Commentaries on selected articles from overseas journals of general practice.

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Asthma and socioeconomic status

THE association between asthma and socioeconomic status remains unclear despite many studies. This paper reviews the literature and points towards the evidence of a link between asthma severity and socioeconomic status, and then goes on to support this argument in a study of Munich schoolchildren. The authors report that severe asthma is associated with low socioeconomic status, but that not all grades of asthma have a socioeconomic link.

These results explain why previous studies failed to reach a consensus on the association between asthma and socioeconomic status in a well formed and convincing way. The study itself is well reported, and its strengths and weaknesses are fairly assessed. However, the use of parental education as a marker of socioeconomic status is not validated or referenced. This method defines 48% of the population as having high socioeconomic status compared with only 24% with a low status. This would seem unlikely to prevail when using more rigid methods of assessing socioeconomic status, and so could bias the study's findings.

The problems of parental reporting to assess asthma are well discussed but, after explaining how unreported mild asthma is most likely to occur in children with low socioeconomic status, the authors dismiss it rather easily. With the low numbers of asthmatics in each group, a relativly small increase in mild asthmatics with low socioeconomic status could alter the study results.

The paper will be of interest to health professionals and those researching asthma, but its results should be seen as a guide rather than a new reference point.

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Source: Mielck A, Reitmeir P, Wjst M. Severity of childhood asthma by socioeconomic status. *Int J Epidemiol* 1996; **25:** 388-393.

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Genetic counselling

THE mapping of the human genome is bringing about a seismic shift in the way in which doctors and patients will have to deal with such key concepts as disease, risk, and responsibility. Long before the modern science of genetics was developed, the importance of the patient's constitution in determining the nature and course of disease was well recognized. However, genomics and the possibilities of genetic screening now open unfamiliar windows on our individual genealogy, the future history of our personal lives, and the constitutional bequests that we can each impose on future generations. Increasingly, the late twentieth century view of disease will move away from the image of 'affliction' to 'biography' — an image previously reserved for the narrative of the patient's development. Disease will increasingly come to be seen by the patient not simply as a biological accident, a malfunctioning of the machine, an environmental assault, but rather as an expression of the essential self.

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Beneath the surface of this commendably succinct and informative article about the implications of genetic screening for the practice of medicine lies the threat and promise of an astonishing agenda for bio-medical re-engineering. The present availability of tests for a variety of disorders like Huntingdon's chorea and cystic fibrosis is described, as is the potential of genetic testing to eventually reveal the 'expressivity' of these genes, which will itself give information about the date of onset and the severity. In many relatively common diseases (for example cancer, cardiovascular disease, diabetes and Alzheimer's) that have a complex multi-factorial genetic basis, it may soon be possible to construct genetic profiles of susceptibility. Ironically, widespread pre-natal genetic screening is currently limited only by the invasiveness of chronic villus sampling and amniocentesis.

What are we to make of all this new information? It is one thing to tell the patient that she is at risk of suffering a stroke, for example, because she has high blood pressure. This is, after all, not a specific prediction about her future: it is an observation from the study of large groups of individuals about the order of risks in groups of people similar to her (in some medically relevant respects). The risk is run by the group to which she happens to belong. There is nothing personal implied. It is quite another thing to explain to the patient that she is personally programmed to develop a fatal disease, and to know when it will develop — to know that this fact is written into the most basic structure of her body. We are moving from probability-based prognosis to a personally predictive medicine.

The power of genetic technology to diagnose will, for the foreseeable future, greatly outstrip its power to intervene and prevent. The consequent ethical questions are touched on in Whittaker's paper, but cannot be explored in any depth. For the practising doctor, perhaps the underlying question is this: When the technology changes, can the ethics remain unchanged and absolute, or are they relative, contingent on what we can know and what we can do?

