nies and accident adjusters. Many of these reports function only to sustain a bureaucracy, and some of the greatest abusers are our governments.

Physicians, who are short of time and annoyed by many of these requests, are also ill-prepared to handle them. The "fuzzy politics" of providing a medical opinion to a third party continues to be flawed because the providers (physicians) and the consumers (all third parties) do not understand each other's specific needs. Physicians do not understand rehabilitative medicine or the concept of fitness to work. Too often, they are caught up as enablers of prolonged disability because of the dictum to "do no harm," or they assume they carry the liability for disease that probably does not exist.

As medicine and clinical care move toward service-based practice and clinical practice guidelines, physicians need better training, skills and experience to deal with third-party evaluations. Clinical advice to remain disabled until physicians can prove or disprove a pathologic cause that may or may not be disabling is bad medical advice. Maintaining patients in a sick role until they are abandoned with no diagnosis or treatment is inappropriate. The best advice is to focus on what patients can do instead of what they cannot do. The road back from disability is hard enough without physicians being a barrier to recovery.

Medical training and the clinical practice of assessing and managing disability require a paradigm shift, and physicians can either be part of the solution or remain part of the problem. The people who make decisions about disability claims will go around barriers to assessment and decisions if they have to. I believe that physicians have a large role to play in helping patients convalesce and return to full function.

This letter is an open plea to the CMA to devote more time to debating and taking action on these issues. Most physicians would welcome the CMA's help and guidance.

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Students work to foster tolerance

The article "Medical curricula for the next millennium: responding to diversity" (*Can Med Assoc J* 1997;156:1295-6), by Dr. Christiane Kuntz, addresses the need to change medical education. The author argues that practitioners who use noninclusive language need to be aware of the negative influence they may have on maturing medical students. However, in view of the promotion of self-directed learning, perhaps the responsibility for developing culturally sensitive attitudes and knowledge of gender issues in medicine should be placed more on the students. We should no longer rely exclusively on the curriculum or the physician-lecturers to guide students toward attitudes that will benefit them in their practice. Students should and are taking the initiative in exploring the issues affecting minorities, women, gays and lesbians that may be ignored or poorly represented in the curriculum.

In a recent study of the first-year class at the University of Western Ontario medical school, more than half of the students responded Yes to the question: "Did you join any extracurricular activities in order to learn more about a subject that is not taught in the curriculum?" Student groups such as Community Link, an outreach program in which students interact with homeless people and refugees, are supplementing the curriculum by fostering tolerance and sensitivity. OMEGA, the medical school's gender-awareness group, has held forums on issues affecting gay, lesbian and bisexual people and on violence against women in the context of medicine. These groups challenge students to examine their roles in the community and in the lives of their patients.

The diminishing number of lecture hours and the movement toward problem- and case-based learning are making students responsible for gaining knowledge of issues affecting community groups. Inclusive ideas should be reinforced through conventional teaching but can be discovered through other aspects of medical education.

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Fishing expeditions in doctors' offices

Everything Daniel Dodek and Dr. Arthur Dodek wrote on patient confidentiality is true ("From Hippocrates to facsimile: protecting patient confidentiality is more difficult and more important than ever before," *Can Med Assoc J* 1997;156:847-52). However, I believe they omitted the single most sinister invasion of a patient's privacy.

Recently lawyers and insurance companies have begun demanding a photocopy of the patient's entire chart rather than a medical report by the attending physician. Several dangers arise because of this practice. The worst is that it gives lawyers and insurance companies a chance to go on "fishing expeditions" through the whole record, not just search for the facts pertinent to the incident concerning them.

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 proportions 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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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