The above letter was referred to the authors of the article in question, who offer the following reply.

To the Editor: In Table 6, the values on the "Total" line were calculated as the means of the individual patients' summed severity scores, not the sum of the mean severity score for each symptom, as Dr. Solin suggests. We should have clarified this in a footnote to the table. A similar data handling procedure was taken in Table 5 as well.

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Epidemiological Abuse

To the Editor: I quite agree with Dr. Gayle Stephens's editorial "Epidemiological Abuse" in the October-December 1990 issue of *JABFP*. I, too, am concerned about the danger of "knee-jerk" adoption of every bit of advice from medical experts. If a particular epidemiological study suggests that certain preventive health measures are prudent, this does not mean that each physician should start foisting these recommendations onto every patient. After all, patients are diverse individuals, not just members of a population group.

For example, all physicians recognize the dangers of smoking cigarettes. Does that mean that we should strongly push every one of our smoking patients to quit as soon as possible? I certainly don't think so. Timing is very important. I do not hesitate to educate a smoker on the hazards of smoking. However, I have on rare occasions advised a patient *against* quitting at a particular time. Let us consider a depressed patient who is going through a crisis, such as severe marital stress or a critical job-related situation. If that patient's physician were to push him or her to quit smoking at that time, attention could be diverted from more immediate problems. If the patient did quit smoking during the stressful crisis and suffered nicotine withdrawal symptoms, the depression could be worsened. This could lead to bad decisions and personal misfortune. I have advised several depressed or anxious patients to continue smoking until their emotional state improved enough to allow a trial of cessation.

If it is sometimes appropriate to postpone advice that has a clear and well-documented rationale, then it is even more appropriate to avoid becoming a rigid advocate of more questionable or less clearly defined recommendations.

Today, physicians face many pressures to do what some expert says is proper, rather than what they judge is in the best interest of an individual patient. On the one hand, the threat of a malpractice suit pressures a physician to recommend each and every test or procedure that has ever been advocated by an article in a medical journal. On the other hand, pressures from HMOs, insurance companies, and Medicare sometimes discourage tests and procedures that are clearly in a patient's interest. Any effort to impose nationwide practice "standards" or "guidelines" will only make a bad situation worse. It is important for physicians to make at least some effort to resist the above pressures and to provide individualized medical care to their patients.

Personally, I endorse the libertarian view that persons have a right to be autonomous and self-sovereign and that they have a right to use their own judgment to decide whether to follow their physician's advice. Even those physicians who don't believe in this view would agree that it is sometimes wrong to be too forceful in pushing patients to follow recommendations.

When dictating their medical records, physicians might be tempted to overstate how strongly they recommended to a patient a procedure that they didn't really believe in, but which some "expert" witness might claim as "standard" medical practice. It would be a sad state of affairs if physicians were to feel the need to exaggerate their medical records in this fashion on a routine basis, but that is exactly where we are headed.

I, too, "protest against what I believe is a coming era of unprecedented medical control over both physicians and patients, fueled by what experts say is good for them." It is important for physicians who really care about the freedom, autonomy, welfare, and individuality of their patients to speak out against this dangerous trend. After all, what is family practice all about—using our minds to help persons be happier and healthier or acting like robots following a cookbook approach to medical care? Having been a patient myself, I realize that there is no contest between the above two approaches, and I'm sure other patients agree. Unfortunately, the cookbook approach is gaining ground, and we must put a stop to this.

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Hypocholesterolemia in Childhood

To the Editor: The recent article by Bell and Joseph in the *Journal* is one of at least two recent reports of mass screening of blood cholesterol in children.[1,2] In both of these studies, the authors found that between a third and a half of children who had elevated cholesterol values had no family history of known hypercholesterolemia. The authors conclude that mass screening of children is therefore justified, as opposed to screening just "higher risk" children of parents with elevated cholesterol values.

I have some concerns about this conclusion. It is clear from population-based surveys that as few as half of an unselected sample of adults have ever had their cholesterol checked.[3] This raises an important alternative explanation for children who have elevated cholesterols and "negative family history." Do their parents truly have normal blood lipids, or is it just that their parents' elevated cholesterol levels have never been detected, because they have never been checked?

Bell and Joseph, as well as Garcia and Moodie, make the point that many hypercholesterolemic parents were identified after their children's cholesterol was found to be high. Before concluding that all children should be screened, we should do a better job screening their parents. In family practices, this should certainly be a

feasible approach, though it would obviously be more difficult for pediatricians. While not addressed by Bell or Garcia, it would seem to me important for them to have examined how many children with high cholesterols in fact had parents with normal cholesterols. These are the children who would truly be missed given effective screening of parents' cholesterol and subsequent screening of "high-risk" children. This is likely to be a much smaller fraction of hypercholesterolemic children than the 36 to 48 percent found in the Bell and Garcia studies.

Until this type of data is available, it may still make sense for pediatricians to screen all children, given their more limited access to unscreened parents. For family physicians, however, who are likely to have the parents under their care, it may be more desirable to screen parents first, and children of hypercholesterolemic parents second.

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References

1. Bell MM, Joseph SJ. Screening 1140 fifth graders for hypercholesterolemia: family history inadequate to predict results. J Am Board Fam Pract 1990; 3:259-63.
2. Garcia RE, Moodie DS. Routine cholesterol surveillance in childhood. Pediatrics 1989; 84:751-5.
3. Schucker B, Bailey K, Heimbach JT, et al: Change in public perspective on cholesterol and heart disease. Results from two national surveys. JAMA 1987; 258:3527-31.

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

To the Editor: Dr. Kelly makes an important point that family physicians need to be diligent in screening adult patients for hypercholesterolemia. As he points out, however, up to one-half of all adults have never had their cholesterol levels checked. Healthy young adults often fail to seek preventive health care and may see family physicians only episodically for acute illnesses. On the other hand, most children do routinely see physicians until age 5 to complete primary immunizations. The preschool visit could be a good opportunity for cholesterol screening, discussion of diet, and a reminder that the parents should also have cholesterol levels tested.

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