routinely inquire about abuse as part of the medical history."[1] Several organizations, including the Canadian Association of Emergency Physicians, the College of Family Physicians of Canada and the Canadian Association of Social Workers, have endorsed a widely distributed manual that recommends universal screening for abuse of all patients seen in the emergency department.[2]

Even in an article that focuses on legal aspects of medical practice, the authors should pay attention to the practicality of the advice they offer. The purpose of intervention with battered women, as with other patients, is to provide high-quality and compassionate care. The elements of care are identification, assessment, documentation, risk assessment and referral; thus, care includes a legal component. The care should be as hassle-free as possible for the abused women. Developing very complex protocols, similar to the sexual assault protocol, may be counterproductive because it may discourage many physicians from addressing this problem. The legal aspects, although important, are but a small part of the day-to-day care of abused women.

I suggest that the authors include practising physicians in the team involved in developing standardized forms for documenting wife abuse.

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[The author responds:]

We are aware that several organizations recommend routine screening by all physicians of all female patients, since identification of victims of wife abuse is crucial.

Unfortunately, there is no evidence to support this routine practice. We feel that evidence of the beneficial impact of routine screening on the patient–physician relationship is needed before we recommend that screening be routine rather than discretionary. That being said, we believe that routine questioning could show patients that their physician is open to discussing the problem and may help patients who wish to broach the topic. Hence, an evidence-based approach to clinical practice guidelines leads us to suggest that physicians weigh the benefits and possible adverse consequences of screening in individual cases.

On the basis of research about the impact of questioning patients in suspicious cases, we support the recommendation that physicians ask about the possibility of abuse when a woman's physical injuries are not consistent with the reason given for them; when a woman exhibits unexpected or unexplainable stress, anxiety, depression or substance abuse; or when a woman has chronic, unexplained somatic symptoms such as headaches, gastrointestinal distress or insomnia. In terms of guidelines for emergency physicians, women with suspicious injuries are often seen in emergency departments, and screening in suspicious cases could greatly increase the rate of identification. We were surprised, given the case mix of patients and the volume of patients seen, that the manual by Dr. Grunfeld and his colleagues recommends "universal screening for abuse of all patients seen in the emergency department," and we appreciate his bringing this recommendation to our attention.

Physicians were substantially involved in our research. The guidelines were reviewed by several physicians before their submission to *CMAJ*. A protocol based on the guidelines incorporated physician feedback. We have conducted a pilot test of this protocol since it was published. FP/GPs who reponded to a survey strongly supported the use of the protocol, overwhelmingly believed that the protocol was useful and indicated that they would use it in their practice. Further testing is planned with other medical specialties.

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Confusion still surrounds third-party forms

From the responses (*Can Med Assoc J* 1997;156:977) to Dorothy Grant's recent article "Independent medical examinations and the fuzzy politics of disclosure" (*Can Med Assoc J* 1997;156:73-5), it is clear that there is still considerable confusion about third-party and formal independent medical examinations (IMEs). There is also confusion about who owns these reports and the duty of the examining physician. I am not surprised by this, because physicians have no training in providing these services.

Grant stated correctly that the number of third-party medical examinations, and not just IMEs, is increasing. There are also increasing demands for the plethora of third-party documents physicians have always struggled with, from sick notes written for employees to clinical-care statements compiled for insurance compa-

nies and accident adjusters. Many of these reports function only to sustain a bureaucracy, and some of the greatest abusers are our governments.

Physicians, who are short of time and annoyed by many of these requests, are also ill-prepared to handle them. The "fuzzy politics" of providing a medical opinion to a third party continues to be flawed because the providers (physicians) and the consumers (all third parties) do not understand each other's specific needs. Physicians do not understand rehabilitative medicine or the concept of fitness to work. Too often, they are caught up as enablers of prolonged disability because of the dictum to "do no harm," or they assume they carry the liability for disease that probably does not exist.

As medicine and clinical care move toward service-based practice and clinical practice guidelines, physicians need better training, skills and experience to deal with third-party evaluations. Clinical advice to remain disabled until physicians can prove or disprove a pathologic cause that may or may not be disabling is bad medical advice. Maintaining patients in a sick role until they are abandoned with no diagnosis or treatment is inappropriate. The best advice is to focus on what patients can do instead of what they cannot do. The road back from disability is hard enough without physicians being a barrier to recovery.

Medical training and the clinical practice of assessing and managing disability require a paradigm shift, and physicians can either be part of the solution or remain part of the problem. The people who make decisions about disability claims will go around barriers to assessment and decisions if they have to. I believe that physicians have a large role to play in helping patients convalesce and return to full function.

This letter is an open plea to the CMA to devote more time to debating and taking action on these issues. Most physicians would welcome the CMA's help and guidance.

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Students work to foster tolerance

The article "Medical curricula for the next millennium: responding to diversity" (*Can Med Assoc J* 1997;156:1295-6), by Dr. Christiane Kuntz, addresses the need to change medical education. The author argues that practitioners who use noninclusive language need to be aware of the negative influence they may have on maturing medical students. However, in view of the promotion of self-directed learning, perhaps the responsibility for developing culturally sensitive attitudes and knowledge of gender issues in medicine should be placed more on the students. We should no longer rely exclusively on the curriculum or the physician-lecturers to guide students toward attitudes that will benefit them in their practice. Students should and are taking the initiative in exploring the issues affecting minorities, women, gays and lesbians that may be ignored or poorly represented in the curriculum.

In a recent study of the first-year class at the University of Western Ontario medical school, more than half of the students responded Yes to the question: "Did you join any extracurricular activities in order to learn more about a subject that is not taught in the curriculum?" Student groups such as Community Link, an outreach program in which students interact with homeless people and refugees, are supplementing the curriculum by fostering tolerance and sensitivity. OMEGA, the medical school's gender-awareness group, has held forums on issues affecting gay, lesbian and bisexual people and on violence against women in the context of medicine. These groups challenge students to examine their roles in the community and in the lives of their patients.

The diminishing number of lecture hours and the movement toward problem- and case-based learning are making students responsible for gaining knowledge of issues affecting community groups. Inclusive ideas should be reinforced through conventional teaching but can be discovered through other aspects of medical education.

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Fishing expeditions in doctors' offices

Everything Daniel Dodek and Dr. Arthur Dodek wrote on patient confidentiality is true ("From Hippocrates to facsimile: protecting patient confidentiality is more difficult and more important than ever before," *Can Med Assoc J* 1997;156:847-52). However, I believe they omitted the single most sinister invasion of a patient's privacy.

Recently lawyers and insurance companies have begun demanding a photocopy of the patient's entire chart rather than a medical report by the attending physician. Several dangers arise because of this practice. The worst is that it gives lawyers and insurance companies a chance to go on "fishing expeditions" through the whole record, not just search for the facts pertinent to the incident concerning them.