

# Our Healthier Nation: are general practitioners willing and able to deliver? A survey of attitudes to and involvement in health promotion and lifestyle counselling

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## SUMMARY

**Background.** The recent Green Paper, *Our Healthier Nation*, identifies professional advice on healthier living as a key component of its national contract for health. General practitioners (GPs) are ideally placed for this work. However, previous research has reported a discrepancy between patients' expectations of lifestyle advice from GPs and their receipt of such advice.

**Aims.** To describe GPs' current attitudes to and involvement in health promotion and lifestyle counselling, and to track changes in these areas over recent years.

**Method.** A postal questionnaire survey of a random sample of 430 GPs, one per practice, from all general practices in Leicestershire, Derbyshire, and Nottinghamshire. GPs who had not responded after two weeks received a reminder telephone call plus two follow-up questionnaires.

**Results.** Four hundred and eleven GPs were eligible for the survey, which yielded a response rate of 68% ( $n = 279$ ). GPs reported spending an average 16% of practice time on prevention and 79% reported educating patients about lifestyle risk 'most' or 'all of the time'. Solo GPs spent more time on prevention than GPs from group practices. Most enquiries and interventions related to smoking behaviour. GPs felt most effective in changing patients' use of prescription drugs, and the largest reported difference between current and potential effectiveness in helping patients change lifestyle behaviour, after information and training, related to reducing alcohol consumption.

**Conclusions.** Despite an increasing workload, GPs remain positive about health promotion and lifestyle counselling. Over the past 10 years, there has been an increase in routine enquiries about lifestyle behaviour, but confidence about effectiveness in helping patients change lifestyle behaviour remains low. More training and support concern-

ing lifestyle intervention is required by GPs in order for them to contribute effectively to the Government's health promotion programme.

**Keywords:** general practice; health promotion; lifestyle counselling.

## Introduction

THE UK Government's recent Green Paper, *Our Healthier Nation*,<sup>1</sup> targets heart disease, strokes, cancers, suicides, and accidents, and identifies professional advice on healthier living as a key component of its national contract for health. General practitioners (GPs) are ideally placed for preventive medicine and health promotion in the form of early enquiry about patients' lifestyles and provision of information and counselling concerning risk factors. Two-thirds of the population visit their GP one or more times each year and 90% at least once in five years.<sup>2</sup> Moreover, patient attitudes towards lifestyle enquiry and intervention by GPs are positive.<sup>3-5</sup> Lauritzen<sup>6</sup> reported considerable patient interest in participating in such programmes. However, there appears to be a discrepancy between patients' expectations of lifestyle advice from GPs and the receipt of such advice.<sup>3-5, 7</sup> There also appears to be a discrepancy between patients' reported interest in lifestyle issues and their perception of GP interest.<sup>5</sup>

Previous research has reported that, although GPs have endorsed lifestyle counselling as part of their role,<sup>8-11</sup> they are also cautious about its effectiveness in achieving change in patient behaviour,<sup>9</sup> and have encountered difficulties in developing this approach in practice.<sup>10</sup> These findings may explain the apparently low levels of lifestyle intervention by GPs in the UK<sup>7</sup> despite the introduction of contractual strategies for this work by the Government.<sup>12,13</sup> This study describes GPs' attitudes to and involvement in health promotion and lifestyle counselling as reported in 1995-1996, and assesses if there have been any changes in these over recent years. It is the first strand of a World Health Organization (WHO) Collaborative Project on implementing and supporting early and brief alcohol intervention in primary health care.<sup>14</sup>

## Methods

The study was a postal survey of a random sample of 430 GPs from the Midlands who were listed as principals in 1995. One GP was randomly sampled from each practice in Leicestershire ( $n = 152$ ), Derbyshire ( $n = 158$ ), and Nottinghamshire ( $n = 120$ ). Each GP was sent a questionnaire with a personalized covering letter and a pre-paid addressed envelope. The covering letter explained the background to the survey and confirmed that local research ethics committee approval had been granted. Two weeks after the original questionnaire was sent, a telephone call was made to all non-responding GPs to encourage them to return their questionnaires. Two further questionnaires accompanied by revised covering letters and pre-paid envelopes were sent out to all non-responding GPs at monthly intervals thereafter.

The 132-item self-administered questionnaire was developed

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as part of the WHO Collaborative Study and was pre-tested and piloted on 160 GPs from 11 countries. The first part of the questionnaire examined attitudes, perceived skills, and current practices relating to preventive medicine, including several areas of lifestyle intervention. The remainder of the questionnaire focused on GPs' involvement in alcohol intervention work; these data are reported in detail elsewhere.<sup>14</sup> All data were coded and entered onto a database (SPSS for Windows).

## Results

Telephone enquiries revealed that 19 GPs had either retired or left general practice and so the eligible sample size for the survey was 411 GPs. Two hundred and seventy-nine GPs returned their questionnaire to the study centre; an overall response rate of 68%. There were no significant differences between the three health districts in response rates, which were 66%, 68%, and 70% in Leicestershire, Derbyshire, and Nottinghamshire respectively.

