Introduction*

Respiratory problems in general practice

This issue of *Huisarts & Praktijk* comprises thirteen contributions on respiratory problems in general practice: a collection of hard facts, less hard opinions and – sometimes pious – expectations.

This publication is based on two postulates. The first is that there is a need for postgraduate training, but that its content should be based on the reality of general practice and that it should be judged on the same basis: the epidemiological setting, the characteristic position of the general practitioner in health care, and the resulting problem definitions like the desirability and undesirability of many interventions in the context of primary health care. Research into general practice and the transference of information from the cornerstones for this publication and are therefore emphatically linked to each other.
The second postulate is that the formulation of theories and research into general practice focused on a particular problem also highlights what is characteristic for general practice in general. This issue on respiratory problems therefore bears a wider significance: it tries to exemplify the specific approach of the general practitioner. This is also the reason why the way in which a judgement on the value of certain actions is formed, can be as relevant as the action itself.

The material presented in this publication is arranged in agreement with our starting points. To begin with, some „hard facts" are presented: quantitative information on the incidence of respiratory problems in the Netherlands.
Van Veen *points out the social implications of this group of health problems: they account for a substantial percentage of mortality, morbidity, hospital admissions and sick benefits. As expected chronic diseases play a different role in this context, than acute problems do.*
Van Weel *discusses the incidence of respiratory problems in general practice on the basis of data from the monitoring project. The main concern is with acute – often self-limiting – diseases, with emphasis on the younger age groups. His data corroborate what is already known from earlier studies. For each disease the therapy prescribed is discussed: symptomatic medication, antibiotics, education and advice, or „nothing". The role of specialist care is (very) limited, and becomes more prominent only in chronic diseases; the treatment of respiratory problems is primarily within the realm of the general practitioner.*
A logical consequence of this situation is that advice and education concerning respiratory problems should be given primarily at the level of general practice.
In this context Huygen and Van der Velden *present a fascinating example concerning infections of the respiratory tract. Their contribution derives from the Nijmegen syllabus* Luchtwegen *and constitutes a basis for lecturing. Its central focus is the interrelation between the various parts of the respiratory tract, resulting in infections with a horizontal and a vertical course.*
This contribution is in fact a sublimation of epidemiological data, because the Continuous Morbidity Registration of the Nijmegen University Department of General Practice is one of its important pillars. The alert reader will notice a few differences between the Nijmegen CMR and the monitoring project as regards the definition of various diseases and their allocation to various systems. For example, according to the E-list used in Nijmegen otitis media is allocated to the respiratory tract, whereas in the contributions from the monitoring project where ICHPPC-2 is used, otitis media is listed under the heading Diseases of the ear.
The extent to which general practice actions can be adequately outlined on the basis of diagnosis, is questionable. Perhaps the presentation of symptoms by the patient would be a better starting point. To conclude the part based on quantitative information, Van Weel *describes the presentation of symptoms and complaints of the respiratory tract, using data derived from the first pilot study with* Reason for encounter classification *(RFEC).*
At the first encounter, as might be expected, the patients mostly present symptoms to the general practitioner. Strikingly often, however, they present a disease or diagnosis as their reason for encounter at subsequent contacts. Another interesting point is the correlation between the reason for and the diagnoses established by the general practitioner. There is generally fair agreement between general practitioner and patient.

The second part more specifically focuses on the interventions of the general practitioner. In the first instance the thread of quantitative data is continued: from the monitoring project, Van Weel and Van Zelst *present an analysis of the interventions of nine general practitioners. The differences found can in part be explained from differences in denomination, another part appears to be based on marked differences in the numbers of problems presented. In therapy, too, there are differences, although in this respect patterns seem to vary much less. Particularly the frequency of recourse to symptomatic treatment and antibiotics in the treatment of diseases of the upper respiratory tract, varies widely.*
This brings us to the need for a method of evaluating the diverse actions of general practitioners. Are the actual differences as many different roads leading to Rome, expressions of a personal style – the art in or behind general practice – or can a distinction be made between decidedly erroneous and appropriate interventions? Two university departments of general practice present examples of how medical audit can be applied. Both contributions accept the symptom as starting-point.
Boeke and Knottnerus *focus on the audit of diagnostic actions in response to the complaint:* coughing. *They list the minimum number of questions to be asked, and then consider the extent to which this mandatory history taking is adhered to in actual practice. In their discussion and detailed description of the developmental process they touch on various aspects in the attempt to explain*

