The general practitioner and community health education

GODFREY D. RIPLEY, M.B., B.S., M.R.C.G.P.
Boreham Wood, Hertfordshire

TRADITIONALLY, the general practitioner's role has been connected primarily with alleviating pain and distress and attempting to cure illness. Some education on health matters forms an integral, though informal and usually pre-cognitive, part of all encounters between patient and doctor. Formal projects of health education, if undertaken at all by doctors, have belonged to the domain of those physicians specializing in preventive medicine, *ie*, the public health service. In the United Kingdom the medical profession has, in the past, made little impact on the field of health education, leaving it, to the teachers and more recently the sociologists. Recent papers, however, have shown a growing awareness, of the place of formal and structured health education within the framework of the practice of family medicine.[1 2 3 4]

Most of these authors have described schemes in which patients, or members of the community, are invited to attend educational sessions with the doctor, thereby requiring some degree of response motivation within the target group. What can our profession offer that section of the population unprepared or unwilling to accept such invitations? This paper presents a personal view of another approach and also of those areas of health to be tackled.

I previously reported[5] that increasing morbidity in adolescent psychosomatic illness (depression, drug abuse, pre-marital conception, venereal disease and delinquency) together with the extended community ill-health produced as direct consequence, should be a priority for the provision of health education. Today abortion could be added. I also suggested the influence of the doctor could most easily and effectively be applied at school and that a structured course on human relationships, in which human interaction played a major part, could be considered a suitable basis for a syllabus which is the responsibility of each individual head teacher. In most British schools, health education has no place in the curriculum; usually there is no uniformity of opinion in the teaching profession as to what is meant by health education, what its content could be, nor who should teach it. It has been generally accepted that the subject of sex, the most provocative and dramatic part of health education was the prerogative of the parent. As early as 1956 it was shown[6] that most parents were failing their children in this respect. A more recent study[7] has shown that not only the parents but also the teachers have been unable to provide children with adequate information on the subject.

I thought it reasonable to seek an entry into the teaching world to attempt to bring a new approach to health education until teachers themselves developed enough interest and knowledge to undertake the task themselves.

Method

In early 1968, within the setting of the local Rotary Club, informal discussions took place with the headmasters of two (out of five) secondary schools in the practice area. The headmasters expressed concern about the state of sex education in their schools and

asked whether I would be interested in talking to some of the older children on this subject.

The invitation was readily accepted on condition:

1. That the talks would not be on sex as an isolated subject, but would embrace the mainstreams of human relationships and would include discussions on drugs, alcohol and tobacco.
2. That the series would be regular throughout the school year. The doctor would not be an isolated visitor (to fill space after the summer examinations) but should be a teacher coming in to school to take his subject once a week each term.
3. That the project must be under the authority of the county medical officer through the divisional medical officer, with whom my practice already had strong and amicable working arrangements.

These conditions were accepted. The scheme started in September 1968 with the county health department being responsible for the course and also employing the doctor on sessional medical officer rates. A third school was added in 1970.

Teaching is carried out in as informal a manner as possible, the approach being more that of a seminar than a lecture. The syllabus covered is shown in the appendix. The depth of presentation is adjusted to the chronological and emotional age of the majority of each class. I have described the sex education part of the course elsewhere[8].

A different age group is taught at each of the schools, varying between 11 and 15. Each class is seen for one term—or half a term at double periods—regularly every week with follow-up in the sixth form. Integration is sought with teachers in related subjects, such as biology, history and geography. The programme attempts to provide a measure of understanding for actions and their motives, so that the young person can make a realistic appraisal on which to base judgement for his individual decision. It allows him to discover and to develop his own code of conduct in relation to his fellow man and fellow woman. The attitude of the doctor in this teaching is uncompromisingly non-moralistic in the accepted meaning. This view has since been reinforced by the opinion expressed by the chief medical officer of the Department of Health and Social Security[9] that the moral factors concerned in the campaign against venereal disease are the concern of professional groups other than doctors.

In the first year of operation, notices were sent to the parents involved by the head teachers informing them that the health education course was going to be a part of the school year, that it would include discussion about sex and that a local doctor would be the teacher. The parents were offered the opportunity of excluding their children if they so desired. None accepted this offer and since that time the course has been treated as a normal and regular part of the work of the school.

