as everyone else seems to be by the apparently conflicting messages about how much and how often to drink?

During the panel discussion that followed the seminar, one member of the audience pointed out that there is no standardisation between Britain, the rest of Europe, and the United States, in terms of alcohol consumption. What if she managed to travel between all three in one week? "Does this mean I should have a glass of wine with my cornflakes?" asked another, with more hope than flippancy

in his voice, when advised to spread intake and reap the maximum benefit of the flavonoids found in wine. What is it about the fermentation process that increases the antioxidant content of wine fivefold compared with grape juice? And how many of the studies have differentiated among the different types of alcohol? And how many have included women? "We are not offering a recipe for preventing your dying from coronary artery disease," said Professor Catherine Rice-Evans of the Free Radical Research

Group at Guy's Hospital, one of the panel members, "but on balance, wine—and red wine in particular—does seem to offer some protection."

The Australian Medical Association has cautiously endorsed the "acceptability of low doses of alcohol," but the Australian Heart Foundation has refused to confer healthy food status on wine. Dr Norrie derives some pleasure from refusing their annual requests for free samples from his vineyard.—CAROLINE WHITE, *freelance writer, London*

PERSONAL VIEW

Moving away from rational medicine?

Gilles de Wildt, Helen Sweeney

The General Medical Council has taken a major step away from the concept of confidentiality in its guidelines on HIV and AIDS, which have recently gone to all doctors in Britain.* The GMC advises doctors to break this cornerstone of the doctor and patient relationship under certain circumstances. It states that "the doctor may consider it a duty to seek to ensure that any sexual partner is informed in order to safeguard persons from infection." Furthermore, in the case of a health worker infected with HIV, the GMC now sees it as the duty of a doctor to inform the patient's employer, or head of service, usually another doctor, of the patient's HIV state, if the patient is thought not to have sought or followed advice to modify his or her professional behaviour. This may have profound effects, not only on the trust between patient and doctor, but also on the practising of rational medicine. The *Lancet* queried the wisdom of breaking confidentiality by informing a patient's partner. We question the wisdom of informing the employer of a patient who is a health professional.

While the GMC acknowledges that there is only one proved case of infection of a patient by a health professional—a dentist in the United States—the guidelines place a strong emphasis on control of individual health professionals who know that they are infected and on their doctors. The GMC does not make clear how breaching patient confidentiality by informing employers can protect the public. This is a fundamentally different situation from, say, a driver of a heavy goods vehicle who suffers from epilepsy. Furthermore, is there no danger that some will perceive informing employers—both a simple administrative measure and a threat—as a medico legally safe alternative to time consuming counselling of patients?

The GMC does not put the risk of health professionals infecting their patients in perspective, apart from stating that it is "very small." Those who know that they are infected

may be only the tip of the iceberg of all those who carry HIV. If health professionals are to infect patients with HIV at all it is not more likely to happen by those who are unknowingly infected, both because of their numbers, and, arguably, because of the lesser degree of protective measures they take?

We wonder about the motivation behind the guidelines. Perhaps part of the explanation lies in the acknowledgment by the GMC that "considerable public anxiety has been aroused by suggestions that doctors who are HIV positive might endanger their patients." Understandably, the GMC wants to be seen to be doing something. Could it be, however, that the council was led less by evidence based medicine, which is unlikely to provide a scientific basis for the guidelines, than by medicine which is led by public opinion and fear of media exposure?

**HIV and AIDS: the ethical considerations. Guidance from the GMC.*

We feel ill at ease with the new guidelines. There are two other developments in society and health care which increase our unease. Firstly, our society is characterised by growing job insecurity, health care not excluded. At the same time insurances, other financial matters, and job applications are increasingly subjected to rigorous commercial risk assessment. Some companies seem to demand an HIV test from their employees and many private sickness insurances, including those for doctors, exclude HIV from their payments. Secondly, there is growing concern about the lack of protection of patient data in the health service. This is important when there is an obvious market for confidential information. The duty placed on doctors to divulge such data to partners and to other doctors will not help patients to feel more secure.

It is essential that those who wish to know their HIV state with a view to protecting themselves and others, including their unborn babies, can do so in a humane setting and without fear of being occupationally, financially, and socially ruined. The GMC's advice does nothing to take this fear away. On the contrary, patients may decide that they put themselves and their dependents at an

unacceptable risk if they undergo testing through the health care system.

Before the current guidelines were issued the editor of *The Practitioner*, apparently wrestling with this problem, suggested that general practitioners should refer patients to genitourinary medicine clinics for HIV testing and other sexually transmitted disease issues, with a view to keeping patients' notes and subsequent reports to insurers free from references to tests or sexual risks. Assuming that doctors in genitourinary medicine clinics are also covered by the guidelines, then this option, which is imperfect but sensible in terms of public health, is undermined. The GMC may thus actively discourage individuals from finding out their HIV state.

There should be a thorough debate among professionals and society at large. The implications of the guidelines could be much wider than perhaps envisaged. Although not all barrier breaking decisions in medicine lead to a slippery slope, we fear that a precedent is being set. Could the GMC reach similar conclusions regarding confidentiality and genetic disorders? For example, will the doctor of a healthy 35 year old male patient have a duty to inform his partner if the doctor thinks that the patient may develop Huntington's chorea? Will the doctor have a duty to inform the patient's employer in the case of a job where intellectual judgment is of the greatest importance if he or she considers that the patient may become demented? To what degree should the task of doctors be expanded to include social control, if at all? And where will this leave curing and caring?

It is disappointing that the guidelines seem to promote an atmosphere where neither patients nor health professionals will be safer. It would be interesting to study how the GMC reached its conclusions, and which implicit or explicit notions, values, and perceived pressures formed the basis for its discussions. This may help to clarify the role of doctors, their professional bodies, and influences from society. This will not immediately help the patients or their doctors who try to practise scientific medicine with compassion. Unfortunately the possibilities of contributing to the prevention and control of HIV and to the care of those infected are undermined by the present guidelines.—GILLES DE WILDT is a general practice registrar in Birmingham and HELEN SWEENEY is a senior house officer in ear, nose, and throat in Birmingham