benefit from a period of formal exercise training with substantial improvement in exercise tolerance.

Patients often ask whether it is safe to ignore their angina and continue exercise. As a general rule the advice should be never to disregard the warning of myocardial ischaemia and to either rest or at least reduce the pace of walking at the onset of pain. Even those who have discovered that they are able to walk through angina should be warned that the phenomenon is variable, not guaranteed—and certainly no justification for fighting or ignoring the symptom.

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Data Protection Act and medical records

A few years ago a bogus orthopaedic surgeon at an NHS hospital managed to carry out 24 operations before he was rumpled. When the news broke patients operated on during his brief reign naturally tried to find out whether or not he had wielded the knife. But the health authority’s legal adviser refused to pass on the information. “If we had told those 24 patients, sure as fate 24 claims would have come in,” he told a recent conference on medical records. “There were no untoward effects in any of those cases, and from that day to this not one of those patients knows.”

Attitudes like this are in for a shake up once the Data Protection Act 1984 comes into full force in November 1987. Introduced mainly to safeguard British firms with international interests by allowing us to ratify the Council of Europe Data Protection Convention (ratifying countries can refuse to allow personal information to be transferred to other countries without comparable data protection legislation, and British computer bureaux process a great deal of data for overseas customers), the Act covers most sorts of personal information about individuals held on computers.

It will require “data users”—anyone holding personal information on computer, which may include health authorities, general practitioners, private hospitals, and insurance companies—to register with the Data Protection Registrar by 10 May 1986.

When the Act becomes fully operational individuals (known as “data subjects”) will be able to apply to a data user for a copy of the data held on them—which will include any expression of opinion about them. They will be able to have incorrect information corrected or erased and may be compensated if they suffer damage through mistakes or through loss or destruction or unauthorised disclosure of the data.

The Act allows the Secretary of State to make orders exempting some types of data from complete disclosure. Among these are “personal data consisting of information as to the physical or mental health of the data subject.” But how should the exemption operate? Should there be no disclosure of medical records at all or free access, as with most other types of record—or should there be a halfway house, information being withheld only when it would not be in the patient’s best interests to divulge?

The third option is the one favoured by the DHSS in its consultation paper Data Protection Act—Subject Access to Personal Health Data. The interprofessional working group on access to personal health information, set up on the initiative of the British Medical Association in May 1983, also advocated freer patient access to records with safeguards to prevent disclosures which might cause harm or distress.

This was the option which initially seemed to appeal to most of the chairman of medical records subcommittees and medical records officers who took part in a meeting on access to medical records held on 30 September under the auspices of the Association of Medical Records Officers and the King’s Fund. But by the end of the day a surprising number of the participants were speaking out in support of unrestricted access.

The decision to restrict patient access throws up a dilemma: should the patient be told that information has been withheld? This might be just as harmful as divulging the information—if not more so. But if the patient is unaware that something has been held back how would he or she initiate any procedure to review the decision to withhold, which the Department of Health apparently considers desirable?

The consultation paper suggests an automatic review obliterating the data user to ask for a second opinion whenever the first opinion opts for keeping data back. That would mean that when a patient requests access to health authority records the records would have to be referred to the doctor who had originated the data (or his successor) for a decision on whether any data should be withheld. When more than one health professional was concerned the decision would be based on the advice of a registered medical practitioner after consultation with other professionals concerned. Then the decision might have to be reviewed by an independent health professional in the same discipline.

Are such complex and expensive procedures really necessary or desirable in a health service already under severe financial strain? Simple expediency—as well as the trend to greater openness between doctor and patient—dictates that withholding data should be kept to a minimum. The department recognises that pressure for access to manual health records will follow once patients are allowed to see their computerised data. Legislation in many American states gives patients the right of access to their medical records, both computerised and manual.

A private member’s Bill, the Access to Personal Files Bill, has been sponsored by the Campaign for Freedom of
A century for the MDU

The medical defence societies engender the same feelings of security among doctors as the Royal Navy must have done for Britain’s far flung colonial administrators. When in distress support was at hand. But medical defence today is more than the ability to call up legal guns to defend a doctor in trouble. As Dr Clifford Hawkins shows in his eminently readable centenary celebration of the Medical Defence Union Mispågar or Malpractice? the defence bodies now cover a complex territory of medicine, law, ethics, sociology, and politics. Doctors today want guidance and education as well as defence; they would prefer to avoid pitfalls than to be hauled out from them. Providing such a preventive, diagnostic, and curative medicolegal service is not cheap—though the subscription of £288 a year for clinicians in the United Kingdom is small change compared with the £82 500 a year that Dr Hawkins reports as the going rate for a Long Island obstetrician.

