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.

Rick Zabrodski, MD
Certified Independent Medical Examiner
Clinical Assistant Professor
Faculty of Medicine
University of Calgary
Calgary, Alta.
Received via e-mail

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.

David Zitner, MA, MD
Director
Medical Informatics
Dalhousie University
Medical Quality Consultant
Queen Elizabeth II Health Sciences Centre
Halifax, NS
Received via e-mail

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 →