Expansion

Discussion groups with teachers at the respective schools take place regularly—to inform them of the scope of the programme and to invite their integration. Lecture or seminars on certain subjects of the course, notably adolescent problems and drugs, have been given at the local teachers' centre, to youth leaders in training, at young people's clubs, to the Samaritans and to parent-teacher associations—the latter often in collaboration with an officer in the drug squad of the police force. The course is given, in a condensed form, to students at the local general hospital nursing training school and forms the basis of instruction for health visitors both in college and those attending training courses.

For its success, this programme requires mutual respect between head teachers, county and divisional medical officers and the doctor undertaking the teaching. I have

been privileged to work with colleagues in both education and health, with whom a most satisfactory liaison has been possible.

Approximately 750 children have participated in this health education programme since 1968. Contrary to customary health and educational practice, no evaluation of its effectiveness has yet been made. Objective criteria of success can be measured only by changes in morbidity. Subjectively, however, satisfaction has been expressed by both the head teachers and the children and, if the absence of adverse comment from parents and the community in general may be considered the equivalent of acceptance, any subsequent evaluation has a good start. Perhaps the most realistic form of future expansion would be into teacher-training colleges and within the framework of in-service training for teachers.

Summary

A programme of health education based on the school is described in which human interaction is seen as the most important topic. It is given by a general practitioner attending school regularly as a teacher throughout the school year under the authority of the county health department.

Acknowledgements

I wish to thank Dr G. W. Knight, County Medical Officer, Hertford, and Dr C. Burns, succeeded by Dr W. Norman-Taylor, Divisional Medical Officer, St Albans, under whose authority the programme is given. My thanks are due to the headmasters of Boreham Wood Grammar School, Hillside School and Holmshill School, Boreham Wood—Mr M. Thomas, Mr H. Smith succeded by Mr K. Newson and Mr C. Willis respectively—and to my partners Drs C. Hodes, J. Marks, S. Nathan, H. Collins, J. Swaine and L. Smythe.

REFERENCES

1. Walt, F. P. (1971). *Journal of the Royal College of General Practitioners*, **21**, 479.
2. Hasler, J. C. (1968). *British Medical Journal*, **3**, 366.
3. McCoy, Y. (1968). *Practitioner*, **200**, 292.
4. Pike, L. A. (1969). *Journal of the Royal College of General Practitioners*, **17**, 133.
5. Ripley, G. D. (1969). *Health Education Journal*, **28**, 157.
6. Schofield, M. (1965). *The Sexual Behaviour of Young People*. p. 95. London: Longman
7. Ripley, G. D., Burns, C. and Dickinson, V. A. (1971). *Practitioner*, **207**, 351.
8. Ripley, G. D. *Practitioner* (in Press).
9. Chief Medical Officer of the Department of Health and Social Security (1970). *On the State of the Public Health*. p. 7. London: H.M.S.O.

APPENDIX

Human relationships		*Syllabus*
Interaction		
1. Biological —	The cell	Anatomy
	Genetics	Genes—elements of theory-environment
	Growth and development	Fertilization
		Nutrition
		Intra-uterine life
		Maternal environment (*e.g.* disease)
		Birth
		Primary sex characteristics
		Elements of anatomy and physiology
		Baby and infant development
		Endocrine system and hormones
		Puberty
		Secondary sex characteristics
		Menstruation
		Sexual maturation
		Coitus
		Pregnancy

2. Sociological	Social maturation Courtship Love making Fertility control Sexually transmitted diseases Marriage The family (compare alternative systems) Illegitimacy Abortion
3. Ethological	
(a) Personal identity—ontology	Emotional pressures—needs for gratification Instinct and environment Conflict Aggression Anxiety—frustration—pain Comfort habits—masturbation—drugs, Displacements—alcohol, smoking Interpersonal relationships Authority—peers Pair formation Sex role—hetero - or homosexuality
(b) Social identity	Ethics—code of conduct—moral code Decision making Sexual patterns and courtship Family—abortion—adoption Social services Current social problems (*e.g.* "test-tube babies") Death