

Opportunistic health promotion: quantity or quality?

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SUMMARY. *A cohort of 130 working class mothers has been studied in depth over five years to quantify the extent of recording and counselling of lifestyle problems by general practitioners and their staff. Clinical records and mothers' personal accounts at two home interviews five years apart provide the data for this work. Fifty-nine per cent of women had one or more aspects of lifestyle recorded in their records, the commonest being smoking habits. Despite this evidence for good coverage of smokers in the population, alcohol and exercise problems were under-recorded. Clinical records only included details of advice given and follow-up plans for lifestyle problems in 40% of patients' records yet the women themselves remembered advice being given in 48% of cases. An analysis of the womens' accounts in conjunction with the clinical records revealed that over three quarters of those receiving advice remembered it several years later. The primary care team was most likely to target advice and plans on women who were heavy smokers and very obese.*

This study shows that clinical records underestimate the amount of lifestyle counselling which is conducted in general practice and that a surprising number of working class women remember and act on the advice from their doctors. The implications for clinical recording of lifestyle factors are discussed.

Introduction

THE government's recent white paper¹ confirms that the primary care team has an important role in lifestyle counselling and general health promotion. Such activities have long been cited to support the case that primary care is a separate discipline with its own unique contribution to make to health care.² However, apart from studies of advice about smoking,³ there are few published accounts of the outcomes of giving advice during the primary care consultation. Audits of this aspect of practice work are also rare and the few that have been published have focused on the recording of risk factor status⁴⁻⁶ rather than details of the type of intervention employed or outcomes measured by patient recall and action. Thus, while lip service is paid to its value, doctors and nurses have not subjected their counselling about lifestyle to the same systematic audit as they have other areas of prevention, for example screening procedures and immunizations.

The reasons for this must include the problems of extracting relevant data from the records and the feeling that records probably underestimate the true extent to which health promotion is undertaken within the consultation as advice about lifestyle

is rarely noted. Doctors are unlikely to audit their records if they have reservations about the quality of the data. What is needed is more evidence that it pays to keep better records and that counselling has some effect on patients.

This study is part of a five year follow-up study of a cohort of working-class mothers whose health beliefs and behaviour were first studied in 1982.^{7,8} This group of women had originally been chosen for study because of evidence that lower socioeconomic groups are most at risk in health matters,^{9,10} being the least likely to take advantage of preventive services offered and least likely to respond to the effort of those concerned to promote health. Traditional audit methods were used to assess the documentation of lifestyle problems by the primary care team and to compare this information with the patients' own accounts. The paper then discusses this dual audit technique for monitoring the extent and efficacy of lifestyle counselling in primary care.

Method

The practice was staffed by members of the department of general practice, University of Wales College of Medicine. The original sample consisted of 204 mothers aged 25-40 years who were classified as social class 4 or 5 (on the basis of their husband's occupation) or were unclassified since they were both single and unemployed. Further details can be found in earlier papers.^{7,8} Five years later in 1987 130 (64%) were still available to be reinterviewed, 49 (24%) had moved away from the practice and 25 (12%) refused to be interviewed again.

The practice records for the women interviewed were audited by applying a standard protocol for determining whether any lifestyle problems, basic screening procedures and life events¹³ had been recorded over a period of five years (January 1982 to January 1987). (The term lifestyle refers to individual habits such as smoking, drinking, diet, exercise.) The total number of consultations with the primary care team was also extracted. In the analysis a distinction was made between simply recording the existence of a lifestyle problem, whether a clinical note was made of advice given or whether there was a record of any ongoing plan to deal with the problem.

Interviews were semi-structured and carried out in the respondents' homes by one of the authors (R.P.) and a research assistant. In both the 1982 and 1987 interviews sociodemographic information was collected (Table 1) as well as data about body mass index (self-reported height and weight) and the women's health practices including smoking, alcohol use, level of physical activity, eating habits, sleep patterns and weight control. Coding followed the schedule developed in the Alameda county studies in the USA to produce a health practices index (range 0-7) which has been shown to correlate strongly with subsequent morbidity and mortality.¹¹ In the present study the women were asked additional questions about whether a doctor or nurse had asked about aspects of their lifestyle or given advice about changing behaviour during the past five years. Their reactions to such advice were explored and they were asked if they had taken any action. Linear analogue scales (range 0-100) were used to measure the degree of stress currently experienced in relation to financial matters, work and relationships with husband and children. The number of negative life events was determined for each respondent based on her own account of what had hap-

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Table 1. Demographic details of the sample of women in 1987.

