endorsed or distrusted. They seem, however, to be unaware of the extensive literature about the limitations of this test. The test for homogeneity advocated by Perry and Persaud would have failed to detect significant variability among the results of trials carried out before the fourth international study of infarct survival (P=0·15) in the magnesium meta-analysis despite the striking asymmetry in the funnel plot.

Two factors are involved in generating this apparent discrepancy. Firstly, the test of homogeneity is notorious for its lack of statistical power, and an important degree of heterogeneity cannot therefore be excluded on the grounds of a non-significant result of the test.[5] Secondly, the funnel plot examines a specific feature of variability in meta-analyses of randomised controlled trials—namely, that the spread of the results should be symmetrical around the combined effect estimate and become less as the sample size increases. In other words, the plot should resemble an inverted funnel. The biases leading to asymmetrical funnel plots such as the selective publication of small studies with positive results and non-publication of small studies with negative results (publication bias), may decrease variability among studies. Clearly, the application of any test for homogeneity is futile in this situation.

In conclusion, contrary to Perry and Persaud's assertion, the simple visual examination of a funnel plot, although subjective, is often more useful than the statistical manoeuvre entailed in testing for homogeneity. It is unfortunate that funnel plots are not more widely used and that too much faith is placed in the results of tests for homogeneity. The development of numerical measures embracing the information contained in funnel plots, together with a statistical test for symmetry, may help to address this issue in future.

MATTHIAS EGGER
Senior research fellow

Department of Social and Preventive Medicine,
University of Berne,
CH-3012 Berne,
Switzerland

GEORGE DAVEY SMITH
Professor of clinical epidemiology

Department of Social Medicine,
University of Bristol,
Bristol BS8 2PA

1 Perry A, Persaud R. Misleading meta-analysis. *BMJ* 1995;310: 1604. (17 June.)
2 Egger M, Davey Smith G. Misleading meta-analysis. *BMJ* 1995;310:752-4. (25 March.)
3 ISIS-4 Collaborative Group. ISIS-4: a randomised factorial trial assessing early oral captopril, oral mononitrate, and intravenous magnesium sulphate in 58050 patients with suspected acute myocardial infarction. *Lancet* 1995;345:669-85.
4 Yusuf S, Koon T, Woods K. Intravenous magnesium in acute myocardial infarction. An effective, safe, simple, and inexpensive intervention. *Circulation* 1993;87:2043-6.
5 Egger M, Davey Smith G. Magnesium and myocardial infarction. *Lancet* 1994;343:1285.

NHS computer network will breach venereal disease regulations

EDITOR,—Ross Anderson raises the serious concern of potential breaches of confidentiality because the proposed NHS network has insufficient safeguards to protect patient information.[1] Aggregated databases containing the records of tens of millions of patients will be a great temptation for dishonest NHS employees, who could access the network to find sensitive medical health records to sell. It would be a dream come true for the blackmailer. Breaches of confidentiality of the kind envisaged in the editorial have the potential to cause much harm to the individual patient.

I have grave concerns about the network and its proposed extension of access to the wider NHS. The changes, if implemented, will be a serious breach of the NHS (Venereal Diseases) 1974 Regulations. Service provision in genitourinary medicine is based on confidentiality, and this has encouraged patients to seek medical advice. It is not enough to concede that databases on patients with AIDS should not be connected to the network. Because of absolute statutory confidentiality, genitourinary physicians have been able to reassure patients of confidentiality of service and encourage patients and their consorts to attend clinics. There are moral, legal, and ethical arguments in maintaining patients' confidentiality within general medicine and genitourinary medicine and HIV and AIDS in particular. Patient confidentiality, if compromised, will considerably damage confidence in the NHS, destroy the trust that is crucial for a successful clinical relationship, and have a serious impact in the control and prevention of sexually transmitted diseases and HIV infection.

R BASU ROY
Consultant in genitourinary medicine/HIV/AIDS
P SRISKANDABALAN
Senior registrar

Pannel Suite,
Royal Bournemouth Hospital,
Bournemouth BH7 7DW

1 Anderson R. NHS-wide networking and patient confidentiality. *BMJ* 1995;311:5-6. (1 July.)

Definitions in palliative care

EDITOR,—The recent correspondence about palliative care services for cardiology fails to differentiate between the three distinct yet interacting aspects of palliative care.