Now the tools are to hand with which to screen for major diseases that we cannot yet cure, but these technologies impose uncomfortable choices. By what criteria will we judge the acceptable quality of a future life? At what point will a genetic screening programme merge with a policy of eugenics presented as public health? The last time that *Homo sapiens* was materially moulded by natural selection we were hunting and gathering on the savannah, and life was both brutish and short. Having moved far beyond Darwinian selection, we are already entering an era of iatric selection. Whether or not we will view such selection as 'unnatural' or 'undesirable' will depend on our deepest instincts about what it means to be human.

Perhaps TS Eliot was right to suggest that "...human kind/ Cannot bear very much reality",[1] but these are the new realities with which doctors, patients and the public must very soon come to terms.

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Source: Whittaker L. Clinical applications of genetic testing: implications for the family physician. *Am Fam Physician* 1996; **53:** 2077-2084.

Reference

1. Eliot TS. *Four Quartets: Burnt Norton.* London: Faber, 1954.

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Quality in general practice

THIS paper addresses the question of what matters most in general practice. The author is a general practitioner (GP) in a capital city who holds an MSc and a diploma in statistics. Part of the paper is about statistical methods applied to qualitative research, which I found rather heavy going. The results of the research are based substantially on the views of only 21 rather unrepresentative patients, but the author assures us that this is meaningful because the research is qualitative rather than quantitative. This rather surprising statement might induce the reader to find out a little more about qualitative research from the useful references that are given.

Rather chillingly, the author begins by describing how he attempts to measure quality in general practice by approaching 'six different stakeholder groups'. Many ordinary GPs will feel somewhat uneasy with this terminology, but will then be relieved by the conclusion that 'this exercise was a valuable re-awakening for the practice which had tended to concentrate a lot of effort on immunization rates, cervical smear registers, and other robotic aspects of family medicine.' The re-awakening was the rediscovery that what mattered most was the attitude of the doctor, his accessibility, and the friendliness of the staff. *Cum scientia caritas.*

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Source: Cullen R. A measure of quality in general practice. *New Zealand Fam Physician* 1996; **23:** 42-46.

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Socioeconomic inequalities in coronary heart disease and stroke mortality

THIS is a rather dry, epidemiological paper in which the main scientific concern is whether epidemiological data from different sources (i.e. death certificates and population screening studies) can be collated to describe and explain trends in current heart disease and stoke mortality within the general population of Australian men. The authors carefully review sources of bias with the effect that one can accept their conclusions. While coronary heart disease (CHD) and stroke mortality rates in men in professional and manual occupations have both fallen, inequalities between these groups widened during the early 1980s, stabilized thereafter and persisted into the 1990s. Decreases in blood pressure and smoking prevalence contributed most to declines in coronary risk and to socioeconomic differentials.

This type of study has limited explanatory value. It is not possible to tell whether trends in blood pressure and smoking prevalence are due to initiatives in primary care or to trends in lifestyle and behaviour in society as a whole. Similar trends have been observed in the United Kingdom (UK), but the implications of these parallel observations are not explored. In particular, one would like to know whether trends in CHD and stroke mortality are mirrored by similar trends for other diseases. It could be that the favourable trends are simply a reflection of the tendency of everyone to be living longer lives.

There is great interest at present in contrasting trends in life expectancy in different countries around the world. The most dramatic improvements have been in countries such as Japan and Hong Kong where life expectancy has leap-frogged above Western societies within two generations. On the other hand, the collapse of the communist bloc has been associated with deteriorating life expectancy in many Eastern European countries. Within the European Union, the largest decreases in life expectancy have been associated with economies in which there has been a narrowing of the range of income distribution. The widening of inequalities in health within the UK is associated with economic trends in the opposite direction. It would be of interest to know which pattern the Australian economy has followed.

These large-scale issues are far removed from the day-to-day concerns of general practice, but they do provide the context in which everyone lives and works. In the wake of the government's false start to cardiovascular health promotion in primary care, it is timely to be reminded of the wider scene. While new arrangements for health promotion should lead to a more rational and evidence-based approach, they should not distract us from issues that can only be addressed by society at large and our political representatives.

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Source: Socioeconomic inequalities in coronary heart disease and stroke mortality among Australian men, 1979-1993. *Int J Epidemiol* 1996; **25:** 266-275.

