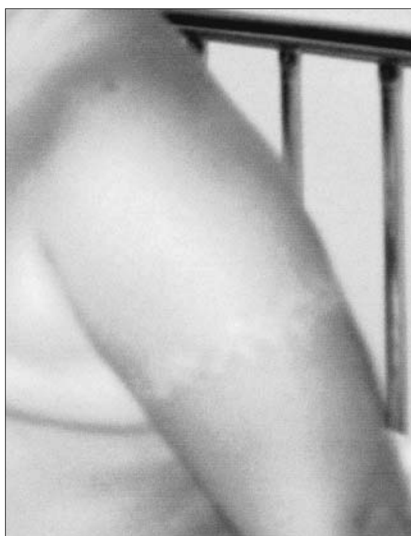

Fig. 1: Geometric keloid scars on left arm in pattern of temporary henna tattoo.

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.

Peter K. Lewin, MD
Hospital for Sick Children
Toronto, Ont.

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 postwar 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

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,