confidentiality is not absolute and that there is this distinction to be drawn between different types of information: "Whatever, in connection with my professional practice, or not in connection with it, I see or hear in the life of men which ought not to be spoken of abroad will I not divulge as reckoning that all such should be kept secret." Despite various attempts this simple enunciation of the ethical principle has not been improved on, and indeed some formal resolutions have been untenable in law or divorced from the realities and humanities of practice. But whether legislation will be introduced to protect privacy, as has been urged in some quarters, and if so how this will affect doctors and patients remains to be seen.

Trainees' Corner: Managing Chronic Disease

Asthma

II: Long-term management

COLIN WAINE, DENIS PEREIRA GRAY, TOM SMITH

This article is based on an audiovisual presentation made for vocational trainees in general practice by the MSD Foundation. Further information about the tape-slide programmes on which this series is based is available from the MSD Foundation, Tavistock House, Tavistock Square, London WC1.

In the first article on asthma we looked at the diagnosis and treatment of the acute attack in four types of patients: baby John; 6-year-old James; teenager Catherine; and middle-aged Mrs Jackson. Once patients have been diagnosed as asthmatic the possibility must be considered that the condition may persist or recur over many years. For the doctor this means long-term surveillance and the constant adjustment and readjustment that the care of this disease entails.

It must be made clear that there is no known cure for the disorder, but that the patient, with correct control, may have every expectation of leading a full life. Long-term treatment is a co-operative partnership between the patient, the patient's family, and the doctor.

Managing the infant

The major principles of asthma care are as clear for baby John as for the older patient. Firstly, you must carefully explain to John's mother what the wheezing is and what the treatment will entail, but not after the first attack. He may never have another one and there is no need to make her worry about something that might not return. In the first attack you might not use the term asthma, but you should still explain what is happening. People are relieved if they know what is going on. Even a second attack may not be the occasion for explanation, as anti-asthma treatment of the very young is geared to treatment of attacks and not to prophylaxis. But after a third episode the mother must not only be fully informed, but she also needs to be given some part to play in initiating treatment herself.

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MOTHER'S ROLE

General practitioners need to ask themselves what they expect mothers to do if and when the child starts to wheeze again. It is important to strike a balance between the mother's understanding at what point delay is wrong or even dangerous and being anxious and dependent on doctors every time the child wheezes. One helpful way of resolving this inherent conflict between neglect and dependency is to write out and agree with the mother a plan of treatment including actions to be taken by her if wheezing goes on for an hour, two hours, six hours, and so on. John's mother should be strongly reassured that it is very reasonable to bring him to the doctor early in the attack so that it can be contained and relieved. Provided she is competent, she may be given supplies of bronchodilator medicine or theophylline to use at the start of each attack. Once he is a little older, and certainly by about 20 months, paediatric beta-adrenergic stimulators may be helpful. If these are given it is important that the doctor learns every detail of the use of one drug and its side effects and sticks to that drug only. It is also important to check regularly on the expiry dates of the medicines he leaves with the parents.

ANTIBIOTICS

Antibiotics, whether prescribed as short-term or long-term courses, play little part in managing infantile or childhood asthma unless there are valid reasons to prescribe them, such as, for example, evidence in ears and throat of bacterial infection. Nor in John's age group is there much point in trying to remove potential allergens or attempting to desensitise the infant. The stimulus to attacks at this age is largely viral, although house-dust mite and pollens may sometimes play a part.

Managing the allergic child

For the 5- to 10-year-old, like James, treatment very much depends on the severity of the disorder. In any chronic disorder care must be taken not to make the treatment worse than the disease itself. You have discovered that James has persistent eosinophilia and high serum IgE concentrations: he belongs to the extrinsic, or allergic, group. Should he have skin tests? Will he need episodic or long-term treatment? What drugs should be used?

