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Letters ❖ Correspondance

Transferring medical records

I am legal counsel to the Ontario Medical Association. My attention was drawn to the article[1] by Dr Faloon et al in the March 2002 issue of *Canadian Family Physician*. Figure 2 was a document entitled "Patient-requested transfer of medical records." The document gave the patient several options, the second of which reads: "Cheque not included with consent form. Our office will notify you when the records are ready. You will send payment and we will forward the record on."

This section suggests that the patient's records will not be sent unless payment is forthcoming. In the context of medical-legal reports, the College of Physicians and Surgeons of Ontario has stated that it is not professional misconduct to request prior payment from a lawyer or third party before a report is prepared and released. If the request for prior payment resulted in undue delay, however, then the physician could be subject to an allegation of professional misconduct pursuant to Regulation 856/93 under the Medicine Act.

In regard to patients, the College of Physicians and Surgeons of Ontario's position is that copies of a patient's chart cannot be withheld on the basis that payment must first be forthcoming. I am supported in my views by the College of Physicians and Surgeons of Ontario's Policy Statement 11-00 entitled "Medical Records." On page 7, the policy statement reads as follows:

> In transferring patient information, a physician may charge the patient only such a reasonable fee as reflects the cost of the materials used, the time required to prepare the material, and the direct cost of sending the material to the requesting physician. A physician may not require prepayment of any such fee. The obligation to pay the account rests with the party who has requested the information. It is an uninsured service and reasonable attempts may be made on the part of the physician to collect the fee. Non-payment of the fee, however, is not a reason to withhold the information.

I believe that your readers require a clarification.

—Robert L. Lee
Toronto, Ont
by mail

Reference

1. Faloon T, Dermer M, Pelletier S, Swiggum S. Transferring medical records: improving the exchange [Practice Management]. *Can Fam Physician* 2002;48:563-7.

Make your views known!

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Response

I appreciate Mr Lee's concern that we, as physicians, must always be cognizant of the rules and regulations set forth by our regulatory Colleges. To this end I submitted the final draft of the chart transfer request form to both the College of Family Physicians of Canada and the College of Physicians and Surgeons of Ontario for their review and comments before submitting the article to *Canadian Family Physician*. Mr Lee's concerns were proactively discussed with the advisors of both organizations.

I would agree with Mr Lee if option 2 were not complemented by the fourth option included on the form: "Our office will notify you when we have sent the record to your new doctor so you can send in payment." This option clearly indicates that the patient does not have to pay in advance of chart transfer.

Since publication of the article, the College of Physicians and Surgeons of Ontario has formally complimented the article and the two forms, and they have requested permission to include these two forms in their next update of medical record-keeping guidelines.

—Tom Faloon, MD, CCFP, FCFP

Broader role for FPs in managing childhood diabetes

Thank you for the article on management of diabetes in children and adolescents.[1] This condition is commonly encountered in family practice, especially in emergency departments. The information in the article was cohesive and relevant. The summary of sick

day management was concise and accurate. I suggest family physicians get more detailed patient handouts regarding advice to parents on management of sick days from a diabetes clinic. There are, however, a few areas in the article I would like clarified.

I appreciate the recognition of the role of family physicians by the authors, but I humbly ask that they consider that rural family physicians fulfil an even broader role, which includes emergency and hospital management of conditions of children with diabetes: diabetic ketoacidosis (DKA), hypoglycemia, and intercurrent illness. In my limited experience, these conditions are often managed by family physicians, perhaps with telephone consultations with pediatricians or endocrinologists, but often without. Rural communities generally have diabetes education services (usually employing nurses), which are invaluable resources to rural family physicians for both inpatient and outpatient teaching.

Rural family physicians need to have an evidence-based approach to managing DKA for the reasons given above. The suggested plan given in the article is a good summary, but there are two areas I would like clarified. The first is the role of potassium repletion. Although I cannot quote any evidence on this, the pathophysiology of DKA suggests that any patient with DKA is potassium-deficient due to the combination of acidosis and osmotic diuresis. Thus, the rehydration fluid that I have seen used after the initial bolus is 1/2 normal saline with 40 mmol/L K+.

Second, the paper states that "too rapid correction of a fluid deficit, especially with hypotonic fluid, might increase risk of cerebral edema leading to permanent neurologic impairment or even death."

Two recent studies challenge this concept. One case-controlled study evaluated 61 children who developed cerebral edema during hospitalization for DKA between 1982 and 1997 at one of 10 pediatric centres and compared their clinical characteristics with those of 355 control children with DKA hospitalized at one of the study centres who did not develop cerebral edema.[2] Researchers found that independent predictors of cerebral edema in children with DKA were a higher initial urea nitrogen level (9.6 mmol/L vs 7.1 mmol/L) and a lower $PaCO_2$ level (11 mm Hg vs 18 mm Hg). They found that age, baseline glucose levels, and rate of fluid or sodium administration were not associated with the occurrence of cerebral edema. Researchers concluded that development of cerebral edema appeared to be related to the severity of the DKA rather than to the nature or timing of treatment given.

Also, a retrospective review of fluid management during the first 4 hours of care in 49 episodes of DKA managed at a tertiary care hospital in Alberta between 1991 and 1996 found that the mean amount of fluid administered by 4 hours was 42.3 mL/kg, yet no patient developed clinical evidence of cerebral edema, and all patients were discharged neurologically intact.[3]

I welcome the authors' views on these topics and would also ask that they comment on the appropriateness of screening all patients with type 1 diabetes for celiac disease.

