and more a luxury to be reserved for the more complex case.

Group cognitive screening may some day be a useful innovation, but major questions regarding its role and value remain unanswered.

John C. Kirk, M.D.
Montreal, Quebec

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1. Rizzolo PJ, Wildman D, Bentz EJ. Group screening for cognitive disorders in elderly persons. J Am Board Fam Pract 1991; 4:131-7.
2. Canadian Task Force on the Periodic Health Examination. Periodic health examination, 1991 update: 1. Screening for cognitive impairment in the elderly. Can Med Assoc J 1991; 144:425-31.
3. Epstein AM, Hall JA, Fretwell M, Feldstein M, DeCiantis ML, Tognetti J, et al. Consultative geriatric assessment for ambulatory patients: a randomized trial in a health maintenance organization. JAMA 1990; 263:538-44.

The above letter was referred to the author of the article in question, who offers the following reply:

To the Editor: Dr. Kirk has raised several concerns regarding potential disadvantages of screening for dementia. He states that the stigma of being labeled as cognitively impaired and the reluctance of institutions and health care providers to deal with dementing illness would place the value of screening in doubt. This concern is valid, and we did not suggest we launch, at this time, a mass screening campaign to detect early dementia. In fact, the first sentence in the discussion section states, "Significant practical, medical, ethical, and socioeconomic issues need careful consideration before launching any effort to identify community-based persons with cognitive impairment by the use of a group-administered screening instrument."[p 134]

Ethical use of any screening instrument requires the physician to inform the patient of the limitations and the benefits of the test, and adequate follow-up must be offered and available, including counseling to help the person deal with the "labeling" issue.

The Canadian Task Force, as quoted by Dr. Kirk, makes the common mistake of considering all persons more than 65 years of age as being in the same risk category. It is clear that the prevalence of dementia begins to rise sharply past the age of 70 years, and we suggest that cognitive screening of persons 75 years and older would identify significant numbers of impaired persons, many of whom would benefit from early detection.

We agree that many community, university, and hospital-based physicians without specific geriatric training are able to diagnose and manage persons with moderate or advanced dementia syndromes; however, patients with more subtle deficits would most likely require the expertise of physicians with specific geriatric experience and training.

If and when definite medical treatment for Alzheimer disease becomes available, it will be important to be able to identify persons with early disease, before extensive neuronal damage has occurred. Parallel to developing such treatments, we need to pursue efficient methods of identifying persons with early disease. Until such time as a reliable biologic marker is available, clinical evaluation of the patient's cognitive function may be our only option. It is reasonable and important, therefore, for researchers to pursue cost-effective, reliable, and easily administered instruments for the detection of early dementia.

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Chapel Hill, NC

Preemployment Evaluations

To the Editor: We would like to commend Drs. Holleman and Matson for raising the important issue of preemployment evaluations by family physicians.[1] It is not surprising that there is a lack of practice standards among family physicians while performing preemployment evaluations.

The following are a few concerns of the practice environment that we believe should be identified as playing a role in preemployment evaluation dilemmas:

1. To match a person to the job properly, some testing may be necessary. For certain occupations, this testing may be mandated by law. One such example is the chest radiograph for those who are exposed to asbestos; another example is preemployment blood lead level measurement for those exposed to lead. Sometimes employers insist upon routine preemployment screening tests that may be of no value. Most tests not only are cost ineffective, but also present the liability and ethical issues of dealing with abnormal results.
2. On the confidentiality issue, most employers do not wish to know the test results, such as the cholesterol level. All they want to know is whether the applicant is fit to perform a prescribed job.
3. When performing a preemployment physical examination, the examining physicians should ask themselves whether this applicant can perform the prescribed job in the near future. Obviously, a person with lung cancer cannot perform even a clerical job because of the potential for frequent absenteeism from his illness. On the other hand, a person with a history of total knee reconstruction surgery may still perform a job of data entry without restrictions.
4. When performing a preemployment evaluation, physicians should limit themselves to the role of medical advisor to the employing agency. Physicians can make medical recommendations whether the applicant is fit to work. They should avoid making comments that may lead the appli-

cant to believe that they are making the hiring decisions based on the medical findings.