The palliative approach is relevant to all patients with incurable conditions. It emphasises the importance of considering psychosocial and spiritual aspects as well as the purely physical. It includes consideration of family and domestic carers. Most specialties and all general practitioners look after patients with life threatening disease; attention to the patients' concerns and fears can guide management and ensure appropriate interventions. A palliative approach should be a core skill of every clinician, who may seek expert specialist help to ensure the best possible quality of life for the patient.

Palliative interventions aim to improve the control of symptoms—for example, palliative surgery, radiotherapy, or chemotherapy. They are usually carried out and monitored by specialists in the relevant discipline.

Specialist palliative care is delivered by clinicians who have specialist accredited training. Specialist palliative care teams are multidisciplinary and relate to both general and hospital practice, being available to provide advice and support that bridges the divide between home and hospital and to provide hospice care.[3] They cooperate with others rather than take over from them. Specialist palliative care has a duty to carry out research and, through effective education, to disseminate widely the lessons learnt. It must be available to support those giving care with a palliative approach.

The importance of recognising these definitions is twofold. Firstly, in many areas confusion exists about the conditions that are the legitimate province of palliative care. Recognition of the difference between the general palliative approach and specialist palliative care can reduce this difficulty. If the cardiology example is pursued, general practitioners and hospital doctors treat patients with end stage ischaemic heart disease with a palliative approach; angioplasty in this context is a palliative intervention done by specialists. A palliative medicine physician may become involved by advising on opioids and sedation for intractable dyspnoea and chest pain and helping with psychosocial distress, including family support. Secondly, because purchasers are uncertain how to contract for palliative care, distinction between the three categories may encourage logical decisions.

I G FINLAY
Consultant in palliative medicine
Holme Tower Marie Curie Centre,
Cardiff CF64 3YR

R V H JONES
Honorary senior lecturer
Department of General Practice,
Exeter University,
Exeter EX2 5DW

1 Gannon C. Palliative care in terminal cardiac failure. *BMJ* 1995;310:1410-1. (27 May.)
2 Beattie JM, Murray RG, Brittle J, Catanheira T. Palliative care in terminal cardiac failure. *BMJ* 1995;310:1411. (27 May.)
3 Department of Health and Welsh Office. *A policy framework for commissioning cancer services. Report of the expert advisory group on cancer to the chief medical officers of England and Wales.* London: DoH, 1995.

Emergency delays

EDITOR,—Commenting on Luisa Dillner's news item[1] on a report by the Clinical Standards Advisory Group on urgent and emergency admissions to hospital,[2] Christine H Dearden states that accident and emergency staff should be given admitting rights for patients seen as emergencies in the accident and emergency department.[3] I chaired the group that prepared the report, and we concluded, "Assessment of need for admission by a house officer of [emergency] patients referred through the accident and emergency department has been described as inappropriate since the need for admission has already been assessed by a more senior doctor in the accident and emergency department." In our recommendations we proposed that handover arrangements should be agreed so that patients may be admitted without repeated examination by junior trainees from other departments.

There is no doubt that the practice of not trusting the accident and emergency department is widespread and causes distress. As Dearden writes, "this has no benefit to either the hospital or the patient."

MICHAEL ROSEN
Honorary professor of anaesthesia
Cardiff CF2 6SZ

1 Dillner L. Emergency delays need urgent attention. *BMJ* 1995;310:283. (4 February.)
2 Clinical Standards Advisory Group. *Urgent and emergency admissions to hospital.* London: HMSO, 1995.
3 Dearden CH. Emergency delays. *BMJ* 1995;310:1199. (6 May.)

Hepatitis C and haemophilia

EDITOR,—In her editorial on hepatitis C and haemophilia Christine A Lee states that recombinant factor VIII "cannot transmit bloodborne viruses."[1] Although this belief is widely held, it is not correct. All biological substances can harbour infectious agents, and consequently all biopharmaceutical products carry some risk of infection, however small. Recombinant factor VIII is prepared from mammalian cell lines containing viral DNA[2]; in addition, substances of bovine, murine, and human origin may be used at several stages in the manufacturing process.[3] Even when technology that inactivates viruses is used, each of these substances has at least a theoretical risk of transmitting infectious agents.

Haemophiliac patients were infected with hepatitis C before effective technologies to inactivate viruses had been developed and at a time when the risk and severity of viral infections from coagulation factor concentrates were not fully appreciated.[4] The degree of safety of plasma derived concentrates in which viruses have been inactivated is now reasonably well established through extensive and detailed follow up of their