—Joel Kroeker, MD
Family Medicine Resident
Family Medicine North, Thunder Bay, Ont
by e-mail

References

1. Curtis JA, Hagerty DH. Managing diabetes in childhood and adolescence. *Can Fam Physician* 2002;48:499-509.
2. Glaser N, Barnett P, McCaslin I, Nelson D, Trainor J, Louie J, et al. Risk factors for cerebral edema in children with diabetic ketoacidosis. *N Engl J Med* 2001;344(4):264-9.
3. Rutledge J, Couch R. Initial fluid management of diabetic ketoacidosis in children. *Am J Emerg Med* 2000;18(6):658-60.

Response

I thank Dr Kroeker for his comments. Our article[1] repeatedly emphasizes that family physicians should be active participants in management of childhood diabetes. For this reason, it includes specific sections on the management of hypoglycemia, intercurrent illness in children with diabetes, and initial management of suspected diabetic ketoacidosis (DKA).

In my experience, family physicians do not treat fully established DKA in children. They do, however, treat the initial stages of suspected or established DKA before transferring patients to secondary or tertiary care pediatric centres. These centres have the pediatric and endocrine expertise and often the intensive care facilities necessary to deal with all contingencies that might arise during the 24 to 48 hours of DKA treatment.

Dr Kroeker also requests clarification of two aspects of the treatment of DKA. Before addressing these points, I should emphasize that our article did not at any stage deal with the treatment of fully established DKA. The treatment schedule we suggested was intended to apply only to children who are being transported to a secondary or tertiary care centre by a family physician practising in an isolated area. The purpose of this modified plan is to prevent further deterioration during transport and achieve partial rather than full correction of dehydration and acidosis.

One of the suggestions was that the patient receive only 20 mmol/L of potassium in the infusion fluid. We recommended this lower dose during transport, which might entail a journey of several hours, because it should guard against accentuation of hyperkalemia, which might already be present in the early stages of DKA, while at the same time prevent development of severe hypokalemia after several hours.[2] Higher doses of potassium should be used only in emergency departments where there is access to continuous EKG monitoring and frequent laboratory analysis of serum potassium.

Space does not permit a detailed treatment of Dr Kroeker's query that perhaps it is now time to disregard the widely held opinion that cerebral edema in DKA might be associated with excessive fluid correction. I am not convinced, however, by the two publications that he cites.[3,4]

Though the study by Glaser et al[3] was large, its authors nevertheless state that they cannot definitely

conclude that factors other than a higher serum urea nitrogen and a lower PCO_2 are unimportant in the pathogenesis of cerebral edema. Rutledge and Couch[4] emphasized that their patient numbers were too small to enable any conclusions to be drawn regarding fluid administration in DKA and its outcome, because cerebral edema occurs in only 1% to 3% of children with DKA.

Furthermore, Rutledge and Couch[4] emphasized the need for conservative fluid replacement in children with DKA and stated quite clearly that these children should not be given a fluid bolus as initial therapy unless they are in shock.

This is in agreement with our approach. The plan suggested in our article, if applied to a child of average weight, would result in the child's receiving about 5.5 mL/kg of saline hourly during transport. A child who is admitted to an emergency department with fully established DKA and without previous treatment, who is 10% dehydrated but not in shock, should not receive more than about 8 mL/kg of saline hourly on a full DKA treatment regimen.

It is impossible in this letter to deal with the place of celiac disease screening in type 1 diabetes. I refer Dr Kroeker to a recent review of the subject.[5]

—Joseph A. Curtis, MB, FRCPC

References

1. Curtis JA, Hagerty DH. Managing diabetes in childhood and adolescence. *Can Fam Physician* 2002;48:499-509.
2. Sperling MA. Diabetes mellitus. In: Sperling MA, editor. *Pediatric endocrinology.* Philadelphia, Pa: W.B. Saunders; 1996. p. 229-63.
3. Glaser N, Barnett P, McCaslin I, Nelson D, Trainor J, Louie J, et al. Risk factors for cerebral edema in children with diabetic ketoacidosis. *N Engl J Med* 2001;344(4):264-9.
4. Rutledge J, Couch R. Initial fluid management of diabetic ketoacidosis in children. *Am J Emerg Med* 2000;18(6):658-60.
5. Roldan MB, Barrio R, Roy G, Concepcion P, Alonso M, Yturriaga R, Camarero C. Diagnostic value of serologic markers for celiac disease in diabetic children and adolescents. *J Pediatr Endocrinol Metab* 1998;11:751-6.

Looking beyond a diagnosis

In clinical practice, the sensitivity of the Mood Disorders Questionnaire, which was published with my recent paper[1] on bipolar spectrum disorders, can be much improved by asking some questions about how patients function in their daily lives.

For example, a 22-year-old unemployed, part-time college student answers "yes" to 11 of 13 items in the questionnaire, suggesting hypomania. The symptoms tend to co-occur; however, she considers them only a minor problem. When asked whether they would present a more serious problem if she were a single parent with a toddler at home full time, she affirms that her symptoms would indeed be a serious problem.

Furthermore, because the episodes of hypomania tend to last only 1 to 2 days, she is able to get her school work done. She would have more difficulty if they lasted longer.

The tendency of patients to adapt their lifestyles to their illnesses should not cloud our ability to discern and judge the diagnostic significance of their symptoms.

—Andre Piver, MD, CCFP
Nelson, BC
by e-mail

Reference

1. Piver A, Yatham LN, Lam RW. Bipolar spectrum disorders. New perspectives. *Can Fam Physician* 2002;48:896-904.

Correction

In the article "Bipolar spectrum disorders. New perspectives" by Dr Andre Piver et al (*Can Fam Physician* 2002;48: 896-904), there was an error in the e-mail address in the correspondence address. The correct e-mail address is **steele_piver@netidea.com**. Also, in **Figure 1**, the citation should be Hirschfeld et al.[20]

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