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Nineteen ninety two

NINETEEN ninety two has become a familiar date, but for many general practitioners the significance of it to their work may seem unclear. With the introduction of the single European act, the changes occurring in the European Community need to be appreciated and understood by all general practitioners in the United Kingdom.

The aim of the single European act,[1] a development of the original treaty of Rome, is that by the end of 1992 there will be no impediment to free circulation of goods, services and persons throughout the European Community (EC). The legislation for 1992 should be seen as part of the continuing development of the EC; the relevant directives on freedom of movement of doctors, for example, have been in existence since 1975[2,3] and 1986.[4] Doctors who are nationals of a member state with a basic medical qualification of a member state, have had the right to practise in another member state since 1975. With regard to general practice all countries must have a vocational training scheme of at least two years duration in place by 1 January 1990 and from 1 January 1995 no EC country will be able to allow a general practitioner to take up practice in its social security system unless he or she has received the minimum two years in vocational training.

The demographic pattern of doctors throughout the EC shows that there are problems with the numbers of doctors unemployed or under-employed. This is particularly the case in Italy, Spain, West Germany and France. In the Netherlands there is often a three year wait before vocational training can be started and a further long wait of up to three years before obtaining a practice. Between 1984 and 1988 full registrations with the General Medical Council by EC nationals rose from 593 to 1309. The largest increases in graduates were from Germany (52 in 1984, 430 in 1988) and the Netherlands (20 in 1984, 160 in 1988) (General Medical Council and University Grants Committee, personal communication, 1989). It is not clear how many of these registrations have resulted in EC doctors working in the UK, but it is clear that some of them are filling senior house officer posts in the hospital service, often in response to health authorities advertising abroad. Some doctors, particularly from the Netherlands, have obtained vocational training posts in the UK. However, despite the attraction of the relatively low level of medical unemployment in the UK, the likelihood of a major influx of general practitioners is probably not great. EC graduates may well compete for posts both for training and partnerships but the competition from UK nationals will be stiff.

The single European act does not involve harmonization of social security systems throughout the 12 countries and reciprocal health agreements between member states will remain the same. Given the UK government's proposed legislation on the organization of health care,[5] one can anticipate an increasingly mixed provision involving both the NHS and the private sector. The UK may become an attractive health care market for overseas companies including European health care companies providing private general medical care in conjunction with professions related to medicine, such as nursing, dentistry and pharmacy.

Although there is a genuine shared sense of the importance of primary medical care and of the need for high quality primary care as the basis of the health care systems the role of the general practitioner varies between EC countries. This is the result of differences in the historical development of the health care systems, and in the training of general practitioners. In some countries there is significant

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,