vant injury has the highest relative frequency. In this case, the relative frequency of scooter injuries was highest among children aged 8–13, accounting for about 72 out of every 100 000 injuries in the CHIRPP database.

Susan G. Mackenzie
Senior Epidemiologist, Injury Section
Health Surveillance and Epidemiology Division
Health Canada
Ottawa, Ont.

Reference

[The author responds]:

I apologize for hastily reading the CHIRPP tables and misinterpreting the denominator. Thank you for the correction to my article.1

Erica Weir
PGY 5 Community Medicine Resident
McMaster University
Hamilton, Ont.

Reference

Occupational and environmental exposure

The recent article by Lynn Marshall and colleagues1 addresses an important issue: occupational and environmental exposures that may have a causal relation to symptoms and illness. However, the example of a photocopier in the sample case is unfortunate.

From the information provided, it is not clear that the photocopier is causing the symptoms. Regardless, some might argue that moving the photocopier is a request that could be easily accommodated. But what if this small business has no other location for it? If the patient’s physician suggested the photocopier is making her ill, she is likely to believe it. Should she leave the workplace? Who is responsible for her lost wages if she leaves?

This is not to suggest that no cases require physician action. Those that do are established clinical entities: asthma, contact dermatitis and toxicities where exposures, dose responses, symptoms, signs and mechanisms are well understood. And there are other cases, sentinel events, where a more direct causality is demonstrable, and the physician may need to notify the employee, workplace and public agencies.

In all cases, a treating physician’s advice should be based on an established scientific body of knowledge.

Michael Schweigert
Occupational Health Services Program
St. Michael’s Hospital
Toronto, Ont.

Reference

[The authors respond:]

We thank Michael Schweigert for his attention to our article1 and for raising some interesting questions. Our primary intent was to suggest organizing principles to aid the physician in taking a comprehensive environmental history. We also wished to illustrate the weighing of evidence and a precautionary approach to guide decision-making in the many (if not most) real-life clinical situations where incomplete objective evidence is available.2 For this purpose we used a composite case example, closely based on actual cases.

The example illustrates the physician weighing the evidence for and against a symptom–exposure association and possibilities for intervention, and deciding that the combined weight of evidence was sufficient to recommend a trial removal of the photocopier (Table 1).

We appreciate that there are differing views as to what constitutes reasonable accommodation. This is particularly so in some modern workplaces where people are share space and have diminished control over their environment. Employers have faced liability when reasonable accommodation was not made.3 If an employer was reluctant or unable to accommodate the employee’s need, or if the employee’s symptoms did not improve with the trial intervention, then the cost of further clinical and workplace investigations could be justified. In this example,

Table 1: Weighing the evidence for precautionary avoidance in case example

<table>
<thead>
<tr>
<th>For</th>
<th>Against</th>
</tr>
</thead>
<tbody>
<tr>
<td>Onset of symptoms concurrent with change in workplace</td>
<td>Symptoms not specific or measurable (as in asthma or contact dermatitis)</td>
</tr>
<tr>
<td>Symptoms worse at work and in winter, better on weekends and holidays</td>
<td>Physical findings nonspecific</td>
</tr>
<tr>
<td>Previously well, high-functioning woman with potentially predisposing mild atopy (infantile eczema) and no other environmental or lifestyle changes</td>
<td>No evaluation of workplace ventilation rate, VOC and ozone levels</td>
</tr>
<tr>
<td>Some objective physical findings</td>
<td>Access to industrial hygiene investigation of ventilation rate and ozone/VOC levels limited by geography and expense</td>
</tr>
<tr>
<td>Shares symptoms, temporal pattern and some scientifically established host risk factors for sick building syndrome</td>
<td>Sensitization to some xenobiotics may occur and may be reversed after removal of the source of exposure</td>
</tr>
<tr>
<td>Workroom small, poorly ventilated, window sealed in winter with frequently used photocopier</td>
<td>Some people metabolize xenobiotics poorly and so may be susceptible to toxic effects at exposure levels tolerated by others</td>
</tr>
<tr>
<td>Photocopies known to emit volatile organic compounds (VOCs) and ozone, which could provoke the described symptoms</td>
<td>Access to industrial hygiene investigation of ventilation rate and ozone/VOC levels limited by geography and expense</td>
</tr>
<tr>
<td>Some people metabolize xenobiotics poorly and so may be susceptible to toxic effects at exposure levels tolerated by others</td>
<td>Trial removal of photocopier likely feasible and inexpensive</td>
</tr>
</tbody>
</table>


2. The example illustrates the physician weighing the evidence for and against a symptom–exposure association and possibilities for intervention, and deciding that the combined weight of evidence was sufficient to recommend a trial removal of the photocopier.

3. Employers have faced liability when reasonable accommodation was not made.
the employer was immediately accommodating (also reinforcing to his employee that she was valued), and the experiment was successful, with beneficial results for the employee’s health and productivity.

Lynn Marshall
Environmental Health Clinic
Sunnybrook & Women’s College Health Sciences Centre
Toronto, Ont.

Erica Weir
Community Medicine Resident
Department of Epidemiology and Biostatistics
McMaster University
Hamilton, Ont.

Alan Abelsohn
Department of Family and Community Medicine
University of Toronto
Toronto, Ont.

Margaret D. Sanborn
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McMaster University
Hamilton, Ont.

How soon they forget

I read with some alarm CMAJ’s recent profile of our new president, Dana Hanson,1 and your statement that “he will become the first Dalhousie University medical school alumnus to head the CMA.”

Have we so soon forgotten Robert O. Jones, who became the first and only psychiatrist to hold this position in 1965? Or more recently my esteemed cousin, Athol Roberts of Charlottetown, who was elected president in 1987?

Merville O. Vincent
Psychiatrist
Kelowna, BC

How soon they forget

You stated that Dana Hanson is the first alumnus of Dalhousie Medical School to become CMA president. I must point out that Robert O. Jones, who held the CMA presidency in 1965, was a Dalhousie graduate. He was also a pioneer in psychiatry and the first president of the Canadian Psychiatric Association.

Judith H. Gold
Psychiatrist
Halifax, NS

Reference

[The News Editor replies:]

I don’t know whose face is redder — ours or Dalhousie’s. The information was supplied by the university, but we failed to provide due diligence in confirming it. And we have since been informed that Ronald Whelan, the CMA president in 1992, is another Dalhousie graduate.

Corrections

In a recent pair of letters to the editor,1,2 Glenn G. Grienier’s last name was incorrectly spelled as Grenier.

References

In Barbara Mintzes and colleagues’ recent letter to CMAJ,1 an error occurred in the second sentence of the third paragraph. The number 2 should have read 24. The sentence should read, “However, physicians and health authorities in the UK have reported 24 times more adverse drug reactions, 11 times more deaths and 3.8 times more seizures per 1000 prescriptions than in Canada (Table 1).”

Reference