* Translation of pages 3-5.

why in so many cases the mandatory history is not completed.
From the Nijmegen University Department of General Practice, Mesker et al. *present a protocol for the complaint:* sore throat. *The well-known formula of general practice conferences comes into its own again. The proposed protocol is modified on the basis of the views of the participants, the results of a pilot study, and the first large-scale applications. The authors' aim is not only to present the two protocols, but also to demonstrate the way in which they were developed.*
The extent to which in both cases the actual interventions of the general practitioner proved to differ from the interventions expected or required, warrants the question whether the reality value of the behaviour shown by selected groups of general practitioners was adequately taken into account: does this behaviour conceal a pragmatism which cannot be traced via literature, textbooks or exchange of ideas? The focus is mainly on the use to be made of this instrument for audit: as a discriminant between erroneous or appropriate action, or as a method to make the actions of the general practitioner visible and open for discussion?
To conclude this part, Nolet *presents a review of the relevance of pharmacotherapy. At the crossroads between epidemiology in general practice and pharmacodynamic efficacy there are few hard arguments in favour of intensive medication. This is to say: there are some hard arguments in favour of limited prominence of pharmacotherapy in the therapy of respiratory diseases.*

The dominant theme in the third part is the specific position of the general practitioner in health care.
The general practitioner is confronted with complaints which may be the first manifestation of severe illness. It is part of the professional duties of the general practitioner to indicate those circumstances where further investigation and perhaps referral to a specialist is required.
Sluis et al. *focus on the diagnosis of bronchial carcinoma – a disease with a notorious reputation in terms of early diagnosis on the basis of clinical findings, and with little better results in population screening. Question: can the general practitioner, in his time-structured relation with the patient, elicit elements which do contribute to actual early diagnosis? The authors approach this problem by a route not previously described in this issue: the method of case description. In this way they illustrate clearly the „added value" which family medicine, course-of-life medicine and other paradigms characteristic of general practice can offer in primary health care. This description, too, affords an insight into the actions of the general practitioner which extends beyond the diagnosis of bronchial carcinoma.*
Bartelds *likewise elaborates on this „added value" in a contribution which is part of a debate on the question whether (and if so, when) extensive pulmonological diagnostic procedures are required for children with recurrent respiratory infections. The strong suit of general practice lies in insight into the epidemiology and the natural course: a time-structured insight into the presence and absence of disease symptoms.*
Neyens et al., *writing from the level of specialized health care, stress the possible significance of lung function tests and objective evaluation of therapy. Both contributions indicate how much uncertainty and how many imponderables are involved. Partly because of this, this debate implies the promise of a constructive dialogue between primary and specialized health care. Apart from this, a difference in accent can be observed between the approaches chosen, which seems to be of a fundamental nature: emphasis on the chance that a person may well be healthy (*Bartelds*) versus emphasis on the risk that a disease may be present (*Neyens et al*).*
Van Veen *discusses the sense and nonsense of the application of lung function tests in general practice. He demonstrates that a particular epidemiological pattern implies particular criteria for application of the available technology.*
Finally, Huygen *guides the reader to one of the focal areas of general practice: family medicine. It needs hardly to be stressed how strongly knowledge of the family contributes to a more profound insight into the illness behaviour of the individual. This is elegantly illustrated in this contribution with reference to respiratory tract problems.*

The papers presented in this issue afford a large amount of information on respiratory tract problems in general practice. Readers looking for new truths will probably be disappointed. But those who are willing to share a train of thoughts, a thinking process and a problem approach, can attain more. For them, some wisdom may dawn at the horizon.

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