health care and its evaluation have led to the expectation that studies of use of health services will become prominent. It would be deplorable if unreasonable procedures regarding access to data were to hinder practical applications of health record linkage.

Some people will undoubtedly argue that the consent of each subject should be obtained for any procedure that links records. We believe that governments, as custodians of health care databases, have a duty to allow scientific investigators access to them in view of the benefits that have resulted from previous studies based on these databases. A requirement for individual consent would lead to the extinction of useful research using health care databases.

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Records prematurely destroyed

EDITOR,—Nicholas Wald and colleagues recently outlined the threats to research based on personal medical records, posed by the recently proposed guidelines from the Department of Health, the BMA, and the European Commission about safeguarding confidentiality.¹ We, in common with many colleagues, share their concerns. A requirement to obtain explicit consent from each patient before records could be accessed, as proposed by the European Commission, would prevent most epidemiological and clinical studies that need to use personal records, with the exception of very small case series. The need to seek the permission of local ethics committees to undertake such research may seem a less serious obstacle, but this process is likely to effectively block some potentially important studies.

A recently published study about the risks and causes of secondary leukaemia after childhood cancer in Britain provides an example.² The results of this study are of use both in planning future treatment protocols—to avoid or minimise such risks in the future—and in providing unbiased and reliable information for the purpose of rationally monitoring and counselling survivors. As the study was a national, population based cohort study involving the records of almost 16 500 patients the complexity and expense of obtaining clearance from individual local ethics committees would have produced an additional financial and administrative burden that could be prohibitive during a time of extremely limited research funds. The study proceeded with the agreement of the BMA's medical ethics committee for the release of cancer registration details, as part of the standard procedures of the Office of Population Censuses and Surveys.

Unfortunately, gaining permission to access

personal medical records is not the only threat to research that depends on such records. As we recently outlined in the *BMJ* there is evidence that medical records are being prematurely destroyed, and at least in part this seems to be attributable to the pressures for space in the NHS; we also indicated the profound consequences of this premature destruction both clinically for patients and for research,¹ it would certainly be imprudent, and arguably irresponsible, if the need for approval by local ethics committees or inadequate storage space prevented the legitimate long term follow up of survivors of childhood cancer or any other potentially "at risk" group in Britain.

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Restrictions unnecessary and obstructive

EDITOR,—The editorial by Nicholas Wald and colleagues on the use of personal medical records for research purposes raises an alarm that should be heard throughout the medical world.¹ It is difficult to imagine that the BMA and the Department of Health would join with the European Commission to propose such unnecessary and obstructive restrictions on access to records. The examples of proved health benefits gained from reviews of medical records are numerous and substantial. We are not aware of examples of harm, either individual or collective. We support the adoption of guidelines such as those promulgated by the Royal College of Physicians. These assure that access will be gained only by responsible investigators and that confidentiality will be protected but do not compromise the ability of the health community to investigate important health issues. These guidelines should replace those proposed by the European Commission, so that important health issues can continue to be addressed by this means.

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- 1 Wald N, Law M, Meade T, Miller G, Alberman E, Dickinson J. Use of personal medical records for research purposes. *BMJ* 1994;309:1422-4. (26 November.)

Guidelines may affect audit

EDITOR,—One point to be made about the use of medical records for research purposes¹ concerns audit. Presumably a straightforward audit of patients' notes to study outcomes does not require approval by an ethics committee, but what happens if it is then to be published? Does it suddenly become research, and is retrospective approval then required from each of the patients?

The directives as currently described are too restrictive.¹ If they are introduced unmodified, consideration should be given to asking patients to sign a waiver form on admission to hospital to indicate their willingness for their case records to

be used for any research purposes provided confidentiality is maintained. This would serve to protect the status quo, and the valuable work that currently accrues from the use of medical records for research purposes could continue.

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Unusual cause of pseudomonal infection

EDITOR,—In the light of recent reports of unusual sources of pseudomonal infection,^{1,3} we wish to report on a preterm infant receiving intensive care in our neonatal unit. He was born at 33 weeks' gestation and required intermittent positive pressure ventilation for the respiratory distress syndrome of prematurity. Delivery was vaginal, there was no history of prolonged rupture of membranes, and surface swabs at birth yielded negative results. After 10 days his condition deteriorated. Clinical and laboratory indicators suggested sepsis with disseminated intravascular coagulation, and blood cultures obtained on three occasions grew *Pseudomonas cepacia*. Isolation of this unusual organism prompted liaison with our microbiology colleagues, and a full environmental screen showed the same organism (confirmed by chromosomal digest with pulsed field gel electrophoresis) in the humidification unit of the blood gas analyser.

The baby recovered with treatment with appropriate antibiotics. The procedure for ensuring hygienic use of the blood gas analyser was reviewed and updated, and staff using the machine were made aware of the new policy. How the organism was transferred to the baby on this occasion remains a matter for speculation.

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Psychotic illness in ethnic groups

Biological factors should not be ignored

EDITOR,—Michael King and colleagues report on increased incidence of psychosis in a migrant population compared with the native born population¹; they ascribe this increase to environmental factors experienced in Britain and thus assume that the incidence of psychosis is the same in Britain and in the migrant's country of origin. This premise—that incidences and prevalences of schizophrenia are similar throughout the world—is widely held but perhaps open to debate.

The main migrant ethnic group in King and