RADIO MEDICINE

Doctor on the air

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SUMMARY. This paper reviews the number of medical programmes in local radio broadcasting and analyses the problems presented by 158 callers on a regular medical, open-line programme in Plymouth, Devon. The problems are similar to those presenting in general medical practice. Most callers are referred back to their own doctor, usually with an explanation or medical advice. Local radio medical broadcasting may prove to be a useful preventive and educational tool as well as providing popular entertainment. General practitioners are appropriate providers of such a service.

Introduction

GENERAL practitioners vary in their attitude to the media. In a postal survey of 1,300 general practitioners, 71 per cent of respondents felt the public should be better informed on medical matters, but 60 per cent felt that ignorant patients were easier to deal with and 66 per cent felt that newspaper articles and television programmes were a hindrance to the doctor in his work *(British Medicine,* 1979).

To be effective health advice needs to be easily understood, repeated frequently, and capable of arousing emotion in the listener (Richardson, 1969; Epstein *et al.,* 1975). That it can be effective through radio and television is undoubted. A safety campaign involving repeated safe-driving commercials was associated with a reduction in road accident deaths during a holiday weekend (De Lorenzo, 1974), and a telephone follow-up study after a series of programmes on mental health revealed improved attitudes to mentally ill patients and an increase in mental health resource uptake (Schanie and Sundel, 1978).

The formation of local radio stations has enabled medical programmes to be broadcast for purposes of education, preventive medicine, and entertainment (BBC General Advisory Council, 1976), and in Britain audience research following a series of broadcasts on cancer confirmed the potential educative role of local radio (Turner *et al.,* 1980). However, although local radio programmes may be effective in promoting health education, their effectiveness is difficult to follow up, chiefly through lack of control groups (Thompson, 1973).

As a prelude to a study of one particular programme I asked 36 local radio stations in England for details of their medical programmes; 22 replied. Fourteen stations had a minimum of monthly programmes devoted to medical topics and six were broadcast in association with advice from the local health authority. Radio Humberside reported as successful an urgent request to find rare blood donors, and Radio Metro had issued 1,000 low reading thermometers in a campaign to prevent hypothermia.

Medical programmes were considered popular and general practitioners and community health doctors were the most commonly used regular broadcasters. Consultants tended to be used when specific issues arose. In one case the doctor had been replaced by a health visitor who had proved a superior communicator. An analysis of the topics for afternoon programmes on Plymouth Sound over a 12-month period showed that 22 of the two-hour programmes had been medical.

Phone-in programmes termed 'open-line' shows are popular, economic to produce and allow listeners to provide the entertainment.

Aim

I wished to classify the medical calls made directly to the doctor on the afternoon open-line broadcast on Plymouth Sound, held on a weekday afternoon, at five-weekly intervals throughout 1979.

Method

Plymouth Sound (261m medium wave) broadcasts to 175,000 potential listeners in the Plymouth area. The general medical programme was broadcast between 14.00 and 16.00 hours as part of the "Talk to Louise" afternoon show hosted by Louise Churchill; with a JICRAR rating of 14,000 per half hour (Joint Industry Council on Radio Audience Research). The programme is broadcast through the winter months at five-weekly intervals. (Through the tourist season 'open-line' shows

are reduced to provide more air time for popular music.)

Listeners are invited to telephone and discuss any medical matters with the doctor. The programme starts with a four-minute introduction on a medical theme such as 'stress and tranquillizers' and there are interruptions for news bulletins and advertising up to a maximum of nine minutes per hour in accordance with Independent Broadcasting Authority regulations.

Callers are not preselected and having rung through to the open line will wait to speak to the doctor giving their christian names only. The short statutory delay between performance and broadcast allows for censorship of doctors' names or drug names. The caller's name and problem is noted and advice is then freely given.

Results

Of 158 callers 18 (11.3 per cent) were men and 140 (88.7 per cent) were women. During their presentation of their problem, 42 callers gave their ages, which ranged from 14½ to 76 with an average of 44 years. Nine callers, all women, had two problems and of all the problems (167) only 15 (eight per cent) were related to the theme at the beginning of the programme.

