



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:]**

**D**r. 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**

**T**he 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."<sup>1</sup> 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.<sup>1</sup> Second, the small sample size complicates the interpretation of the differences in proportions of patients who had "high" scores. We carried out a  $\chi^2$  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.<sup>2</sup> The limitations of this study considerably hinder the strength of the conclusions concerning the behavioural effects of lipid screening.

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**References**

1. Achenbach TM. *Manual for the Child Behavior Checklist/4-18 and 1991 profile*. Burlington (VT): University of Vermont Department of Psychiatry, 1983.
2. Sattler JM. *Assessment of children*. 3rd ed. San Diego (CA): Jerome M. Sattler; 1992.

**[One of the authors responds:]**

**W**e 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



the child's behaviour includes many months before diagnosis. Although parents may attempt to review the entire 6 months, they are likely to recall recent events more clearly and to give more weight to them in their replies. Second, data were collected 1 month after the definitive diagnosis, but this diagnosis was the culmination of an extended evaluation process which, in one of the hospitals, involved 4 visits to the clinic. Therefore, the diagnosis was at least a strong possibility for much of the 6 months before the first CBCL was completed. Finally, these concerns do not apply to the cases of long-term hyperlipidemia.

The second issue concerns the omission of the social competence section. We decided to omit this section because our primary interest was in psychological and behavioural problems. The social competence section was also omitted in the interests of time; as it was, each mother spent more than an hour completing questionnaires. The social competence of these children is certainly of interest and concern.

Finally, we feel that a division of CBCL scores into high ("clinical range") and normal is the most meaningful way of examining data on

a group of children in a research study. We agree that a score near the cut-off point needs to be interpreted within the whole clinical context when treating an individual child. Yet we know that children with scores in the clinical range are much more likely than those with normal scores to have behavioural problems that cause important difficulties in their lives. It is true that the clinical significance of a mean score of 62 in one group versus 64 in another group is not at all clear.

A larger-than-normal proportion of our subjects had behavioural problems. This is a cause for concern and needs to be assessed in other populations before widespread lipid screening can be recommended.

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### Correction to French edition of CPS

I wish to inform *CMAJ* readers of a correction to the product monograph for Fluoracaine, by Dioptic

Laboratories, that appeared in the 32nd (1997) edition of the *Compendium des produits et spécialités pharmaceutiques*.<sup>1</sup> The information in the product monograph should be replaced with the following:

**FLUORACAINE (TM)**

Dioptric

Sodium de fluorescéine — Chlorhydrate de proparacaine

Agent de diagnostic ophtalmique — Anesthésique

Présentation : Un mL de solution stérile ophtalmique contient du sodium de fluorescéine à 0,25 % et du chlorhydrate de proparacaine à 0,5 %. Agent de conservation : thimérosal à 0,01 %. Flacons compte-gouttes de 5 mL. Protéger de la lumière. Réfrigérer entre 2 et 8°C.

We apologize for any inconvenience this error may have caused our users.

**M. Claire Gillis, BSc (Pharm)**

Editor-in-chief

*Compendium of Pharmaceuticals and Specialties (CPS)*, 32nd edition

### Reference

1. *Compendium des produits et spécialités pharmaceutiques*. 32<sup>e</sup> éd. Ottawa : Association pharmaceutique canadienne; 1997:680.

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