The rôle of the general practitioner in health education

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THERE is a dearth of medical literature relating to health education in general practice. The impression gained is that general practitioners look upon health education as dirty words. Fears arise immediately of telling the patient too much and encouraging hypochondriasis; visions are conjured up of surgeries full of patients with imaginary lumps and bumps, clamouring for checkups and smear tests. Surely it would be better to work toward a more intelligent approach to health, thus eliminating the trivia and making the patient more self-reliant and responsible. Little *formal* health education is being undertaken by general practitioners despite the views of Pike (1969). Following on a questionnaire to which 526 selected practitioners replied he concluded that almost 25 per cent carried out some formal health instruction. However when measured in time spent this must be minimal.

As a general practitioner in active practice doing two weekly sessions of medical examinations at child health clinics and schools for a local authority I developed an interest in health education. The 'face to face' or 'one to one' confrontation can become repetitive, monotonous and therefore boring, when probably it will be done badly. I thought that group discussions could be more interesting, profitable and of wider range. These were established monthly at a child health clinic and at two schools through their parent teacher associations two years ago and are still active. Some ideas on group discussions in health education of mothers and parents have thus developed.

This paper is a generalization ranging over the whole aspect of health education with special reference to the general practitioner. It indicates a possible wide and active rôle for him, suggests some programmes, discusses responsibility in health education and draws some conclusions. One is conscious of its superficiality and that various specific studies in depth are necessary.

The rôle of the general practitioner

Obviously his major rôle is in terms of the 'face to face' confrontation in the surgery. Here he is a dominant and at times an autocratic force. The patient seeking help and advice is usually motivated to follow reasonable suggestions particularly when made by *his own* practitioner. In this context when made with thought, care and sympathy health education is most valuable. On the other hand dogmatic forthright statements may initiate anxiety and guilt. When the patient consults because of a relatively minor ailment, should the practitioner draw attention to the evident obesity or nicotine-stained fingers? Or should he rather leave it to a more appropriate occasion, possibly at a time of need, when co-operation would be more easily obtained. An aggressive approach is not recommended but rather a quiet, firm but gentle encouragement. On occasion, however, the instillation of fear is apparently justified and may be successful. The chronic bronchitic who will not stop smoking or the cardiac who will not stop eating needs to be admonished severely or even frightened.

How ethical is this? Is it right for the general practitioner to threaten, cajole and breathe forth fire and brimstone? No rules can be laid down; the onus of assessing the

approach in each case devolves upon the doctor. Health education should be one of his tools used with perception in both the preventive and therapeutic fields. Unfortunately few are trained in its techniques while aids remain a poster or pamphlet on the waiting room notice board. Health education if done with sympathy and thought can be rewarding but may lead to boredom with persistent repetition. Is it not better then to arrange for discussion meetings of specially selected groups within the practice to be talked *with* by doctor and health visitor? Other groups should be organized through the community physician and his staff in which general practitioners can participate, thus establishing a team of health educators. The public at large have a tremendous interest in their personal health and in health personnel. The doctor's advice is held in high regard though they probably prefer the more glamourized versions of the mass media with Dr Finlay and Dr Somers. The health education team need not compete but should rather fill in the gaps and consolidate knowledge.

Some practitioners are already involved in 'high risk' groups through obesity clinics (Lord) and special groups (Pike) and one (Midgley) has built a film studio within the practice where films and tapes on specific disease are available for enlightening the patient. This could be most advantageous and even economical within health centres. The practitioner at an occupational health unit may lecture to student nurses, ancillary health staff, contact patients in the factory environment and instruct in first aid (Ellison, 1970). Hasler (1968) and also McCoy (1968) have reported on health education for patients of the practice by the community health team and Walt (1969) has established discussion groups with the parents of school children whom he examines as a part-time school medical officer. Cope and Smith (1968), rural general practitioners, organized a concentrated screening programme by way of a health week for the inhabitants of their village and area, which, being so successful, has recently been repeated. Although formal health education was not offered, people had to make a decision to attend for screening. This alone is a positive act and a form of health behaviour. Baric (1969) discusses this and talks of accepting or rejecting an 'at risk rôle'. After screening when something abnormal is found the person is immediately 'at risk', eg, obese, hypertension. Whether he accepts this rôle or not will depend on previous health education as well as the reaction of his general practitioner. This is a form of health education which could well be extended in the future with the general practitioner playing a major rôle.

The field of general practice is ever-expanding and although the doctor has been trained mainly as a clinician he has had to become a counsellor as well. Now he must prepare to take his part in the community as a health educator to prevent ill health. He must try to put himself out of business but to be successful he needs some training in the behavioural sciences and sociology. Better that it should commence while at medical school. Recently a Guy's Society for Social Responsibility in Medicine was formed. Our college could contribute by establishing a course in health education for general practitioners.

