and community controls we published both sets of results.

The component of the study that looked at acute myocardial infarction was not powerful enough for analysis of subgroups (except perhaps the community controls). In the British dataset for the component that looked at venous thromboembolic disease there were no differences in the estimates of risk between the hospital and community controls.

Table 1—*Use of oral contraceptives by controls in component of transnational study looking at venous thromboembolic disease*

	No current use	Third generation pills	Second generation pills
Hospital controls	470	103	180
Community controls	558	146	222

Given that for this component the ratio of use of third to second generation oral contraceptives was 0·57 among the hospital and 0.66 among the community controls (table 1), the results for the acute myocardial infarction component may be due either to random variation resulting from the small sample size or to Berkson's bias.[4]

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Cascade system for getting urgent information to doctors

CSM should use email and the Internet

EDITOR,—The failure of the first class postal service and the Department of Health's "fax cascade" to prevent another drug scare (the recent scare over the safety of third generation contraceptive pills)[1] should prompt the Committee on Safety of Medicines to consider an effective alternative: electronic mail or the Internet. One of the problems described by the committee was its inability to provide the necessary information to general practitioners quickly enough.

All that general practitioners needed was information on which drugs were involved, why the decision was taken, and the recommended action. Since over 90% of practices have a computer and 55% have a desktop computer[2] a route exists for the transfer of information. The information needed could have been made available virtually instantaneously if an electronic pathway to these practice computers had been developed.

The roughly 10 000 practices for which email or the Internet could have been used would have needed a modem (£150), appropriate software (email £50 or web browser £50), and training (up to £50).[3] So for less than £2.5m the "impossibility of dissemination" could have been handled smoothly. The cost of the package could be added to the £45m currently spent on primary care computing (personal communication, NHS Executive) and be deemed to attract 100% reimbursement under existing regulations in the red book (the statement of fees and allowances for general practitioners). This one off cost and the £100 per practice per month necessary if a commercial company is used to give access to the Internet might pay for themselves the next time a drug is withdrawn from the market or a scientific journal publishes a new league table of pharmacological lethality.

Email and the Internet would also allow many other sources of information to become available to practices[4] (and potentially to patients). There is no shortage of recommendations, guidelines, and protocols waiting to cascade on to general practitioners' desks. Rapid and reliable availability would be one way of moving towards Stephen Dorrell's stated aim for practising clinicians: "They need ready access to research results—an effectiveness index on tap, if you like."[5]

What about the 5-8% of practices that do not have a computer when the next "drug scare" hits the press? Perhaps some of the money saved by not posting letters to the 10 000 that do and the time saved by ministers and senior doctors could be used to activate a parallel system more effective than that currently operating.

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The system works

EDITOR,—We are pleased, given the problems with communications about the contraceptive pill,[1] to note the success of the government's cascade system in informing doctors about the fresh evidence on treatments for head lice.[2] As the BMA made clear at the time of the controversy surrounding the government's warning about the pill, our concern was solely about the government's problems in contacting general practitioners before patients received the news through the media.

It was unfortunate that certain elements in the media chose to misrepresent the BMA's views and imply that the association believed that the controversy over the pill had been created by the government's desire to save money. As our press office made clear to the media once such a suggestion had been made, this was not the association's view. We have always understood that the government's decision was based on the advice of the Committee on Safety of Medicines—a body that has the utmost confidence of the medical profession.

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Publishing information about patients

Obtaining consent to publication may be unethical in some cases

EDITOR,—At its last meeting the International Committee of Medical Journal Editors revised its guidelines regarding the protection of patients' rights to privacy in manuscripts submitted to biomedical journals. It changed its policy from one stating that anonymity should be maintained to one stating that information that might identify a patient should not be published unless it is essential for scientific purposes and the patient has given written informed consent for publication.[1,2] Gaining informed consent for this purpose requires that the patient be shown the manuscript to be published. This raises ethical and legal problems.

In good clinical practice informed consent is an integral part of medical treatment. Doctors provide information at the patient's request or because the patient needs it to make valid decisions about treatment. The content of the information given to the patient, and the manner in which it is given, depends on individual circumstances and needs. But informed consent for publication is different because the process of informing the patient and the information given are governed not by the patient's requests and needs but by the requirements of scientific publishing as part of research. Case reports are written in a short, precise, and objective manner; use medical terminology; and are often in a foreign language (for example, English)—this is not the type of information that many patients request.

In psychiatry and psychotherapy in particular, this kind of information can be a risk to the patient's mental health. Case reports are published precisely because of problematic or unsolved elements in the medical treatment of severely ill patients. But many psychiatric patients are vulnerable and may not tolerate the information required for them to be able to give valid informed consent for publication; this makes it unethical to confront them with a scientific manuscript about their case. Furthermore, psychiatric patients may be incompetent to give valid informed consent. In Germany legal guardians or courts cannot give consent for publication because scientific publication, like non-therapeutic research, is generally not in the patient's personal interest.[3,4]

In practice, important case reports in psychiatry and psychotherapy will have to remain unpublished under the new guidelines. Unfortunately, the medical editors do not seem to have considered this. No proposals have been made to improve methods of anonymising case reports, but such methods should be tested empirically before the existing policy of scientific publication is changed completely.

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GMC's guidelines should be followed before information is put on Internet

EDITOR,—We were perturbed by the last paragraph of Mark Pallen's article on the world wide web, which described how the department of orthopaedics at Queen's University of Belfast