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,³ 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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- 1 Greaves I, Porter KM. Holy spirit? An unusual cause of pseudomonal infection in a multiply injured patient. *BMJ* 1992;305:1578.
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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

colleagues' study among the total migrant population of 54 was black (n=38); this group included Caribbean (n=19) and black African (n=14) subjects. Countries with a majority black population do not feature at all in the study most quoted when similar worldwide prevalences of schizophrenia are claimed.² Limited data exist on prevalence in some African and Caribbean countries, but these studies do not use standardised criteria. Because the provision of services is different in the developing world underreporting may well occur.^{3,4}

As the incidence of schizophrenia in Britain is thought to be declining⁵ it is important that studies of migrant populations relate to the countries of origin as well as the host countries. While I am not trying to suggest that biological factors can fully explain the increased incidence of psychosis in migrants, I do not think that they can be ignored.

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- 1 King M, Coker E, Leavey G, Hoare A, Johnson-Sabine E. Incidence of psychotic illness in London: a comparison of ethnic groups. *BMJ* 1994;309:1115-9. (29 October.)
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Conclusions of study are unwarranted

EDITOR,—Michael King and colleagues draw some unwarranted conclusions from their study on psychosis in ethnic groups.¹ On the basis of their finding of high rates of both schizophrenia and affective psychoses in black and Asian patients they suggest that "the current focus on African Caribbeans and schizophrenia [is] misleading." High rates of serious mental illness in British African Caribbean people have been noted in studies over three decades, and this has often included affective illness.^{2,3} In contrast, no consistent picture has emerged for Asians. The authors rightly avoid multiple statistical comparisons of small numbers but then extrapolate from their results specific conclusions about African Caribbeans with schizophrenia, of whom there were just nine in their sample.

In discussing the limitations of their work King and colleagues imply that knowledge of the predictive validity of psychiatric diagnosis in ethnic minorities awaits the completion of their planned follow up study. They may not be aware that, for African Caribbean patients with schizophrenia, the predictive validity has already been established.⁴

The phrase "all ethnic minority groups are vulnerable" is offered as a clinical implication; worst of all, the paper concludes that the "personal and social pressures of belonging to any minority group in Britain are important determinants of the excess of psychotic disorders." These views may be attractive to many commentators, but the latter in particular remains without foundation. While some widespread environmental factor seems to precipitate extra cases of schizophrenia in African Caribbean families at risk,⁵ circumstantial evidence points to prenatal viral infection.⁶ At present no empirical data or plausible mechanism exist to relate racial prejudice and disadvantage to population rates of psychosis.

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Social observations on childhood

EDITOR,—As the producer of Clifford Yorke's talks on BBC Radio 3, *Childhood and Social Truth*, I wish to respond to Mark Berelowitz's review.¹ Berelowitz says that Yorke does not explain why the children of stable families have become unstable parents. In fact, his talks concentrate on answering this question. The reason is that parents often fall victim to fashionable ideas and social pressures and therefore act in ways that are contrary to their good understanding of children's needs. Berelowitz is disappointed that the talks do not offer new theories of childhood. This shows that he has missed the point, which is that we should pay much more attention to what we know.

Berelowitz misrepresents the contents of the talks. Yorke does not say that it hardly matters whether a child suffers from divorce or marital disharmony. He makes it clear that divorce is likely to be much worse. He certainly does not say that the whole of parenting consists of teaching the child to manage frustration. He mentions frustration to show how regressive "doing your own thing" is. Yorke gives a vivid picture of the harmony with oneself and others to which most parents aspire.

Many criticisms in the review are of the brief for the series rather than its contents. Berelowitz thinks that the talks should have been commissioned to "encourage parents"; to give a blueprint for reversing poverty, illness, and poor schooling in Britain and pestilence, war, and famine abroad. He wanted more treatment of the role of fathers within a stable household. But there are already plenty of manuals for parents and politicians. I commissioned a set of social observations by an authority on normal child development. The purpose of the broadcasts was to stimulate thought among listeners, and that thought was to be about what individuals can do to mitigate the weaknesses of society.

It is not easy to understand why a doctor should be less able than some dozen newspaper journalists to digest and summarise Yorke's arguments correctly.

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Circumcision

EDITOR,—Disappointingly, the discussion concerning the personal view¹ and book² on the joy of uncircumcising failed to emphasise the central issue with a clear statement that the practice of social circumcision is unacceptable in a civilised society. It is unacceptable not because of the increased surgical risks,² surgical complications,³ harmful long term outcome,⁴ difficulty in reversing the process,¹ or increased sexual dysfunction⁵ but

primarily because systematic ritual genital mutilation is both unnecessary and unjust.

Parents pursuing personal, social, and religious beliefs may request such an operation, and surgeons may then carry it out seemingly without question and sometimes for not entirely altruistic reasons. When such a permanently mutilating procedure is proposed and performed without clinical need there seems to be no individual culpability; surely a systematic deformation on any other part of the body would have been deemed to be a form of ritual child abuse. Furthermore, society has traditionally turned a blind eye to this problem, and seldom is any comment or criticism made by politicians and parliamentarians; social pundits and religious gurus; organisations entrusted with the welfare of children and the prevention of cruelty; or medical mandarins in the higher echelons of the General Medical Council, Royal Colleges of Surgeons and Physicians, and BMA.

Is it not time for all members of our society to reflect on this issue and to give a considered judgment on whether social circumcision could be deemed justifiable? While the jury is out—and it could be out for a long time—the least we can do is to stop performing such operations on children until they are old and mature enough to give informed consent.

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Triglyceride concentration and coronary heart disease

EDITOR,—We wish to respond to two letters concerning our paper.^{1,2} Despite the intuitive appeal of lowering triglyceride concentrations along with cholesterol concentrations when both are raised, there is no evidence that this strategy is more effective than targeting treatment at cholesterol alone. Even treatments that raise triglyceride concentrations reduce the risk of coronary heart disease in hypercholesterolaemic subjects. In the Lipid Research Clinics coronary primary prevention trial, treatment with diet and cholestyramine resulted in a 19% reduction in the risk of coronary heart disease despite an increase in serum triglyceride concentrations averaging 2.5%.³ Oestrogen treatment is also associated with increased triglyceride concentrations and a reduced risk of coronary heart disease.⁴ Clinical trials have not established which subgroups of hypercholesterolaemic patients, if any, benefit from a reduction in triglyceride concentrations.

A M Cruickshank notes that the rare patient with severe hypertriglyceridaemia is at risk of pancreatitis⁵; this association, however, is insufficient justification for universal screening of triglyceride concentrations. Certainly, screening would detect some hypertriglyceridaemic subjects who would otherwise be overlooked. But severe hypertriglyceridaemia, in the range associated with pancreatitis, is usually obvious from its physical manifestations and visual inspection of the lipaemic blood specimen. Seldom will the result of a screening test be the sole clue to a very high triglyceride concentration.