## Those third-party reports

I read with interest the excellent summary by Dorothy Grant of the current issues concerning who has access to the information contained in third-party independent medical examinations (IME) ("Independent medical examinations and the fuzzy politics of disclosure," *Can Med Assoc J* 1997;156:73-5). Her suggestions about what to tell patients are excellent. However, I suggest that the word "patient" in itself is inappropriate because there is, in fact, no physician–patient relationship. In my reports, I generally describe the individual as the "examinee," as this is one way to ensure that a clear distinction is made.

It is important that the physician advise the examinee that an IME will be conducted but no treatment will be performed and no patient–physician relationship will exist. I suggest that the following statement be read and signed by all people undergoing an IME.

"I understand that the purpose of the examination is evaluation only, and no treatment is undertaken. I further understand that the client requesting and paying for the assessment will receive a report. I realize that no physician–patient relationship is established during the course of this assessment."

Since I began using this signed statement and discussing its intent, I have had no problems concerning inappropriate requests for copies of reports from my office. When required, a photocopy of the examinee's signed statement may be produced.

Canadian physicians should know that formal training for independent medical examiners is available through the American College of Occupational and Environmental Medicine. Physicians may then sit the American Board of Independent Medical Examiners examination. Those who pass are generally well prepared to deal with the special requirements of the IME.

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## Costs of care

In her article "Factors explaining the increase in cost for physician care in Quebec's elderly population" (*Can Med Assoc J* 1996;155:1555-60), Dr. Marie Demers recognizes that "the increase in physician costs is more strongly related to the way the health care system responds to the health problems of the elderly population than to demographic factors."

Unfortunately, she does not discuss the value of health care. The unique purposes of health care are to increase some or all of comfort, function and life span. Treatments for disease and, consequently, the costs of care, depend on the availability of care that can succeed. The cost of care is low when no treatment is available and higher when potentially successful treatment is available.

Demers alludes to the influence of changes in knowledge on the cost of care by stating that "the availability of new drugs, diagnostic techniques and surgical techniques has made it possible to treat older and more seriously ill patients than was possible previously."

However, to assess the appropriateness of the increased costs we need to know whether the costs were associated with increased benefits; to assess the benefits of care we need reliable information about each person's health status. Unfortunately, no Canadian jurisdiction systematically collects information about patient health before and after medical intervention.

Consequently, it may be impossible to learn whether the increases in costs are worth while because they are associated with increases in patient benefits.

It is surprising that Canadian physicians and health administrators have not made a more serious effort to collect information about the effectiveness of care, since that information is essential for proper allocation of financial resources and management of our health care system.

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## Novel therapies for Crohn disease and colitis

I have several comments about the recent review by Dr. Donald S. Daly of my book *Crohn's Disease and Ulcerative Colitis* (*Can Med Assoc J* 1996;155:1452-3).

First, the novel therapies with lidocaine (Xylocaine) and short-chain fatty acids *are*, in fact, readily available to patients. Lidocaine (in a 2% gel) has been on the market for many years; 30-mL tubes can be purchased over the counter in most pharmacies. At Sunnybrook Health Science Centre, our pharmacy sells the patients a 35-mL catheter-tip syringe for self-administration of lidocaine. Further information on this treatment, which is recommended mainly for patients with intractable distal ulcerative colitis, can be obtained from the literature.[1]

The first article concerning the use of short-chain fatty acids to treat colonic inflammation was published in 1989.[2] There have been 2 trials of enema therapy with these acids for ulcerative colitis.[3,4] The articles give


For prescribing information see page 718 →

the "recipe" for the enemas, which are easily manufactured by hospital pharmacies.

My final comment is about the target audience for this book. When I was invited to write the book, the goal was to create a user-friendly, comprehensive text for patients and their families. Reviews to date indicate that this objective was achieved. However, colleagues have pointed out to me that the book is also very useful for medical students, house staff, family practitioners, general internists and other health care professionals.

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**References**

1. Bjorck S, Dahlstrom A, Johansson L, Ahlman H. Treatment of the mucosa with local anaesthetics in ulcerative colitis. *Agents Actions* 1992:C60-72.
2. Harig JM, Soergel KH, Komorowski RA, Wood CM. Treatment of diversion colitis with short-chain-fatty acid irrigation. *N Engl J Med* 1989;320:23-8.
3. Steinhart AH, Brzezinski A, Baker JP. Treatment of refractory ulcerative proctosigmoiditis with butyrate enemas. *Am J Gastroenterol* 1994;89:179-83.
4. Patz J, Jacobsohn WZ, Gottschalk-Sabag S, Zeides S, Braverman DZ. Treatment of refractory distal ulcerative colitis with short chain fatty acid enemas. *Am J Gastroenterol* 1996;91:731-4.

## Modifying prescribing of regulated analgesics

In response to our previous article "Effectiveness of notification and group education in modifying prescribing of regulated analgesics" (*Can Med Assoc J* 1996;154:31-9), by John F. Anderson, Kimberley L. McEwan and William P. Hrudey, it has been suggested that longer follow-up may reveal important differences between the education and the notification intervention with respect to reducing prescribing of regulated analgesics.[1] To this end, we have examined prescribing data for the 7 to 12 months after the intervention by conducting a 1-way analysis of variance (ANOVA) of the difference scores in prescribing between baseline and 1-year follow-up. The original article had examined prescribing patterns after only 6 months in 3 groups of physicians: those who underwent group education, those who were notified of their prescribing status, and those subject to no intervention (the control group). At that time, prescribing of analgesics was significantly reduced in both intervention groups compared with the control group, but no statistically significant difference was found between the education group and the notification group.

Results of the ANOVA based on 1-year follow-up data revealed no overall difference among the groups, suggesting that reductions in prescribing seen after 6 months diminished over time. Although at 1-year follow-up the prescribing practices of the physicians exposed to the interventions were no longer significantly different from those of the control group, there was a trend similar to that found in the first study. The mean difference scores were aligned with the intensity of the intervention, with education showing the greatest reduction and no intervention (the control group) showing the least. We also noted that 76% of the education group, 65% of the notification group and 53% of control group continued to prescribe narcotic analgesics at a rate lower than their rate at baseline. In a larger sample, these differences may have emerged as significant.

We attempted to determine whether group education was superior to notification in reducing prescribing of regulated analgesics over a 1-year period in a sample of 49 physicians and found no support for this hypothesis. We acknowledge, however, that our limited sample size may not have been adequate to test Britten's[1] hypothesis. The durability of interventions to alter prescribing warrants further investigation.

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**Reference**

1. Britten N. Letter from a licensing body and group education reduced prescribing of regulated analgesics [commentary]. *ACP J Club* 1996;125:25.

## When physicians' loved ones are patients

Dr. Michael C. Klein's thoughtful and courageously written article, "Too close for comfort? A family physician questions whether medical professionals should be excluded from their loved ones' care" (*Can Med Assoc J* 1997;156:53-5), struck a nerve. It has been 3½ years since my wife Kathy had a myocardial infarction, and we too had both good and bad experiences with the medical and nursing professions. I still cannot think about those experiences without feeling a great deal of anger toward those who treated us poorly and gratitude that we finally found a team that gave us high-quality care. Even now, it is hard for me to write about it.

I will not go into the details of our experience, but I will make some general observations. I am a pediatrician and my wife is a nurse who used to work in intensive care. When she became ill, the staff at the first hospital resented what they described as my "omnipresence." They could not