Oxford were cancelled because beds were not available in the intensive therapy unit. Identifying the problem has allowed a solution to be devised, and we look forward to fewer cancellations of major elective operations in the future.

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Women consultants

EDITOR,—Luisa Dillner castigates the East Anglian region for a poor record in appointing women consultants.[1] In the two years to September 1993, 47 consultant vacancies were filled in the region. Women were more likely to be shortlisted and more likely to be appointed than men (table). A

Number of male and female applicants for consultant posts in East Anglian region

	No of applicants	No (%) shortlisted	No (%) appointed
Female	37	25 (68)	12 (32)
Male	242	118 (49)	35 (14)

woman was apGointed to 12 of the 22 posts for which there was at least one female applicant. Hence when women apply they stand at least as good a chance of being appointed as men. We suspect that the number of female applicants is small not because of "prejudice and discrimination against women" but because of the difficulties a partner (who is often also in a profession, if not a doctor) would have in finding suitable employment in the small towns in which most East Anglian hospitals are found.

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1 Dillner L. Why are there not more women consultants? *BMJ* 1993;307:949-50. (16 October.)

Information management and patient privacy

EDITOR,—Alison Tonks's editorial was a useful summary of some of the key parts of the NHS Management Executive's information management and technology strategy and will assist in further disseminating the objectives of the strategy to the medical profession.[1] Ensuring that the clinical professions are aware and involved is important, and we are making considerable efforts to achieve this. Indeed, we would be pleased to take any opportunity to present the strategy to clinical audiences.

Parts of the article did, however, give only a partial and somewhat misleading view of the work which is being directed to protecting personal data. We would like to redress the balance.

It was implied that the NHS population registers of administrative details of patients that are being developed would be a totally new feature of the NHS; would be vulnerable to unauthorised access; and would be used for non-NHS purposes. All family health services authorities already have comprehensive patient registers, as do many other parts of the NHS. The NHS Central Register holds basic details and the NHS number of all individuals in England as from birth. Access to these registers is controlled, and over many years there have been few, if any, major problems of unauthorised access. The new registers will build on these but will additionally be designed for joint ownership by several NHS organisations and, in that respect, will specifically have additional built in access controls and audit trails.

The article additionally picks up a theme that has been evident elsewhere: that the new NHS number may become a national identity number. Again, it needs to be recognised that everybody already has a NHS number and that has been the case for over 50 years. The intention is simply to replace the existing 23 formats for the existing number with one that is less susceptible to transcription error and can be checked in computers by a check digit.

Because the NHS has handled population registers and NHS numbers for many years without major confidentiality breaches, and without the number being used outside the NHS, no need has been foreseen to take special additional legislative measures to protect new versions. The NHS number is protected by Crown copyright, and the new forms of population register will have technical access controls and administrative controls. The management executive is determined to ensure that the NHS number and population registers are, as now, used only for NHS purposes, and the data protection registrar has been informed that if the existing and new controls prove to be inadequate, legislation will then—but only then—be considered.

Finally, Tonks raised the question of protecting confidentiality in an environment of increased electronic networking. The management executive is very conscious of this need. The use of electronic networks to transmit data is growing daily in the NHS and is currently not coordinated nationally. That is why the management executive has decided that networking (for data, voice, images, and radio frequency mobiles) will be subject to a national strategy within which national standards will be implemented. These standards must include security measures. Outline proposals for appropriate measures have been formulated and are considerably more comprehensive than any currently being applied. The measures are to be developed in close collaboration with the clinical professions, and we are currently seeking a range of professional representatives including the Joint Consultants Committee and General Medical Services Committee to join a working group for that purpose.

The management executive has always regarded the protection of the confidentiality of personal data as a serious matter and, in collaboration with all parties, we intend to see that the NHS continues to do so.

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1 Tonks A. Information management and patient privacy in the NHS. *BMJ* 1993;307:1227-8. (13 November.)

No deception in symposium supplement

EDITOR,—Peter Lurie and colleagues express concern[1] that the International Committee for the Evaluation of Hypertriglyceridemia as a Vascular Risk Factor inadequately identified support it received from Parke-Davis for a symposium issue of the *American Journal of Cardiology* that its members authored and edited.[2] They also question the objectivity of the supplement. We, the co-chairmen of the committee, wish to correct their misapprehensions.

The international committee, comprising 28 eminent researchers, was established and sponsored by the Fondazione Giovanni Lorenzini of Milan and the Giovanni Lorenzini Medical Foundation of Houston. Both are non-profit, independent foundations devoted to international research and education in medicine, biochemistry, and pharmacology. Their activities are supported by a variety of public and private sources. The committee's task was to review comprehensively the data on plasma triglyceride concentrations in relation to the risk of cardiovascular disease and from that review to provide a written perspective, including recommendations on managing hypertriglyceridaemia.

There was no attempt at deception in the supplement: the *American Journal of Cardiology* does not peer review supplements; it publishes them under separate cover and clearly denotes the nature of their contents. It is standard practice for supplements to be reviewed by only their designated editors, but in this instance an additional peer reviewer, or reviewers, was assigned to each article. Soliciting underwriters for journal supplements is standard practice as well: publication was underwritten by the Giovanni Lorenzini Medical Foundation. Parke-Davis partly supported the dissemination of the printed journal but did not become involved until after the committee's deliberations had ended and the document had been written. Neither Parke-Davis nor any other company was involved in the writing or approval of the supplement.

As evidence of the committee's bias Lurie and colleagues state that the published supplement's "concluding article, on the pharmacological management of patients with hypertriglyceridaemia, devotes nearly half its space to gemfibrozil (Lopid, Parke-Davis) and other fibrates." There are only two major categories of approved lipid lowering agents with appreciable clinical triglyceride lowering activity: nicotinic acid and the fibrates. Statins produce only modest reductions in triglyceride concentrations. The two and a half page article in question, one of 11 subject specific supporting articles in the 42 page supplement, includes one column on nicotinic acid and one and two third columns on bezafibrate, fenofibrate, and gemfibrozil.[3] The section on fibrates is longer because the different agents vary in the characteristics reviewed (for example, pharmacokinetics, dosage). No trade names are given. The supplement's introduction, which presents the committee's conclusions, states in bold face that drug treatment to lower triglyceride concentrations "may be considered if diet is ineffective, although this remains controversial."[4]

Lurie and colleagues also state that the article failed to mention "the increased non-cardiovascular mortality after treatment with gemfibrozil." The international committee's deliberations preceded the debate about whether ancillary data and 3·5 year follow up data from the Helsinki trial indicated excess mortality. These results were not available, and the *Physicians' Desk Reference* of 1990 cited by Lurie and colleagues contains only 1·5 year follow up data, at which point there was no significant excess mortality.

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1 Lurie P, Newman TB, Hulley SB. Caution over journal supplements. *BMJ* 1993;307:1140. (30 October.)
2 International Committee for the Evaluation of Hypertriglyceridemia as a Vascular Risk Factor. The hypertriglyceridemias: risk and management. *Am J Cardiol* 1991;68(suppl).
3 Franceschini G, Carlson LA. Management of hypoertriglyceridemic patients. D. Pharmacologic management of hypertriglyceridemic patients. *Am J Cardiol* 1991;68(suppl):40-2A.
4 Assman G, Gotto AM Jr, Paoletti R. Introduction. *Am J Cardiol* 1991;68(suppl):1-4A.