peripheral steroid blocking congeners, somewhat analogous to the fascinating modern history of the β blocker family so valuable in the topical (in both senses) treatment of glaucoma. A more general application for a peripheral corticosteroid blocker (compare the more central metyrapone) apart from open angle glaucoma is probably limited, however—and mainly to topical treatment: Dendritic ulcer? Dermatology? Puerperal depression? Vascular hypertension? Peptic ulceration? Diabetes?

The biochemists and pharmacologists are certainly helping to reunite us specialists into the general medical fold, just as the operation microscope and so forth keep us in the general surgical fold.

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Cerebral haemorrhagic infarction in young patients with hereditary protein C deficiency

SIR,—We read with interest the report by Dr A R Wintzen and others detailing cerebral vein thrombosis in patients with hereditary protein C deficiency and the association with deep venous thrombosis (2 February, p 350). We have experienced a similar problem in a patient who suffered a deep venous thrombosis of the calf and pulmonary embolus after an intrauterine death at 27 weeks' gestation in 1981. A second intrauterine death at 18 weeks' gestation in 1982 was aborted with intravenous prostaglandin covered by prophylactic low dose subcutaneous heparin. Despite this she developed a cerebral vein thrombosis. This was diagnosed by computed tomography and treated by evacuation of the haematoma and dexamethasone. After operation the patient developed an iliofemoral thrombosis necessitating full anticoagulation with heparin for five days followed by warfarin. Coagulation studies failed to show any abnormality and unfortunately the protein C was not measured.

We would be interested to know if the authors' series of patients with protein C deficiency had an increased incidence of missed abortion or intrauterine death. We would also inquire about their views on the suitability of treating such patients with long term heparin rather than coumarins for their thromboembolic episodes, since it is suggested in the report that coumarins played a part in the generation of cerebral vein thrombosis in one of their patients.

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*.*Dr Broekmans and Dr Wintzen reply below.—ED, *BMJ*.

SIR,—In our patients with protein C deficiency, who now number over 80, we did not observe an obviously increased frequency of abortion or intrauterine death, nor have such events been noticed by other investigators dealing with protein C deficient patients.

We did not intend to suggest that coumarins had played a part in the generation of cerebral vein thrombosis. Three of the four cerebral

events described occurred in the absence of (adequate) oral anticoagulation. The second cerebral event in the first patient, however, was exceptional, presenting as a profuse haemorrhage into the subarachnoid space from the fourth ventricle, probably from the haemorrhagically infarcted choroid plexus, and occurring during the induction phase of coumarin treatment. In our report we suggested that this haemorrhagic event was due to an initial increase of imbalance between protein C and the other vitamin K dependent coagulation factors in a patient already deficient for protein C.

With respect to treatment of thrombotic manifestations in protein C deficient patients, according to our experience coumarins are effective; however, to avoid coumarin induced skin necrosis at the start a loading dose of coumarins should not be given and the prothrombin time should be checked daily. We do not have experience with long term heparin treatment. It has proved ineffective in preventing massive thrombosis in severely protein C deficient neonates.^{2,3} In heterozygous patients heparin does not always prevent coumarin induced skin necrosis.^{4,5} Moreover, administering heparin on a long term basis is impracticable and may have adverse effects, such as osteoporosis and thrombocytopenia.

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Confidentiality for NHS employees?

SIR,—The principles of the draft code of practice for medical information under the Data Protection Act 1984 (8 December, p 1559) emphasise that information about a patient is kept only for the purpose of health care and that the patient has a right to expect that health authorities will respect the confidential nature of this information and not disclose it to members and employees of the authority for reasons other than his or her health care. While there are several exceptions to these principles, when disclosure may be made without consent, there is one category which lacks precise definition where the health authority may require access to clinical records "for investigation of complaints and for essential management functions." Within this category there are a number of bona fide reasons why disclosure without consent may be necessary. The supplementary notes emphasise, however, that all such cases must be scrutinised to ensure that the disclosure is considered to be essential and not merely convenient.