The many fields of health education

These can be directed at particular age groups each needing a different approach and different personnel to guide them (figure I).

Mothers

At antenatal and postnatal clinics a large amount of good work is already being done in this field with a fair proportion of general practitioners taking part, although the major work is apparently carried out by health visitors and midwives. Rather than the practitioner giving the injection and doing simple routine work he would be better employed in group discussion with mothers about their problems both before and after their pregnancies. Guidance in regard to the new-born and particularly the children up to the age of two could well be undertaken. Parentcraft classes are most useful where

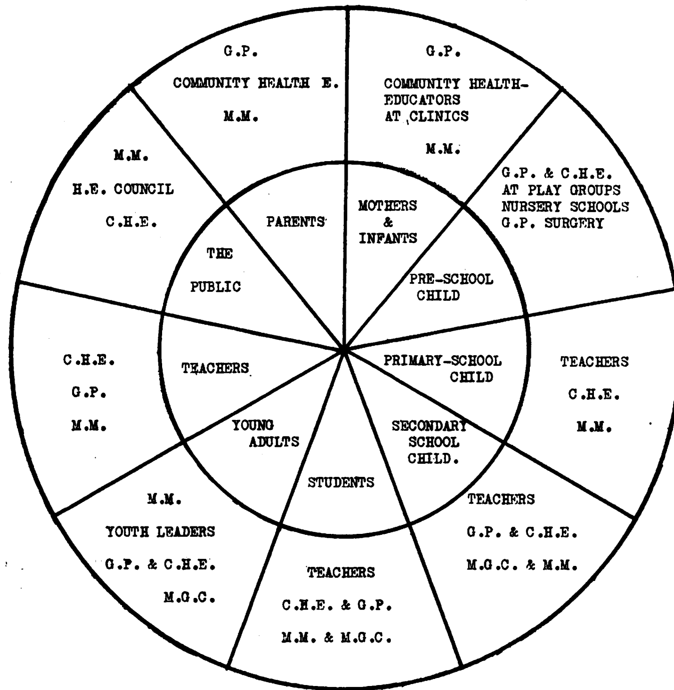

Figure 1

fathers can be encouraged to play their part in the family unit sharing responsibilities related to the children and even household chores. Life must be a partnership if the quality of life is to be valued.

Infants

The discussion of health in infancy, be it preventive immunization, behaviour problems, handling or ailments is ideally tackled at child health clinics at local authority level, surgeries or health centres. This is a time of need for mothers; a need to build up their confidence by instilling knowledge.

Pre-school child

There seems to be a health education gap in this group because once a mother stops attending with the child at the child health clinic between the age of one and two nothing seems to happen for them until the age of five when contact is made again through the primary school. The mother could be advised through nursery schools and play groups, and helped in the care of the toddler. This is the time when there are tremendous behaviour problems within the family and when the mother often needs a large amount of support and help. Here the general practitioner has an important part to play.

Primary school

This is an ideal time for inculcating habits into school children who are ready to be trained in personal care and hygiene and when sex in its simplest form can be discussed. At school entry five-year-olds soon learn to brush their teeth regularly and with enjoy-

ment. But by ten years of age the habit may be waning, presumably because of a developing independence, with less supervision by parents.

Secondary school

At both these levels the school teacher should play the major rôle. This is where adolescence, venereal disease, sex, the National Health Service and personal relationships are very important, and unless we can make our teachers health-education conscious and get them to orientate their work within the class-rooms towards these subjects, we will lose much. It may be that headmasters are not convinced that this is a major part of school teaching but their connivance and active enthusiasm must be obtained.

Teachers are essential in the school community health team and their co-operation absolutely necessary. The health educators would supplement the health teaching, encourage projects, produce materials and instil enthusiasm. However, the presence of the teacher in group discussions with adolescents on personal relationships is unwise. The doctor should participate on occasions as his authoritarian image would support and confirm the teaching and attitudes of teachers and community health educators.

Young adults

These can be reached through youth groups, factories and occupational health units but much organization will be needed to stimulate and interest them.

Students at colleges and universities

These need to be made aware of health problems for themselves and also for those with whom they are likely to come into contact once they move into their professional fields. Here the student health service should play the major part. All such institutions should appoint at least one medical practitioner as a lecturer in health education.

Teachers

These obviously should be reached at colleges of education. Health education programmes within the training period must be looked at practically and with a view to encouraging teachers to carrying them through their whole syllabus and into their class-rooms and schools once they start practising.

