

Correspondance

Improved ranking for *CMAJ*

A *CMAJ* news item recently reported that the journal's impact factor for 1999 is 2.4, placing *CMAJ* fifth among the world's medical journals.¹ Although the impact factor was correctly cited, the Institute for Scientific Information ranks *CMAJ* 14th among medical journals. The journal in fifth position is in fact the *Annual Review of Medicine*. How did the editors of *CMAJ* determine the new ranking for *CMAJ*?

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References

1. *CMAJ's* impact factor improves. *CMAJ* 2000;163(9):1182.
2. Institute for Scientific Information. 1999 journal citation reports. Philadelphia (PA): The Institute; 2000.

[The editor of *CMAJ* responds:]

Ah, impact factors. I think that most journal editors would rather do without them. The Institute for Scientific Information annually ranks about 8000 journals.¹ These are grouped into about 200 categories, such as allergy, emergency medicine and critical care, and developmental biology. This is done in part because citation practices vary across disciplines;^{2,3} the categories represent an attempt to partly standardize the results. For example, in the geriatrics and gerontology category the leading journal has an impact factor of 3.4, whereas in the immunology category the leading journal has an impact factor of 47.6.¹ *CMAJ* is in the category of medicine, general and internal. When reviewing information on impact factors, we compare ourselves with similar journals. Thus, in the *CMAJ* article Etmninan refers to, we ranked ourselves against other general medical journals.⁴ The *Annual Review of Medicine*, which publishes 1 issue per

year and contains only review articles, is not a general medical journal.

John Hoey

References

1. Institute for Scientific Information. 1999 journal citation reports. Philadelphia (PA): The Institute; 2000.
2. Joseph KS, Hoey J. *CMAJ's* impact factor: room for recalculation. *CMAJ* 1999;161(8):977-8.
3. Garfield E. Journal impact factor: a brief review. *CMAJ* 1999;161(8):979-80.
4. *CMAJ's* impact factor improves. *CMAJ* 2000; 163(9):1182.

Preventing deaths from long QT syndrome

I write this letter following the tragic death of a 10-year-old child. The child presented with a syncopal episode on a school sports day. The ensuing investigation included a detailed cardiology examination. The child's electrocardiogram (ECG) was normal, but the possibility of an intermittent pattern of long QT syndrome was considered. Holter monitoring was being organized when the child suffered another syncopal episode while swimming and died.

Family members were tested for the markers for long QT syndrome by ECG examination. The ECG of one child, who was a close relative of the index child, showed long QT abnormalities. Thus, not only was the cause of death in the index child identified more definitively but the other child was treated and what could well have been another sudden and unexpected death was prevented.

Long QT syndrome is manifested in some people who are highly vulnerable to ventricular tachycardias and may progress to ventricular fibrillation, with frequently fatal results.¹ The ECGs of most patients with this pattern of polymorphic ventricular tachycardia (also known as torsades de pointes) show a long QT interval, even if the patient is in sinus rhythm at the time of testing.²

Some lives might be saved by considering the possibility of long QT syndrome in a young person presenting

with syncopal symptoms.^{3,4} Regrettably, some deaths will inevitably occur, as this syndrome frequently presents for the first time as a sudden death.

In all situations in which long QT syndrome is diagnosed or under serious consideration, it is important that physicians consider ordering a detailed ECG examination of the patient's family members, because in a small number of cases long QT syndrome has a hereditary component. Testing of asymptomatic family members may identify other children at risk for sudden death and allow preemptive intervention at low cost and with great effectiveness.

Although the death of the index child in this case was probably unavoidable, family testing did identify another child at risk of a preventable death from the same syndrome. We can make a difference if we all think about the possibility of long QT syndrome whenever a child dies suddenly and unexpectedly.

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References

1. Ackerman MJ. The long QT syndrome. *Pediatr Rev* 1998;19(7):232-8.
2. Roden DM. A practical approach to torsade de pointes. *Clin Cardiol* 1997;20(3):285-90.
3. Lewis DA. Syncope in the pediatric patient. The cardiologist's perspective. *Pediatr Clin North Am* 1999;46(2):205-19.
4. Berger S. Sudden cardiac death in infants, children, and adolescents. *Pediatr Clin North Am* 1999;46(2):221-34.

The stethoscope at ease

William Hanley and Anthony Hanley are quite correct to emphasize the importance of time management in their consideration of the traditional (T) versus the cool (C) position for resting stethoscope placement.¹ Before we adopt their recommendations, however, I will offer a word of caution via the following case report.

Forty years ago, I was called to the emergency department to examine an unconscious patient. Rapid assessment

revealed a rather large, muscular 20-year-old male medical student who was apparently experiencing insulin hypoglycemia. Venipuncture was performed in the left antecubital fossa and a sample of blood withdrawn for glucose estimation. This was followed immediately by intravenous glucose injection. The patient began to stir, then suddenly sat up. With his right hand he grabbed the stethoscope from around my neck (T position) and, with an expletive, smashed it into my face with stunning force, lacerating my nose. I managed to keep the patient's left arm secure and complete the injection while others calmed him.

As a result of this unfortunate experience, I have made a practice of advising medical students and others to carry the stethoscope in the pocket (P position). Besides safety considerations, the financial benefits of this method to our national resources are obvious, as questions of workers' compensation are unlikely to occur.

Perhaps a more elegant position may be advocated by those of us who still wear jackets or white coats. This is the subaxillary (SA) position, in which the jacket is opened with a flourish, the stethoscope ear pieces are hooked into the upper inside sleeve and the jacket is rebuttoned. This is both safe and cool, and may even enhance the bedside manner. Regrettably, it is probably too time consuming and is unlikely to attract many adherents today.