When acting as employers rather than providers of care health authorities are becoming increasingly involved in legal action with their

employees—for example, when an employee is suing the health authority for an injury occurring at work. In these circumstances it is known to be common practice for the health authority to arrange access to that employee's complete hospital NHS record so that its legal adviser can assess the case. This process normally bypasses the consultant with clinical responsibility for the employee/patient, and access is obtained through administrative procedures without consent. When the district medical officer or specialist in community medicine takes part in this procedure the ethics of his action must be open to question.

If, on the other hand, the legal adviser to an employer outwith the NHS sought similar access without consent that record would be jealously guarded within the "fundamental principles" outlined in the code. That legal adviser would then normally be required to seek the medical information desired by obtaining the employee's consent to commissioning a medical report from the clinical consultant or general practitioner concerned. If consent were not obtained he would then have to convince the court that it should order the relevant part of the record to be produced.

The discrepancy between these two arrangements represents an unacceptable two tier concept of confidentiality. The exception which is made to the principles of confidentiality must be perceived as a convenience to the health authority rather than an essential management function. While the Secretary of State responsible for health actually owns the NHS records in the limited legal sense, his responsibility to maintain their confidentiality surely takes precedence over aspects which may be of convenience to him as an employer. With an NHS workforce of 1 000 000 people it is incongruous that one level of confidentiality applies to this large group, while non-NHS employees can enjoy a higher level of confidentiality. This situation should be clearly identified within the code as a non-essential management function and it should be of concern to the BMA and all other health service trade unions that this anomaly is recognised and appropriate safeguards taken within the framework of the new code.

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Medical education and practice in Britain 150 years ago: a verbatim testimony

SIR,—Dr Norman Howard-Jones mentioned that the members of the House of Commons committee often referred to surgeons and apothecaries as "lower," "humbler," or "inferior" grades of the medical profession and stated that, in the case of the surgeons, such appellations were not justified (16 February, p 539).

This is equally so with the apothecaries. As Dr Howard-Jones pointed out, the requirements for admission to either of the "humbler" orders, surgeons and apothecaries, had been quite exacting for some years. My researches into the history of apothecaries both in London and in the provinces show that they were not inferior in any sense either then or in the seventeenth and eighteenth centuries.¹⁻⁶

From the earliest times they had strictly controlled apprenticeships, and those apprenticed to the London society had to pass exam-

inations conducted by both the society and the College of Physicians. The standard must have been high as candidates were examined for their basic knowledge before being bound and for their practical knowledge at the end of their apprenticeships. Some were refused to be bound because of insufficient education, and there are numerous examples of final candidates being referred and required to undergo further study. A surprisingly large number of apprentices came from the provinces and many of them returned there to practise.

The apprentices came mainly from the educated classes, often being sons of the gentry, the clergy, physicians, apothecaries, and occasionally county families. A few were the sons of titled persons. Many London and provincial apothecaries were armigerous. Many were granted episcopal licences to practise medicine or surgery, or both, and many of their sons went to the ancient universities and became physicians and clergymen or continued in their father's practices.

Many of the early British botanists were apothecaries, and members of the occupation made considerable contributions to other sciences.⁷ Several apothecaries became fellows of the Royal Society.⁸

I have examined the wills of over 100 apothecaries and they show that most were wealthy men, some extremely so, and that they and their families were on friendly terms with physicians and theirs and there was considerable intermarriage between them. In London a few apothecaries held high office in the city, four being aldermen; in the provinces they were often active in local government and many became mayors.

The myth of the poor unlearned apothecary may have developed from the character in Shakespeare's *Romeo and Juliet* but was not typical of British apothecaries. One of Shakespeare's friends was the wealthy Stratford apothecary John Hall.⁹

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Credit transfers

SIR,—The idea put forward by Sir Reginald Murley (9 February, p 466) of credit transfer between districts for treating individual patients requiring renal dialysis could be applied with benefit to district specialties as well as regional ones.

Many districts have on their medical staff one or more consultants of outstanding ability and organising skill who develop special interests and over the years build up units where work of high quality is carried on,

often more efficiently and at less cost than average. These units inevitably acquire a wide reputation and attract cases from outside the district boundaries. At this stage the district runs into financial trouble because its revenue allocation is based on its own population and takes no account of the extra cost of treating patients from outside its borders. The management is faced with the choice of either forcing the unit concerned to limit its operations severely or allowing it to continue at the expense of other services in the district.

