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Occupational respiratory disorders

The impact of work on health is a crucial but often under-estimated dimension of general practice; for instance, as the author points out, 5–20% of new cases of adult asthma are estimated to be work-related with more than 200 work-place agents implicated in occupational asthma.

The review covers common presentations and related causes: upper respiratory irritation, bronchitis and chronic obstructive pulmonary disease, acute flu-like syndrome, asthma, and interstitial lung disease. The spectrum of interstitial lung disease, as in the UK, shows silicosis and coal worker's pneumoconiosis declining as the population ages whilst asbestosis continues to increase following exposure from the 1940s through the 1960s and more recently.

The importance of a good occupational history remains a cornerstone of clinical diagnosis, and the review includes a sample questionnaire which, in the context of occupational lung disease, could usefully be supplemented by the MRC questionnaire on respiratory symptoms which highlights details of cough, phlegm, breathlessness, wheeze, chest illnesses and smoking. The author develops the more detailed questions required to indicate an occupational link and goes on to summarize physical examination and laboratory tests, including chest X-ray, serology, peak flow and spirometry, most of which are available in general practice.

The example of a patient information leaflet devised by the American Academy of Family Physicians seems rather detailed for the target audience and we are fortunate in this country to have well-produced free leaflets available from the Health and Safety Executive, including literature both for employers and for employees under the Save Your Breath campaign.

This review of occupational lung disease from the US perspective shows a strong resemblance to the UK experience, and written by a family physician, provides insights and emphases which are useful to general practice in this country.

KEN PRUDHOE
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Source: Verdon ME. Common clinical presentations of occupational respiratory disorders. *Am Fam Physician* 1995; **52:** 939-946.

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Pharmaceutical representatives

There can be no dispute that pharmaceutical representatives (PRs) are cost-effective in marketing their companies' products. Companies would surely cease to fund this expensive resource if this were not so. They do have access to their company's unique medical information services and have been shown to play a significant part in the continuing medical education of doctors on both sides of the Atlantic. This paper describes a study in which the presentations of PRs were assessed, using an evaluation from, by GP registrars in the Harrisburg, Pennsylvania, Family Practice Residency Programme. It was shown that residents (registrars) rapidly acquire the ability to identify potential fallacies of logic and other misleading sales techniques in a representative's presentations. Compared with the pre-test results of an attitude survey of residents towards pharmaceutical representatives, the post-test scores confirmed that PRs and the acceptance of promotional items can affect prescribing behaviour. The paper concludes that, with the plethora of information now directed at physicians, it is important that registrars learn to become information managers and that useful information can indeed be obtained from PR presentations.

This paper may be of particular interest to course organizers in vocational training schemes in this country in teaching trainees how to critically appraise the information imparted by pharmaceutical representative.

RICHARD HORNE
General practitioner, Stockton on Tees

Source: Shaughnessy AF, Slawson DC, Bennett JH. Teaching information mastery: evaluating information provided by pharmaceutical representatives. *Fam Med* 1995; **27:** 581-585.

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Rational prescribing

General practice trainees in New South Wales, Australia, were randomized to receive either a seminar on 'rational prescribing' or on 'cancer prevention' (control group). The 3-day prescribing seminar, using a variety of sound educational methods, sought to decrease the rates of antibiotic prescribing for undifferentiated upper respiratory tract infection and of prescribing of benzodiazepines. The control 'cancer prevention' seminar was conducted on similar lines.

Forty-three (66%) out of a possible 68 trainees recorded data from a minimum of 80 consecutive patient encounters before and after the seminars. Prescribing rates did not show any important change. However, it would be wrong to imply that a well-conducted trial of an educational intervention appeared to have no statistically significant effects. As with much educational research, logistical difficulties greatly affected the power of the study. On average, each trainee issued only two or three relevant antibiotic prescriptions during each recording period. The position with benzodiazepines was similar. It would have been difficult or impossible to eliminate the problem of small samples. Perhaps the authors should have made this more clear, because it would be a pity if the article had negative effects. They are to be congratulated on a brave attempt to evaluate an educational intervention in a scientific way and others should try to follow their example.

ROSS J TAYLOR
Chairman, Prescribing Task Force,
Royal College of General Practitioners

Source: Zware NA, Gordon JJ, Sanson-Fisher RW. The evaluation of an educational programme in rational prescribing for GP trainees. *Aust Fam Phys* 1995; **24:** 833-838.

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General practitioners and HIV infection

There is a substantial literature on attitudes of patients with HIV infection to their general practitioners, most of it emanating from the UK.

