

(54 times higher) and female nurses (5.9 times higher) compared with the workforce as a whole.⁵ It appears that despite a variety of preventive strategies, guidelines and legislative measures^{3,6} there remains a worrisome burden of illness from violence in the health care workplace.

Gary M. Liss

Department of Public Health Sciences
University of Toronto
Toronto, Ont.

References

1. Fernandes CMB, Bouthillette F, Raboud JM, Bullock L, Moore CF, Christenson JM, et al. Violence in the emergency department: a survey of health care workers. *CMAJ* 1999;161(10):1245-8.
2. Yassi A. Assault and abuse of health care workers in a large teaching hospital. *CMAJ* 1994;151(9):1273-9.
3. Liss GM, McCaskell L. Violence in the workplace [editorial]. *CMAJ* 1994;151(9):1243-6.
4. Lee SS, Gerberich SG, Waller LA, Anderson A, McGovern P. Work-related assault injuries among nurses. *Epidemiology* 1999;10:685-91.
5. Liss GM, McCaskell L. Injuries due to violence: workers' compensation claims among nurses in Ontario. *AAOHN J* 1994;42:384-90.
6. California Department of Industrial Relations. *Guidelines for security and safety of health care workers and community service workers*. San Francisco: The Department; 1993.

[One of the authors responds:]

I thank Gary Liss for his comments regarding our recent article on violence. As he notes, and as confirmed by more recent workers' compensation statistics, violence remains a significant issue in the health care setting. However, failure to acknowledge its impact on staff may be as detrimental as the violence itself. To mobilize sufficient resources to prevent violence, and to help its victims, we must first recognize the extent of this major health care problem. The fact that this issue has not gone away in the 5 years since the Yassi article that Liss cites was published suggests that we have not taken this first step.

In a follow-up study now underway, we are prospectively examining the impact of violence on various professions in the emergency department and ways to reduce this violence. We hope that this research encourages further funding to study the issue and to promote

more innovative approaches to a pervasive and ever-expanding problem.

Christopher M.B. Fernandes

Department of Emergency Medicine
University of British Columbia
Vancouver, B.C.

Peerless accuracy (or not)

I presume "Old Dr. Jim" McGarry knew better than to prescribe his nuxvomica according to the apothecary measures in Table 1 of the article by Ronald McGarry and Pamela McGarry.¹

Even given the disclaimer that "values are approximate," the equation 1 minim = 65 mL misses the mark by a factor of 975 (approximately). As the name might suggest, a minim was the smallest unit of liquid measure and was commonly considered to be about one drop.

Peer review indeed. Our peers should have peered more diligently!

W. Sara

Family physician
Crownsnest Pass, Alta.

Reference

1. McGarry RC, McGarry P. Please pass the strychnine: the art of Victorian pharmacy. *CMAJ* 1999;161(12):1556-8.

[One of the authors responds:]

I absolutely agree with Dr. Sara's assessment of the typographical error in our article, but please don't blame the peer review system. The correct value of the minim was quoted in the reviewed manuscript and altered when the proofs became available. I actually corrected it in correspondence with the editor, but somehow the change was not incorporated in the final version of the article. I am sure that the pharmacist of the era would have picked up such a gross error in the compounding. I might add that the symbols for other units of measure, such as the dram, are not available in modern fonts and were

not included in the final draft of the article.

Ronald C. McGarry

Department of Radiation Oncology
Indiana University
Indianapolis, Ind.

High marks for the physical exam

In a medical world that bows down and worships technology, it was a delight to read Kenneth Flegel's balanced editorial on the future of the physical examination.¹ It would appear that students and tutors in many medical schools in the United Kingdom, North America and elsewhere are being taught that knowledge of technological advances is of paramount importance, whereas the role of adequate histories and complete physical examinations is downplayed. There is still a great need to do an adequate physical examination rather than a cursory localized assessment, followed by a plethora of tests and then referral to a specialist who does know the various modern technologies available. Of course, we need modern technology — but surely the most common and the greatest problems facing family physicians lie in the lifestyle and family problems of their patients and the shading between normalcy and abnormality.

Joseph Jacobs

Emeritus professor of pediatrics
Hamilton, Ont.

Reference

1. Flegel KM. Does the physical examination have a future? *CMAJ* 1999;161(9):1117-8.

Kenneth Flegel should be commended for drawing attention to an ominous trend in medical training, the gradual elimination of the physical examination in favour of laboratory investigation and imagery.¹ Far worse are so-called outcome analyses based solely on questionnaires and telephone interviews of patients who have undergone a

surgical procedure.² How can one pontificate about the success of an operation if the patient is not examined after the operation, preferably by independent observers? To rely on telephone interviews in potentially contentious situations involving third parties (such as worker's compensation cases and automobile accidents) is to court very unpleasant consequences both for the patient and the surgeon.³

Emile Berger

Neurosurgeon
Montreal, Que.

