economic, political) on symptom reporting, degree of disability, perceptions of severity, or use of illicit substances (*3,7*). For example, it has been noted that blacks may evidence reticence in disclosing symptoms as a way of testing the competence of the physician (*8*). Physicians, too, can contribute to problems in communication by failing to understand the subtle effects of ethnic differences on their nonverbal interactions with patients (*7*).

Rapport is facilitated when patients perceive the physician as sharing similar beliefs, attitudes, and values, as caring about the patient, and as accepting the patient as a worthwhile person despite current circumstances (*9*). Black Americans interface with a health care system where physicians within that system, for the most part, do not share a similar cultural or ethnic background (*7*). For the black patient, initial rapport may be more readily accomplished when there is perceived racial similarity. Yet the importance of the physician's ethnic background is controversial (*3*). When ethnic differences are present, verbal and nonverbal behaviors that communicate sensitivity and concern are often the first and critical bridge to developing rapport (*7*).

While we cannot comment on the relevance of Dr. Duh's ethnicity in facilitating disclosure by his patient, it does appear that something in his approach may have differed from that of the physicians in the ER or CCU. It is possible that Dr. Duh's manner, and not his ethnicity, established a common ground for communication. We also agree that ethnic differences between patients and physicians should not function to justify possible avoidance of these issues because the physician experiences discomfort in transcending cultural barriers.

Vickie M. Mays, PhD, Univeristy of California, Los Angeles, and Susan D. Cochran, PhD, California State University, Northridge

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Choking Victims: Back Blows and Chest Thrusts Are Hazardous, Even Lethal

In a letter to the editor (*1*), Dr. William H. Montgomery of the American Heart Association (AHA) and Dr. Joseph Greensher of the American Academy of Pediatrics (AAP) provide inaccurate information in defense of their recommendation that chest thrusts be used to treat a choking infant. They state that the 1986 AHA Standards and Guidelines (*2*) resulting from the 1985 AHA national conference "were reviewed and approved by key individuals such as Dr. Heimlich . . . . " That statement is not true.

Dr. Montgomery, Chairperson of the 1985 AHA conference, knows through written communications to him, to editors of the Journal of the American Medical Association, and to the AHA that I disapproved of chest thrusts in infants and repeatedly advised that the 1986 AHA Standards and Guidelines must warn of the proven dangers of backslaps and chest thrusts. My opinion remains that excluding those facts will lead to additional injuries and deaths.

Doctors Montgomery and Greensher (*1*) acknowledge that chest compressions during CPR "have produced complications." They then contend that chest thrusts to relieve foreign body airway obstruction and external chest compression during CPR "are not the same and should not be compared. This is very clear to those who teach or are taught CPR and management of foreign body airway obstruction." In a letter to the editor of Pediatrics, June 6, 1983, Dr. Montgomery (*3*) made the same claim: " . . . chest compressions as performed during CPR are not chest thrusts and the comparison should not be made to mislead the reader." My response in the same issue of Pediatrics revealed that, according to the following quotes from the 1980 AHA Standards and Guidelines (*4*), chest thrusts and CPR chest compressions are identical and can be lethal:

> Page 465: The hand position for an application of chest thrust is *the same as* [my emphasis] that for applying closed-chest heart compression, i.e., in the adult, the heel of the hand of the lower half of the sternum, see "Introduction" p. 453 and Frontispiece, lower panel [diagrams for chest compression as performed during CPR].

Page 475: . . . four chest thrusts are delivered in rapid succession *in the same manner* [my emphasis] as external chest compressions are performed in the infant (Fig. 5, lower panel). [Fig. 5 illustrates chest compression for infant CPR.]

Page 469: . . . even properly performed external chest compression may cause rib fractures in some patients. Other complications that may occur despite proper CPR technique include fracture of the sternum, costochondral separation, pneumothorax, hemothorax, lung contusions, lacerations of the liver, and fat emboli.

In addition, Dr. Montgomery's 1986 AHA Standards and Guidelines (*2*) state in regard to choking infants:

Page 2960: . . . four chest thrusts are performed in the same location as external chest compression but at a slower rate (Fig. 7). [Fig. 7 illustrates how to perform CPR chest compressions in infants.]

Doctors Montgomery and Greensher state they would like to end their controversy. They need only inform the AHA and AAP that they were in error and that the public should be warned that back blows and chest thrusts for the treatment of choking adults, children, and infants are "hazardous, even lethal" and that there is no known published report of a choking infant being saved by chest thrusts (*5*).

Henry J. Heimlich, MD, President, The Heimlich Institute, and Professor of Advanced Clinical Sciences, Xavier University, Cincinnati, OH

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Abdominal Thrusts: Overzealous Application May Be Hazardous to Small Children

Dr. Heimlich's past and continuing objection to the treatment of choking utilizing back blows and chest thrusts is well known.

As a result of the recommendation of the 1985 National Conference, the Heimlich Maneuver became established as the single recommended method for relieving choking in adults and children over 1 year of age. This aspect is now a non-issue.

For infants under 1 year of age, the consensus was to remain with the previous recommendations of back blows in a dependently positioned infant and, if this fails, to use four chest thrusts followed by opening the airway and ventilating the infant.

We can understand Dr. Heimlich's great concern about potential damage from back blows and chest thrusts, for we have similar concerns for the overzealous application of abdominal thrusts (Heimlich Maneuver) on infants and young children. Recent published literature adds to the concern that the Heimlich Maneuver may be hazardous or even lethal, especially when these data are extrapolated to the infant or small child (*1-4*). Dr. Heimlich alludes to data of injury to choking *children* from back blows and chest thrusts but when challenged fails to produce factual support.

Children have benefited from the continuing controversy over the treatment for choking victims because the public has become alert to the hazards of choking on a variety of foods and objects. Long overdue, however, is a shift in our energy and resources into good research and good data collection on the progress to date from the current recommendations rather than continuing these arguments.

Joseph Greensher, MD, Chairman, Department of Pediatrics, Winthrop-University Hospital, Mineola, NY, and Past Chairman, Committee on Accident and Poison Prevention, American Academy of Pediatrics, and William H. Montgomery, MD, Chief, Department of Anesthesiology, and Director, Surgical Intensive Care Unit, Straub Clinic and Hospital, Honolulu, HI

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