The average age of GP responders was 43.7 years (standard deviation [SD] = 8.5) and 24% were female. Over three-quarters (77%) worked in group practices, with an average of three partners per practice (SD = 1.9). Half of the sample described their practices as urban, 16% as rural, and 34% as mixed urban/rural. The average time spent practising as a GP was 13 years (SD = 8.3), and responders spent an average of 5.4 days (SD = 1.0) per week in practice. Forty-eight per cent of the sample reported seeing more than 150 patients per week in practice and 39% between 101 and 150 patients per week.

### Current practices in preventive medicine

GPs reported that, on average, 16% (SD = 10.8) of their total clinical time was spent on preventive medicine. There were no significant differences in the reported proportion of time spent on prevention between male and female GPs or those from urban, rural, and mixed practices. There was also no relationship between GP age and reported proportion of time spent on preventive medicine. Solo practitioners reported spending significantly more time on prevention than GPs from group practices ( $\chi^2 = 5.1$ ;  $df = 1$ ;  $P = 0.02$ ). However, among group practices there was no significant difference in reported time spent on prevention between GPs with different numbers of partners.

The majority of GPs estimated that, during preventive check-ups, they educated or advised their patients about lifestyle or health risks 'most of the time' (55%) or 'all the time' (24%), with none indicating that they would 'rarely' or 'never' do so. During an illness visit (that is, one with specific symptoms), 61% of GPs indicated that they would educate or advise their patients about lifestyles 'some of the time' and 33% 'most of the time'.

Just over half of the GPs (54%) indicated that they placed a 'somewhat high' priority on disease prevention, with a further 21% placing it 'very high' and only 1% placing it 'very low'. When asked how their emphasis on disease prevention compared with other medical practitioners, 69% felt the emphasis was 'somewhat more' and 13% felt it was 'much more'.

### Relative importance of different lifestyle behaviours in health promotion

Two hundred and thirty (82%) GPs rated seven lifestyle behaviour patterns in terms of importance in promoting good health in patients. Rating was on a four-point scale (very important [4 points] to unimportant [1 point]). Table 1 illustrates GPs' perceptions of the relative importance of different lifestyle behaviours in promoting patients' health. Not smoking was reported as being most important in health promotion and stress reduction reported as least important.

### Involvement in lifestyle counselling

Table 2 shows the extent to which GPs obtained information from patients about lifestyle behaviour. Information was obtained most frequently about smoking and alcohol consumption and least frequently about stress and illicit drug use. Figure 1 shows the proportions of GPs who reported being 'prepared' or 'very prepared' to counsel patients on the seven lifestyle issues. Rating was on a four-point scale (very prepared [4 points] to very unprepared [1 point]). GPs were most prepared to counsel on smoking issues and exercise and least prepared to counsel concerning stress and illicit drug use.

### Effectiveness in helping patients change lifestyle behaviour

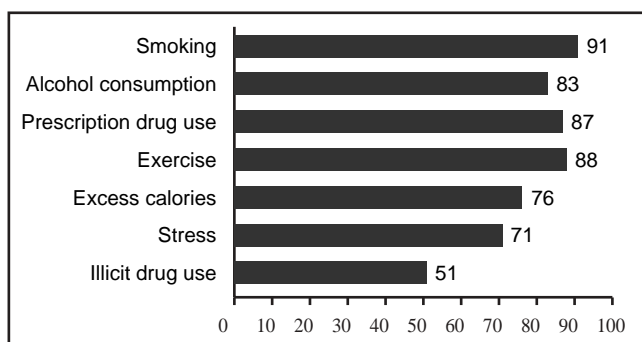
Finally, GPs indicated on a four-point scale (very effective [4 points] to very ineffective [1 point]) their current perception of their effectiveness in helping patients change lifestyle behaviour and their potential effectiveness if provided with adequate information and training. Figure 2 shows the proportions of GPs who currently felt 'effective' or 'very effective' in changing patient behaviour and those who felt that they could be so after adequate information and training. For all categories of lifestyle behaviour, potential effectiveness was perceived as being greater than current effectiveness. The greatest difference between current and potential effectiveness was reported for reducing alcohol consumption.

**Table 1.** Relative importance of lifestyle behaviour in promoting good health: numbers and percentages of GPs (n = 230) rating lifestyle behaviour as 'important' or 'very important'.

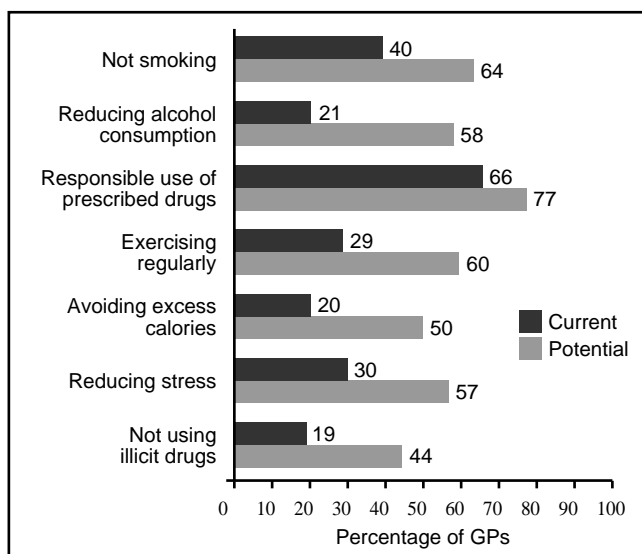
| Lifestyle behaviours                  | Number of GPs | Percentage |
|---------------------------------------|---------------|------------|
| Not smoking                           | 230           | 100        |
| Exercising regularly                  | 212           | 92         |
| Not using illicit drugs               | 209           | 91         |
| Drinking alcohol moderately           | 177           | 77         |
| Responsible use of prescription drugs | 175           | 76         |
| Avoiding excess calories              | 173           | 75         |
| Reducing stress                       | 166           | 73         |