May I therefore recommend the pocket as the safe, practical position for a stethoscope at ease.

David Leak

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Reference

1. Hanley WB, Hanley AJG. The efficacy of stethoscope placement when not in use: traditional versus "cool." *CMAJ* 2000;163(12):1562-3.

The groundbreaking research of William Hanley and Anthony Hanley into the efficacy of the tradi-

tional versus the cool placement of the stethoscope when at rest has made a valuable contribution to medical practice.¹ However, the good doctors have missed the true significance of the position of the resting stethoscope. It is, in fact, all about the power of the physician and the stethoscope's place as an icon of that power.

Down through the ages the physician's power has been symbolized by various icons. In ancient Greece it was the caduceus, later the physician's staff, and so on. In the 19th century it became the white lab coat. However, lesser members of the "health care team," jealous of the physician's power, have usurped that symbol so that today even the volunteer working in the hospital admitting office wears a white coat.

Through all of this, the stethoscope remained uniquely the physician's. The surgeons, recognizing its symbolism early on, took to carrying one as well. However, because they did not understand its use, they took to letting the instrument peek coyly out of the pocket of their lab coat. A true physician, of course, always has his stethoscope at the ready around his neck in the traditional position.

It was inevitable that sooner or later the lesser orders would take to wearing a stethoscope in the hope that some of its power would pass to them. And so, for example, the stethoscope used for taking blood pressures no longer hangs on the blood pressure machine but around the nurse's neck. However, some nonphysician wearers of the stethoscope, not being skilled in its use, have taken to just slinging it around their neck in the cool position. Hanley and Hanley have shown us just how inefficient this position is, but as the wearers have no practical use for their stethoscopes, it doesn't really matter.

It is a telling commentary on the quality of clinical teaching in today's medical schools when we see so many of our younger colleagues wearing their stethoscopes in the cool position. Obviously, they too are unfamiliar with its use and rely entirely on the lab and the diagnostic imaging department to make their diagnoses for them.

It is interesting that it was the surgeons who first recognized the symbolism of the stethoscope and it is they who have been the first to recognize its decline. Our surgical friends have turned in their stethoscopes and have taken to parading around in their scrub suits as their icon of power. Inevitably, others, jealous of the power surgeons now exude, have taken to wearing scrub suits as well. Sadly, the nursing profession has given up its symbol of power, the crisply starched uniform, in favour of this forerunner of the grunge look.

As for the stethoscope, I would suggest that the T or traditional position be renamed the U or user's position and that the C or cool position be renamed the U2 or usurper's position. Meanwhile, the traditional in-the-pocket position can remain the SP or surgical position as a reminder of the good old days.

John D. Campbell

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Reference

1. Hanley WB, Hanley AJG. The efficacy of stethoscope placement when not in use: traditional versus "cool." *CMAJ* 2000;163(12):1562-3.

[The authors respond:]

We were pleased that at least 2 people read our paper and we appreciate their comments. We were shocked by the unfortunate assault on David Leak by the medical student and certainly hope a few marks were docked from the student's next examination. Had the doctor's stethoscope been in the cool (circumcervical) position it is possible that strangulation might have ensued, with a less satisfactory outcome.

We agree with Leak that the P position is the safest and most practical but as John Campbell points out this would negate the visibility of the stethoscope as an icon of the physician's (and allied health care provider's) power.

We are confident that all this is just a passing fad and that the next generation of health care providers will become enlightened and wear their

stethoscopes in the traditional manner (and their baseball caps forward).

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Lest we forget

I read with considerable interest the letter from Siroos Mirzaei and Peter Knoll drawing attention to the treatment of physicians in Iraq who refused to be involved in torture.¹ It is unfortunate that they did not name the physician who was executed for refusing to exercise medicine punitively. He must have espoused the highest Hippocratic ideals to give his life rather than inflict pain on another person. This man should be honoured by remembrances and scholarships. How many of us would give our lives in such a sacrifice?

Alan L. Russell

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Reference

1. Mirzaei S, Knoll P. The last trial of a Nazi doctor [letter]. *CMAJ* 2000;163(5):498,500.

[The authors respond:]

The name of the Iraqi physician who was executed was not stated in the Amnesty International report in which the incident was mentioned.¹ However, the names of many other health care professionals at risk have been published.^{2,3} For example, the Turkish Medical Association has protested against torture and executions, and several of its members have been threatened with imprisonment, including Veli Lök.² A Romanian physician, Atilla Kun, refused to cover up incidents of torture and was sent to prison for 3 years.³

Many physicians uphold the Hippo-

cratic oath in the face of imprisonment, mistreatment and even execution. Their courage, will and struggles have to be honoured, but not by scholarships. Rather, we should try to understand why physicians have faced human rights violations and we should work to help our colleagues who are presently at risk. The best way to honour them is to share their sense of responsibility to uphold the Hippocratic oath.

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3. Amnesty International. Harming the healers: violations of the human rights of health professionals. London: Amnesty International; 2000. Report no.: ACT 75/02/00.
4. Amnesty International Medical Commission, Marange V. *Doctors and torture: collaboration or resistance?* Paris: Bellew Publishing; 1991.

[Editors' note:]

Information on human rights issues particularly relevant to health care workers is available through Amnesty International Health Professionals Network Online (www.web.amnesty.org/rmp/hponline.nsf).

Cervical manipulation: How risky is it?

The article by John Norris and colleagues on sudden neck movement and cervical artery dissection does not mention risk factors for stroke such