



The record is unlikely to record repetitive symptoms every time the patient is seen, especially during a long illness or protracted recovery. To lawyers and insurers, this absence of notation means patients no longer have a symptom, although the physician knows they do. It is not economically viable to write, during every visit, notes that are complete enough to be used in place of a properly constructed medical report. It is also quite impossible to obtain this kind of detailed information from most charts, which I have reviewed for both hospitals and the Canadian Medical Protective Association. Illegibility and personal abbreviations further compound the problem.

It is time for physicians to bring this practice to a resounding halt. If we can stop the demand for the entire chart, we must respond by producing timely and accurate medicolegal reports.

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[The authors respond:]

Dr. Riley has raised an interesting point concerning potential "fishing expeditions." We raised the same concern in our article by suggesting that physicians ask patients if there is any information they want omitted from the written record or not released as part of a general request for all medical information.

However, the point is that, instead of a general release of the entire medical record, patients should provide consent concerning the release of specific information. Riley's point is well taken.

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Measuring behaviour in children with high cholesterol levels

The article "Cholesterol screening of children at high risk: behavioural and psychological effects" (*Can Med Assoc J* 1997;156:489-96), by Dr. Ellen Rosenberg and associates, adds to the growing literature on the harms of preventive medicine.

Although the authors are cautious with their conclusions, we believe that several methodologic problems limit their ability to draw the conclusions that they did. The first is the timing of administration of the Child Behavior Checklist (CBCL). The authors did not provide the baseline measurements; furthermore, the CBCL protocol requests that parents rate behaviour during the 6 months preceding the test. Thus, the CBCL scores at 1 month may reflect behaviour during the 6 months preceding the test, before the diagnosis of hyperlipidemia. Likewise, the 12-month assessment may reflect the immediate postdiagnosis scores. The authors omitted the competence section of the CBCL, which states that the problem section "measures the disturbances most relevant to [their] subjects." Data obtained from the competence section provide valuable information and may be equally important in evaluating behavioural problems. Indeed, the authors of the CBCL have determined that inclusion of competence scores can reduce the chance of misclassifying children's behaviour as being in the "clinical range."¹ Moreover, examining the child's abilities in sports and friendships taps important aspects of a child's behaviour that may be affected by a chronic illness.

The authors report no differences between scores on any of their outcome measures, but then state that children in the case group were "much more likely" to have behavioural disturbances, based on the pro-

portions of the group with high CBCL scores. This conclusion is flawed for 2 reasons. First, child behaviour is a continuum. Making categorical distinctions on the basis of the CBCL score is less reliable for children who score in the "borderline" category (around 62), and there is clearly an advantage to comparing continuous quantitative scores.¹ Second, the small sample size complicates the interpretation of the differences in proportions of patients who had "high" scores. We carried out a χ^2 analysis of the proportions of children with high scores at any time; it did not show a statistical difference between the groups.

Behavioural scores in children result from a myriad of personal, social, cognitive and situational variables.² The limitations of this study considerably hinder the strength of the conclusions concerning the behavioural effects of lipid screening.

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References

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2. Sattler JM. *Assessment of children*. 3rd ed. San Diego (CA): Jerome M. Sattler; 1992.

[One of the authors responds:]

We acknowledge that the lack of a baseline score limits our ability to attribute the behaviour problems reported by the mothers of children with newly diagnosed hyperlipidemia to the diagnosis. Dr. Joyce and Ms. Limbos are also concerned that the 6-month period during which the parent is asked to report on