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. 174). He points to 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 under-publicized fact that the norm in insurance is to offer standard rates to about 90% of proposers.

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.

WILLIAM HAMILTON

References

1. Lorge RE. How informed is patients’ consent to release of medical information to insurance companies? BMJ 1989; 289: 1495-1496.

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.

J D YOUNG

The Medical Centre
72-74 Medomsley Road
Consett
County Durham DH8 5HR