The role of the general practitioner in health education

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The old North London Faculty of the College, met recently for a conference on *The Role of the General-practitioner team in health education.* Also invited were health visitors, district nurses, midwives and social workers. About 70 people attended. The words health education needed clarification, but the college subdivisions of the subject hardly seemed likely to warm up the discussion. These were clarified as: prevention and management, including self-managsment of disease; health promotion; better use by patients of the medical services. Clearer, though rather all-embracing, were the definitions: " helping people to prepare for life, or to reach their full potential; helping them to acquire knowledge, skills, and attitudes (the future general practitioner; or even just ' preventive medicine." It probably helped the interchange of ideas and attitudes that we were not quite sure what we were discussing.

Some of the health visitors had experience in group instruction to mothers or children, or of formal lectures to selected groups of patients. A few general practitioners had such experience too, but most of us are more familiar with the usual one-to-one interview. Many of the practitioners felt that we ought really to tell our patients what is good for them more actively, which led to the extreme suggestions that we ask everyone about their smoking, drinking, and contraception for example! Most of us felt ignorant about the more formal approach to patients by lectures, group discussions or even posters, and retreated behind the suggestion that perhaps the College should tell us what to do—or the government.

Others pointed out that unless you are talking to someone who is eager to listen, what you say will not be heard. Patients cannot even absorb instructions on treating scabies, while they are still wondering where they got it from, or whom they might have given it to. Education on smoking does not seem to have been very successful and exhortations to give it up, or to diet, seem likely to work only on the patient who is guilty, frightened, pregnant, or all three.

Health visitors pointed out how difficult it is to help someone who does not expect them to call, or who does not feel the need for help at that moment. General practitioners, apart from their work in some formal clinics, usually have the enormous advantage of responding to patients in distress, and have a wide choice of possible responses to what we see as the patient's needs. Gone are the days when the practitioners thought of social workers as " pretending to give services that don't exist to people who don't want them anyway." But even if we know each other better than that, the concept of a general-practitioner team seems still to be an ideal rather than an established fact for most of us.

Many speakers referred to the need for more communication within the team, for regular meetings, for avoiding conflicting advice, and more understanding of each other's work, perhaps by sitting in with each other more often. I had the impression that the social workers, and perhaps the health-visitors too, saw us practitioners as rather authoritarian and bigoted, *en masse* anyway. Perhaps this is how the public see us too. Certainly the doctors were more numerous and vocal at the conference.

The interview

Discussion turned to the technique of the interview, which is something we all have in common. There was soon the usual polarisation into two camps. On the one hand are those who enjoy their role as medical authorities, treating the patient's illness by telling him what to do, perhaps giving the backache patient a printed instruction card on how to lift and bend, and telling the antenatal patient exactly what to do and what to expect in advance. On the other hand are. those who enjoy seeing the patient behind the illness, and are more likely to try to understand, with the patient, why he should need to come to the doctor at that particular moment with backache, and help him find solutions in those terms.

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The patient, of course, needs both approaches, and nothing could be more disastrous than a doctor unable to move in both areas, the patient, and the illness. Doubtless a conference makes people wave one or other flag more extremely than we do with our patients in the consulting room.

Education by example

Finally there was the good advice that we should care for our own health, and that good health is infectious to our patients, but perhaps one should add—only if they want to catch it. On the whole it was an enjoyable and stimulating conference, enabling us to meet and understand a little better the non medical colleagues of the general practitioner.

DEATHS FROM ROAD ACCIDENTS

Country	*Number of deaths caused by motor vehicle accidents per 100 deaths from all causes*	
	All ages (%)	*15–24 years* (%)
Switzerland	*3·8*	*34·2*
Netherlands	*3·8*	*47·3*
Austria	*3·7*	*43·3*
France	*3·6*	*43·8*
Federal Republic of Germany	*3·6*	*50·2*
Finland	*3·3*	*32·5*
Denmark	*3·2*	*45·6*
Iceland	*3·1*	*24·1*
Belgium	*2·9*	*44·2*
Czechoslovakia	*2·5*	*28·1*
Portugal	*2·5*	*21·6*
Bulgaria	*2·3*	*20·3*
Greece	*2·3*	*28·8*
Northern Ireland	*2·2*	*41·0*
Sweden	*2·0*	*35·3*
Scotland	*1·8*	*33·2*
Norway	*1·8*	*27·2*
Poland	*1·8*	*14·9*
England and Wales	*1·8*	*41·9*
Ireland	*1·7*	*28·0*
Hungary	*1·3*	*14·4*

REFERENCE

Havard, J. D. J. (1973). *World Health Organization Chronicle*, **27**, 83.