

Prevention in general practice: the views of doctors in the Oxford region

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SUMMARY. A postal questionnaire was sent to all 1291 general practitioners in the Oxford region to determine the pattern of preventive care and their beliefs about its effectiveness. Replies were received from 1014 doctors (79%). Doctors' attitudes to their role in prevention and health promotion were very positive and a large majority claimed to discuss health related topics with their patients when indicated. Fewer respondents said they made a point of discussing smoking habits (64%), alcohol intake (26%), diet (12%), or exercise (11%) as a matter of routine with all their adult patients. Most general practitioners said they usually offered simple advice, leaflets, or other aids when they had identified a problem, but few said they would refer these patients to the practice nurse. With the exception of cervical screening (45%), few respondents said they maintained statistics on the distribution of risk factors in their practice population.

Despite considerable enthusiasm for their role in preventive health care, before the imposition of the new contract most general practitioners in the Oxford region had not yet embraced the model of prevention which the contract aims to encourage: systematic screening for risk factors and lifestyle advice for all patients.

Introduction

THE 1990 contract for general practice in the National Health Service¹ states that health promotion and disease prevention, including the provision of advice through regular check ups and screening, should be part of the work of all general practitioners. This idea has a long pedigree; in 1970 Tudor Hart² described the screening of a whole community for hypertension within the normal framework of general practice. In 1979 Stott and Davis³ included opportunistic health promotion as part of the potential of each primary care consultation. This view was encouraged by evidence that general practitioners' advice could make some impact on smoking rates.^{4,5}

In 1981, the report by the Royal College of General Practitioners on the prevention of arterial disease in general practice⁶ recommended that blood pressure and weight should be measured and smoking habits recorded for all adult patients, either opportunistically or in health checks. More recently there have been recommendations to include routine enquiry about alcohol consumption⁷ and selective measurement of serum cholesterol⁸ in normal anticipatory care.

In order to assess the impact of the new contract we need to know about patterns of preventive care in general practice prior to its implementation. The survey reported here aimed to

establish the circumstances in which general practitioners perform various aspects of preventive care and their views on prevention and health promotion in general. It represents the situation in one regional health authority before the details of the new contract were known.

Method

A questionnaire was designed and piloted with 10 general practitioners and then mailed in 1987 to all 1291 general practitioners on the lists of the four family practitioner committees in the Oxford region (Berkshire, Buckinghamshire, Northamptonshire and Oxfordshire). Up to two reminders were sent to non-respondents. The questionnaire asked a number of questions about identification and recording of risk factors, about advice offered to patients, and about the respondents' views on prevention and health promotion. Most questions offered respondents a range of precoded options from which they could choose all that applied (see Appendix 1 for a sample question).

Results

Completed questionnaires were received from 1014 general practitioners: a response rate of 79%. Of the respondents, 21.1% were women, 59.7% were aged under 45 years, 72.5% had entered general practice within the last 20 years and 55.5% had completed vocational training. These proportions match closely those for all principals in general practice in the Oxford region.

Opportunistic health promotion

The questionnaire asked about the circumstances in which the respondents would enquire about smoking, diet, drinking habits or exercise (Table 1). While almost all doctors said they would aim to identify risk factors if the patient had a relevant history of symptoms or had presented for a health check, a much smaller proportion enquired about health related topics, with the exception of smoking, in routine consultations. Drinking habits were regarded as an appropriate area of enquiry in patients with anxiety, depression or marital problems by 69.4% of respondents, but only 25.9% said they would enquire routinely.

Systematic recording of lifestyle risk factors (defined as records of the presence or absence of a specific risk factor on the notes of more than 70% of a general practitioner's patients) was rare except in the case of smoking, where nearly half felt they had achieved this. Very few respondents reported that their practices kept statistics on the distribution of risk factors in their practice population. Only 23.5% said that they recorded a patient's occupation on their notes.