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The discontinuation of inhaled steroids

THIS is an observational report of 89 mildly asthmatic adult patients already participating in a randomized controlled study designed to investigate the effect of continuous versus intermittent bronchodilator therapy in general practice.[1] In this paper, a sub-population (n = 89) of the original group was assessed for the effects of stopping inhaled steroid treatment on the control and progression of asthma. Nineteen patients who had stopped inhaled steroid treatment for the purpose of the original study, the 'stop-steroid group', were compared with 70 patients who had not taken inhaled steroids during the previous year, 'the no-steroid group'.

During the two-year follow-up period, the proportion of patients whose asthma deteriorated was significantly higher in the stop-steroid group (63%) than in the no-steroid group (11%); $P<0.0001$. For most patients whose condition worsened, deterioration occurred between eight weeks and six months after stopping inhaled steroids. The annual decline in FEV_1 was significantly greater in the stop-steroid group (165 ml/yr versus 40 ml/yr, $P=0.022$).

Even when considering the observational nature of this study, we have learnt that (1) even mild asthmatics suffer dangerous relapses and it is difficult to predict who will do so after discontinuation of inhaled steroids, (2) there seems to be a period (at least 8 weeks in this study) where patients remain protected following discontinuation, and (3) it may take up to two years for relapse to occur. It is questionable that the groups were well matched at the start of the study — we don't know why the 19 patients had initially required inhaled steroids (were they more severe, or were their doctors more aggressive in their treatment?), and why the others had not. Also, eight weeks may be insufficient to wash out the effects of long-term inhaled steroid

therapy. It is also possible that stopping the treatment led to a rebound of their asthma, possibly explaining the difference in outcome. Until similar studies have been undertaken, it seems wise for general practitioners and asthma nurses to follow up their patients carefully, for at least 6 months, and to warn them that relapse may occur after stopping inhaled steroids.

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Source: van Grunsen PM, Dompeling E, van Schayck CP, *et al.* Treatment of mild asthma with inhaled corticosteroids: is discontinuation of therapy possible? *Fam Med* 1996; **28:** 46-51.

Reference

1. van Schayck CP, Dompeling E, van Herwaarden CL, *et al.* Bronchodilator treatment in moderate asthma or chronic bronchitis: continuous or on demand? A randomized controlled study. *BMJ* 1991; **303:** 1426-1431.

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Third parties

IF, like mine, your daily practice is cabined by the preoccupations of the post-reform NHS, it is easy to forget to how great an extent the dynamics of the consultation transcend social and national boundaries. It is now more than 40 years since the Hungarian psychoanalyst Michael Balint and his cohort of 14 London-based GPs began their work of mapping the psychological jungle through which we continue to hack. In that time, the exploring task force has become truly international. That Granek and Weingarten from Tel Aviv can publish, in a Scandinavian journal, a paper so astutely describing a phenomenon immediately recognizable to British readers is a testimony to the health and catholicity of the Balint tradition.

The authors' insight is that many consultations, especially problematic ones, are not simply encounters between two people, doctor and patient. The presence of a real, or felt, third party often intrudes and changes their relationship from an infantile dyadic one, in which both doctor and patient are comfortable with their roles, into a more complex Oedipal triad. The third party might be a powerful off-stage figure such as a consultant or a medically-qualified ally of the patient, or an institution exerting irksome constraints on clinical practice, or even something inanimate like a telephone, computer or protocol. Granek and Weingarten offer a simple map of these third party processes using two axes. The interference may be 'real' or 'projected' (arising from transference or counter-transference), and it may be 'helpful' or 'disturbing'. In the course of developing their thesis they succinctly remind us of several more of the core Balint themes.

Given that the first thing to do in tricky circumstances is to see whether they can be made to make sense, this short and easy-to-read paper with its perceptive discussion helps reassure us that even the most turbulent consultations are navigable.

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Source: Granek M, Weingarten M. The third party in general practice consultations. *Scand J Prim Health Care* 1996; **14:** 66-70.

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