References

1. Flegel KM. Does the physical examination have a future? *CMAJ* 1999;161(9):1117-8.
2. Berger E. Persistent pain following lumbar spinal surgery in 1000 patients. *Can J Neurol Sci* 1999;26(Suppl):S23.
3. Berger E. Post-traumatic lumbar disk conditions in a thousand workman's compensation patients: late results following surgical intervention. *J Spinal Cord Med* 1990;22:27.

The *CMAJ* special issue on the impact of new technologies in medicine (Nov. 2, 1999) reminded me of an exceptional collection of clinical case reports by Noel Fiessinger. In the 1940s, Fiessinger headed the Department of Medicine of the Hotel Dieu in Paris. He was one of the last giants who combined clinical genius with (what we call today) evidence-based medicine. He was a consummate writer and dramatic speaker; "tout Paris" attended his weekly grand rounds. His book entitled *L'investigation clinique* was divided into 3 parts (*L'investigation fait tout*, *L'investigation aide* and *L'investigation deroute*), each substantiated with well-chosen clinical cases. I think Fiessinger would wholeheartedly agree with Kenneth Flegel's editorial¹ and perhaps warn against blindly relying on technology. *L'investigation* sometimes deroute.

William D. Dorian

Internist
St. Michael's Hospital
Toronto, Ont.

References

1. Flegel KM. Does the physical examination have a future? *CMAJ* 1999;161(9):1117-8.

We agree with Kenneth Flegel¹ that the clinical examination plays a critical role in the evaluation of patients. We would like to highlight a fact often neglected by those physicians who argue for more widespread use of technologically advanced "definitive investigations" rather than "old-fashioned" tools such as the history and physical examination in the assessment of patients: definitive investigations are not always as definitive as we think. For example, experts often disagree in their interpretations of definitive investigations and the clinician's use of such test results often depends heavily on pre-test clinical assessment.² For instance, we would view 1.8 mm of ST depression on an exercise stress test very differently in a 55-year-old man with a history of exertional, crushing retrosternal chest pain than in a 20-year-old woman with a history of fleeting, non-exertional, stabbing left-sided chest pain.³

However, despite the importance of the clinical examination, reviews of the literature consistently reveal substantial gaps in the knowledge base.² Many of the physical examination pearls we were taught in medical school have never been properly evaluated. This presents a quandary: should we cast aside all signs or symptoms that have not been validated in rigorous studies, or continue to use and teach all but those that have been disproven? We believe this question is unanswerable and such a debate will generate far more heat than light; instead, we view this situation as a

rallying call for clinicians to reevaluate what we do. We call on our colleagues to join us in an international collaborative effort to design and execute large, simple studies of the history and physical examination. Since the inception of the CARE (Clinical Assessment of the Reliability of the Examination) group 1 year ago, over 350 clinicians from 30 different countries have joined the group and have carried out 2 of the 3 largest high-quality studies ever done assessing the accuracy of the clinical examination for obstructive airways disease (manuscripts currently under review). The CARE group (www.carestudy.com) is open to health care professionals at any stage of training and in any setting, and all members can participate in the design, execution and analysis of these studies.

Finlay A. McAlister

Internist
Edmonton, Alta.

Sharon E. Straus

Geriatrician
Toronto, Ont.

David L. Sackett

Trout Research and Education Centre
Markdale, Ont.

References

1. Flegel KM. Does the physician examination have a future? *CMAJ* 1999;161:1117-8.
2. McAlister FA, Straus SE, Sackett DL, on behalf of the CARE-COAD1 group. Why we need large, simple studies of the clinical examination: the problem and a proposed solution. *Lancet* 1999;354:1721-4.
3. Diamond GA, Forester JS. Analysis of probability as an aid in the clinical diagnosis of coronary artery disease. *N Engl J Med* 1979;300:1350-8.

Submitting letters

Letters may be submitted by mail, courier, email or fax. They must be signed by all authors and limited to 300 words in length. Letters that refer to articles must be received within 2 months of the publication of the article. *CMAJ* corresponds only with the authors of accepted letters. Letters are subject to editing and abridgement.

Note to email users

Email should be addressed to pubs@cma.ca and should indicate "Letter to the editor of *CMAJ*" in the subject line. A signed copy must be sent subsequently to *CMAJ* by fax or regular mail. Accepted letters sent by email appear in the Readers' Forum of *CMAJ Online* (www.cma.ca) promptly, as well as being published in a subsequent issue of the journal.