Respondents were asked to specify their likely actions once they had identified a patient with a lifestyle related problem. Almost all general practitioners said they would offer simple advice where necessary. Many respondents reported offering diet sheets to patients who require advice about losing weight or improving their diet and anti-smoking literature to smokers. Literature about safe levels of alcohol consumption and information about local sports centres and recreational facilities were mentioned less frequently, but the majority of respondents said they were likely to offer a prescription, for example Nicorette, to help patients stop smoking.

The majority of respondents were willing to offer further consultations to patients who required help with smoking, diet or

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Table 1. Preventive activities carried out by general practitioners: circumstances in which discussion would be initiated, records and statistics kept and likely actions.

	% of GPs responding positively for: ^a			
	Smoking	Drinking	Exercise	Diet
<i>Circumstances in which subjects discussed</i>				
When patient presents with relevant symptoms	96.3	90.3	83.8	95.8
In health checks	93.7	93.6	82.1	84.1
In most adult consultations	63.5	25.9	10.8	11.6
<i>Records and statistics kept of factors</i>				
Recorded on >70% of patients notes	46.3	17.4	2.4	20.6
Practice statistics	11.5	5.0	1.1	4.8
<i>Likely actions when problem identified</i>				
Offer simple advice	94.8	92.8	97.4	95.5
Offer leaflets	70.5	36.7	22.4	48.6
Offer specific aids ^b	80.4	27.9	40.1	88.7
Offer another consultation	54.4	71.2	11.5	75.0
Refer to practice nurse	9.6	3.5	2.9	30.2
Refer to another professional	28.6	39.7	0.8	69.1
Refer to self-help group	10.8	75.9	37.4	42.3

^aRespondents could choose more than one option. ^bPrescription (smoking); drinking diary; information about local sports centres and recreational facilities; diet sheets.

alcohol problems. Referral to the practice nurse was mentioned only infrequently, apart from the 30.2% who were prepared to refer patients for advice about diet or weight loss. There was greater interest in referring to other professionals such as acupuncturists or hypnotists for smoking and dieticians for weight loss. Three-quarters of all respondents said they were likely to refer a patient with a drinking problem to a self-help group.

Screening programmes

Seventy one per cent of the respondents said they aimed to take blood pressure measurements on all their adult patients as a matter of routine. However, 20.1% of respondents said they did not routinely identify groups of patients at risk, such as those who had had a previously high blood pressure measurement or those who had stopped taking anti-hypertensive medication. Only 20.3% said that their practices kept statistics on the proportion of patients who had blood pressure measurements in the last five years.

At the time of the survey the district health authority cervical screening call and recall systems were being set up. A total of 75.6% of respondents reported that their practices operated their own call and recall systems and only six respondents said their practice was not participating in any routine call and recall scheme.

Sixty eight per cent of respondents said they only informed their patients of the smear test result if it was abnormal; 13.8% said they asked their patients to leave stamped addressed envelopes for their test results; 7.2% said they told their patients to enquire about the test result but operated a fail-safe system if they did not contact the practice and only 11.0% said their policy was to contact all women after a cervical smear test, regardless of the result. More practices kept statistics on cervical screening coverage than on any of the other preventive pro-

cedures: 44.5% of respondents reported that they kept such figures.

For the most part the decision to measure cholesterol levels was taken in response to known family history or clinical signs rather than as a routine screening test. For example, 94.1% of respondents said they would measure cholesterol levels on a patient who had a family history of heart disease, or who had physical signs such as arcus or xanthelasma; 63.9% would measure it on patients who had high blood pressure; and 35.5% on patients who were obese. Only 3.0% said they would measure cholesterol levels routinely for all patients.

Other preventive activities

The questionnaire asked 'With which patients do you initiate a discussion about sexually transmitted diseases and what advice do you give?'; the results are shown in Table 2. Doctors were more likely to raise this issue with patients who were suspected of having multiple partners than with homosexuals, and very few said they initiated discussion routinely. Once they had identified a patient who was potentially at risk, most respondents would recommend use of condoms, safer sex techniques or monogamy.

