	Senior	Junior	No Consensus Diagnosis	1970 Diagnosis
Total no. of diagnoses	876	698	8	292
Major difference (A)	18 (2·1%)	56 (8·0%)		2 (0·7%)
Minor difference (B)	41 (4·7%)	77 (11·0%)		12 (4·1%)
Total A + B	59 (6·8%)	133 (19·0%)		14 (4·8%)

been obtained in all but eight of the first 300 cases reviewed. Differences between the consensus diagnosis and the participants' diagnoses are placed in two categories; (*a*) a diagnosis that gives a misleading prognosis or one that would lead to inappropriate treatment, and (*b*) a minor diagnostic difference of no clinical relevance. The consensus diagnosis has been compared also with the original 1970 diagnosis. Nine pathologists participated. These have been divided into two groups, senior pathologists who have obtained the M.R.C.Path. diploma and junior pathologists without this diploma. The results of the first 300 cases are shown in the table. Since clinical information was minimal and since consultation between pathologists before diagnosis was not permitted, the figures may be interpreted as the maximum for incorrect diagnosis.

The benefits of this on-going system are as follows. (1) It has proved to be a valuable educational exercise for consultant and trainee pathologists. (2) Uniformity of nomenclature and diagnostic criteria have been promoted. (3) It is a valuable guide to the suitability for delegation of responsibility for reporting. We can see that a comparable system may have advantages in the clinical field.—We are, etc.,

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1 Royal College of Pathologists of Australia, Board of Education. *Report of Surveys:* 1969, 1970, 1971. Sydney, R.C.P.A.
2 Penner, D. W., in *Pathology Annual*, vol. 8, ed. S. C. Sommers, p. 1. New York, Appleton-Century-Crofts, 1973.

Disclosure of Medical Records

SIR,—Since August 1971 the Rules of the Supreme Court have provided (Order 24 Rule 7A made under the Administration of Justice Act 1970) that before commencing proceedings a potential plaintiff in a personal injury case may apply to the court for an order requiring a medical practitioner who is a potential defendant to disclose his clinical records. Similarly, once proceedings have been started to which a medical practitioner is not a party (for example, a factory accident case) a medical practitioner who would be a material witness in the case can be required by order of the court to disclose his clinical records at an early stage in the proceedings rather than delaying this until he is in the witness box. It is worth pointing out in general terms that an order of the court is not made automatically and that if the practitioner chooses not to submit his records voluntarily (as is his absolute right) the court will consider the merits of each application and restrict the disclosure of records to that which justice requires.

This subject has been dealt with in detail on more than one occasion in the medico-legal columns of your journal[1-3] as well as in a letter from Dr. P. H. Addison, past Secretary of the Medical Defence Union,[4] and there is no need to go over the same ground again. What we wish to do now is to bring to the notice of members of the profession a particular aspect of the problem.

Two recent cases[5 6] heard by the Court of Appeal and supported by the M.D.U. have established that when a court orders disclosure of medical records they shall normally be produced only to another medical practitioner, acting as medical adviser to the party that obtained the order for disclosure, and not to solicitors. A practitioner's records may well include letters written to him by another practitioner—for example, a general practitioner may have had letters from a hospital consultant about the patient. The precise description of the documents the production of which may be ordered will be set out in the order, but it should be assumed that when the order specifies "all the medical records of Dr. X relating to . . ." this will include not only the practitioner's own notes but all consultants' letters and other clinical documents which are relevant to the case.

Our purpose is to point out to all practitioners in the United Kingdom that letters to other doctors about patients should always be written in the knowledge that they may be subject to detailed scrutiny by other practitioners prior to any court hearing, as well as by the judge and lawyers when the case gets to court; and that accordingly their tone should be serious and precise, even though this may mean the loss of the "personal touches" which have in the past lightened correspondence between colleagues.—We are, etc.,

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Secretary,
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J. W. BROOKE BARNETT
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Medical Defence Union
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1 *British Medical Journal*, 1972, **1**, 577.
2 *British Medical Journal*, 1973, **1**, 623.
3 *British Medical Journal*, 1974, **1**, 652.
4 Addison, P. H., *British Medical Journal*, 1972, **1**, 565.
5 Davidson *v.* Lloyd Aircraft Services Ltd., *The Times*, 15 May 1974, p. 20.
6 Deistung *v.* South West Metropolitan R.H.B., *The Times*, 26 October 1974, p. 24.

Retinitis Pigmentosa

SIR,—The leading article on this subject (17 August, p. 429) is misleading with regard to the genetic advice to be given to a family with affected members and also the visual prognosis to be given to an affected individual.

You state that the disease is usually transmitted as a recessive condition without differentiating between X-linked and autosomal recessive disease. In a family with X-linked disease the chances of affected individuals appearing in future generations is high, while in autosomal recessive disease it is low if cousin marriages are avoided. This differentiation is particularly relevant when a heterozygote seeks advice. You correctly point out that heterozygotes for the X-linked gene (female carriers) show some phenotypic expression of the abnormal gene by early adult life,[1 2] but it should also be emphasized that heterozygotes for the autosomal recessive gene rarely if ever have recognizable ocular changes. Therefore these two forms of the disease, which are equally common in south-east England,[2 3] must be distinguished one from another before genetic advice is given.

Your statement that retinitis pigmentosa, once recognized, leads to blindness within a few years is quite wrong. There is no doubt that patients with severe recessive forms of the disease may be blind in early life, though such cases are rare. Even males with X-linked disease who notice loss of dark adaptation in the first decade of life are not severely handicapped until the third decade and may retain some useful vision until they are 50 or 60 years old. Autosomal dominant retinitis pigmentosa, which represents 25% of all cases in our practice, is mild and may give rise to little disability even in late life.[2] —We are, etc.,

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1 Bird. A. C., and Blach, R. K., *Transactions of the Ophthalmological Societies of the U.K.*, 1970, **90**, 127.
2 Krill, A. E., *American Journal of Ophthalmology*, 1967, **64**, 1029.
3 Jay, B., and Bird, A. D., *Transactions of the American Academy of Ophthalmology Otolaryngology*, 1973, **77**, Op.—641.

** We did not expand on the various patterns of retinitis pigmentosa inheritance as this was not the aspect with which our article was primarily concerned, but we deemed it sufficient to refer readers to a recent genetic analysis—indeed, by the authors of this letter. We said that retinitis pigmentosa "usually . . . leads to blindness within a few years." We readily accept these authors' findings that this was unduly pessimistic.—ED., *B.M.J.*

Diagnostic Test for Multiple Sclerosis

SIR,—The degree of inhibition by linoleic acid of the response of human lymphocytes to antigens has been claimed by Field *et al.*[1] to be much greater in patients with multiple sclerosis (M.S.) than in other neurological disorders and could be used as a diagnostic test. Mertin *et al.*[2] failed to confirm that the test was diagnostically useful in double-blind trials on M.S. patients selected according to the criteria of Allison and Miller (see McAlpine *et al.*[3]). Without wishing to take sides we would like to draw attention to a new factor which we believe should be taken into account in patient selection if an effect of linoleic acid is to be tested on the patients' macrophages.

Low blood linoleate levels were demonstrated in 1966[4] in patients with M.S.; early in 1973 Millar *et al.*[5] published evidence that sunflower seed oil might act as a remission agent. At that time we were including M.S. patients in a study of blood fatty acids. However, considerable press and television publicity was given to these findings of Millar *et al.* and by the autumn of 1973 most of the M.S. blood samples we