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Personal medical attendant reports

Sir,

In his letter (September *Journal*, p.395) David Haslam questions my conclusion that the ethical issues for general practitioners in completing insurance reports are now largely resolved (letters, April *Journal*, p. 172. He confuses the separate issues for general practitioners and for their patients. My study clearly demonstrated that general practitioners feel entitled to pass information to insurance companies, because of the safeguards given to their patients by the access to medical reports act 1988. The issue for the patient is more complex. Do we have anything other than anecdotal evidence to suggest patients do not consult their general practitioner for fear of jeopardizing future insurance? Even if we accept this evidence, it cannot be ethically correct for a patient who perceives himself or herself to be at high risk of disease to deny this on the proposal form and expect to be corroborated by the general practitioner's report? This would, of course, invalidate the insurance policy too.

Secondly, the 57% of patients in Lorge's study who expected their general practitioner to withhold sensitive information have not been ignored.[1] This figure related to lifestyle questions, which have since been considerably changed by insurance companies. This group of patients would also be comforted by the underpublicized fact that the norm in insurance is to offer standard rates to about 90% of proposers.[2]

Finally, may I recommend that we general practitioners telephone the patient directly after completion of all reports. Almost no delay is caused by a request to see a report. The access to medical reports act 1988 has encouraged general practitioners to be accurate in their reports, and they are being so. In this they do their patients a service, not a disservice.

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Sir,

Following the letters from William Hamilton (April *Journal*, p.172) and David Haslam (September *Journal*, p.395), I think readers should be made aware that it is now RCGP policy that should information be divulged in a personal medical attendant's report which in the opinion of the general practitioner would be prejudicial to the patient then the patient should be involved either by being sent the report with a covering letter or by being informed of the detrimental nature of the information and of the implications of divulging it (*RCGP Connection* 1993; October: 3).

This by no means solves all the ethical problems these reports create but it is a significant improvement in current practice. I would suggest that all such reports are sent to the patient for their perusal before being forwarded to the insurance company.

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Making London better?

Sir,

In her wide ranging editorial Iona Heath covers many of the problems facing general practice in the London area (August *Journal*, p.314). Problems lie in the organizational structure of the National Health Service, the mode of delivery of care to vulnerable groups and the resourcing of primary care in the city.

Several solutions to the underlying problem of supply and demand regarding health provision in the city are suggested. Reorganization, re-financing and reappraisal of the methods of delivery of health care are but some of the possibilities. However, Iona Heath does not address the issue of the health seeking behaviour of the clients of the primary care team. It is assumed in the editorial that the demands of the patient are appropriate, when practical experience teaches that many of the demands of patients are inappropriate in their timing or direction.

The greatest strain on the health service both in terms of individuals and finances is the ever growing demands placed on it by the client group. In a climate of financial restraint these wants cannot be equated with needs. Unless the profession addresses the issue of educating people to have realistic expectations of what can be provided by their family doctor we will be swamped by their demands. We should take the lead in educating our patients in what is an appropriate use of the service and not allow their expectations to be shaped by the short term political expediency of those in power.

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Measuring alcohol consumption

Sir,

The use of units of alcohol as a standard by which to assess an individual's drinking habits is widespread and greatly simplifies the collection of data for health promotion purposes. How standard is the unit?

A visit to my local supermarket revealed beers and lagers which varied in strength from 2.3% to 5.6% alcohol by volume. Cider varied even more, from 3.5% to 8.4%. These were not barley wines or speciality drinks, although some were labelled 'extra strong'. Wines were mostly 12.0% alcohol but varied between 9.5% and 13.0%. The consequence of this variation in alcohol content is that a half a pint or one unit of a strong beer might contain more alcohol than two units of a weak one.

If we assume a standard strength for wine of 12.0% and that a standard 750 ml bottle provides six glasses, then a unit of wine contains 15 ml of alcohol. In order for a half pint of beer (284 ml) to contain the same amount of alcohol it would have to have a strength of 5.3%, which is near the top of the range of strengths quoted above. The sort of beer sold in large plastic bottles by supermarkets is often 3.0% alcohol by volume, so that a pint would only contain slightly more alcohol than the glass of wine.

While accepting the value of having a rule of thumb by which to compare different types of drinks, it is clear that there could be problems in using units of alcohol for quantitative research.

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