prevented. If dental procedures other than extractions are included the cost becomes considerably higher. In addition, there is the extra work for the dentist and his staff, and the occasional adverse reaction to amoxycillin.

Although amoxycillin allows a very attractive simple regimen its unselective use would thus be very expensive. But when antibiotic prophylaxis is restricted to the 5% of dental patients estimated[5] to have a susceptible heart lesion the cost:prevention ratio is reduced to $1{\cdot}74 \times 5/100$ (325 470):1/2 (20) = £2 800:1, if we allow for the fact that only half of endocarditis cases have known heart disease. These ratios are not the absolute risk of developing endocarditis when the patient is unprotected by antibiotics since some degree of prophylaxis is already practised. An estimate from the pre-antibiotic era was 500:1 for cardiac patients.[6]

Are there other strategies which might reduce the incidence of endocarditis? The provision of antibiotics for dental patients could be simplified. Although one hesitates to deny any pharmacist the dispensing fee, it would be more practical to recompense dentists for providing amoxycillin direct to the patient. At present he would have to pay the £1·74 from his fee-per-extraction of £2·50. Preventive dental techniques could play a part for younger patients with heart disease. Some endocarditis patients with no known disease may have had a bicuspid aortic valve or prolapsing mitral valve; detection of such cases could be improved.

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Treatment of erythema multiforme secondary to herpes simplex by prophylactic topical acyclovir

SIR,—The properties of dimethyl sulphoxide to which Dr Juel-Jensen refers (5 December, p 1544) are well known but do not of necessity preclude the possibility of any other solvent penetrating human skin. May I make two comments?

Firstly, although the preliminary reports in Washington of topical acyclovir in the treatment of developed *recurrent* infections were "disappointing," the results in primary genital herpes were most encouraging (L Corey *et al*, Interscience Conferences on Antimicrobial Agents and Chemotherapy, 1980 and 1981). Studies of recurrent disease in which treatment is started very early in the illness are already under way and the results awaited with interest. Secondly, the drug can be shown to be in the plasma after application of 5% acyclovir in a modified aqueous cream base through human skin (unpublished data).

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Confidentiality and informed consent

SIR,—Mr D H Howe is attempting to flog the confidentiality controversy back to life (2 January, p 53). As a lay practitioner of life assurance who has spent many years on medical selection of risks I wonder if you would allow me the courtesy of your columns to put Mr Howe's comments into better perspective.

I am no expert in staff recruitment, but as I see it a prospective employer needs to assess a job applicant medically in order to answer two questions, which are: (*a*) is he medically suitable for the job he will be asked to do—for example, will his health permit him to turn up regularly—and (*b*) is he eligible to join a pension and life assurance benefit scheme which could provide up to four times annual salary on death in service? How, other than by asking for the applicant's medical history, can the employer begin to make these assessments? A casual clinical examination by a disinterested referee is not necessarily an adequate substitute for the testimony of a medical attendant who knows the applicant well. Recruiting staff is an expensive and, with present levels of employment protection, hazardous business and managers cannot afford to ignore the medical aspect of recruitment.

The same broad consideration applies to the selection of life assurance risks. The underwriter assesses as best he can the mortality to which each proposer is subject, and often he can do this only by collecting medical evidence. If the underwriter needs a good *history* to help with the assessment—and, remember, he is generally striving to pass as many cases as possible at normal rates—then the best historian is usually not the proposer or the casual medical examiner but the personal medical attendant.

By agreement between the BMA and the life office associations the consent wording in life assurance applications runs as follows: "I consent to the [company] seeking medical information from any doctor who at any time has attended me concerning anything which affects my physical or mental health . . . and I authorise the giving of such information." I quite fail to see what more we could do to promote "informed consent to disclosure." If I may say so, I think that the confidentiality pot has been stirred overenthusiastically for too long by a tiny minority of the medical profession. I am convinced that the vast majority of doctors take the only possible view based on commonsense: at the end of the day a man must read what he signs, and we must pay him the compliment of assuming that he understands what it means.

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SIR,—Dr David Howe's letter (2 January, p 53) raises the issue of "the patient's consent to disclosure of medical information" and goes on to suggest that this may in some cases be given under duress. From my experience as assistant general manager, chief underwriter, and chief medical officer of a large life insurance company, I question the validity of this view.

It is the long-established practice of life assurance companies to underwrite proposals for life assurance on an individual basis, and it is often necessary to seek a report from the applicant's own medical practitioner in order to establish the appropriate premium level. Consent to approach the doctor is obtained from the proposer—the wording of the consent has been agreed between the BMA and the life assurance associations. The proposer also provides the name and address of his doctor and I find it hard to believe that the proposer when signing the consent is unaware that inquiries may be made about his state of health. Moreover, since the issue of life insurance policies is so widespread—some seven million in 1980—the suggestion of duress is nonsense.

I would just add that as an employer as well as a chief medical officer I would be disturbed at the implications of a person with a serious medical condition applying for a job for which he is medically unsuited. If employment were always obtained without important medical information, there would be cases where employees could endanger themselves and others as a consequence of taking up unsuitable employment.

Dr Howe quotes one case only in which an applicant was refused a job because he wanted his medical details kept secret. The conclusion is obvious. Would Dr Howe like to travel in a bus, taxi, or aeroplane the driver or pilot of which was subject to epileptic fits or a candidate for a coronary? Members of the armed Forces are all subject to strict medical investigation, as also are airline pilots. Is that what Dr Howe calls duress?

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SIR,—Mr David Howe (2 January, p 53) raises the issue of confidentiality and informed consent to disclosure again—principally in the context of employment, but later he refers to insurance. I would like to put in a word, primarily about insurance and life assurance. Before doing so, may I support Dr Howe's view that this difficult problem merits re-examination; but, should this be undertaken by the Central Ethical Committee—or other BMA committee—I hope that the problem will be looked at from all relevant directions.

Next, to declare an interest, I am adviser to a health insurer, and as such am frequently seeking medical reports on both applicants and subscribers. I think that it is fair to say, however, that not only have I been a family doctor but that my present job brings home to me that there are other points to be considered.

Firstly, I would like gently to challenge Dr Howe's repeated use of the somewhat perjorative phrase "under duress." Information about one's health and future fitness has a special significance to both patient and doctor, but is inquiring about it really any different from, say, the taking up of a character reference? Is a potential employee "under duress" if he is told to give the names of referees who will vouch for his honesty—or otherwise? I would imagine that most family doctors would wish to do this when considering the appointment of a secretary or receptionist.

Next, if one follows the line that applicants for insurance or life assurance should not be asked to provide evidence of their state of health, nor should their medical advisers be asked to provide it, certain consequences must flow from such a policy. The obvious one is that all premiums will materially increase. Again, to bring the matter nearer home, would all the healthy BMA members who have taken out cover with PPP or BUPA be content to pay more, to cover fully the higher risks of colleague subscribers with known health prob-