A recent article from Melbourne, Australia, offers a different perspective relating to a different model of general practitioner care where patients can consult a general practitioner of their choice at any time.

A questionnaire survey of 238 patients attending HIV clinics (response rate 61%) found that 63% had consulted a general practitioner about HIV-related issues before attending hospital, that most of these (75%) had attended a general practitioner known to specialize in HIV care, but that only 46% continued to use a general practitioner for HIV-related care once they started attending hospital. Although there was some support by patients for general practitioner involvement in shared care, a rather surprising finding was that only 7% were in favour of general practitioner care in the terminal phase of their illness.

The main determinants of patient attitudes to general practitioners were the general practitioner's attitude and concerns about confidentiality. Patients were less likely to see knowledge and skills as significant for general practitioners than for specialist general practitioner. Another factor determining attitudes to general practitioners was the services provided by the general practitioners, such as whether or not they offered home visits or an out-of-hours service.

This paper suggests that issues of general practitioners attitudes and confidentiality are of particular concern to HIV patients in Australia, as they are in the UK, where the majority of those with HIV infection are homosexual men. This should be a further stimulus for general practitioners to consider displaying notices about non-discrimination policies and making clearer statements to patients about confidentiality.

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Source: Cheroweth IG, Piterman L. HIV: patients attitudes to GPs. *Aust Fam Phys* 1995; **24:** 1084-1093.

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Snoring

THE possibility that snoring during sleep is a risk factor or marker for heart attacks and strokes has provoked much interest in recent years. Cross-sectional studies have indicated an association between habitual snoring and such risk, but the extent of confounding by well-established cardiovascular risk factors, such as smoking, remains uncertain. Moreover, cross-sectional studies cannot provide evidence of causal relationships.

This paper from Copenhagen, Denmark, is based on the follow-up of a cohort of 804 men and women aged 70 years who, in 1984, provided questionnaire information about lifestyle and about snoring habits; they also had a brief medical examination. In 1990, information about hospital admissions and death certificate diagnoses of coronary heart disease and stroke was obtained from the Danish national health service register.

Snoring was reported by nearly a third of women and nearly half of men. During the 6-year follow-up period, no association was found between snoring and coronary heart disease, stroke risk, or all causes mortality — reassuring news for snorers.

However, the validity of self-reported information about snoring is uncertain: surprisingly, perhaps, there is some evidence that those who do not snore are more likely to report that they do than vice versa. The findings in this study are at variance with those from some others, but epidemiologists elsewhere will envy the access that their Danish colleagues have to a national database which records all contacts with hospital services.

GODFREY FOWLER
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Source: Jennum P, Schultz-Larsen K, Davidsen M, Christensen NJ, *et al.* Snoring and risk of stroke and ischaemic heart disease in a 70 year old population. A 6 year follow-up study. *Int J Epidemiol* 1994; **23:** 1159-1163.

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International students

In this paper, Herag Hamboyan, a family medicine resident, and Anne Bryan, a counsellor, draw our attention to students' health problems. The students under consideration are international and the health problems are more psychosocial than physician. We are encouraged to develop our understanding of the kind of problems which students face when they spend time studying in a country other than their own.

The problems listed include climate, diet, language, racial discrimination (disappointing!), cultural peculiarities, psychosocial distress and loneliness. Cultural differences in particular may result in students from other countries becoming ethnocentric with misunderstanding and mistrust of the culture of the host country. It is estimated that there are now more than one million students worldwide travelling abroad for education and the authors point out that, on average, 6% of the student population of Canadian universities are students from abroad, with a much higher proportion in some specific institutions. Of course, these figures are likely to increase. We are reminded that students' mental health is at greater risk than that of non-students with reference, in particular, to psychiatric disturbance, depression and suicidal concerns. Therefore, international students, subject to 'culture shock' and 'uprooting disorder', are at additional risk.

Measures aimed to help prevent psychosocial difficulties are considered both before departure and in the host country. These include physical and psychological screening, language assessment and financial considerations before departure, and encouragement to students to accept nonpharmacologic therapy should treatment of psychopathology become necessary. Therefore, doctors are encouraged to have a reasonably high degree of awareness of the possible health problems of international students, a group likely to increase in size in the years ahead, and to understand something of the reasons underlying these problems.

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Source: Hamboyan H, Bryan AK. International students: culture shock can affect the health of students from abroad. Can Fam Physician 1995; **41:** 1713-1716.

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