Adult-onset asthma

The recently published article by Burdon (*AFP*, August 2015) describes environmental pollutants and exposure to irritants and sensitisers as important risk factors for the development of adult-onset asthma.[1] However, this article did not mention the important role of climate change in the concentration and dispersion of these environmental pollutants and irritants.

Air pollutants can either be:

- particulate matter – dust or liquid suspended in air
- biological molecules or aero-allergens (eg pollens, moulds, house dust mites, animal gander, cats, dogs)
- ground-level ozone.

Ongoing climate change has caused the increased availability and concentration of these pollutants and, in turn, a significant increase in respiratory morbidity and mortality. These pollutants act as irritants and senstisers to trigger new cases of adult-onset asthma.[2]

Climate change, evident by changing precipitation, humidity and temperature, leads to heatwaves and droughts. Particulate matters from dust storms and bushfires are carried for long distances and exposed to unsuspecting individuals who then present with adult-onset asthma.[3]

On the other hand, flooding and rainstorms will cause prolonged pollen seasons, therefore more people are sensitised to these aero-allergens. The aftermath? Increased incidence and prevalence of adult-onset asthma.

To reduce the burden of adult-onset asthma on our health system, measures have to be put in place to create more awareness in the public about this medical condition. There is the need for a central (Commonwealth) air quality warning system to update the public about the potential risks of air pollution. More so, mitigation strategies like close control of allergenic plants through genetic modification to yield less allergenic species and planting of non-allergenic gardens by 'at risk individuals' should be implemented.

The government should be actively involved in setting up strict standards to reduce the emission of greenhouse gases and their precursors. These can either have direct effect through irritation and sensitisation of the airways (eg ground-level ozone) or, in the broader picture, contribute to global warming and climate change.

This letter identifies the potential mechanisms through which climate change could impact directly and indirectly on health, and the complex interactions between these and other population and environmental factors.

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References

1. Burdon J. Adult-onset asthma. Aust Fam Physician 2015;44(8):554–57.
2. Begs PJ, Bennett CM. Climate change, aeroallergens, natural particulates, and human health in Australia: State of the science and policy. Asia Pac J Public Health 2011;23(2 Suppl):46–53S.
3. Spickett JT, Brown HL, Rumchev K. Climate change and air quality: The potential impact on health. Asia Pac J Public Health 2011;23(2 Suppl):37–45S.

Not to attend a pharmaceutical company function is a moral not an ethical decision

I read with interest the paper on general practice ethics[1] regarding a general practitioner (GP) who chose, for apparently ethical reasons, not to attend a function hosted by a pharmaceutical company for a retiring practice partner (*AFP* November 2015).[1]

From my understanding, the medical council neither regulates nor forbids doctors from meeting pharmaceutical company representatives, receiving medical literature, drug samples or attending functions hosted by pharmaceutical companies. Consequently, the question of ethics does not arise. The issue as to whether the GP should or should not attend the function hosted by a pharmaceutical company is a moral one for the GP to decide.

Where does the potential conflict of interest arise in such a case? Doctors are expected to keep up to date with medical advances, especially in their own field of practice. Many GPs only become aware of new drugs from the pharmaceutical representative. This is followed by promotion by the pharmaceutical company. The GP is expected to make an informed decision on the appropriate use of the new product after further study of the available literature. Later, with the passage of time, new information appears about the problems encountered with the new product, and this needs to be evaluated. The moral of the story is GPs should keep in touch with and update themselves by continuous medical education to enable them to make correct, evidence-based decisions.

All of us, including housewives, face similar challenges in our daily lives. New products are constantly introduced with a barrage of promotion and gifts. Educated choices have to be made. Just like drugs, cars that initially appeared excellent start showing flaws due to poor testing and quality control. Government bodies and consumer associations serve as watchdogs in the public interest. The same happens in the relationship between pharmaceutical companies and GPs;

evidence-based information provided by independent bodies assists the GP in appropriate decision-making.

GPs should be open to receiving information from all sources, be it the pharmaceutical company or the medical literature, but the onus is on the GP to make decisions based on evidence from a review of all available information in the best interests of patients.

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References

1. Mintzker Y, Braunack-Meyer A, Rogers W. General practice ethics: Continuing medical education and the pharmaceutical industry. Aust Fam Physician 2015;44(11):846–48.

Reply

We agree with several of the points raised in Dr Sinniah's letter. Indeed, doctors do have the duty to educate themselves about new treatments and to be up to date with current medical knowledge. We also agree that acquiring knowledge from different sources and being able to critically appraise new knowledge are among the important duties of GPs today. However, we think it is mistaken to presume that information provided by pharmaceutical companies is a potentially good source of knowledge about new treatments. Information provided by pharmaceutical companies may promote treatment for diseases for which the drug is not indicated and contain biases in the assessment of efficacy and effectiveness.[1] In addition, receiving information in the context of hospitality, such as a free meal, will unconsciously bias the recipient towards prescribing the relevant product,[2] and that effect probably persists even if this bias is acknowledged.[3] Most importantly, the educational agenda in this context is directed by the financial interests of the companies, not by the health needs of the population.[4]

Given the ready availability of multiple sources of relevant information (Dynamed, UptoDate, Micromedex, among others), there is no justification for relying on commercial sources for learning about new treatments. And unlike the purchase of household goods, doctors have an ethical duty to act in the best interests of their patients. This means that there is a significant moral obligation to seek the best available independent evidence about new treatments. By contrast, there is no obligation to inform oneself about a new car or washing machine purchased for personal use, although of course it would be prudential to do so.

Finally, we follow common practice in using the terms 'moral' and 'ethical' interchangeably: both refer to matters of right and wrong. Whether or not particular medical councils permit or prohibit industry-sponsored education, it is wrong to accept or rely on information that is not to the highest possible standard when using this information to make decisions about the healthcare of patients.

Medical ethics deals not only with what doctors actually do but also with what they should do. Our moral (ethical) duties can and should be debated even if the discussion runs ahead of current practice.

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References

1. Wall LL, Brown D. The high cost of free lunch. Obstet Gynecol 2007;110(1):169–73.
2. Spurling GK, Mansfield PR, Montgomery BD, et al. Information from pharmaceutical companies and the quality, quantity, and cost of physicians' prescribing: A systematic review. PLoS Med 2010;7(10):e1000352.
3. Dana J. How psychological research can inform policies for dealing with conflicts of interest in medicine, Appendix D. In: Lo B, Field MJ, editors. Institute of Medicine (US) Committee on Conflict of Interest in Medical Research, Education, and Practice. Washington DC: National Academies Press, 2009. Available at www.ncbi.nlm.nih.gov/books/NBK22950/ [Accessed 15 December 2015].
4. O'Connell C. Pressure mounts to strip industry funding from continuing medical education programs. CMAJ 2010;182(17):E775–76.

Erratum

Hannan K, Hiscock H. Sleep problems in children. Aust Fam Physician 2015;44(12):880–84.

Due to a production error, there was a misprint in Figure 2 of this article. The K-cohort was listed (left to right) as 5, 4, 3, 2, 1 (years). The correct labelling is 5, 6, 7, 8, 9. The correction has been made to the HTML and PDF versions of this article.

We apologise for this error and any confusion this may have caused our readers.

Letters to the editor

Letters to the editor can be submitted via:
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