SKIN TESTING

Whether skin testing of young children is justified is still being debated, partly because many general practitioners doubt the value of the information obtained, and partly because it is inevitably unpleasant for small children. The difficulties are that it is usual to find responses to house dust, animals, etc, and it is then not clear, and a matter for fine judgment, how far such results should alter management. Eradicating the house-dust mite is far from easy, although some common sense measure such as conscientious vacuuming of curtains, bedding, carpets, etc, may help; removing an animal sometimes causes emotional upset, which is justified only if much is to be gained. Also theoretical doubts exist about the relevance of skin testing to the activity of allergens in the bronchial tree, and most general practitioners do not believe that in practice specific antimite desensitisation is helpful.

IGE CONCENTRATIONS

Another way of finding out which allergens are important to a particular child is to have the serum IgE concentration estimated. A high IgE concentration probably indicates that the child will make a good response to disodium cromoglycate. At his age of six years James can be taught to manage a spinhaler to give the disodium cromoglycate, and the drug is likely to have a prophylactic effect. More and more laboratories are able to provide estimates of IgE concentration for general practitioners, and the information is similar to that provided by skin testing. When RAST (radio-allergo-absorption testing) is available it is at least equivalent to skin testing, and many practitioners believe that it is more helpful in indicating allergens that are really important to a child.

PROPHYLAXIS

Nevertheless, do not rush to start prophylactic drugs. The child with mild, well-spaced, intermittent attacks may need only an oral bronchodilator, and the fuss and bother of regular cromoglycate, which has to be taken four, or at least three, times a day, may be more inconvenient than an occasional attack. This kind of balance is best discussed with the parents and with the child himself once he is old enough. If attacks become more severe then you should use inhalers containing beta-adrenergic stimulators if the child is old enough, and you should consider using steroid inhalers. Such treatments are often useful if frequent attacks start to interfere with school or other activities such as family outings, sleep, or games.

Prophylaxis with disodium cromoglycate should always be considered if the pattern of the child's life is being affected. A practical tip is to ask patients to use the beta-adrenergic stimulator inhaler about five minutes before using the spinhaler; this may improve the spinhaler's effect. If prophylactic treatment with disodium cromoglycate is unsatisfactory the next step is usually treatment with steroids in the form of an aerosol. Such aerosols do not arrest or retard growth, but they may make patients liable to monilial infection. When using such treatment you should make sure that the drug is truly inhaled and not just deposited on the throat or swallowed. A recent development makes it possible to give both salbutamol and topical steroids together. Inhalers should be demonstrated and the patient's use of them checked.

Only when these combinations—beta-adrenergic stimulator drugs, disodium cromoglycate, and steroid aerosols—have failed should oral steroids be considered. It is appropriate for general practitioners to start oral steroids for children, and they should not hesitate to do so if steroids are indicated as it will often save a hospital admission. Short courses under careful supervision should not create great clinical problems, but if long-term treatment appears to be needed it is probably better to give an alternate-day dose since this seems to cause less adrenocortical suppression. In these circumstances a paediatrician's opinion should be sought.

Managing the asthmatic adolescent

Drug treatment is only one aspect of Catherine's management, and in her case it is little different from that of James's. She is probably better able to manage a salbutamol inhaler than the younger child, and this should probably be tried before introducing disodium cromoglycate. Cromoglycate alone has the disadvantage of producing no immediate effect, and it is often discarded by the patient; an action that she may regret later.

Teenagers rebel against many things—except perhaps against their own peer groups—and if they have a continuing disorder, such as asthma or even diabetes, they are likely to rebel against the unfairness of having to take prophylactic drugs. Just as important as the pharmaceutical treatment are the general common sense measures that you can adopt to build up a relationship with the asthmatic teenager. The doctor treating patients like Catherine must maintain a dialogue with them. No matter how irritated the doctor may be by the patient, he or she must be able to create an atmosphere of trust. The attitudes of doctor and patient are crucial: the teenager must be treated as an intelligent adult and be given the opportunity to be seen alone without either parent present.

Doctors disagree on the relation between asthma and psychological disturbance. Some think that a dominant mother, if not actually responsible for illness, will at least aggravate it. Certainly if there is a prominent neurotic facet to the patient's personality—and this is more likely to arise in Catherine's age group than in those of the other patients—the management should be reviewed.

