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Coronary heart disease: preventable but not prevented?

THE consensus report of the Coronary Prevention Group on risk assessment for prevention of coronary heart disease published in this issue of the *Journal* deserves careful reading by every primary care team.[1] Its scientific advisory committee included Godfrey Fowler and its primary care advisory group was chaired by Theo Schofield, so general practice was expertly represented and its conclusions are realistic. Mortality from coronary heart disease accounts for about one third of all deaths among 45 to 64 year olds and most of these are preventable so why are they not prevented? One answer we still hear is that they cannot be prevented but I think we shall hear less of that argument, in the same way that the agnostic lobby on smoking and lung cancer eventually faded away.

There are huge differences in mortality from coronary heart disease between countries, and within countries over time, and by social class. In 1982 the mortality rate from coronary heart disease among men aged 50–54 years was 11 times greater in Scotland than in Japan while in the USA it fell from 11% more than in Scotland in 1968, to 37% less than Scotland in 1980.[2] With a time lag of 20 years or more, young migrants from low risk countries come to resemble their high risk hosts as they discard their original patterns of eating and living.[3] In the UK the mortality rate from heart disease for male professionals is 58% below the average, but 74% above the average for unskilled workers,[4] a social difference which first appeared in the 1950s and has increased ever since. Such facts are explicable only by differences in environment and experience, which can be changed. Most of these deaths must therefore be preventable, if we can find ways to change environment and experience. Less certainly but more profitably, some deaths may also be avoided by biochemical manipulation, without changes in environment or experience.

'Dangers, by being despised, grow great', said Burke in 1792, using his considerable rhetoric to oppose a petition of unitarians for religious tolerance. This should remind us that to judge any plan for social action, three questions need to be answered: 'What is it for?' 'How will it be implemented?' and 'Who is it for?' 'How?' gets higher priority than 'What for?' For example, we have no general population data on immunization for tetanus, but in my experience, there seems to be hardly a man, woman or child in the UK whose immune status for this disease is not known, and if deficient, is not acted upon. In 1971 there were five deaths from tetanus throughout England and Wales. They were unnecessary, but why were five deaths at all ages from tetanus taken more seriously than 37 118 deaths from ischaemic heart disease in those aged less than 64 years in the same year? It may be because a simple process easily done and well rewarded is more conscientiously performed than a poorly defined but potentially more important process requiring hard work and imagination.

Against this it will be said that the new contract pays £45 a session for each health promotion clinic. However, clinics do not necessarily prevent heart disease. The great danger of paying for means rather than ends is that the means become the end. Health promotion clinics for cardiovascular disease attract people who need them least and repel those who need them most.[5-8] At best, they are a means to an end, at worst they become yet another profitable but irrelevant ritual.

Clinics are usually an inefficient method of identifying need, recognizing potential motivation and initiating effective action, though they are probably essential for follow

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up.[9,10] Expanded consultations of a traditional type[11] are probably more effective, but without more consultation time, the expansion cannot occur. Priority is rightly given to demand, so that without enough time, identifying need is omitted.[12,13] Although there is evidence to support the general feeling that general practitioners already have too much to do[14-16] the new contract encourages not more time but more patients.

If we must have a 'stick and carrot' policy, it should relate to ends rather than means. Smoking habit, blood pressure, cholesterol level, body mass index, glycosylated haemoglobin level and other reversible risk indicators should be expressed first as proportions of relevant populations screened, then as differences before and after treatment. Those that run our administration claim that this would be too complicated and that we must start simply, with what we know. Exactly so. What we know is at least the beginnings of scientific medicine, not business. We are not donkeys, and neither sticks nor carrots are appropriate to our task; as Mike Pringle[17] predicted, the new contract is widening the gap which already existed between high and low investment practices, inversely reflecting the social and clinical burdens with which they contend.[17-19] In all senses and on both sides of the surgery desk, the rich get richer and the poor get poorer.

The widening social chasm was beyond the remit of the Coronary Prevention Group's report, but engulfs all its conclusions. All factors promoting premature coronary senescence, in childhood as well as adult life, are becoming more concentrated in those who have least of everything.[20] If personal salvage has any meaning in this context, it must be concentrated where it is most needed. What we actually want for better personal anticipatory care is help in identifying needs on a mass scale, and then providing lifetime support. This can be done, even under the most difficult conditions of inner city practice, provided the aims are clear and resources are made available.[21] The resources required are mostly more labour (more doctors, many more nurses, and very many more lay counsellors of various kinds) and in-service training for that labour.[9] We have the beginnings of this in the many prevention facilitators and health promotion officers who are serious about their work and aware of the limitations of the new contract, as well as that growing cohort of primary care teams who have for the past 10 years braved a rising tide. Their time will come.

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The consultation and health outcomes

DESPITE its acknowledged importance in British general practice and in medical education, the doctor–patient relationship is an area that has received less attention from general practice research than epidemiology (for example, morbidity classification and recording) and practice organization. Exceptions can, of course, be found, for example, the descriptive work of Balint[1] or Byrne and Long,[2] the analytical work of Pendleton,[3] the studies of Morrell[4,5] and, more recently, Howie,[6] concerning the length of consultations and Freeman's study[7] of continuity.

Paradoxically, a growing body of investigation into the effectiveness of doctor–patient communication is emerging in Canada and the United States of America, despite the latter's lack of support for generalist practice. These studies relate specific aspects of communication between doctor and patient to evidence about their effectiveness in improving outcomes. This area of study may deserve exploration in the United Kingdom because of the special strengths of general practice in this country. Such exploration could lead to improved teaching and better practice in all clinical fields.

Two examples relate particular aspects of communication to change in physiological measurements — a narrow focus, but one which offers a particularly clear illustration of the relation between process and outcome.

Inui and colleagues[8] achieved significant improvement in the control of raised blood pressure in an experimental group of patients whose physicians had had one two-hour tutorial to improve their effectiveness as managers and educators for this disorder. No improvement occurred in the control group of patients whose physicians had not had a tutorial. The tutorial concentrated on reasons for failure in controlling blood pressure, barriers to compliance and patients' needs for knowledge. The strategy for altering compliance was to stress the need to study the patient's own ideas about the disorder and its treatment. In