	Mean (range)	Number (%) of women (n = 130)
Age (years)	35 (30–45)	
Number in household	4.34 (1–9)	
Has children under 16 yrs in household		108 (83)
<i>Education</i>		
Left school as soon as possible/no further education or training		89 (68)
Stayed on at school and/or had further education/training		41 (32)
Had further education/training in last 5 years		38 (29)
<i>Marital status</i>		
Married		97 (75)
Single/separated/divorced		33 (25)
<i>Employment</i>		
Employed now, full or part-time		77 (59)
<i>Husband's work status (n = 97)</i>		
Employed		72 (74)
Unemployed		25 (26)
Unemployed one year or more		23 (24)
<i>Religious commitment</i>		
Attend church/chapel regularly		23 (18)
<i>House tenure</i>		
Private buyer		31 (24)
Council buyer		57 (44)
Council tenant		42 (32)

n = total number of women in sample.

pened to her over the last five years and was weighted according to the scoring system devised by Gottlieb and Green¹² in their national study of the health practices of American adults. Negative life events include bereavement, marital problems, serious illness or hospitalization and financial, work and family problems. Finally, a linear analogue scale (range 0–100) was used in both 1982 and 1987 to give a measure of how the women's perceptions of their own health had changed over the five years studied.

To compare the characteristics of the women who had lifestyle problems recorded with those who had no recorded problems, standard sociodemographic variables and a number of attitude and behavioural measures derived from the second interview were compared as well as the items collected by the protocol. One-way analysis of variance was used to test for the level of significance between differences in the continuous variables while the chi-square test was used for the discrete variables. The data was coded and analysed on computer using the Minitab statistical package.

Results

Over the five year period a total of 3454 consultations were reviewed in 130 patients' records (mean 5.31 per annum). Seventy-seven women (59%) had one or more lifestyle problems recorded during the five year period, most commonly smoking and problems with weight (Table 2). Over 90% of eligible women had had at least one cervical smear recorded and over 83% had a record of their blood pressure during the five years studied (Table 3). The high proportions of women with cervical smear results recorded was due to a recall system being in operation.

Only half of the smokers and two-thirds of the overweight

Table 2. Documentation of lifestyle problems and advice in the practice records.

	Number (%) of women (n = 130)		
	Problem noted	Problem noted and advice recorded	Problem noted, record of advice and plan made
Smoking	56 (43)	28 (22)	12 (9)
Weight	35 (27)	23 (18)	14 (11)
Diet	12 (9)	10 (8)	3 (2)
Alcohol	7 (5)	1 (1)	0 –
Exercise	6 (5)	6 (5)	2 (2)
Relaxation	5 (4)	1 (1)	0 –
Any data recorded	77 (59)	52 (40)	26 (20)

n = total number of women in sample.

Table 3. Documentation of screening procedures in the practice records.

	Number (%) of women with record in 5 year period (n = 130)		
	None	Once	Twice or more
Cervical smear test	10 (8) ^a	64 (49)	53 (41)
Blood pressure measurement	22 (17)	23 (18)	85 (65)

^aThree of the 13 women with no record of a cervical smear test had had a total hysterectomy and are excluded here. n = total number of women in sample.

women who had their problem noted also had a record of advice given in the clinical notes and a smaller proportion still had detailed plans recorded (Table 2).

Targeting of advice

In the 1982 survey the results for the 130 women were as follows: 71 (55%) had reported they were smokers; 42 (32%) were overweight (that is above the range of 19–24 on the body mass index); 28 (22%) took little or no physical exercise; and 23 (18%) reported that they typically had five or more drinks at any one occasion.

Only 28 (39%) of the 71 smokers had a clinical record of advice about smoking yet 35 (49%) of them reported that they had been counselled about smoking by their doctors. This degree of under-recording of smoking advice is not surprising given the pace of work in general practice but there was evidence that heavy smokers were receiving more focused attention than the rest. Thus 69% of the 32 heavy smokers (20+ cigarettes per day) recalled being counselled compared with 33% of the 39 women who smoked less ($\chi^2 = 8.82$; $df=1$; $P<0.01$).

Those who were overweight were significantly more likely to have advice recorded in their notes and to report they had been counselled than those who were not overweight at the time of the first interview. Thus 40% of the 42 overweight women had advice documented compared with 7% of the remaining 88 women ($P<0.001$) and 29% of the overweight women reported receiving advice compared with 2% of the rest ($P<0.001$). In contrast to the pattern of smoking advice, therefore, fewer women remembered receiving advice than the doctors recorded in the notes. Ten women were very obese (30+ on body mass index) and interestingly seven of these had advice recorded in their notes but only one woman reported having had advice when she was interviewed.