At least as important as drug treatment for the teenage asthmatic is guidance on how to manage his or her social life. The teenager with a medical problem tends to shy away from company and should be encouraged to enjoy a little independence, to take part in group activities with other teenagers—for instance, swimming and other sports. A wheeze should be neither a handicap nor an excuse.

Managing the middle-aged asthmatic

Similar rules apply for Mrs Jackson: beta-adrenergic stimulator aerosol inhalations such as salbutamol or orciprenaline are usually more effective in the older patient than disodium cromoglycate prophylaxis, which is probably worth prescribing only as a last resource before turning to steroid treatment.

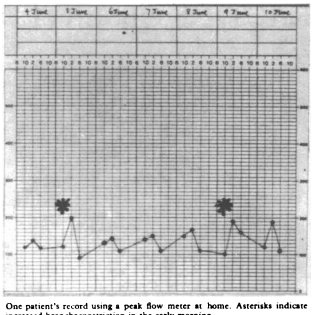
Long-term management

We can leave our four imaginary patients now, but we cannot leave the real patients in our practice. As you know, 5% of your patients are likely to have asthma at one time or another. It is no use making the diagnosis of asthma, starting treatment, then losing sight of the patient. Each practice should lay down rules on asthma management, agreed by all partners, and stick to them. In what practical ways can follow-up be organised?

When managing the asthmatic patient the doctor must always try to maintain the initiative. He should try to ensure that the patient never leaves the surgery without a further appointment. How far ahead should it be? This depends on the control and the history of attacks, but there is a case for a doctor or nurse in the practice seeing every asthmatic, even those who say they are in excellent control, at least twice a year.

PEAK FLOW MEASUREMENT

At every consultation peak flow measurement is important to detect any deterioration in lung function and to renew or alter treatment accordingly. There is no excuse for any surgery being without a mini peak flow meter—it is both cheap and efficient. Some doctors find it useful to give patients a mini peak flow meter to use at home and keep their own records. This makes it possible to keep a much tighter control over treatment and to change the dosage of their drugs as soon as any improvement or deterioration in their treatment appears. With use of this device at home, the so-called "morning-dippers" (those patients who have increased bronchoconstriction every morning) may be picked out and managed accordingly. The figure shows a record of one patient using her peak flow meter. The points marked by the asterisks show a dip in the early morning that the doctor might never have known about, enabling him to tailor more carefully the timing of treatment.



One patient's record using a peak flow meter at home. Asterisks indicate increased bronchoconstriction in the early morning.

Asthmatics taking steroids must be seen much more often, and the aim of each review must be to try to reduce the dose or to return to less threatening treatment. Any practice system aiming to care comprehensively for its asthma patients might wish to set up some kind of systematic surveillance. We suggest that the following principles should be considered:

(1) All asthmatic patients to be on asthma list.
(2) Each patient to have one partner who feels responsible for the care of the patient's asthma.
(3) Every patient to be under long-term management by the responsible partner, with patients on the list being easily subdivided according to main treatment.
(4) Targets to be set for each patient for peak flow rates. Partner agreement on acceptable peak flow measurements before decisions are made to investigate further or refer for specialist help.
(5) Limitation on life style to be recorded in writing on the record and asthma card. Written records to be kept by patients of their symptoms.
(6) A policy to be decided for chasing-up defaulting patients.
(7) The partners to meet regularly to discuss targets and achievements.

By putting into practice this form of surveillance you are likely to ensure that your asthmatic patients get the best and most appropriate care for their chronic disease.

Do you have the time, the energy, and the will to do it?