Three of the callers were advised to take urgent action. For example, one caller complained of a bleeding mole on the leg which was potentially malignant.

Ninety-six callers were referred directly back to their general practitioner and 12 were referred to a specialist, either directly because they were already awaiting outpatient appointments or through their general practitioner in order to request a second opinion from a consultant. Although based on the problems of individual callers, 55 calls (33 per cent) were answered with an explanation that could have been educative to caller and public, and in 15 cases a preventive point was made.

Eight callers made indirect calls concerning relatives and only six made reference to dissatisfaction with their general practitioner.

A general analysis of the types of problems was made by system (Table 1), and a separate analysis of the social problems was made (Table 2).

The most unusual calls concerned Gilbert's disease (1) and Duchenne's disease (1), but topics varied from how to get a second opinion (1) to radiation hazards (1).

Table 1. Number and type of problem.

System	Number of problems	Percentages
Skin	24	*14.4*
Emotional	18	*10.8*
Gynaecological	15	*8.9*
Genito-urinary tract	14	*8.4*
Musculoskeletal	12	*7.2*
Central nervous system	12	*7.2*
Cardiovascular system	11	*6.6*
Weight	11	*6.6*
Social	11	*6.6*
Contraception	7	*4.2*
Respiratory	6	*3.6*
Urological	6	*3.6*
Obstetric	3	*1.7*
Others	17	*10.2*
Total	167	*100*

Table 2. Analysis of social problems.

Problem	Number
Procedure for changing doctor	2
Parental control	1
Complaint of doctor not visiting frequently enough	1
Horror films and effect on pregnant mothers	1
Worries over planned admission to hospital	1
Behaviour of the year-old baby	1
Lonely: living alone	1
Handicapped child	1
Kidney donor cards	1
How to get a second opinion	1
Total	11

Discussion

Most local radio stations use medical practitioners for varying amounts of air time. These doctors deal with callers' questions and, in order to prevent 'switch off', the response of the doctor has to be ethical, appropriate, and entertaining. The ideal aims of education and preventive medicine must also be borne in mind.

A proportion of radio stations screen their calls first to exclude obscenity or those who have not already been to their general practitioner. In most cases a second opinion is given from the history alone. No assessment of the type of patient willing to divulge their problem to thousands of others has been made, but it seems likely that with an anonymous doctor and an anonymous caller a high degree of confidentiality is maintained.

The naming of drugs and practising doctors is discouraged or censored and the radio doctor is careful never to criticize another doctor or to alarm a caller.

The problems presented to the doctor bear a close resemblance to the experience of general medical practice (RCGP, 1979) with surprisingly few neurotic or emotional calls. The time of the day and nature of the series accounts for the high proportion of female callers and of course only patients able to use a telephone are able to consult the doctor. A service of this kind may be ideal for the agoraphobic patient but is of no use at all to a deaf person.

Despite the time taken to give a lead into the programme only a small proportion of the calls related to the initial theme. In addition, the chances for making a general preventive point were fewer than would be considered ideal for such a programme.

Conclusion

The popularity of medical programmes confirms their entertainment value, and where listeners have unrestricted telephone access to a radio doctor the problems dealt with mimic general medical practice. There is some opportunity to make educational and preventive medical points to a large group of people.

Open-line programmes involving a general practitioner provide a useful and ethical addition to other medical services, but further work should be undertaken to evaluate the effectiveness of the health advice that may be given.

References

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Long-term use of benzodiazepines

The Committee on the Review of Medicines has made it clear that long-term prescribing of benzodiazepines for use in the treatment of anxiety or insomnia is inadvisable . . .

The Committee is concerned that the similarity of withdrawal effects to the symptoms of the original illness may suggest to the prescriber that previous treatment was inadequate and that a further course of treatment with benzodiazepines is indicated. It believes that that might contribute to the high number of repeat prescriptions which are issued. Whatever the reason for repeat prescribing, all the present evidence suggests that long-term therapy with the drugs, especially with inadequate supervision, is undesirable.

Reference

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