

current dissemination of information this is very important. It does mean that any citations to these abstracts would tend to inflate the impact factor. If you check the ISI's Journal Performance Indicators file you can determine just how much these extra citations affect this journal or any other.

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In the recent editorial on *CMAJ*'s impact factor,¹ what is the basis for the statement that "short reports ... are less likely to be cited"? Brevity by itself is not the problem. Consider Watson and Crick's 1953 paper.² However, the increased number of short reports may lead to a lower average impact. I would think that these short reports would eventually be supplemented by more definitive or complete papers so that long-term impact might be affected, but in the short run you might be surprised at the outcome.

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2. Watson J, Crick F. Molecular structure of nucleic acids. *Nature* 1953;171:737-8.

[The editor-in-chief responds:]

I have no data to support our contention that short reports are less likely to be cited. The Watson and Crick paper is a superb counter-example to our statement. However, looking through the short reports that are now published in the *Lancet* and that we publish, I would guess that they are less likely to have as major or as lasting an effect on the scientific literature as the longer, more complete scientific articles — although some will.

John Hoey

Osler's unusual case

I enjoyed *CMAJ*'s tribute to Sir William Osler in the Oct. 5, 1999 issue, especially Peter Warren's article.¹ He put forth strong arguments that Osler's unusual case, presented on Oct. 15, 1900, was indeed the syndrome described 51 years later by Churg and Strauss.²

Another example of an unusual case reported by Osler is his astute description of mitral valve prolapse 83 years before Barlow's landmark paper on the midsystolic click and late systolic murmur,³ which was subsequently called the Barlow syndrome.⁴ I would like to quote parts of Osler's paper entitled, "On a remarkable heart-murmur, heard at a distance from chest-wall" published in the *Medical Times and Gazette* in October 1880.⁵

"Numerous cases of heart-disease are on record in which a murmur could be heard at some distance from the chest. The following instance is remarkable from the absence of any evidence of serious disease, and from the exceedingly variable nature of the murmur... As she sits upright in the chair the heart-sounds at apex and base loud and clear; no murmur. When she stands, a loud systolic murmur is heard at apex ... it varies a great deal, being loud for three or four beats, and then faint for one or two succeeding ones, due to influence of respiration ... It disappeared quite suddenly, and could not be detected on most careful examination ... on causing her to lean forward and relax the chest the murmur was at once heard, and with greatly increased intensity. It was distinctly audible at a distance of three feet two inches by measurement, and could be heard at any point on the chest and on the top of the head ... On July 13 I saw her again at her home, and failed, after prolonged examination, to hear the murmur ... July 21 ... — When she stood up, the murmur at once became evident, presenting the same character as before described ... August 31 — Saw her again, and failed to hear a murmur in any posture, after a prolonged examination ... The points of interest in this case are,

as stated above, the absence of sign of grave heart-disease, and the extreme variability of the murmur ... It was worthy of note that in three of the five cases of this sort here mentioned the patients were women — two of them weak and anaemic; and the third (the girl under my care) delicately built and nervous, though not anaemic."

Osler, of course, was describing all the characteristic features of mitral valve prolapse — its preponderance in young women, the extreme variability of the murmur depending on the delicate balance between the end-diastolic volume of the left ventricle and the amount of the mitral valve apparatus, and the benign nature of the condition.⁶

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Violence in the health care workplace

I read with interest the article by Christopher Fernandes and colleagues on violence in the emergency department.¹ Violence in the workplace has previously been discussed in *CMAJ*^{2,3} and violence in the health care setting was the subject of another recent report.⁴ On the basis of workers' compensation data, a colleague and I documented significantly increased rates of lost-time claims owing to acts of violence for both male nurses

(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.

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5. Liss GM, McCaskell L. Injuries due to violence: workers' compensation claims among nurses in Ontario. *AAOHN J* 1994;42:384-90.
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[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.

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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

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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.

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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.

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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