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-