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Promoting exercise in primary care

Sir,

There is increasing evidence that physical inactivity increases the risk of coronary heart disease[1] and other ill health, while a nationwide study confirmed low levels of physical activity in England.[2] *The health of the nation* recommends increased physical activity and this is reflected in the 1993 amendment to the general practitioner contract.[3] To qualify for band three remuneration, general practitioners are required to record the level of physical activity of their patients. They are also encouraged to assess the patient's need to change activity level, to intervene appropriately and negotiate for such change and to follow up the intervention.

In order to assess the knowledge and attitudes to exercise of doctors and nurses working in primary care, a selected sample of general practitioner trainers and practice nurses were interviewed. Trainers were selected because they are among the best informed in their specialty, are trained in educational methods and subject to regular reaccreditation. The preliminary results are reported here.

In the study, which was undertaken in 1994 and supported by the British Heart Foundation, 30 randomly selected general practitioner trainers from the four Thames regional health authorities were invited by letter to participate, and then were telephoned to make an appointment. Twenty trainers agreed to take part (67%) and so a semi-structured interview was carried out with each trainer and the associated practice nurse. A nurse was available in 19 of the 20 practices. All participants were asked about the relationship of inactivity to coronary heart disease risk; information or training received about promoting healthy exercise; their confidence about their own ability to inform patients about healthy exercise; their assessment of their effectiveness in changing behaviour; and their views about which population groups would be most amenable to behaviour change.

In order to explore the importance attached to physical inactivity participants were asked to rank five factors in order of their perceived coronary heart disease risk (Table 1). There was more consistency among doctors than nurses but the overall results were similar.

Sixteen general practitioners could not recall receiving any communication about promoting healthy exercise from their family health services authority or director of public health, two reported that they had received information and two were unsure. Eight nurses had received some information or training, five of whom felt confident about their ability to promote healthy exercise. None of the nurses and four of the general practitioners mentioned *Better living, better life,* the Department of Health sponsored resource manual for lifestyle interventions in primary care.[4]

Ten general practitioners and nine nurses were uncertain about their effectiveness in promoting healthy exercise; three general practitioners and one nurse thought they were probably ineffective. Seven general practitioners and nine nurses were confident about their effectiveness. There was no agreement on the patient groups for whom they thought they were most effective; the replies ranged from 'under fives' to 'over 60s', from 'the uneducated' to 'the educated'.

Exercise is now recognized as a key protective factor against coronary heart disease, yet if this sample of well-informed general practitioners and nurses is typical, little support or training is available even though primary care teams are expected to be actively involved in promoting healthy exercise. General practitioners and nurses were equally unsure about their effectiveness in improving patients' exercise patterns although some nurses who had received some training were confident in their knowledge about the health benefits of exercise. The communication and motivational skills required to change exercise behaviour have not been conveyed to staff, possibly because the nature of these skills is poorly understood.[5]

Despite the current enthusiasm for prescription for exercise schemes, evidence of the effectiveness of primary care interventions in increasing exercise uptake that produces enduring improvement in health is not yet available.[6] Without training in behaviour modification, and in the absence of sound evidence of efficacy and effectiveness, the uncertainty expressed by these general practitioners and practice nurses about their role in promoting healthy exercise seems entirely reasonable.

Table 1. General practitioners' and nurses' ranking of the importance of five risk factors for coronary heart disease (CHD).

	Importance of risk factors in CHD									
	Ranked by 20 GPs					Ranked by 19 nurses				
	1	2	3	4	5	1	2	3	4	5
Smoking	18	2	–	–	–	12	6	1	–	–
High blood pressure[a]	1	14	4	–	–	4	10	1	3	1
Fatty diet[a]	–	2	7	6	4	3	1	11	3	1
Lack of exercise	–	5	5	10	–	1	–	3	8	7
Stress	1	2	4	2	11	1	2	3	5	8

[a]One general practitioner did not rank risk factor.

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Personal child health records

Sir,

The national, parent-held, personal child health record, introduced in 1990, is intended to provide a single comprehensive record of a child's health and development and to replace the many varieties of parent held records previously in use.[1,2] Benefits will be greatest if the personal child health record is indeed widely used and a genuinely national record. A survey of district health authorities in England in 1993 explored the progress of the record towards fulfilling these goals. Of 145 districts, 99.3% responded to a questionnaire addressed to directors of public health, who were asked to pass them on to the appropriate person if unable to answer the questions themselves.

