competition between specialists and general practitioners for patients, and with other professions such as nurses and pharmacists. In certain countries it is felt that the widespread adoption of practice nurses and the development of their role in the UK is undermining general practice as a discipline. In most respects primary care in the UK is held in considerable regard in Europe, particularly our training programmes, research and publications. However, we must be aware of the considerable diversity of practice in Europe and in view of our changing political scene we are likely to benefit from a closer study and understanding of the different ways in which primary care is delivered throughout Europe.

The quality of care which is provided by doctors is an area of increasing importance as far as the EC institutions are concerned. The economic and social committee of the European parliament is currently drafting a charter of social rights and the European Commission itself intends to revitalize its consumer protection policy. Other areas in progress or being planned include a study of the problems of health care for the elderly, a new five-year programme for cancer prevention and a programme for avoiding road traffic accidents (Rowe AJ, personal communication). Although such initiatives may not seem immediately relevant to British general practice it is important that we become increasingly aware of any proposed developments over the next few years so that early and appropriate representations can be made. Such representations can be made at a national level to our own government and directly to the European Commission, but in many cases a joint approach will be more effective when made with general practice colleagues from the other EC countries and where appropriate in conjunction with our specialist colleagues. Bodies such as the European Union of General Practitioners (UEMO) and the Standing Committee of Doctors of the EC (CP), allow joint views to be formulated and presented.

The single European act will also have a significant effect on the European pharmaceuticals industry. Legislation is being prepared on quality control, equal acceptance of drugs by all EC countries, prices, monitoring of side effects and provision of information for both doctors and patients. There have been suggestions for a European data base to cover 2000 drug products. It is not yet clear whether there will be an EC licensing system so that new drugs will have to satisfy only one set of safety criteria and national licensing/safety authorities will no longer operate. There have been suggestions that the 1992 act will permit greater competition between pharmacists and doctors in relation to dispensing drugs to patients; making it easier for doctors to dispense would make the present UK dispensing agreement redundant. There is in fact no evidence to support this interpretation of the act and there are currently no plans at EC level to alter the dispensing agreement between pharmacists and doctors.

Under the original treaty of Rome and the single European act the subjects of health promotion and prevention were not envisaged as being of EC supra-national concern. Nevertheless there is increasing interest being shown in both subjects at the level of individual nations, European Commission and European parliament and because of outside pressure from bodies such as the World Health Organization. The UK government's policy on prevention is confused; its resistance to new tobacco pack warnings left it in a minority of one (the argument being that the European acts do not specifically cover such subjects) but, in contrast, our government was signatory at heads of government level to the 'Europe against cancer' campaign and the EC programme against the acquired immune deficiency syndrome. Clearly, it will be necessary for the UK government to develop a coherent policy on these topics within the community.

With regard to medical research, the European Commission both initiaties research projects and provides funds for approved programmes. An example of the former is the current proposal on human genome analysis and of the latter the advanced informatics in medicine programme. It is important to be aware that EC research funds are primarily available for cooperative research projects involving two or preferably three EC countries. Unfortunately the Brussels bureaucracy does not always accept that the UK and Irish Republic are separate for these purposes. It is anticipated that new initiatives and funding will be forthcoming with the closer integration of EC countries after 1992.

Nineteen ninety two should not be seen as a cataclysmic date when new arrangements will suddenly be in place. Rather it should make us more aware of the European context of our practice of medicine and encourage us to take a positive attitude to influencing the way in which general medical practice is developed.

PHILIP R EVANS
General practitioner, Bury St Edmunds

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Double agent

THERE is an increasing trend among general practitioners for screening patients and collecting certain details of their lifestyle. When documented, either in written form or on computer systems, this information adds to the extensive existing personal records held in general practice. With only a few exceptions, doctors are obliged to preserve secrecy and confidence on all they know about a patient. One exception is when a patient has given informed consent for information to be disclosed. This consent is valid only if it is given freely and if the patient understands the nature and consequences of what is being proposed.[1,2] How then is a general practitioner placed when acting on behalf of and for the benefit of an insurance company seeking information about a patient? Does the present system of providing medical reports for insurance purposes create ethical dilemmas?

