Preventive strategy and general practice

PREVENTION and health promotion are in the news, and politicians have set impressive targets for improvements in the nation's health. Who is responsible for the achievement of these targets? Some doctors remain enthusiastic about their role in prevention, others feel disillusioned, and most remain ambivalent. At the Department of Health the more enlightened acknowledge that the National Health Service is not the main determinant of the nation's health, but one searches the recent white paper[1] in vain for a governmental acknowledgement of political responsibility.

The incidence rates of nearly all major diseases are in a state of flux. The rates of some conditions are rising quickly (such as fractured femur, or cervical cancer in younger women) while others are falling (such as peptic ulcer, or chronic bronchitis); stable rates are exceptional. In addition, a problem that is common in one geographical location generally proves to be rare somewhere else. These facts reveal two things: most diseases are potentially preventable, there being no biological reason why every population should not enjoy the lowest rates of illness; and the main determinants of incidence rates must lie in environmental or lifestyle factors which can change rapidly. But can we control the medical history of the population, or must we be content merely to observe and analyse it?

Medicine has scored dramatic successes with some infectious diseases. John Snow's epidemiological research into cholera[2] led to the compulsory filtration of water supplies drawn from the river Thames, bringing epidemic cholera to an abrupt end; and other infections have since yielded to immunization. The decline of chronic bronchitis and lung cancer in men has resulted from the vigorous anti-smoking campaign by doctors (initially opposed by the media and officialdom).[3] More often, however, the medical contribution to falling rates of disease has been less clear (as, for example, with coronary heart disease[4]), and the white paper's targets[1] represent little more than a projection of current trends.

Doctors turn naturally to the high-risk strategy of prevention,[5] which offers support to the most susceptible or exposed individuals. This has been effective in the detection and control of hypertension, and efforts are now being made to extend this to other coronary risk factors. However, the aim should be to detect and reduce overall risk rather than the level of an individual factor. A large American study[6] found that the same raised cholesterol level carried a five times greater risk if it was associated with smoking and hypertension than if it occurred alone. Fixed levels for treating a particular risk factor make no sense, and we must learn to think multifactorially in both the detection and management of risk. Further, we need to establish how to maintain the control of risk factors under normal practice conditions and over a period of years.

The high-risk strategy has come to dominate the whole medical approach to prevention. Its purpose is to truncate the risk factor distribution by identifying and controlling patients with deviant factors (hypertension, hypercholesterolaemia, obesity, heavy alcohol intake, drug abuse, depression, low birthweight and so on), while ignoring the rest of the population. Such a truncation has never yet been achieved. The strategy could be compared with famine relief which feeds the hungry but does not tackle the causes of famine. The high-risk strategy succours some needy individuals but the main problem persists.

Success in preventing illness is also limited by our poor ability to predict which individuals will become sick. Risk factors can identify a group with increased relative risk; but most 'high-risk' individuals are likely to remain well, while most clinical cases occur in those who are not at conspicuous risk. This is because a large number of people exposed to a small risk commonly generates more cases than a small number exposed to a conspicuous risk.[7] If prevention is to be effective then it must address the risk status of the population as a whole — the population strategy of prevention.

The occurrence of disease, whether conspicuous or sub-clinical, cannot be understood except in the context of a distributional shift of risk factors and health status involving the whole population.[8] The cross-national geriatric study in the United States of America and the United Kingdom[9] found that the prevalence of senile dementia was about one third higher in New York than in London, the reason being a community-wide shift in the whole distribution of cognitive performance. 'Why was there more dementia in New York?' is the wrong question to ask. The right question is, 'Why was the whole range of performance worse in that community?' The prevalence of clinical disease is just one aspect of influences which bear on the whole community, and prevention depends on finding and controlling those influences.

Within the UK there are large regional and social class differences in the prevalence of psychiatric disorder. It has now been shown[10] that once again these are simply a reflection of corresponding differences in the mental health of the population as a whole: the average status of mental health (general health questionnaire score) in any community predicts accurately the prevalence of psychiatric 'cases' (correlation coefficient 0.92). Equally accurate predictions of case prevalence can be made for obesity from average body weight, hypertension from average blood pressure, alcohol abuse from the amount drunk by Mr and Mrs Average, and so on.[8] The part of the iceberg of illness which doctors see (prevalence) is a function of its total size (the population average), and the one cannot be reduced without the other. Differences in the numbers of cases, whether geographical, temporal or socioeconomic, seem to be secondary to mass shifts involving the population as a whole.