Unemployment in My Practice

South Shields

C P TANNER

Unemployment is no stranger to Tyneside. Those who lived through the intense deprivation of 50 years ago are now pensioners, but although the tradition is alive the effects are very different. The coming of the welfare state removed the possibility of the intense poverty of the 1930s so that even the word "poverty" has taken on a new meaning as expectations have risen. Employment was maintained by overmanning and by the introduction of new industries which had few roots and were destined to wither in the first drought. The recognition of a future in which less work will be needed from fewer people and the relatively new phenomenon of the working wife have blurred the issues and softened the impact. The other side of the coin was debilitating. Pubs, clubs, and other manifestations of the escapist industry did good business. "It is not worth going back to work until next week doctor." Annual sick leave was taken up for precisely the number of days allowed. Sudden increases in certification heralded a coming strike, and the return to work occurred a week or so before its end was announced in the newspapers. One doctor, when challenged to publish his figures, said, "I have lived in my practice all my life, and my patients have been good to me. The unions know, the employers know, the Government knows: why should I publish?" The scars of the 1930s were still tender, affluence was spurious, full employment was brittle, and the benefits of welfare enervating.

Now, with more than one in five out of work, alterations in behaviour patterns reflect changing attitudes. People with jobs are increasingly reluctant to stay off work and having been off work are keen to get back. Unemployment is increasingly the precipitating factor in all the stress conditions. The young man of 18 with a rising attendance rate to surgery presents with increasing introspection and concern with his soma and turns out to have never had a job. He is bored and uninterested, with little to look forward to and fewer ideas about how to occupy himself. The middle-aged man—a good worker, responsible citizen, and devoted father—indulges in a brief moment of tearful anguish that is indistinguishable from that seen in bereavement. He is redundant.

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No easy solutions

Tom has been out of work for a year but Mary is working. They had economised, and both sets of parents were helping. They were coping well until one day Mary forgot to take her pill and now she is pregnant. They come to surgery together. She is furious with herself for being so careless, angry with Tom for even mentioning termination but tempted nevertheless. She is tense, miserable, sleepless, and doesn't want tablets. Tom is equally tense but hurt and aggrieved. He has been badly mauled over the termination idea and now doesn't know what to say next, so he keeps quiet. What can a doctor do except make himself available to help them work out what is going to be best for them? One thing is certain: the slick, easy, imposed solution is a sure recipe for disaster.

The drive to maintain self-respect and the sense of personal value remains. A 24 marathon run inspired by a local international athlete recently produced a numerically bigger response than from the whole of London.

Eddie is 40. He works in the pit and has severe obstructive airways disease. In the past he has had a lot of time off work and has been noticeably reluctant to go back. Today his chest is worse again. His treatment is adjusted and I reach for the certificate. "Not this time doctor." "Do you think you can manage?" He stands up and seems a foot taller. "I'll manage."

Opportunities for preventive intervention are appearing. Father is more involved with the family. He appears with his wife when she attends, and contributes to the consultation. He brings the children when they are ill, appears in antenatal and well-baby clinics and thereby learns a lot. Sometimes role reversal is almost complete and father becomes the housewife while mother is at work. Some men are a bit sheepish about it, some over react with phrenetic activity, some show resentment, aggression, and a prickly sensitivity but most get stuck in with good grace, good humour, and a heightened appreciation of shared responsibility. Families are painfully establishing new sets of priorities.

Industry generally has responded to the economic climate with various methods of shake out, some of which have caused medical problems. Conditions of employment long ignored have been applied strictly long after their original basis has been overtaken by medical practice. This is starkly illustrated in the shipping industry, in which the British Council of Shipping has a proper responsibility to identify employees whose medical condition may be a risk to a man's safety and that of the ship at sea, far from medical aid. The young man with hypertension will remain under surveillance for years to prevent or delay the long-term consequences, with his abilities and skill unimpaired; but if the condition comes to light at whatever stage of his career, he is discharged. The effects are disastrous. The economic climate has to be accepted and is, but everyone concerned, including the doctor, feels bitter trying to cope with a man whose career is ruined by the resurrection of outmoded regulations in a way that smacks of unfairness. As one such discharged chief engineer said, "I wish I'd never listened to all that crap you fed me about my blood pressure; I might not have lived as long but at least it would have been a better life for me and my family."

