when abnormalities had been reported by patients—that is, lumpy semen (cells and spermatozoa around eggs), semen that was more fluid than usual, blood in the semen, or discoloration of the semen.

Often this group of travellers has been exposed to potentially infected waters in a range of countries in Africa. The references cited by P Jordan and G Webbe attest to the longstanding focus of infection in Lake Malawi. Our point in emphasising the occurrence of infection among those exposed only in this lake was to indicate that travellers are often not aware of this risk.

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Should insurance companies have access to patients' medical records?

Risk of being denied access would be relatively small reduction in companies' profits

EDITOR,—P H Smee claims that access to medical records is necessary to enable an insurance company to prevent some policyholders from profiting at the expense of others.¹ The company, however, is not merely an honest broker apportioning risk between customers. It has a vested interest in maximising its profits, and this is surely the main reason for requesting medical details that would otherwise remain confidential between patients and doctors. To minimise losses, companies must be able to identify policyholders who are likely to make claims before they have paid many years' worth of premiums. The issue at question is how far they should be entitled to use medical notes, compiled for an entirely different purpose, in order to do this.

As Smee suggests, the principle of insurance is based on risk. What additional risk would devolve to the insurance company if it were denied access to medical records? The risk would simply be that of reduced profits because a small minority of clients might conceal an appreciable health problem. This risk would probably be relatively small because, according to Smee, 95% of all applications for life insurance are completely unaffected by medical evidence. Thus there seems no overwhelming reason why the confidentiality of the medical consultation should be jeopardised for the benefit of the insurer.

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Onus should be on insured person to disclose information

EDITOR,—As a general practitioner, like H Lavender,¹ I have considerable unease about the erosion of confidentiality arising from the disclosure of medical information about patients to various agencies. The present position, whereby medical practitioners allow themselves to act as confidants to patients and as agents for a third party, cannot be simply justified by seeking the patients' consent for disclosure. Other general practitioners have previously expressed concern about the ethics of disclosure of medical

information.² The arguments of P H Smee in favour of disclosure are well rehearsed and add little more to the debate.¹

It is noteworthy that, from next year, the Inland Revenue is introducing a self assessment policy for tax liability. It might be appropriate for insurers to consider a similar policy, whereby the onus is on the insured to disclose information and further verification from the general practitioner is sought only if a claim is made.

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2 Toon PD. Ethical aspects of medical certification by general practitioners. *Br J Gen Pract* 1992;42:486-8.

Prejudicial records may be destroyed by GP

EDITOR,—H Lavender is entirely right in arguing against the current practice of insurance companies requesting short reports based on general practitioners' records.¹ The records are bulging, and the compilation of reports has become a difficult task to complete. It is done in the middle of a busy day, when one has many more important thoughts on one's mind; one tends to ignore difficult hand written records, to depend on incomplete summary cards and scrunched up x ray reports, and to use computer recorded information if it is handy but to ignore it completely if the task has to be done at home. I sometimes wonder if our efforts at recording lifestyle information since the introduction of the 1990 contract are being plundered by the insurance industry and individual patients are being disadvantaged without their knowledge or consent.

I feel uncomfortable when a patient ticks the box to view my report before it is sent to the insurance company because I feel vulnerable to a challenge on its fairness and accuracy. My attitude to recording all that is discussed in confidential consultations has certainly changed, and I remember well a particular case when I had noted down details of a request for an HIV test that the patient subsequently decided against having when I made him aware of the possible consequences. He rang me the next day to ask me to remove any reference to the subject because it would prejudice any insurance in the future. I felt divided in my loyalty to the patient and to the integrity of the medical record. To my surprise, my medical defence adviser said I should destroy the record, which included another doctor's previous entry. Does this inspire confidence in the completeness and reliability of the short reports?

I would certainly do without the modest additional income from this work, but at present my refusal would only cause difficulties for my patients. It is time for the BMA and the Royal College of General Practitioners to debate the issues and then, hopefully, extricate us from this inappropriate task.

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GPs' records may have little diagnostic validity

EDITOR,—H Lavender's and P H Smee's articles reopen the question of confidentiality of patients' records.¹ I am not reassured by the soothing words of Smee, who is head of life insurance at the Association of British Insurers: my

experience suggests that many arbitrary decisions are taken by insurance companies on the basis of inadequate evidence, particularly where nervous illness is concerned.

Although there have been dramatic improvements in recent years, general practitioners' records are often terse, opinionated, and sometimes illegible and were not intended as more than an aide memoir. An irritating patient may be described as "neurotic," a recently divorced woman as depressed, and a man complaining of indigestion as "drinks too much" without any of these statements having diagnostic validity. Yet in some circumstances these statements are used as an indication of risk.

As a postgraduate dean I was aware that a high proportion of junior doctors show evidence of stress, including depressive symptomatology, at some time during their years as a preregistration house officer and senior house officer. Thus I emphasised the importance of registering with a general practitioner and of seeking help when they were under pressure. After years of preaching this message I was disturbed to learn that two young women whom I knew well had been refused payment on an income protection policy when later in their careers one of them developed a depressive illness and the other a mild hypomania. Both made good recoveries. Their claims were rejected on the grounds that they had made false statements in failing to declare "nervous illness," a conclusion presumably based on their complaints of being exhausted and tense during difficult and overburdened jobs.

If the patient agrees then the general practitioner and not a representative of the insurance company should interpret the meaning of the often obscure record.

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Insurance practice inhibits GPs exploring the sexual behaviour of patients

EDITOR,—P H Smee, the head of life insurance at the Association of British Insurers, states that incorrect evaluation of health risks by a life insurance company would be unfair to an applicant. But this is exactly what may have happened to many applicants who declared even a low risk of HIV infection in the past and were declined insurance. The interests of individuals with any risk of HIV infection are now perceived as best served by their not declaring that risk to the insurers and, by association, their general practitioner. The general practitioner can be bypassed by self referral to other health care services.

While demanding full information from prospective clients, the insurance companies keep their underwriting policies confidential. Potential clients cannot know in advance how a company would now react to the risk factors that they face. The problem is compounded by sharing of data on clients between competing companies. Patients cannot give informed consent to the release of information from their medical records.

Because 1% of clients are declined life insurance and 4% have loaded premiums,¹ completion of reports to insurance companies is detrimental to the prevention, diagnosis, and treatment of disease in the individual patient. When the disease is infectious the underwriting process carries implications for the wider community. Insurance practice inhibits patients being open with their general practitioner about their sexual behaviour²; general practitioners