There was much less evidence that counselling was directed at the appropriate people who were at risk for alcohol and exercise related problems but this was due largely to the low levels of counselling overall in these areas. Of the 28 women identified as taking very little physical exercise only six had this fact recorded and only one had a record of advice being given; four reported having received advice. Of the 23 women drinking five or more drinks at any one time only seven had a record of this fact and only one had advice documented; none mentioned being counselled.

There was a clear association ($P<0.001$) between patient recall of counselling when interviewed and a more detailed record than simple identification of the problem: in 77% of women who recalled being given advice, there was a more detailed clinical record to confirm it (Table 4).

Table 4. Relationship between recall of counselling and the recording of the information in clinical notes.

	Number (%) of women	
	Clinical record of advice	No record of advice
Advice recalled	40 (77)	22 (28)
Advice not recalled	12 (23)	56 (72)
Total	52 (100)	78 (100)

$\chi^2 = 29.68$; $df = 1$; $P<0.001$.

Reactions to counselling

Those who recalled being given advice on a specific topic were asked how they had felt and, specifically, whether they were surprised, annoyed or worried by the intervention. Of 37 women who mentioned smoking advice 36 (97%) claimed not to be surprised and 34 (92%) were not annoyed. Of 14 women who mentioned weight 13 (93%) said they were not surprised or annoyed. However, rather different reactions were reported by nine women who remembered being advised about exercise; only two were not surprised and six were not annoyed.

The respondents were also asked what, if anything, they had done after being counselled. Of the 37 smokers who recalled being counselled, 18 (49%) had tried to stop and five (14%) had maintained the improvement up to five years later. All those counselled about their weight had taken action and eight (57%) reported maintained improvement. Of the nine women who had been told about exercise, two had done nothing, five had tried (with two of these maintaining their behaviour) while the remaining two gave no reply to this question.

Differences between those with and without a record of lifestyle problems

No significant differences were found between the 77 women who had lifestyle problems recorded and the 53 with no problems recorded for the following variables, irrespective of the level of documentation in clinical notes: marital status; number in household; husband's work status; extent of participation in outside organizations; level of religious commitment; perceived support from friends or relatives; degree of stress experienced as wife or parent; beliefs in control over health. However, those who had one or more lifestyle problems noted in their records had consulted significantly more often over the period ($P<0.01$) and scored lower on the index of health practices, that is had poorer health-related behaviour ($P<0.05$).

Both of these factors also distinguished between the 52 women who were recorded as being given advice and/or a plan and the 78 who had only a problem noted or had had no record of any kind about lifestyle problems (Table 5). In addition it was found that those with a record of advice were more likely to be unemployed, have more dependent children, rate themselves as having more stress about their financial situation and score higher on the scale of negative life events. Thus women for whom the doctors made an effort to record the nature of advice given rather than simply noting the problem were significantly different from the rest of the sample.

Analysis of the women's own perceptions of their health over the five years showed the mean rating for 77 women with no lifestyle problems recorded in their clinical notes did not change significantly over the five year period (68.7 to 70.4) whereas the 53 women who had lifestyle problems recorded started from a lower baseline level ($P<0.01$) and improved significantly over the five years (60.1 to 66.4; $P<0.02$).

Discussion

These data do not demonstrate the efficacy of clinical counselling but they do provide evidence that family doctors were targeting their efforts at those at greatest risk and that improvement in self-perceived health status over time is possible in this group. In addition, when family doctors took the trouble to record advice or a plan to help patients modify lifestyles, the recall and response by patients over the next few years was remarkably high. The results are encouraging because this study was conducted on lower social class women with young children, a group which is often regarded as being resistant to health promotion.

Of course, our remarks refer only to those patients whom the doctors had selected for special attention and whose details were carefully recorded in their clinical records. A conventional record audit would probably have given a more negative picture.¹³

The study raises certain issues in relation to the promotion of healthy lifestyles. Is comprehensive coverage of the popula-

Table 5. Differences between women who had a record of advice for a lifestyle problem(s) in their notes and those who did not.

	No record of advice given ^a (n = 78)	Record of advice given (n = 52)	
Percentage unemployed	29	58	$\chi^2 = 10.28$; $df = 1$; $P<0.01$
Mean no. of children under 16 yrs (range 0-7)	1.48	2.15	$F = 6.98$; $df = 1$; $P<0.01$
Mean no. of consultations over period (range 3-82)	21.90	33.58	$F = 15.87$; $df = 1$; $P<0.01$
Mean no. of negative life events (range 0-24)	1.98	4.11	$F = 6.94$; $df = 1$; $P<0.01$
Mean score on health practices index (range 0-7)	4.68	4.01	$F = 7.36$; $df = 1$; $P<0.01$
Mean score on financial stress scale (range 0-100)	42.0	56.0	$F = 5.69$; $df = 1$; $P<0.05$

^aProblem may or may not have been noted.

tion a desirable or realistic target for primary care teams? Is selective targeting of high risk groups occurring in general practice? Is the standard of clinical recording a marker of the likely outcome (quality) of the consultation?