The public

This includes all those who have had little health education in the past and who need to know some basic facts of preventive medicine. The mass media should provide this and the general practitioner would have a minor rôle. Those with the ability and flair to project a good image could advise and help producers and editors.

Programmes

For each of these groups specific programmes would need to be worked out and correlated. These must depend on planning to give factual knowledge to the recipient, hoping the facts will be acceptable and possibly change behaviour. Many people today accept the fact that smoking does help to cause lung cancer but few behave differently because of this and actually stop smoking. We think we know what a person needs. This is not necessarily what he wants and the problem of health education appears to be how to get " his wants to him when he needs them." It is no use talking to youth about leisure in old age, or to ten-year-olds about venereal disease, or to present infant problems to childless couples, or to start a campaign on influenza when there is no epidemic.

Topics for discussion could be:

For school parents

The school health service. The family unit—rôle of mother, rôle of father, family planning. Psychology and the school child. Your child and sex. Adolescence and its problems. Simple childhood ailments. The National Health Service. Drugs. Cancer; lung, breast, cervix. Obesity and nutrition.

For adults

Common illnesses: carchis vascular disease, backache, colds, bronchitis, menopause, obesity.

Common problems and personal relationships: money, sex, job satisfaction, children, leisure, retirement. First aid. Group meetings in factories.

At child health clinics

Accidents. Feeding and obesity. Handling. Common ailments. Behaviour problems. Clothing and equipment.

Technical help:

Aids to teaching, posters, pamphlets, films, books, slides are available from many organizations. Some are free but others for hire or purchase. Recently the Health Education Index 1970 has been prepared and published for The Health Visitors Association; it is an excellent book full of useful information on material, people who help, professional organizations, important reports and equipment. It is essential to anyone actively involved in health education.

Evaluation of health education

This is most difficult because of the lack of reliable measurements. When specific campaigns are launched—cervical smear tests, local screening or vaccination programmes, venereal disease—it is possible to measure numbers attending and assess response and possible benefit to the community. But response to general health education is not easily measured. Rosenstock (1969) defines 'health behaviour' as "any activity undertaken by a person who believes himself to be healthy, for the purpose of preventing disease or detecting disease in an asymptomatic stage." In the USA it is practised more by whites than non-whites and most by younger or middle-aged people, more by women and the better educated and higher income groups. People have to be motivated to seek help but this will depend upon what they believe. If they believe in their susceptibility to disease they may take action; and if they also believe this would be beneficial many more will be motivated to seek advice. Motivation is also dependent upon intellectual and emotional factors and does not make for concise measurement.

Medicine has progressed at such a pace as to be dependent on social and economic forces. The field of preventive medicine which is health education has expanded with it.

Whose responsibility?

By the establishment of the Health Education Council the State has accepted a large measure of responsibility. From what has been discussed in this paper team work is essential together with some planning because of the complexity of preventive medicine and its wide horizon but surely the co-ordinator should be the community physician. Through the local authority clinics, the school medical service, and more recently, a closer liaison with general practitioners and their health visitor attachments he has a ready made organization for expanding health education. He should be the enthusiastic leader in preventive medicine. Many may feel that in the past he has been slow to lead. This does not absolve the general practitioner from playing his part and if necessary giving a lead, but he must equip himself with teaching materials and aids and learn the techniques of communication for all ages, be they single or in groups; be it by lecture discussion group, didactic teaching or authoritarianism. We must try to get his needs to him and convince him that he wants them. A difficult but challenging task.

Conclusions

1. The general practitioner should become involved in formal health education.
2. The Royal College of General Practitioners should encourage this by offering a short course in health education which should include not only specific subjects, demonstrations of aids, how to use and where to obtain them, but also the techniques of communication with patients.
3. It could also help by publishing more relevant articles in the College *Journal*.
4. The general practitioner of today has a social responsibility to prevent disease.
5. The College should accept this too and press for medical lectureships in health education in all colleges of education.
6. It must also remind the community physician of his duty in preventing disease and the rôle the general practitioner could undertake if given the opportunity and encouragement.

Summary

The wide fields of health education are indicated and the rôle of the general practitioner discussed.

A few programmes are suggested and some conclusions are drawn.

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The Visit

You can with reason hope to see from year to year in constant lease trees, buildings, contours of the hills,
These will endure, no fear their loss;
But not this body, lying cancer-filled, sure he will be in months no more a man but ash,
This human, talking, loving be no more than cloud washed off the sky;
How holy then this room which holds a passport to the tomb!
What god there be you touch his girdle here and feel the whirlpool of his common speech.

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