Therapeutic Inertia

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Hypertension is certainly an important public health problem. It can be easily detected and it may be controlled by a variety of resources available, from a perspective of individual treatments.

In this same edition of the Brazilian Archives of Cardiology, the article "Therapeutic inertia and control of hypertension in the primary health care units in the city of Joinville" ("*Inércia clínica e controle da hipertensão arterial nas unidades de atenção básica à saúde no município de Joinville*")[1] analyzes some primary care services, and it draws attention to the negative impact on the adequate control of the problem.

The analysis of medical records considered the demographic characteristics and risk factors, such as smoking, sedentary lifestyle, obesity, family history, as well as comorbidities.

It is appropriate to be concerned about the inertia of health professionals in controlling blood pressure. That is why continuing education programs, teaching tools, training, and intervening in the work of students, residents and other health professionals have been suggested, in line with successful examples reported in the medical literature.

Besides the natural limitations of a retrospective study based on the analysis of medical records of a group originating from spontaneous demand, without a population base, one must consider the characteristics and psycho-social conditions of the people studied by the gradual awareness of their relevance as a determinant of health and disease, including in cardiology.

If there is concern about therapeutic inertia in relation to a risk factor, one should not overlook the inertia in considering the conditions that are responsible for the higher prevalence of all other risk factors, or the aggravation of any disease, whether such disease is associated or not. We should also be sensitized to the lack of information on the economic and psychosocial characteristics of patients in medical records.

At one time, there were no medical records in outpatient clinics. Blood pressure was neither measured nor recorded. Maybe one day we will also learn to attach importance to the basic conditions under which people live inside the society.

The simple observation of isolated variables and results of imaging tests or laboratory tests of patients receiving care in clinics or hospitals, which are far from the environment where such patients live and work, creates the illusion that we know the essential elements to control their health problems[2,3].

To get us out of the inertia, the image below can serve as an example. This image was published in the same journal[4] and it shows the mortality rates and risk of premature death (45 to 64 years) as a result of cardiovascular disease, in the period from 2000 to 2004, per district and based on socioeconomic characteristics, in the city of Porto Alegre. Nearly half of premature deaths could be attributed to such factors, which are more than three times greater when compared to people living in districts that are in less privileged regions and those in privileged or satisfactory regions.

In 1978, in a representative sample of the entire adult population (20-74 years) of Rio Grande do Sul State, and later, in 1987, in a sample of the population above the age of 18 in the city of Porto Alegre, in an article published in this same journal[5], we demonstrated the importance of including individuals in the context of society and the production system, for the prevalence of hypertension and other risk factors, as one may see in the figures below, taken from such article.

It should be noted that not only the prevalence of hypertension, but also the mean systolic blood pressure and diastolic blood pressure, standardized by age and sex, varied significantly in inverse proportion to social privilege.

If we consider that hypertension is merely a restricted pathophysiological problem, and that the pharmacological approach is sufficient, we will never be able to control hypertension and, even if there is a reduction in blood pressure levels, without dealing with the rest of the causal complex, the results will be very poor, partial and not sustainable.

The current inertia is based on our satisfaction with the social position that we have achieved, on the pressure exerted by the economic interests of the pharmaceutical industry, and on the political inaction that tends to hide the social ills and which draws attention to the sources of resources that tend to keep the *status quo*.

Three quotations may help us overcome our therapeutic inertia, both in relation to risk factors alone and with respect to their basic determinants:

1 - Sir Michael Marmot, in his recent review of the subject, says that "reducing inequalities is a matter of fairness and social justice" and that "inequalities are a matter of life and death, of health and sickness, of well-being and misery"[6].

Key words

Hypertension; prevalence; inertia; medical records; primary health care.