This holds important implications for prevention. Efforts hitherto have been focused on deviant minorities with conspicuous problems. This is attractive to the public and to politicians, for it affirms the normality of the majority; but as a basis for prevention it has been a failure. Attention must move towards understanding and controlling those underlying characteristics of the population which are the real determinants of health and disease. Cases cannot be understood or prevented except in their societal context. As Dostoevsky wrote, 'We are all responsible for all.'[11]

Who should take the lead in bringing about the social, economic, environmental and lifestyle changes on which the nation's health depends? Ultimately, of course, people themselves must make their own choices, but regrettably their freedom is obstructed by many factors outside their control — poverty (both absolute and relative), bad housing and education, lack of healthy food in schools (and hospitals), and the distortions of mass advertising. Action in these domains must be political.

Where do general practitioners come into this? In many ways, but in four ways in particular.[7] First, illness needs to be understood in its social context: one should constantly ask 'Why did this illness occur, and how might it have been prevented?' Secondly, the detection and management of those at overall high risk (not just those with individual risk factors) can be life saving for the individuals concerned, but the process is often organized

inefficiently and ineffectively and this must be rectified. Thirdly, doctors must provide education in healthier living as this not only influences those receiving it but through them it diffuses out and influences the community; doctors' attitudes and personal example also influence the community. Finally, doctors should be concerned about all those social, economic, environmental and political issues which are the main determinants of the nation's health, for doctors are, or should be, opinion formers and leaders in all matters that influence health.

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Asian general practitioners and the RCGP

AN open discussion on the future participation of Asian doctors within the Royal College of General Practitioners could be considered as long overdue. The vast majority of general practitioners from overseas working in the United Kingdom are Asian in origin;[1] they comprise about one fifth of all general practitioners in the UK. The difficulties that these doctors encounter are considerable.[2-4] Asian doctors have contributed considerably to the maintenance of British general practice within the National Health Service. It is not surprising that, by carrying a heavy burden for many years, many feel somewhat aggrieved by the attitude of their profession's academic body to their overall situation.

The Leicester faculty presented a discussion document to the RCGP council and this was considered on 23 September 1989. The paper referred to problems faced by Asian doctors with regard to the MRCGP examination, under-representation on committees and in the award of fellowships, and discrimination in the appointment to general practitioner principal posts. The RCGP accordingly convened a working group to ascertain any differences in performance in the MRCGP examination between Asian and non-Asian doctors. The conclusions were that the examination did not systematically discriminate against Asian doctors but the poor performance of some doctors was a cause for serious concern.[5]

Discrimination in medicine against members of ethnic minorities has been suspected for some time.[6] The *British Medical Journal* published an editorial on the disadvantages suffered in the competition for jobs within the NHS.[7] St George's Hospital medical school was found guilty in 1988 of acts of discrimination;[8] the Commission for Racial Equality revealed a selective policy over race and sex in the medical school's admission policy.[9] The position of the RCGP could be described as one of a silent observer of these proceedings.

For Asian doctors the process of alienation continues when applying for a practice partnership. Many resign themselves to having their application classified mainly by the ethnicity of their name, followed by a sifting process based on their country of origin, and only then is there an analysis of the depth and appropriateness of their UK experience. The hidden agenda is the need by the appointing party to find someone with whom they can work amicably or perhaps even dominate, if that is the plan. McKeigue and colleagues showed that the main block to being appointed as a practice partner for British graduates from ethnic minorities is at the short listing stage and not at interview.[10] This system of medical apartheid forgets that race is a poor discriminating factor in judgements of personality.

Is it possible to lay down guidelines for what constitutes fairness in the mechanism by which practice partners are appointed? Although the RCGP has no prescriptive role regarding guidelines for appointments, it has not voiced any concerns over the denial of fair opportunities. As general practitioners, we may consider ourselves to be independent business units, but our income is derived from the taxpayer, and equal opportunity is not an empty catchphrase.

The present debate on professional competence is central to the beliefs of the RCGP. Sadly, the profession still appears to be struggling to attain a consensus among its peers of what competence actually means and where it should be specifically defined. The Joint Committee on Postgraduate Training for General Practice has deemed that its certification at the end of training is a declaration that a general practitioner is competent. The MRCGP examination tends to favour applicants who are at the endpoint of their training but does not admit to testing the competence of the general practitioner. It is time for all bodies involved in standards to look to the assessment of all general practitioners in training and formulate a satisfactory and acceptable measurement for all doctors, whatever their background.

The MRCGP examination is a barrier which many overseas trained doctors find difficult to cross. The number of Asian born, foreign trained doctors who attempt the examination is low and the percentage pass rate for this group is also low. However, a study has suggested that a general bias against foreign born candidates does not exist.[5]

Anecdotal evidence would suggest that the sense of isolation felt by many Asian doctors leads them to withdraw from mainstream postgraduate educational and medicosocial activities. It is no accident that many mining, inner city and heavy industrial communities are served by Asian doctors. Ironically, they often enjoy a close affinity with the community they serve, a perverse illustration that many graduates of British medical schools are