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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References

1. American Medical Association Council on Ethical and Judicial Affairs. Physicians and domestic violence: ethical considerations. *JAMA* 1992;267:3190-3.
2. Hotch D, Grunfeld A, Mackay K, Cowan L. *Domestic violence intervention by emergency department staff*. Vancouver: Vancouver Hospital and Health Sciences Centre, 1995.

[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-