Bob is 56. He has worked in the shipyards all his life, the noise has made him deaf, and he has industrial dermatitis. Now he has a bronchial carcinoma that is not responding, and he knows his days are numbered. He has been off work for three months already. "Doctor can I go back to work for a few weeks to qualify for the redundancy money?" I stare at him and his round, red, friendly face breaks into a grin as he sees the expression on mine. "Do you realise what you're doing?" The grin fades, "Yes, doctor, my mates will look after me." I would like to think I am one of his mates.

Clinical controversy: death certification

In refusing to accept "old age" as a cause of death, surely the Registrar General is encouraging doctors to commit perjury as well as flying in the face of common sense and public opinion. A lady 90 years of age, resident in a well-run home, becomes frailer and takes to her bed. Doctors and staff agree she is dying and three weeks later she does, in the absence of abnormal physical signs. Several doctors and many laymen we have spoken to agree unanimously that it should be possible to die from "old age," but the registrar of deaths does not accept this diagnosis. Unless we invent "bronchopneumonia" or "myocardial degeneration," or other disease of which there was no evidence, the coroner must order a post-mortem examination "at a cost of £40 of public money," according to his officer. The officer is unable to advise what we should do. Surely we are deluding ourselves if we insist on post-mortem examinations when death is due to age and not disease.—J A WILLIAMS, M K WILLIAMS, G B CLARIDGE, M CHILTON, G A PILKINGTON, general practitioners, Ashtead, Surrey; A M EASTON, general practitioner, Bookham, Surrey.

Oddity remembered

In the 'twenties and 'thirties I was in practice in one of the Western Isles of Scotland, and in those days we had no gas, no electricity, no telephone, and no vet. We got along quite happily without what are now regarded as essential services, but many people found it very inconvenient to have no vet to call on, especially in animal emergencies. It was inevitable, therefore, that the local doctor's services should be sought on occasion, and one had to do one's best to cope. Many such occasions arose, but a few still remain firmly rooted in my memory.

One morning I was in my surgery when a dapper little gentleman walked in carrying on his glove-protected wrist a large bird with a leather hood on its head. This bird I recognised as a Peregrine falcon. Its owner was an Englishman from Bath who had taken a lease of a shooting in the area and was interested in falconry. "Good morning, doctor," he said. "Polly here has a sore throat, and I would be grateful if you would paint it." "Well," I said, "I know nothing about the ailments to which falcons are liable, but if you say she has a sore throat I'll take your word for it." And getting him to hold the bird's beak open, I painted its throat with Mandl's Paint, a medicament common enough in those days but which, if it exists at all now, is probably relegated to the witch doctor's pharmacopoeia. I did not see the bird after that but know that it lived to "swoop" again.

On another occasion as I was getting into my car to set off on my rounds a man rushed up and implored me to come and see his dog, which appeared to have a painful mouth. I was ushered into a bedroom where tied to the leg of a dressing table was a viciously snarling sheep dog. I told the man to put the dog in a cupboard, and soaking an old sock in chloroform I threw it in beside the dog. When the snarling had been replaced by snoring I pulled the animal out of the cupboard and examined its mouth. An exceptionally long tooth in the lower jaw had pierced the upper jaw and must have caused considerable pain. As I usually carried dental forceps I extracted the tooth and made myself scarce before the dog should regain complete consciousness.

Older readers will probably recall that a year or two before the outbreak of the second world war stirrup-pumps were issued to communities to deal with incendiary bombs in the event of war. I found one of these instruments very useful in dealing with a constipated bull. I found a handbook called *Veterinary Counter Practice* very useful.—A M CAMPBELL, retired general practitioner, Skipton, North Yorkshire.

We will be pleased to consider for publication other interesting findings made in general practice.—ED, *BMJ*.

Correction

A J Gordon Hunter: Lord High Everything Else of Dumfries

An error occurred in this article by Dr J Elliot Murray (20 June, p 2018): James Laurie was a member of Council of the Royal College of Physicians of Edinburgh and not president.