

ment reports.¹ The Access to Medical Reports Act 1988, in force since 1 January 1989, has suffered from imprecise drafting, multiple amendments, and rather hurried and confused debate in its passage through parliament as a private member's bill.

Its sponsor, Mr A Kirkwood MP, has stated that: "The purpose of the bill is to allow individuals access to medical reports that are made about them by their general practitioners when they apply for insurance policies or jobs."² His reassurance, however, that "The bill will not increase the administrative or bureaucratic procedures that employers or insurance companies face" has not been adequately fulfilled in its final enactment.

The act requires a series of written requests, consents, advices, and notifications between the parties, which may extend up to a 12 stage procedure before a report can finally be released. This ensures a right not only to access to a report but also to edit or to embargo it if any part is considered to be incorrect or misleading.

The act applies when a doctor who is (or has been) responsible for the clinical care of an individual patient is asked to supply a report for insurance or employment. Unfortunately, this terminology has left the scope of the act open to different interpretations, particularly in the case of an occupational physician, who routinely communicates with family doctors on one hand and with employers on the other. To interpret the act as applying to both these communications, as in the BMA guidelines to occupational health doctors,³ is to consider occupational physicians as passive agents of the employer when they write to family doctors but then to regard them as employees' personal medical advisers when they make recommendations or report to the employers.

This interpretation is not in line with the normal practice of occupational health, which is neither to represent an extension of staff functions nor to substitute for primary medical care. In our view it is also inconsistent with both the spirit and the letter of the act, which refers to medical practitioners with *responsibility* for the clinical care of the individual, where care is directed towards medical treatment (our emphasis). Certainly in the United Kingdom that role is clearly accepted as belonging to the family doctor, supported by hospital specialist services. Most occupational physicians would not normally see themselves as fulfilling that function, however much they might contribute to the health care of employees, collectively or individually.

There now seems to be increasing uncertainty and divergence of both medical and legal opinions on the application of the act in occupational medicine.^{4,5} The medical defence societies have still to come forward with an opinion, but it is evident that the BMA's guidance is not entirely consistent with other authoritative views so far expressed.

In the mean time we urge that the BMA, through its occupational health committee, might consider the question further in view of the appreciable practical implications of its interpretation of the act for occupational health.

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- 1 Kirkwood A. Access to Medical Reports Bill. *House of Commons Official Report (Hansard)* 1988 July 8;136:col 1330. (No 183.)
- 2 Anonymous. Occupational health doctors and access to medical reports. *Br Med J* 1989;298:192-3.
- 3 Anonymous. Access to medical reports: a new right for employees [Editorial]. *Incomes Data Services Brief* 1988;379:1.
- 4 Anonymous. Access to medical records. *Institute of Personnel Management Digest* 1988;280:16-7.
- 5 Anonymous. Medical reports: access to medical reports. In: Cooke P. *Croner's employment law*. New Malden, Surrey: Croner Publications, 1988:C75-7.

6 Pitt G. Access to Medical Reports Act 1988. *Industrial Law Journal* 1988;17:239-40.

7 Aikin O. New legislation on medical records. *Personnel Management* 1989;21:58-9.

Risk factors for acute myocardial infarction in women

SIR,—The association between a history of toxæmia of pregnancy and myocardial infarction described by Drs Peter Croft and Philip C Hannaford¹ is important.

Additional data, if available, would be helpful. In what proportion of cases and controls did the episode of toxæmia occur in first or later pregnancies and how precisely was toxæmia defined in the study? Patients with toxæmia are a heterogeneous group, and a diagnosis of idiopathic toxæmia or pre-eclampsia or eclampsia is commonly erroneous, particularly in multigravid women, many of whom have underlying essential hypertension or chronic renal disease.² Indeed, the remote prognosis of eclampsia may be predicted from the pregnancy in which the condition occurs. Women who have had eclampsia during their first pregnancy have a survival at 40 no different from that in the general population whereas women who have had eclampsia in subsequent pregnancies have a death rate three times that in the general population.³ Hypertensive vascular diseases account for 80% of the excess deaths.

