EDITORIAL:
THE NEED FOR GREATER AWARENESS ON THE IMPORTANCE OF PREVENTION

Although advances in medicine have been dramatic and, generally, patients have benefitted from this, it has become increasingly clear that while demand for medical services is virtually limitless, available resources are limited. This is not only true of Malaysia but even of such developed countries such as the USA. National priorities will have to be considered to ensure that the health dollar is well spent.

Many procedures are so expensive that it is not possible for everybody who may benefit from it to receive it without incurring enormous increases in the health expenditure. It was estimated that the cost of renal dialysis or transplantation in the USA in 1982 was US$1.8 billion.[1] The cost of some 160,000 coronary bypass operations in the USA in 1981 was US$3.25 billion.[2] The cost would be easier to accept if the procedures were to be curative, which it were not. Nonetheless, there are other even more expensive procedures such as heart, liver and bone marrow transplantation or the use of artificial hearts.

In attempting to set priorities, it is important that new technologies, procedures and therapies be carefully assessed, and the benefits and the costs known before it is accepted into our practice. The role of coronary bypass surgery in unstable angina is controversial, and a large randomised study conducted by the National Institute of Health did not find a significant difference in mortality or non-fatal myocardiac between patients treated medically and those treated surgically.[3] In a more recent multi-centre, randomised, prospective study comparing medical therapy alone with coronary artery bypass surgery plus medical therapy, it was found that unstable angina pectoris had a similar outcome after two years in the two groups.[4] The long-term experience with coronary angioplasty performed by the late Andreas Gruentzig has been recently reported,[5] and several studies have been initiated to compare angioplasty and coronary bypass surgery in symptomatic patients with multivessel disease in the USA.[6] Until results of such studies become available, decisions about management will be based on incomplete information and clinical judgement. This situation is all too familiar to us in so many other conditions.

As pointed out by Leaf,[7] until such time that specific and effective cures for the major diseases are available, should not the clinician play a more active role to promote preventive medical practices? It is surely irrational to attempt to treat patients with ischaemic heart disease with bypass surgery at enormous costs. It would be more cost-effective for doctors to actively advise on weight reduction, stopping of cigarette smoking, proper dietary habits, blood pressure control and moderate exercise. This should be targetted at the high risk individuals as well as the population at large. There has been a consensus in the United Kingdom and in Europe about strategies and measures to be taken in the prevention of coronary artery disease.[8] The important role of the doctor in influencing opinion, promoting social changes which are necessary to make a significant impact on the prevalence of disease cannot be overemphasised. The obligations of the doctor to individual patients are not incompatible with his duties to the population at large. For too long, clinicians have paid too little attention to preventive medicine in their clinical practice. It is time that this attitude is changed, and the public can only be convinced if it is shown that doctors are interested in the health of all, rather than confin-

ing their interests to a few, with dramatic, invasive and all too often expensive therapies.

In this issue of the journal, some local experiences with cardiovascular diseases are reported. In the future, it is hoped that apart from documenting local experience with therapies and procedures related with various diseases, results of preventive measures taken locally, in relation to various diseases would also be reported.

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