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Doctors as teachers

Because general practitioners come into direct contact with large numbers of people, the possibility exists for them to communicate messages that can help to prevent cardiovascular diseases, malignancies and other serious conditions. In order for this to be achieved on the greatest possible scale, however, most doctors will have to develop their educational skills.

Health for all means including prevention in everyday clinical routines, being aware of the distribution of disease and of the factors that affect health, and relating consciously to a defined population. In Denmark, the United Kingdom and other countries where physicians have their own lists of patients, this is a familiar way of thinking, as it is in rural communities. Elsewhere, it may be a new and exciting challenge.

In Western countries, the major health problems are cardiovascular diseases, cancer, accidents, mental disorders, and diseases of the musculoskeletal system. An analysis of the years of life lost in Norway by men under the age of 75 in 1973–74 (1) gave the following results.

Causes of death	Lost years < 75
Cardiovascular diseases	68 731
— Coronary disease	48 556
Accidents	44 699
Malignant diseases	36 610
— Lung cancer	5 627
Infections	1 850

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To a very large extent the way a person chooses to live determines whether he or she lives to a ripe old age. Many doctors now accept that, in order to bring about improvements in health, more effort must be put into prevention. A difficulty here is that critical factors are often beyond the control of the health authorities. Nevertheless, a number of measures have proved their usefulness in promoting health by influencing people's life-styles. Among them are:

- marketing and advertising restrictions;
- restrictions and quality requirements imposed on products;
- price policies;
- environmental planning;
- education in schools;
- community action;
- use of the mass media;
- training for the health professions.

However, it is prevention at the individual level that presents a real challenge to the general practitioner. During a consultation, a doctor can:

- assess current symptoms and problems;

- assess former or continuing symptoms and problems;
- assess the patient's use of medical services and self-care;
- promote primary and secondary prophylaxis.

In prophylaxis, important parts are played by diagnosis at an early stage, risk assessment, and health education.

Health education

The greatest potential for influencing public health probably lies in this field.

In a study in Oslo, men aged 40 were examined in 1972 and later. Of those who scored high on cardiovascular disease risk factors (excessive blood cholesterol, high blood pressure, and smoking), half were selected at random for intervention; 600 had a half-hour conversation with a doctor and were given advice on diet, and there were 600 controls. All risk factors continued to be monitored. The patients in the intervention group were subsequently given advice on their life-styles once or twice a year, in sessions lasting half an hour each (2). In the course of nine years, 17 of the controls and 7 of the men in the intervention group died of cardiovascular disease. Eight of the controls had undergone major heart surgery but only one man in the intervention group had done so.

In another study it was demonstrated that simple advice and leaflets given by general practitioners at ordinary consultations helped patients to stop smoking (3): 5% in the intervention group abandoned the habit within a month and were still nonsmokers a year later, whereas there was no improvement among controls. It was suggested that general practitioners who registered their patients' smoking habits,

advised them to stop smoking, backed up their advice with printed material, and made follow-up appointments, could expect 25 long-term successes each year.

In Norway between 1950 and 1984 there was a steady decline in the numbers of men and women doctors who smoked, and it is predicted, by extrapolation, that all Norwegian doctors will be nonsmokers before the year 2000 (4). Smoking may come to be regarded as a matter of bad hygiene, on a par with spitting. However, it would be unreasonable to expect the population as a whole to achieve the results projected for doctors. We can assume that physicians are particularly aware of the harm done by smoking; they are also under pressure to set an example for the rest of the population. As a social group, they make better use of written information and have higher health indicator ratings than groups with less education, lower incomes, and less support from social networks. Nevertheless, the conclusion is inescapable that doctors have good opportunities to encourage people to abandon unhealthy habits.

The Troms project

In 11 municipalities of Troms county in Norway an age-specific programme for preventive intervention was worked out (5).

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People aged 25 and over were invited to consult their doctors. The programme called for 20-minute consultations comprising procedures that varied with age, including simple medical examination, risk assessment,

and health education. Help was arranged for anyone found to need it. The older the client, the more frequent were the consultations.

By the end of 1985, 25 000 people had been called to participate and the overall attendance rate was 54%. One striking fact

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that emerged was that most general practitioners lacked the educational skills needed when bringing up the matter of smoking and exercise with people in their forties or when asking older people about their preparations for retirement. The doctors found it difficult to formulate messages and felt uncomfortable in the role of teacher during consultations. Some tended to moralize or resorted to very thorough anamneses in order to fill up the allotted time.

The patients who attended these consultations were seen by their own doctors, who had their confidence, usually had seen them before, and were likely to see them again. Doctors who had been in their practices for any length of time were familiar with the local community and knew how the social networks, if any, could be mobilized to support their patients. But they also felt a need to improve their skills in health education. To this end, four pieces of advice can be given.

- Keep the message simple.
- Repeat it.
- Combine printed and oral information.

- Make follow-up appointments.

It is important not to ask too much of patients to begin with. Slight improvements should be the main objective. Thus it is more realistic to expect moderately reduced smoking or fat consumption after a few months than the complete cessation of smoking or the adoption of a perfect diet.

The imparting of health information takes time and general practitioners are always busy. Some have asked whether they might not seek allies in this enterprise. Norwegian public health nurses, for instance, traditionally provide mothers and children with health information. They could also play an important part in individual prevention programmes for adults. However, it is advisable to ask whether some of the time devoted by general practitioners to diagnosis and treatment might not be better spent on health education.

The Troms project cannot reveal whether intervention by general practitioners will result in large-scale improvements in public health. It is difficult to distinguish the effects of their work from those of all the other influences to which the population is exposed.

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Let me sum up my views on the role of the general practitioner in health education.

- information given in individual consultations should be concerned with major diseases;
- it should be prepared for specific age groups;
- getting messages across is a skill attainable only through much practice.

Although population studies do not provide direct proof that intervention by general

practitioners has a decisive effect on public health, I believe that any doctor who engages wholeheartedly in giving health information will derive great satisfaction from the results achieved in individual patients.

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References

1. Waaler, H. T. & Hjort, P. F. [Lost life years under 75. Norwegian men 1973–74.] *Tidsskrift for den Norske Lægeforening*, **98**: 720–725 (1978) (in Norwegian).
2. Hjermann, I. et al. Effect of diet and smoking intervention on the incidence of coronary heart disease. Report from the Oslo study group of a randomized trial in healthy men. *Lancet*, **2**: 1303–1310 (1981).
3. Russell, M. A. et al. Effects of general practitioners' advice against smoking. *British medical journal*, **2**: 231–235 (1979).
4. Thürmer, H. [*Trends in smoking habits of Norwegian physicians.*] Oslo, the National Council of Smoking and Health, 1985 (in Norwegian).
5. Siem, H. [*Protocol for the Troms municipal implementation trial.*] Oslo, xeroxed document, 1983 (in Norwegian).

Put the brakes on "car culture"

Traffic in Beijing—with thousands of new sedans, minibuses, vans and taxis on top of the regular increase of other vehicles involved in production and trade—has already become as bad as that of other metropolises in the world. Beijing was never planned as a city with parking lots, so parking is already a big problem. Road accidents are on the rise. The Avenue of Eternal Peace is no longer peaceful. Nowadays it is tough for drivers, tough for cyclists, and even tougher for pedestrians.

With such a big population [1 billion], China should not have too many motor vehicles. It is better for us to develop our public transport system and keep our bicycles. It would be more practical and healthier.

—C. L. Feng. *China reconstructs*, **36** (12): 62 (1987).