Semi-creative tension?

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In his Arthur Hall lecture[1], John Swales drew attention to the possible tension between a medical culture based on individual need (clinical medicine), and that based on the needs of populations (public health medicine, or 'numerical medicine'). This is far from being an absolute antithesis: both are important, both are necessary. For most of the time, most doctors will be involved with individual medical problems; but they must also be alive to the public health implications of their actions. And for the health of the nation, and its component populations, a strong dedicated public health profession is essential.

So much for generalisation. The paper by Trewby and colleagues[2] in this issue illustrates clearly the nature of the tensions which might arise. Using a written questionnaire followed by interview, they assessed the expectations and probable compliance of three groups of patients/subjects in relation to a hypothetical preventive medication against myocardial infarction. Group 1 had recently been discharged from a coronary care unit; Group 2 had no recent history of myocardial infarction, but were taking preventive medication; and Group 3 had no history of infarction and were not on any relevant preventive medication. Asked what level of 'absolute risk reduction' (ARR) they would expect before agreeing to take the medication, the three groups said 20%, 20% and 30% respectively. In some contrast to this, the expectation of ARR from current drug strategies in this context is of the order of 5% or less (see Table 1, p 528).

The actual compliance in the three groups is of course undetermined; but the stated medication in the three groups was presumably 100%, 100% and 0%; yet their alleged willingness to comply, if told the expected benefit was 5% or less, was respectively 32.4%, 28.6% and 21%. However, if the medication was specifically recommended by their own doctor, these figures rose to 69.3%, 74.3% and 56%. Since the postulated medication was free of all side effects, the figures from this 'best-case' scenario may be on the high side, but that does not affect the dilemma, which the authors crisply state thus:

> *Our enthusiasm to lower disease prevalence in the community needs to be tempered by respect for the individual's expectation of drug benefit and a realisation that many are reluctant to take drugs long-term from which they have little chance of benefit.*[2]

The authors advise that doctors, 'as treatment brokers, must inform their patient of the quite small percentage chance that they will benefit from preventive drugs'. They must then take their views into account, 'even if this leads to a decrease in the uptake of preventive drugs in the community'.

This advice gives full weight to the principle of autonomy, and to the practice of openness. But does it perhaps threaten one modality of the principle of doing good and not harm (as a simplifying 'lumper', I tend to confound 'beneficence' and 'non-maleficence'). The hypothetical model used is deficient in actuality, particularly in its exclusion of side effects; and it can take no account of the value of vaccines in promoting herd immunity. (However, the actuality of the dilemma itself is simply shown by the debate over MMR triple vaccine – a matter on which I refrain from comment, beyond expressing innocent surprise that anyone should think to report a doctor to the GMC for trying to mitigate a parent's fears).

What would I have done myself? For the individual patient, I would offer advice based on information, rather than a mass of unsolicited information. I would ask about worries, and try to set them in context; but would not offer a five-minute synthetic medical course. For the more general problem – the tension between individual and public interest – I would recognise my general biases, first against doing things merely because they can be done; and secondly against the rigid application of guidelines, which is the surest way to marginalise the individual patient, rather than 'putting him at the centre of things' (where as it happens, he has always been).

However, having made confession of those old-fashioned views, I must at once modulate them, in the light of another cherished belief, that to discover what people really think, you should go by what they do, rather than what they profess to believe. On that basis, as a lifelong disciple of Austin Bradford Hill, and an admirer of Richard Doll, I have taken part in whatever trial of preventive medication I have been asked to participate in; and have recommended such

†Sir Douglas Black died shortly after completing this article, following a long illness. He was a regular and valued contributor to this journal and will be greatly missed.

medication to countless patients – and even to relatives, which may count for more. It has also been my experience that patients are more altruistic than most of their self-appointed proxies; and are quite at home with Richard Titmuss' 'gift relationship', the basis of our blood transfusion service. And so, on balance, I would continue to recommend reasonably established preventive measures (the most important being not to smoke); and to encourage patients to take part in controlled trials.

References

1 Swales J. The troublesome search for evidence: three cultures in need of integration. *J R Soc Med* 2000;**93**:402–7.

2 Trewby PN, Reddy AV, Trewby CS *et al.* Are preventive drugs preventive enough? A study of patients' expectation of benefit from preventive drugs. *Clin Med* 2002;**2**(6):527–33.