Editorial

Tony Townsend has been a general practitioner for 30 years. Although he has dabbled in medical politics, medical ethics, community-based teaching, university-based teaching, quality improvement and assessment, his passion remains clinical general practice. He is currently a full-time general practitioner in Whangamata.

Disease prevention

Prevention is better than cure. Of course. It makes sense that it is better to prevent disease and the associated disability and suffering that accompanies it rather than wait until we need to intervene with surgery, medicines or other weapons from our therapeutic armamentarium. But it is not that simple. The cliché belies the complexity of the concept.

Although good research and critical analysis has had a major impact on helping to define what is useful in disease prevention there is still a long way to go. We know less about what is not useful although the various evidence-based institutions that have developed in the last decade or so are helping us with that. Disease prevention is difficult, many people do not want to know and others do not want to hear. It is expensive, as in the huge cost of national screening or immunisation programmes or even the costs associated with exercise and healthy eating. It may be harmful, exemplified by the quote attributed to Dr Muir Gray in the recent National Screening Unit Newsletter,[1] *'All screening programmes do harm; some can do good as well'.* Or it may even turn out to be largely a waste of time as shown by two studies looking at the effectiveness of preventive health strategies for reducing cardiovascular disease in the UK.[2,3] What at one time is thought to be a useful preventive intervention may later turn out to be doing more harm than good as we know from the recent publicity about HRT and, perhaps, with the use of SSRIs to prevent suicide in adolescents.

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A 58-year-old healthy man came to see me today. He had a rash that he wanted me to look at but at the same time thought that it would be good to have a bit of a check-up. There was nothing too much to be concerned about in his personal or family history, he didn't smoke and wasn't overweight. His BP was 160/90 but he said that he took it periodically on his machine at home and it was usually around 140/80. OK, but we will check it again later. I suggested that we should check his fasting lipids and glucose and then he asked about prostate tests. Well it took at least another five minutes to go through the sensitivity and specificity of prostate examination and PSA testing and the uncertainty about what to do if the results were either normal or abnormal. I explained that some prostate cancer is aggressive but we don't yet know how to tell which ones are. At the end of all this he said that perhaps as he had no symptoms he should forget about it, but the problem was that he had already mentioned it and that if he did come back in the future with aggressive metastatic prostate cancer we would both feel rather foolish. So we opted to do the tests and to then make a decision on what action to take based on the results. I just wish he hadn't asked!

In 1996 the US Preventive Services Task Force (USPSTF) updated their *Guide to Clinical Preventive Services*, which assessed more than 200 common screening tests, counselling interventions, immunisation strategies and medications for the prevention of disease and only two years later, in 1998, they convened again and found that more than 50 of the 70 chapters in the earlier guide required substantial updating.[4] Preventive health care programmes may postpone but do not prevent death.

Despite all of these barriers we have taken preventive health care on board. Most of our consultations include an ounce of prevention; taking a BP, enquiring about concerns or family history or smoking or suggesting a screening test. Much of this is interwoven in other elements of the consultation and may not be easily accessible to audit. We have established sophisticated practice management systems that facilitate screening, audit and recall. Our practices have become more evidence orientated. We believe that prevention is an important component of general practice and we try to indi-

vidualise our preventive interventions to suit the needs and personal health care beliefs of our patients.

In this issue of the journal we have contributions from experts in the field of prevention and look specifically at some areas of particular concern to Maori, developments with respect to immunisation, the management of hypertension and obesity and managing AF to enhance stroke prevention. We are only able to touch on a few areas of concern, as the preventive health care literature is vast. It is contentious and politically sensitive but our hope is that the contributions published here will stimulate you to reflect on how you can best deliver preventive care to the patients in your practice.

References

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A note from a colleague

My daughter is dying, courtesy of a brain tumour provided by her breast cancer. She is not that old. Her young grandchildren will grow up without her. She went early with her concerns. It was over four months before she got to the top of the mammogram list. The report was normal tissue. Her back pain a few weeks later was treated with six weeks physio, before a spinal x-ray showed two collapsed vertebrae. A few weeks later, her MRI was reported as erosions due to non-specific trauma. She persisted in asking for a surgical referral, and his biopsy finally gave the correct diagnosis.

The oncologist has been superb, in empathy as well as a variety of therapies, but he got a hospital pass with this one. I'm retired now, but am still proud and grateful to belong to a skilled and caring profession. But - three of my colleagues, in different disciplines, made serious errors of judgment in this case. I'm fiercely proud of the ethics and training of our profession, but somehow I feel betrayed by this family experience. I have to ask the question - how often is this occurring in this stressed-out health system? Do we GP's have the time and energy to challenge technical reports when they don't quite gel with our clinical suspicions? Through the cacophony of phones and computer screens, do we still allow time to hear the voice of the patient?

In my book, three professional errors is not just bad luck, but a symptom that needs to be sorted out.

Name withheld by request

"Lifestyle is the new pink (or black, or whatever). Even governments now witter on about reducing obesity, changing diet, and increasing exercise. That is a wonderful thing to see, but a problem can sometimes be that ordinary folk may not know which part of the message to concentrate on. Should I lose weight, or reduce my salt intake? Take more exercise, or eat more fruit? The answer is that comprehensive lifestyle modification is the key to getting on top of moderately raised blood pressure."

Bandolier. 2004;11(3):3