The personal child health record appears to have been rapidly adopted, particularly during 1991 and 1992. By mid-1993, the record was already used throughout 77 of 144 districts (53.5%), at least for new births. In a further 11 districts (7.6%) it was used in part of the district. Twenty two districts (15.3%) had definite plans to introduce this record. The remaining 34 districts had not introduced the record and had no plans to do so. There were 96 provider units in the 88 districts already using the record. Of the 96 provider units 76.0% had made local modifications; 41.7% had modified one or two sections only and 34.4% had made more widespread modifications.

Virtually all the provider units who commented felt that the personal child health record was being used by parents and health visitors on the majority of appropriate occasions (94.4% of 72 respondents and 97.4% of 76 respondents, respectively). Use by other professional groups was less satisfactory: 47.9% of 71 respondents reported general practitioners used the record on the majority of appropriate occasions, 35.8% of 67 for paediatric departments, 14.9% of 67 for accident and emergency departments, and 11.9% of 67 for other hospital departments. Several respondents commented spontaneously that general practitioners used the record for child health surveillance but much less well during other contacts.

Twenty seven units had audited the use of the record. Although others based their responses on less systematic feedback, the finding of poor use by some groups is nevertheless plausible. There are several reasons why general practitioners and hospital staff could be expected to be slower to use the record; these include difficulties using the record when a child is acutely ill, having less to gain from the record, less chance to reduce other record keeping, and inadequate training. Thus, this survey suggests that although the personal child health record is being widely adopted, there may still be some way to go before it is always a comprehensive record.

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Trainees' on-call arrangements

Sir,

I read with interest the survey on trainees' out of hours work reported by Elizabeth Goyder and Barbara Kneale (letter, November *Journal*, p.533). A similar survey was carried out at a regional study day for trainees in the West Midlands region in December 1993. Although the results are similar my conclusions are different.

A total of 111 people attended the study day, of whom 94 (85%) returned completed questionnaires. Most trainees were regularly on call, the commonest rota being a one in four but two had no general practice on-call experience at all. The hours of 13 respondents (14%) were limited either by a deputizing service or because their trainer was in a cooperative where a group of practices shared the on-call commitment. One of the 13 respondents was on call one night every three weeks. In common with Goyder and Kneale's results, nearly all trainees were doing the same on-call rota as their trainer. Trainees felt that there should be a balance between service commitment and learning opportunity, and that the value of the trainee year was lessened when a trainee was too tired.

As with principals, trainees' views of 24-hour cover varied. Of respondents, 33% felt that both trainees and principals should be on call at night, 35% felt that neither should. The remainder thought that it should be optional for the trainee, the principal or both. Overall, 57% of respondents thought that general practitioners should not be obliged to provide 24-hour cover for their patients.

Some trainees thought that continuity of care was not the issue when most doctors practise in group practices, and that the quality of care from tired doctors at night and in the following morning's surgery was likely to be reduced. Others commented, however, that professional integrity and the personal quality of general practice might be lost with the decision not to provide out of hours cover.

An area provoking most comment was the problem of unaccompanied doctors going into unfamiliar areas at night. Of trainees, 31% admitted to having felt threatened at some time during the day or at night when on call. Three trainees had called a police officer to accompany them on visits and three others indicated that they expected to do so at some point. One trainee had reported a patient's threatening behaviour to the police.

This survey shows that there is an enthusiasm among trainees to do the work, but that there are worries surrounding that commitment that are similar to those of principals.

The finding that 57% of trainees thought general practitioners should not be obliged to provide 24-hour cover compares with the results of another study which found that of 223 West Sussex general practitioners who had been in practice for a mean of 12 years, 86% felt that a general practitioner should be able to opt out of 24-hour cover.[1]

One of the features of general practice and for many one of its attractions as a career, is the variation in work patterns. Currently, trainees are equally remunerated whatever the on-call work. However, a night on call is not the same in all practices, making comparisons and standard setting difficult. With the fall in the numbers applying for trainee posts it is important that junior doctors consider these differences. Some districts in the West Midlands region have a good practice guide compiled by trainees leaving posts, containing details such as the rota, the support and the workload. If this were more widely established and available, perhaps from the regional advisers office, potential trainees could make a more informed choice.

Trainee pay already equates poorly with hospital junior doctors so there is a danger that the on-call issue could also become one of pay. Efforts should be made to show trainees the variation in general practice, and prepare them well for whatever style they choose.