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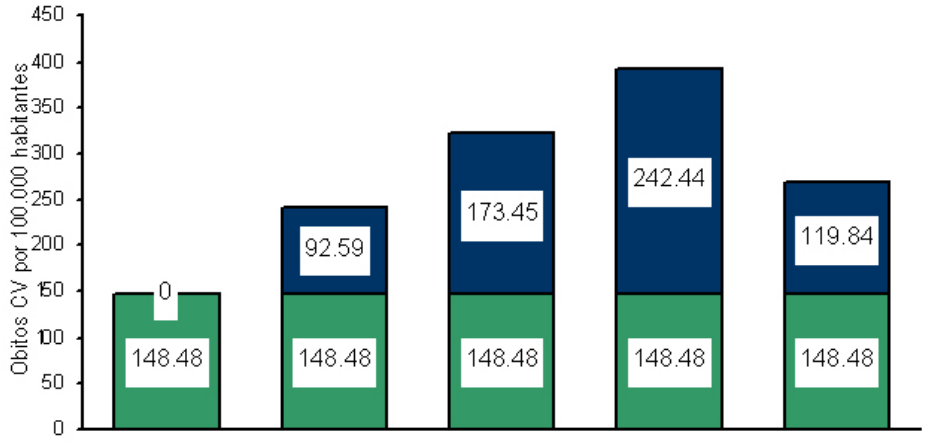

Stratum	1	2	3	4	All
Relative risk [95% Confidence Interval]	1	1.62 [1.28 – 2.10]	2.17 [1.72 – 2.75]	2.63 [1.09 – 3.35]	1.81 [1.47 – 2.24]
Attributable risk	-	92.59	173.45	242.44	119.84
Fraction of attributable risk (%)	-	38.41	53.73	62.02	44.66
Annual No. of attributable deaths	-	64	126	140	322

Figure 5 - Coefficient of Mortality due to cardiovascular disease for 45-64 years age bracket, relative risk, attributable risk, fraction of attributable risk, and annual number of attributable deaths, as per socioeconomic strata. Porto Alegre, 2000-2004.

Table XI - Growing prevalence of hypertension proportional to the position occupied by the individuals inside the production system

Employment relationship groups, standardized in %	Reasons for prevalence
Farm owners	76.50
Partners	81.17
Rents and pensions	92.86
Public servants	94.34
Company owners	95.29
Lessees	98.43
Salaried rural workers, bailees and squatters	101.44
Helpers and people allowed to live on a farm for subsistence farming	103.27
Helpers and employees of individuals	114.67
The self-employed and odd-jobbers	120.87
Salaried workers from the private sector	121.11
All rural workers	85.1
All non-rural workers	113.79

Source A. Achutti et al.[5]

Table XII - Prevalence of risk factors according to educational levels in Porto Alegre, 1987

Education	Hypertension	Alcohol	Obesity	Smoking	Physical activity
College degree	6.6	9.8	10	46	74.7
High school degree	8.0	18.2	18	47	79.1
Primary school degree	19.9	18.1	31	55	85.3
Illiterate	27.8	33.3	47	72	87.3

Source: World Bank A. Achutti[5]

Editorial

2 - When it set goals for 2020, the American Heart Association, through its strategic planning and statistics committee, stated that "the quality of life shall be monitored for the first time in the absence of cardiovascular diseases, as a measure of cardiovascular health".

"The committee and the Association recognize the importance of improving the quality of life (not only reducing disease) as an important component of cardiovascular health in the overall impact for 2020. The concept of HRQOL (health-related quality of life) often extends beyond traditional measurements of mortality and morbidity, and it may include physical, mental and social functioning, as well as the general well-being"[7].

3 - Finally, to minimize the feeling of guilt, without avoiding the responsibility, it is worth remembering a lapidary phrase used by late Professor Geoffrey Rose.

"Who is responsible? It is clear that physicians only have limited responsibility for the nation's health. Our role, as well as the role of health education, is not to manipulate, but to inform, guide, challenge and support. This is certainly important, its impact on the average weight of the population, lifestyle and alcohol drinking are constrained by other, more important forces. Doctors are trained counselors in society, but we are not responsible for their choices"[8].

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