5. The dilemma for the physician to switch from a treating role to an investigating role is well understood. Therefore, to avoid a conflict of interest, most occupational health physicians recommend that the same physician avoid treating a patient and performing a preemployment or fitness-for-duty examination. Most would agree that physicians who perform a preemployment evaluation do not have physician-patient relationships.

Finally, if employers insist on performing unnecessary testing, we as physicians should attempt to educate employers about what testing is medically indicated to answer the question of whether the applicant can perform a prescribed job.

Frederick Y. Fung, M.D., M.S.
Roy S. Kennon, M.D., J.D.
San Diego, CA

References

1. Holleman WL, Matson CC. Preemployment evaluations: dilemmas for the family physician. J Am Board Fam Pract 1991; 4:95-101.

To the Editor: As Holleman and Matson (J Am Board Fam Pract 1991; 4:95-101) have correctly observed, there is little in the recent literature that family physicians and other primary care doctors can use as a guide to performing preemployment examinations fairly and effectively. Their paper and others they cite indicate a need to take a fresh look at relevant ethical and procedural issues. Most of these matters, however, have proved less problematic in practice than might be expected on theoretical grounds.

Because applicants for employment are usually examined by physicians with whom they have no preexisting professional relationship, physicians should seldom face ethical pressure to overlook information that might properly lead to rejection. Indeed, the practitioner has both contractual and ethical obligations to record all significant findings. An applicant who has an alcohol problem severe enough to be evident to an examiner who has not seen the person before may be sick enough to pose danger to self or others on the job; accepting such a person for employment may also perpetuate his or her denial of the existence of the problem. It is reasonable for an employer to expect an applicant with an inguinal hernia to get it repaired surgically before starting work rather than later claiming it to be job related. Businesses that have faced deteriorating employee performance, rising work-related injury rates, and other consequences of illicit drug use in the workplace understandably want to do whatever they can to avoid hiring more drug users.

Holleman and Matson correctly note that applicants for work should be clearly informed that information obtained in the course of the preemployment examination, including drug screening tests, can be communicated to the employer and used as a basis for rejection. It has been my personal experience, however, that businesses want to know only whether applicants are capable of doing the work for which they are being hired; they do not wish to misuse information provided by the physician. As the authors have indicated, the practitioner should retain the physical examination record and notify the employer only that the applicant is acceptable for employment, acceptable with specified qualifications, or not acceptable. If something is found that requires further medical attention but is not disqualifying for the particular position, such as mild hypertension or glucose in the urine, it is a simple matter to write the findings on a piece of paper and hand it to the applicant with instructions to take it to his or her family physician for further action. The examiner keeps a photocopy of the note, of course.

The authors correctly note that most employers do not tell the examining physician what the job demands will be. There are three ways to address this problem. One is to ask the employer to provide the information. Another is to ask the applicant, who usually has at least general knowledge of what will be expected. The third and best is to pay a visit to the workplace. In my experience, employers are delighted when a physician asks for a plant tour. If nothing else, the practitioner will then know what an applicant means when he says, "I've been hired to run the batch machine," or whatever.

In my view, it is important for physicians not to fall into a Robin Hood posture, which sees all employers as avaricious and all workers who claim disability as deserving. In my section of the country, for example, there is a remarkable upsurge of reports of disability from chronic work-related backaches just before the first week of deer-hunting season. A large number of workers submit spurious or exaggerated injury claims, and the physician who helps an employer guard against them is not violating standards of medical ethics. The physician's commitment must be to the truth, whether that favors the worker or the company. That, in my experience, is what most employers want.

Performing preemployment examinations requires a different mindset than true family practice, but it is a service that family physicians and other primary care physicians can provide appropriately and without misgivings as an integral part of their practices without compromising appropriate standards of medical ethics.

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The above letters were referred to the authors of the article in question, who offer the following reply:

To the Editor: We appreciate the letters by Drs. Fung and Kennon and Dr. Gillette, which mostly support