In 1885, when the MDU was founded, the annual subscription was 10 shillings, a sum not so little as it sounds when the first secretary of the union, Mr Charles Rideal, drew £250 as his annual salary. The union was registered on 23 October in the offices of Messrs Criddland and Paget, solicitors, of Bedford Row, a street adjacent to London’s Covent Garden, where Hampsons, the union’s present solicitors, who first acted for it in 1893, still dispense their skilled advice. The “two solicitors and five gentlemen” who launched the union left no clues about whose idea it was—though the lay origins suggest that widespread anxieties in Victorian Britain about the dangers of unqualified practitioners may have played a part. Their aims, however, were clearly set down as follows:

“To support and protect the character and interests of medical practitioners practising in the United Kingdom.”

“To promote honourable practice and to suppress or prosecute unauthorised practitioners.”

“To advise and defend or assist in defending members of the union in cases where proceedings involving questions of professional principle or otherwise are brought against them.”

“To consider, originate, promote, and support (so far as is legal) legislative measures likely to benefit the medical profession and to oppose all measures calculated to injure it: and for the purposes aforesaid to petition parliament and take such other steps and proceedings as may be deemed expedient.”

Would the remit differ today were a group of lawyers and gentlemen to sit down to a similar task? Probably not, give or take an archaic phrase or two, even though the tasks that the MDU is called on to perform are vastly more complex and now include dentists as well as doctors. The tasks may be harder and the arguments about law, medicine, and ethics increasingly fierce, but the conduct of the business is smoother and the financial base sounder than during its first decade of life, when under the rumbustious leadership of a Birmingham surgeon, Mr Lawson Tait, the union nearly foundered. Dr Hawkins puts it in a nutshell when he says: “Mr Lawson Tait (1845-99) was a remarkable character; he made the MDU but, ironically, he could have destroyed it.” The author’s subsequent portrait of Tait’s character and skills adds a personal dimension to the book, a cameo that exemplifies his success in extending the book beyond just a historical record or text on medical indemnity.

Mispågar or Malpractice? is well spiced with reports of cases—some famous, many anonymous—culled from the union’s files. Dr Bodkin Adams’s acquittal from a murder charge in 1957, the “drawn” libel suit brought against the BMJ by a dentist anaesthetist in 1968, and Lawson Tait’s own successful defence against an alleged libel of a medical colleague are all chronicled. Lawson Tait had, incidentally, called on the union to support him, and that interprofessional dispute led the council to resolve that it was “undesirable that finances should be used to defend or support any action made against another member of the profession . . .,” a policy that remains to this day. Even so, the MDU does try to help its members in such disputes—and they still occur—by recommending arbitration. Indeed, work behind the scenes forms the bulk of medical defence work: advice, solicitors’ letters, negotiations, and out of court settlements are daily practice, with only occasional cases emerging in the courts or close by at the General Medical Council. Many of the union’s successes go unsung—except, perhaps, in those compulsively readable annual reports—and no doubt the council and its staff would prefer it that way.

Dr Hawkins performs a valuable service in demythologising the horror tales of medical litigation in the United States of America, giving readers a balanced perspective of the international scene. Though patients in North America are more litigious than in Britain, and occasional awards have reached horrendous levels (as in Germany and France), it seems unlikely that the worst excesses of the American medicolegal system will cross the Atlantic. Even so, the union is prudent in restricting its services in the USA, though more of its nearly 130 000 members practise outside Britain than in.

In the United Kingdom more patients are complaining and court awards are rising in numbers and size, but the profession could do much to save itself simply by communicating more effectively with patients. In addition, “Failure of doctor to doctor communication is almost a weekly matter for the defence bodies.” Frankly, it should not be so. Doctors who complain about the rising costs of medical defence would do better to divert their energies to helping the profession to brush up its communication. Dr Hawkins does his bit in his final chapter, “Causes of complaints and their prevention.”

The rising costs have led to suggestions that the BMA should include medical indemnity among its numerous services to the profession—a suggestion turned down,