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LEADING ARTICLES

CLINICAL RESEARCH • PAPERS AND SHORT REPORTS • PRACTICE OBSERVED

MEDICAL PRACTICE

NEWS AND NOTES

SUPPLEMENT

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CORRESPONDENCE

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters should be typed with double spacing between lines and must be signed personally by all their authors, who should include their degrees. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included. Titles of papers are not, however, included in the correspondence section.

Confidentiality of medicolegal reports

SIR,—Most doctors will at some time be asked to provide a medical report to solicitors in a case of claim for personal injuries. Many by virtue of their particular specialty will compile such reports very often. Medicolegal reports are submitted to lawyers in good faith. Until recently we had assumed they were treated as confidential by the instructing solicitors until such time as their disclosure in open court or their being "agreed" with the other side in the case of exchange of expert medical opinion.

We have therefore been disturbed to find that some firms of solicitors routinely, and at an early stage in the proceedings, provide their client with a full copy of the medical reports "so that he may indicate whether or not he accepts the views expressed by the consultant" (we quote from a reply to our written protest in one such instance). This practice of early and unselective medical disclosure we have since discovered to be common. We deprecate it most strongly for the following reasons.

While in cases of simple and uncomplicated limb fracture there is probably little practical objection to disclosure, in cases of head injury the report will contain discussion of epileptic risk, premature senescence, life-expectancy, earning potential, possible institutional care, and confidentially given clinical information from the patient's relatives, any or all of which may be very undesirable reading for the patient himself. A medical expert must feel free to express his opinions candidly. If he knows or suspects that his report will, in effect, be published he may hedge or water down his opinions or express himself so obscurely that the report loses its value as a means to settlement.

When the solicitor's client is at the same time the medical expert's patient, indiscriminate disclosure may gravely prejudice the medical relationship. There may be an unresolvable conflict of professional obligations.

Other firms of solicitors have been affronted when we asked them specifically not to disclose our reports, protesting that such would never be their practice. They have been surprised to learn that it was anyone's practice. But it would seem that the Law Society's attitude is to leave the matter of disclosure entirely to the solicitor's own professional discretion.

We warn our colleagues that this discretion is not to be taken for granted. All medical reports, but especially those containing information or opinions of a delicate or distressing nature, should be provided with a covering letter specifying any portions of the text that should neither be disclosed to nor (except in a general way) discussed with the subject of the report. This is already the case with medical reports to the Department of Health and Social Security and the Criminal Injuries Compensation Board, although recently one of us had some anxieties with the latter body. Our experience in court has been that a high measure of discreet consideration is invariably accorded to the plaintiff when potentially distressing evidence is to be heard: he leaves the court. Justice is not hampered by his absence.

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Postmenopausal osteoporosis

SIR,—In their review article (28 August, p 585) Dr J C Stevenson and Dr M I Whitehead conclude that loss of ovarian function is the most important factor in the development of postmenopausal osteoporosis, and they advocate greater use of oestrogen for prevention and treatment. I would like to put forward an alternative hypothesis—namely, that the primary cause of postmenopausal osteoporosis is lack of exercise and that hormonal factors are secondary.

There are strong a priori reasons for rejecting a hypothesis that attributes a pathological condition to a physiological state. The lowering of oestrogen concentrations at the menopause is physiological, and there is therefore no reason to suppose that it is the primary cause of pathological bone loss in postmenopausal osteoporosis. Dr Stevenson and Dr Whitehead gave the usual list of causes of osteoporosis in adults, which include aging and immobilisation. These two factors are combined in our civilised way of life because most over the age of 40 take little or no exercise. This is the cardinal factor in the causation of osteoporosis, which is essentially a disuse atrophy of bone.

As long ago as 1870 Wolff demonstrated that