**Table 2.** Percentages of GPs collecting information about lifestyle behaviours (n = 230).

| Behaviours                | Always | As indicated | Occasionally | Rarely/never |
|---------------------------|--------|--------------|--------------|--------------|
| Smoking                   | 53     | 44           | 3            | 0            |
| Alcohol consumption       | 32     | 58           | 9            | 1            |
| Use of prescription drugs | 28     | 50           | 20           | 2            |
| Exercise                  | 16     | 63           | 20           | 1            |
| Diet/nutrition            | 9      | 61           | 28           | 2            |
| Stress                    | 3      | 66           | 29           | 3            |
| Illicit drug use          | 8      | 45           | 35           | 12           |



**Figure 1.** Percentages of GPs (n = 230) who were prepared or very prepared to counsel patients on lifestyles issues.



**Figure 2.** Percentages of GPs (n = 230) who reported feeling effective or very effective at helping patients change lifestyle behaviour both currently and potentially (after adequate training and support).

## Discussion

Responders in this survey appeared to be representative of United Kingdom (UK) GPs with regard to age, sex, years in practice, practice type, and numbers of patient consultations per week.<sup>15</sup> Previous UK research has suggested that younger doctors may be more amenable to preventive medicine<sup>16,17</sup> and that female doctors may be more involved in preventive general practice.<sup>18</sup> No such trends were shown by our responders. However, solo GPs reported spending a greater proportion of practice time engaged in preventive medicine than those in partnerships.

General practitioners in this survey estimated that preventive medicine took up approximately 16% of total general practice clinical time. This proportion is similar to figures reported for the United States<sup>19</sup> and Sweden,<sup>20</sup> and slightly less than in New Zealand.<sup>8</sup> GPs were positive about their involvement in disease prevention and lifestyle counselling, as 75% placed disease prevention 'somewhat' or 'very' high in their overall clinical priorities, while 79% reported that they educated patients about lifestyle risk 'most' or 'all' of the time. This level of support and enthusiasm seems to have been sustained from the studies of the 1980s.<sup>9-11</sup>

Fry<sup>21</sup> reported that the 1990 UK General Practice Contract increased GPs' involvement with preventive medicine from 5% to 25%, and he predicted that this increase might add an extra

10% or more to the numbers of patients attending per year. This extra attendance may explain part of the increase in GP workload reported in the UK in recent years.<sup>22,23</sup> Despite the fact that UK GPs have experienced more stress, less job satisfaction, and poorer mental health since the new contract was introduced,<sup>24</sup> it is encouraging to see that attitudes towards health promotion and lifestyle counselling have remained high.

Another positive finding was that GPs appeared to be more active in enquiring about smoking, alcohol consumption, and exercise than in earlier studies. Information about smoking, alcohol consumption, and exercise was collected routinely by 97%, 90%, and 79% of GPs respectively. Similar figures for enquiring about smoking and alcohol consumption were found in a 1993 survey of London GPs.<sup>25</sup> By contrast, corresponding figures for routine enquiry about these issues in 1987<sup>10</sup> were 64%, 26%, and 11%.

In all seven lifestyle areas included in this survey, there was a large difference between proportions of GPs who reported being prepared to counsel patients on lifestyle issues and proportions of GPs who felt effective at helping patients change these behaviours. For instance, although 83% of responders felt 'prepared' or 'very prepared' to counsel about alcohol consumption, only 21% felt they were 'effective' or 'very effective' in helping patients reduce alcohol consumption. These figures are lower than in earlier studies.<sup>26-29</sup> The fact that the largest increase in current to potential effectiveness in helping patients change behaviour, after provision of adequate information and training, was reported for reducing alcohol consumption, suggests that particular efforts should be directed towards this area of continuing professional development. Indeed, only 13% of GPs in this survey had received more than 10 hours of postgraduate education or training on alcohol-related issues.<sup>14</sup>

In conclusion, this survey shows that, despite an increasing workload, GPs in the UK remain positive about health promotion and lifestyle counselling. Over the past 10 years, routine enquiry about smoking, alcohol consumption, and exercise has increased but GPs' confidence in their ability help patients change lifestyle behaviour has remained low. Further information, training, and support is required by GPs to help them work more effectively in health promotion and lifestyle counselling and thus contribute fully to the UK Government's ambitious national contract for health.

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