

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.

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Reference

1. Scooting into the ER. *CMAJ* 2002;167(1):55.

[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

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Reference

1. Scooting into the ER. *CMAJ* 2002;167(1):55.

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

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Reference

1. Marshall L, Weir E, Abelsohn A, Sanborn MD. Identifying and managing adverse environmental health effects: 1. Taking an exposure history. *CMAJ* 2002;166(8):1049-55.

[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.⁸ 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

For

Onset of symptoms concurrent with change in workplace
Symptoms worse at work and in winter, better on weekends and holidays
Previously well, high-functioning woman with potentially predisposing mild atopy (infantile eczema) and no other environmental or lifestyle changes
Some objective physical findings
Shares symptoms, temporal pattern and some scientifically established host risk factors for sick building syndrome³
Workroom small, poorly ventilated, window sealed in winter with frequently used photocopier
Photocopiers known to emit volatile organic compounds (VOCs) and ozone,⁴ which could provoke the described symptoms⁵
Some people metabolize xenobiotics poorly⁶ and so may be susceptible to toxic effects at exposure levels tolerated by others
Sensitization to some xenobiotics may occur and may be reversed after removal of the source of exposure⁷
Access to industrial hygiene investigation of ventilation rate and ozone/VOC levels limited by geography and expense
Trial removal of photocopier likely feasible and inexpensive

Against

Symptoms not specific or measurable (as in asthma or contact dermatitis)
Physical findings nonspecific
No evaluation of workplace ventilation rate, VOC and ozone levels

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.

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References

1. Marshall L, Weir E, Abelsohn A, Sanborn MD. Identifying and managing adverse environmental health effects: 1. Taking an exposure history. *CMAJ* 2002;166(8):1049-55.
2. *The health and environment handbook for health professionals*. Ottawa: Health Canada; 1998. p. 19-23. Available: www.hc-sc.gc.ca/ehp/ehd/catalogue/bch_pubs/98ehd211/98ehd211.htm (accessed 2002 July 3).
3. Stenberg B, Eriksson N, Hoog J, Sundell J, Wall S. The sick building syndrome (SBS) in office workers. A case referent study of personal, psy-

chosocial and building-related risk indicators. *Int J Epidemiol* 1994;23(6):1190-7.

4. Tuomi T, Engstrom B, Niemela R, Svinhufvud J, Reijula K. Emission of ozone and organic volatiles from a selection of laser printers and photocopiers. *Appl Occup Environ Hyg* 2000;15(8):629-34.
5. Paz C. Some consequences of ozone exposure on health [review]. *Arch Med Res* 1997;28(2):163-70.
6. Daly AK, Cholerton S, Armstrong M, Idle JR. Genotyping for polymorphisms in xenobiotic metabolism as a predictor of disease susceptibility. *Environ Health Perspect* 1994;102(Suppl 9):55-61.
7. Rosenstock L, Cullen MR, editors. *Textbook of clinical occupational and environmental medicine*. Philadelphia: W.B. Saunders Company; 1994. p. 11.
8. Fink S. Health authority failed to protect radiographer from x-ray fumes [case note]. *Saf Health Pract* 1996;July:38-40.

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?

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Reference

1. Sibbald B. Physician shortage a personal issue for CMA's incoming president. *CMAJ* 2002;167(3):290.

You stated that Dana Hanson is the first alumnus of Dalhousie Medical School to become CMA president.¹

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

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Reference

1. Sibbald B. Physician shortage a personal issue for CMA's incoming president. *CMAJ* 2002;167(3):290.

[The News Editor replies:]

I don't know whose face is redder — yours 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. Griener's last name was incorrectly spelled as Grenier.

References

1. Griener GG. Placebo tribulations [letter]. *CMAJ* 2002;167(5):455.
2. Weijer C. Placebo tribulations [letter]. *CMAJ* 2002;167(5):456.

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

1. Mintzes B, Bassett K, Wright JM. Drug safety without borders: concerns about bupropion [letter]. *CMAJ* 2002;167(5):447.

Submitting letters

Letters may be submitted via our Web site or by mail, courier, email (pubs@cma.ca) or fax. They should be no more than 250 words long and must be signed by all authors. Letters written in response to an article published in *CMAJ* must be submitted within 2 months of the article's publication date. Letters are subject to editing and abridgement.

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