From the point of view of the insurance company, accurate information about individual clients is important. By this means, accurate assessment of risk is possible and insurance premiums for most people can be kept low, while loading the premiums of individuals who are at risk of illness or early death.

Before an insurance company can obtain information from a general practitioner about a patient, it must obtain the patient's written permission. The patient is informed, sometimes briefly, of his or her rights under the access to medical reports act 1988,

but how often do patients understand the implications? Certainly patients do not usually see the questions posed to the general practitioner by the insurance company in the personal medical attendant report. Lorge,[3] in his survey in 1989, reviewed 195 patients who previously had personal medical attendant reports completed about them by their general practitioners. He found that 57% expected doctors to withhold sensitive information and 68% were surprised that their doctor was asked certain of the questions in the report. So there is genuine concern that the present arrangements do not ensure fully informed consent.

In communicating to the patient, insurance companies mention the patient's rights and offer a number of alternatives. Consent for the provision of a report can be withheld. The report can be viewed, if requested, within 21 days. Up to this time the doctors can, if asked, amend those parts of the report that patients find inaccurate or misleading. Finally, the report can be viewed within a six month period. Few patients will withhold consent, for this could prevent their being accepted by the insurance company, and few may exercise their right under the act to review the report written by their doctor. Should they do so and certain information is withheld or amended, this decision has to be declared to the insurance company. A typical example on one personal medical attendant report is 'Has the report been viewed by the patient?' 'Has any information been withheld or altered on this report after consultation with the proposer?' Insurance proposal forms are sometimes phrased in such a way that the patient is deterred from viewing the report: 'Please bear in mind that if you do wish to see the report, the acceptance of your application will be delayed'.

What are the possible outcomes if the current UK system of providing insurance medical reports continues? One problem concerns patients who in good faith declare risk factors which over time are reversed yet could significantly alter their chances of obtaining normal life or health insurance cover at that moment, or possibly permanently. Those patients not presenting information, for whatever reason, will gain normal acceptance. Another possible outcome is that doctors could be tempted or exhorted to withhold or fudge information destined for insurance companies. This would be unethical and possibly illegal. Society depends on the integrity of its professional groups. The worst medical outcome of the current situation would be if patients failed to come forward for screening procedures, and doctors were unable to give advice and help modify risk factors for lack of declared information.

General practitioners now appear to be in an untenable situation. On the one hand they actively encourage patients to reveal confidential information, and on the other hand they supply this information, for a fee, to a third party with the rather unconvincing evidence that the patient understands what is taking place.

In 1986, Toon and Jones[4] considered this issue and were unhappy about the nature of the written consent. They made a number of suggestions: never accept, without corroboration that the written consent equates to informed consent; ensure that the patient understands the implications of disclosure and the change in the doctor's role; act to protect the patient's interests, which may mean advising him or her not to proceed with the insurance or not furnishing a report. The Royal College of General Practitioners has already taken a stance on the question of lifestyle that relates to infection with human immunodeficiency virus (HIV): 'The College recommends that when GPs complete short insurance forms, they should not answer questions about lifestyle that relate to HIV infection'.[5]

There are other ways of obtaining the necessary information; insurance companies could rely on personal statements concerning health status supplemented by independent medical examinations and assessment. Certainly, insurance companies in other countries manage to assess the health risks of their clients without the benefit of general practitioner reports. The objections to these arrangements are doubts about accuracy of personal statements and the expense of independent medical examinations. But, while these present arrangements are convenient and cheap for the majority of patients they may be placing in jeopardy the benefits which flow from the full disclosure of information by patients to their personal physician.

Nearly four years have now elapsed since Toon and Jones' article. General practice is now more proactive, obtaining a wider data base from a variety of sources. Other players are entering the scene, including the government[6] and private screening agencies. The debate needs to be raised again concerning the reality of the so-called informed patient consent, the position of the general practitioner as a double agent in this issue, and the future of the personal medical attendant report.

JOHN NOAKES

General practitioner, South Harrow, Middlesex

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