In my own district, where such a situation has developed in the case of hip replacement surgery, we have attempted to get out of the dilemma by offering to treat patients of neighbouring districts in exchange for transfer of some of their revenue. Not unexpectedly, we have had no takers.

It is clear to me, as consultant representative on the district management team, that the existing financial strategy has a dampening effect on enthusiasm and efficiency, engenders unenterprising uniformity at district level, and does not allow really cost effective units such as I have described to develop their full potential. Interdistrict charging for individual patients would correct all this.

I am told by management colleagues that such a scheme would be complicated and expensive; that the "swings and roundabouts" effect would result in it making little difference to a district's overall budget; that it would be resented by many consultants; that to pursue the idea through administrative channels would be unsuccessful. I do not accept all these arguments and would like to suggest that strong pressure from our professional organisations might induce the DHSS at least to investigate the possibility of benefits, both in quality of work and better use of limited financial resources, from credit transfers between districts.

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Cremation certificate fees: a case for charity

SIR,—The intense distress of the parents in cases of perinatal death must be well recognised. What is less well known is the acute financial problem with which the parents may be faced. In Macclesfield health district it is to the credit of the medical profession that the doctors in our district general hospital have for some time waived their right to charge £15 per signature for the cremation certificate. Recently, however, a child born in Macclesfield died in another district and the parents were charged £30 for the signatures required. The parents were further distressed, but it would be unfair to castigate the doctors concerned since they may well have been unaware of all the circumstances.

I confess, however, to being disappointed that the private practice and professional fees committee of the BMA, while sympathetic, does not feel able to take any action. Surely it could make a recommendation (not direction) that doctors might consider waiving their right to a fee in these rare but particularly sad cases. The death grant in these circumstances is the grossly inadequate sum of £9.

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Private practice for whole timers

SIR,—I would like to draw the attention of consultant members of the BMA to the illogicality of the 10% earnings rule in relation to private practice. I presume that it was originally introduced to ensure that full time consultants did only a certain amount of private practice, and therefore it would be logical to assume that the aim would be to restrict all full time consultants to the same amount of private practice work.

However, the present rule says that full time consultants may earn up to 10% of their NHS salary, including merit awards but no other earnings. Thus a person with an A merit award could earn up to £48 470, whereas the consultant without a merit award could earn only £26 080. This obviously means that the two consultants have very different workloads in private practice. It also means that the newly appointed consultant can do less work than the senior consultant, and that a consultant with a large domiciliary practice is not allowed to include this in his calculations, whereas the merit award is allowed, and this again is illogical.

We also have the ridiculous situation where the 10% rule applies to gross earnings. Therefore the consultant who chooses to practise outside health service premises has to pay for his own rent, etc, whereas the consultant practising within health service premises does not have to pay this charge because there is a separate hospital charge raised against the patient, which is not included in the calculations on the gross earnings.

Therefore, the whole method of calculating the amount of private earnings which whole time consultants can undertake is not only illogical but inequitable, and a complete change of system is needed so that all whole time consultants are allowed to do the same amount of private practice.

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How many authors does it take to write a paper?

SIR,—In current times it is very important to have previous publications for the benefit of one's curriculum vitae, if not for the advancement of medical science. In view of this it is important to get among the authors of any published research in which one might have taken part. I note that a case study (not a large multicentre trial) published on 23 February (p 592) had no fewer than 12 authors. Is this a record?

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Inadvertent duplicate publication

SIR,—The notice of inadvertent duplicate publication of an article (16 February, p 517) fulfils the promise forewarned in 1984.¹ Only by such embarrassing revelations will authors be dissuaded from succumbing to the temptation of seeking duplicate, or even triplicate, publication. Few papers are of such importance that they demand publication in different languages or on both sides of the Atlantic. However, one must ask what motivates busy doctors to produce multiple publications? Perhaps the answer is that appoint-