If, as we suspect, the deaths from myocardial infarction were associated with toxæmia occurring in multigravid pregnancies this paper emphasises the importance of careful postpartum evaluation and follow up of these high risk patients.

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- 1 Croft P, Hannaford PC. Risk factors for acute myocardial infarction in women: evidence from the Royal College of General Practitioners' oral contraception study. *Br Med J* 1989;298:165-8. (21 January.)
- 2 Taylor DJ. The epidemiology of hypertension in pregnancy. In: Rubin PC, ed. *Handbook of hypertension in pregnancy*. Amsterdam: Elsevier, 1988:223-40.
- 3 Chesley LC, Annitto JE, Cosgrave RA. The remote prognosis of eclamptic women: sixth periodic report. *Am J Obstet Gynecol* 1976;124:446-54.

AUTHORS' REPLY.—We cannot characterise in more detail the toxæmic subjects in our case-control study. Most women with a history of toxæmia had the episode before they were entered into the main cohort study in 1968-9, and the general practitioners were simply asked to indicate on the recruitment form whether the woman had such a history. Details about the pregnancy in which the toxæmia had occurred were not obtained, nor were diagnostic criteria specified. Thus we do not know in which pregnancy most multigravid women developed toxæmia.

We agree that the clinical diagnosis of toxæmia includes entities other than "true" pathologically defined pre-eclampsia and eclampsia. Although eclampsia occurring in multigravid women may explain the association between toxæmia and myocardial infarction found in our study, there are three reasons for doubt. Firstly, true eclampsia is rare, especially after the first pregnancy. Secondly, multigravid women with eclampsia often have established hypertension¹ whereas in our study toxæmia of pregnancy was associated with subsequent myocardial infarction independently of a history of hypertension. Thirdly, we have estimated the relative risk associated with a history of

toxæmia among patients who at the time of their acute myocardial infarction were either primigravid or multigravid. The point estimates of relative risks were similar: 2.3 (95% confidence interval 0.7 to 7.0) and 2.6 (1.6 to 4.2), respectively.

As Drs Perry and Beevers point out, the different risks associated with the various conditions labelled as toxæmia need clarification.

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Word processing and data security

SIR,—Mr John Ainslie's article on choosing a word processor was an excellent introduction to the subject,¹ but I would like to add a few words of caution on the use of word processors and other computerised information stores.

My first point concerns relatively expensive microcomputers with hard disk drives that can store upwards of 32 million characters. Having the equivalent of a filing cabinet of information available in this way is tremendously useful, but, because access is so much easier, it is also more tempting to the thief. Making use of someone else's word processor also allows access to all of their work stored on the hard disk. In one instance a member of the medical staff "borrowed" a secretary's word processor to prepare a curriculum vitae; when she returned she found two versions of the curriculum vitae on the disk and nothing else. Computer based systems therefore need to be kept in a secure environment and protected by a user password.

Most word processors use disks for storing the text before it is printed or for reloading later. Once the text has been saved on to the disk, however, very few computers actually ever delete it. They mark the text file "deleted," thereby ignoring it, and eventually more text gets overwritten on the old files.

The Amstrad personal computer word processor has a feature called "limbo" for rescuing deleted files. A deleted file goes into limbo and can be recalled if the disk is not too full. Even a file deleted from limbo can often similarly be recalled (unless it happens to be a very important file that you deleted by accident, and have no other copy of).

The problem is highlighted when you realise that there are programs for all computers freely circulating which "un-erase" deleted files. Thus, apparently blank disks that are lying around or have been used to exchange documents in computer readable form may contain any amount of sensitive information. Reformatting a disk should erase all of its contents, but some people make a living by recovering data from such disks, and so even this technique is not secure. The only answer when a disk is to be available to others is for it to be new or to have been used only for non-sensitive information. Surprisingly little information in medicine falls into this category.

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1 Ainslie J. Choosing a word processor. *Br Med J* 1989;289:514-5. (25 February.)