Disclosure and independent medical examinations

In her recent article "Independent medical examinations and the fuzzy politics of disclosure" (*Can Med Assoc J* 1997;156:73-5), Dorothy Grant discussed issues concerning independent medical examinations (IMEs). Examinations done in Ontario for patients who have experienced motor-vehicle trauma may serve as a good model for contrasting the effects of disclosure concerning IMEs. Across Canada, an IME may be requested by a third party and the information is therefore controlled by the third party. In Ontario, under the auspices of the Ontario Insurance Commission and no-fault auto insurance, designated assessment centres have been established. A centre is chosen by agreement between the insurance company and the insurer. The centre completes a report that is released not only to the insurer but also to injured parties and their family physicians.

If the centre determines that the injured person does not meet the criteria for disability payments or for a physical impairment that would be compensated, the person knows the basis for the decision. Without this information, the injured person cannot determine whether the decision was fair and the evaluation accurate, or whether the evaluator was in any way misinformed. Knowing that the report will be reviewed by the injured party also makes report writers more accountable by forcing them to demonstrate how they reached their conclusion.

The open-disclosure policy also means that a poorly written report based on erroneous data and insignificant evidence can be refuted by the injured party, allowing for an evaluation process that can be more just. I look forward to more articles on this important and timely topic.

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At our disability-management company, insurance companies and employers often call on us to arrange IMEs and submit a report when there is a dispute regarding an employee's benefit payments. Following a careful review of the law, our company formulated IME report guidelines that are at times contrary to the advice given by Dorothy Grant.

A 1992 Supreme Court of Canada decision (*McInerney* v. *MacDonald*) established a common-law right of access to one's own medical record, with very limited exceptions. This decision made clear that the patient (or in our case, the employee) can upon request obtain a copy of the IME report. If we believe the report contains information that could harm the employee's or another person's health, the report is provided to the employee's family physician. The Ontario government's recently released consultation paper "A Legal Framework for Health Information" (July 1996) also supports this position.

Physicians should remember that a patient's medical record can be revealed to a person other than the patient only with the consent of the patient (or his or her authorized representative) or as required by law (a court order or a specific provision in a statute). Accordingly, the IME report can be released to the insurance company or to the employer only if the physician preparing the report obtains the employee's written consent. Employees will not usually withhold consent if this means that their benefits will be discontinued. In the absence of written consent, the physician can provide the third party with information on the employee's functional restrictions, the requirement for investigations, consultation or therapy, and the prognosis, if known.

To protect employers against possible human-rights complaints, it is generally advised that they not obtain a copy of the IME report. Employers should be provided with summaries that explain employees' ability to work and their need for accommodation in relation to the verified medical condition.

If the employer and the employee are involved in legal proceedings and the employee has not consented to the report's release, then the rules of the courts or the relevant administrative tribunal (such as a workers' compensation board) should govern the release of medical information to the employer. We hope this information dispels some of the myths surrounding IMEs.

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Know your residency applicants well

Dr. Tara Young deserves great credit for using her article "Teaching medical students to lie" (*Can Med Assoc J* 1997;156:219-22) to focus on ways the current method for matching trainees to specialty programs encourages deception and lying. She clearly points out how harmful this is to all those involved in the matching process.

Cardiac surgery is a newcomer to the matching process, and we are very disturbed by this phenomenon,

even if it is understandable. The steps Young proposed for remedying the situation, such as listing all programs that a candidate has applied to, would help solve the problem. They should be considered by the Canadian Resident Matching Service.

In our program we now give serious consideration only to those who have spent some elective time with us. In this way we learn about the students, and they learn about us. With only 1 position available per year, we consider this a vital aspect of the screening process. It may place a well-intentioned student who has not done a rotation with us at a disadvantage, but under the current circumstances we believe it is the most reliable method for ranking our applicants.

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Drug to treat obesity: editorial writer responds

We are concerned that the letter by Sana R. Sukkari (*Can Med Assoc J* 1997;156:768-9) misrepresents the relationship that Dr. Manson and I had with the pharmaceutical industry. Upon invitation, we wrote an editorial about pharmacotherapy for obesity.[1] In the process, a series of miscommunications and misunderstandings occurred between the *New England Journal of Medicine* (*NEJM*) and us.

As stated in our subsequent letter to *NEJM*,[2] we had briefly served as scientific consultants to Servier, the manufacturer of dexfenfluramine (Redux) and had submitted a proposed disclosure statement to *NEJM*. *NEJM*'s written disclosure policy statement had ambiguities, and our direct discussions with their editorial staff were misinterpreted. This led to a series of misunderstandings.[2]

Most important, we had and have no financial interest in any manufacturer of anti-obesity drugs, nor do we stand to gain from the commercial success of any of their products. The opinions that we expressed were entirely our own and independent of industry. The editorial was carefully written and was in no way intended as an endorsement of appetite suppressants. We urged long-term studies and cautious prescribing to patients with medically significant obesity who had failed an exercise and diet program.

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Managing benign prostatic hyperplasia

As a very busy urologic surgeon in Toronto, I found that after reading the article "Efficacy and safety of finasteride therapy for benign prostatic hyperplasia: results of a 2-year randomized controlled trial (the PROSPECT Study)" (*Can Med Assoc J* 1996;155:1251-9), by Dr. J. Curtis Nickel and colleagues, I was even more confused than before as to the appropriate management of benign prostatic hyperplasia (BPH).

Patients with symptomatic BPH usually require or request some treatment. To say that finasteride is a viable and safe alternative to watchful waiting is confusing and inappropriate. If one has embarked on watchful waiting, then there is an understanding between the patient and the physician that no intervention is necessary because the symptoms or signs of BPH are not significant. There should be no therapy, not even a "safe, nonoffensive therapy," that is not required.

If, however, one has determined that the symptoms (as defined by the symptom score), urinary flow or sequelae of BPH demand treatment, then one must prescribe the most effective, reliable and safe treatment. There is no golden pill that works for everyone, even if patients have the same size of prostate. In my hands, terazosin has been very safe and reliably effective.

I find it hard to reconcile the fact that, in a recently published study of BPH in veterans,[1] the investigators found no improvement in the patients taking finasteride compared with those taking a placebo. Even if we accept the retrospective analysis that finasteride, because of its mode of action, should be more effective in larger prostates, we still find significant discrepancies. In the subset of patients with prostate volumes greater than 50 mL, the urinary flow improved by 2.5 mL per second in the group taking finasteride v. 3.9 mL per second in the group taking terazosin. A similar trend was found in the symptom-score improvement. Another unexpected discovery in the study was that the prostate-specific antigen (PSA) level decreased in the group taking terazosin, but not in the group taking finasteride.

It seems logical that finasteride would work more effectively in larger prostates and that the patients' PSA level would decrease. However, this was not corroborated in the 2 studies.

Logically, as well, α-blocking agents should be more effective in the smaller prostates usually seen in younger patients; in such patients, the impotence that is a side effect of finasteride would be more troublesome.

At the primary care level, once one has decided that therapy is indicated