The issue of population coverage of lifestyle risks is an epidemiological concept rather than a patient-centred one and has sometimes been interpreted, in the general practice context, as providing the statistics to show that every patient on the list has had appropriate screening or lifestyle intervention. Such an interpretation is likely to be fostered by the white paper on primary health care¹ which encouraged doctors to feel that high population coverage in screening may also receive financial rewards. An alternative approach, illustrated by our results, is to argue that total coverage may not be necessary or desirable provided doctors can demonstrate that they are identifying those most at risk for smoking and obesity among their patients to a level which approaches the proportions derived from national survey data.^{14,15}

In whole population screening, general practitioners may be in danger of raising levels of anxiety or opposition among their patients and creating iatrogenic disease. The implications of false positives in cervical and breast screening are beginning to give some people cause for concern. Already there is evidence that screening for hypertension can have significant effects not only on patients' self-image and symptomatology¹⁶ but also on levels of absenteeism from work.¹⁷ This question is particularly topical for general practitioners in the light of the current vogue for lipid screening of whole populations without consideration of opportunity costs or the effect of increased attendance by the 'worried well' with borderline lipid values.¹⁸

The thrust of this paper has been to suggest that general practitioners can be successful in concentrating counselling on those at greater risk. In our sample, the doctors were identifying percentages for smoking and obesity that approach those found in recent national surveys^{12,14} and it was the heavy smokers and the obese (as opposed to the merely overweight) who had detailed advice and management plans recorded. Patients do not always find doctors' exhortations to modify their lifestyle acceptable and it is important to note that this advice was acceptable to over 90% of patients with these problems. Both smoking and weight are, of course, recognized by doctors and lay people as health-related problems and legitimate issues to be raised in the consultation.

The position with alcohol and fitness problems was rather different; these were under-recorded when judged by national survey data.^{12,14} Although doctors were recording major drinking problems their under-recording of moderate drinking probably reflects the slow diffusion of concern about moderate alcohol use, particularly for women, and doctors' ambivalence over the value of such data. The documentation of smoking was in a similar state 10–15 years ago and it is likely that, given current concern over alcohol use, progressively higher levels of recording will be seen during the next decade.

Exercise was the most paradoxical lifestyle factor because seven out of nine patients were surprised that their general practitioners should raise the topic, perhaps because it does not fit with the stereotype of 'doctor's business'. Attempts to achieve 100% coverage in the context of exercise advice would have to be very discreet (and probably time consuming) or risk rejection by patients.

The advocates of full 'coverage' in population terms must be careful to consider the opportunity costs of this philosophy and doctors (and perhaps nurses) who are achieving considerable success with selective targeting of higher risk groups need to consider whether time spent on more comprehensive coverage of

all patients will be either efficient or consistent with patient-centred clinical practice.

This study also raises a questionmark over the standard of clinical recording of lifestyle problems. Only a minority of recordings included details of advice or a plan of management for smoking. Even obesity and alcohol abuse often had limited plans of management recorded. Yet it was also shown that the few patients selected by doctors for detailed records were much more likely to remember and act on the counselling. One possible interpretation of this finding is that more comprehensive documentation of advice given during consultation reflects the greater effort expended on counselling on that particular occasion, leading, in turn to higher levels of recall by the patient at a later date. This is despite the fact that, as a group, these patients with detailed records were characterized by higher social risk factors (for example, unemployment, single parent) than those who had a lifestyle problem defined without advice or plan. It seems logical to record advice and plans for all problems of lifestyle, even if only to state 'patient not motivated to change'. This will help other clinicians to avoid repetitive unwanted counselling and encourage a more negotiating attitude to patients. However, we do not claim that more comprehensive plans for all patients will lead to better outcomes for all because the association we have shown in this cohort may be lost if doctors become less selective in which patients to target. There is a need for a study to compare level of intervention with outcome in a wide range of people.

Finally, this study shows that the success rate for lifestyle change judged by the patients themselves was much higher than the clinical records revealed. That the general practice outcomes proved to be better than the apparent clinical process will come as no surprise to the conscientious practitioner because many of the most important aspects of general practice are the least easily documented and measured and the most sophisticated record systems are unlikely to ever reflect the realities of human behaviour.

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