agnostic decisions, and that the WHO "suspect case" definition does not include radiographic findings, it is no wonder that physician judgement was more accurate. It would have been fairer to compare physician judgement with the WHO "probable case" definition, which includes radiographic evidence.[4]

Finally, the WHO criteria had poor sensitivity for ED screening because fever and respiratory symptoms are often delayed, in some cases appearing after radiographic changes.[2] In the Wong Wing Nam study, a patient who presented with a fever of 37.8°C, a positive contact history and radiographic changes would most likely have been correctly admitted as a suspected SARS case according to physician judgement, but would be considered a "miss" by the WHO criteria, even if the patient later progressed to develop a higher temperature (>38°C) and respiratory symptoms. In such a case, the ED physician was accurate, and the WHO criteria fulfilled its surveillance function. It is important to recognize the distinction between "screening tool" and "case definition." Misunderstanding may lead to unnecessary discredit to the WHO.

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Correct way to wear respirator head harnesses

To the Editor: The cover photo of *CJEM*'s July 2003 issue showed 3 physicians who had intubated a patient at the North York General Hospital in Toronto.

My training in occupational hygiene at Mount Royal College and with the Canadian Navy gave me familiarity with respirators, and I noticed the 3 were wearing full face respirators with the head harnesses outside the hoods of their protective suits. One worker was wearing a hair net under his mask, which was visible through the visor.

Wearing respirators in this manner reduces the protection afforded. The correct way to wear the respirator head harness is under the hood of the protective suit. Hair nets are not to be worn under the respirator.

Protective equipment gives a false sense of security when worn incorrectly. The 3 workers in the picture were doing just that.

SARS is a very serious disease, and full protection is a must.

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Medical myth: The usefulness of pelvic exam

To the Editor: When I first read the article by Brown and Herbert[1] in *CJEM*, I thought it was amusing. However, its conclusion was illogical and not supported by the studies cited. I believed that this was not a critical review of the literature and was not a threat to the time-honoured practice of pelvic examination used to guide ancillary investigations. It was not going to change my practice.

I have since discovered that some of my less experienced colleagues have misinterpreted this article and have stopped doing pelvic exams — instead, they are arranging outpatient ultrasounds for the next day, since our hospital does not provide 24-hour availability. My colleagues no longer perform speculum examinations to assess bleeding, discharge, foreign bodies, traumatic or other lesions; and they do not remove products of conception from the cervical os. Nor do they perform bimanual pelvic examination for the rapid and helpful information it provides. They have accepted Brown and Herbert's "evidence-based" statements questioning the usefulness of this procedure. Their change in practice compels me to address the quality of this article and its recommendations.

A key problem is the authors' premise that an investigation is useless unless it has the sensitivity and speci-

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