Table 2. General practitioners' responses regarding sexually transmitted diseases (including the acquired immune deficiency syndrome): circumstances in which discussion would be initiated and likely responses.

	Percentage of respondents ^a
<i>Circumstances in which subject discussed</i>	
Patients who may have multiple partners	50.7
Patients asking for contraceptive advice	43.9
Patients who may be homosexual	42.1
Routinely with most teenage girls	13.1
Routinely with most teenage boys	4.7
Routinely with most adult patients	0.8
<i>Likely actions when problem identified</i>	
Advise use of condoms	81.6
Advise monogamy	65.5
Advise on safer sex techniques	64.8
Offer literature or leaflets	34.0
Referral to self-help group or other agency	6.9
Referral to another member of practice team	1.6

^aRespondents could choose more than one option.

In an open-ended question respondents were asked to give details of any other health promotion activities in which they were involved; 63.4% of respondents mentioned at least one activity. These included health checks, 'human MOTs' and well woman/man clinics, mentioned by 27.7%; anticipatory care for patients with chronic diseases, 14.9%; health education groups for patients, 10.3%; and the development of health education materials, 3.6%.

The effectiveness of prevention

In the second part of the questionnaire respondents were asked how important they thought a range of factors were in contributing to an individual's risk of coronary heart disease, and how effective they believed a range of activities were in the prevention of coronary heart disease and deaths from cancer. The results are shown in Tables 3 and 4.

Cigarette smoking was clearly identified as a very important risk factor and an overwhelming majority said they believed that anti-smoking advice was an effective way of preventing coronary heart disease and cancer. There was more uncertainty about the

Table 3. General practitioners' views on the importance of factors contributing to the risk of coronary heart disease.

Risk factors	% of GPs regarding factor as:			% of GPs who are uncertain
	Very important	Moderately important	Not important	
Cigarette smoking	97.3	2.5	0.1	0.1
Blood pressure	75.0	23.4	0.9	0.7
Blood cholesterol	65.6	33.0	0.5	0.9
Weight	51.1	46.9	1.1	0.9
Diet	33.7	61.6	2.1	2.6
Exercise	32.0	63.7	2.8	1.5
Stress	30.2	56.7	7.1	6.0
Socioeconomic status	16.1	56.8	18.4	8.7
Working environment	10.7	56.2	22.9	10.2
Housing	3.3	28.0	50.8	17.9
Educational attainment	3.2	27.5	50.9	18.4

Table 4. General practitioners' views on the effectiveness of various activities aimed at preventing coronary heart disease and deaths from cancer.

Preventive activities	% of GPs regarding activity as:		% of GPs regarding evidence as inconclusive	% of GPs with no opinion
	Probably effective	Probably ineffective		
<i>Coronary heart disease</i>				
Advice to stop smoking	96.9	2.6	0.4	0.1
Treatment of high blood pressure	77.5	6.0	16.3	0.2
Advice to reduce weight	76.9	7.7	15.2	0.2
Advice to increase exercise	71.5	9.6	17.9	1.0
Dietary advice	70.3	11.4	17.2	1.1
Advice on stress reduction	49.0	20.5	29.5	1.0
<i>Cancer</i>				
Advice to stop smoking	94.2	3.5	1.7	0.6
Routine cervical cytology	91.6	2.6	5.8	—
Routine mammography	63.9	11.6	22.6	1.9
Regular breast self examination	61.0	15.8	22.8	0.4
Dietary advice	28.5	28.0	38.7	4.8
Advice on stress reduction	9.1	44.3	38.8	7.8

risk of high blood pressure and the benefits of treatment, and less than two-thirds of respondents believed that blood cholesterol level was a very important risk factor in coronary heart disease. Less than two-thirds thought that routine mammography was probably effective in preventing deaths from cancer. Stress and social factors were seen as less important risks in coronary heart disease by many respondents, and over half felt that housing and educational attainment were not important risk factors.

Attitudes to preventive care and health promotion

The responses to a series of statements about prevention and

health promotion are shown in Table 5. In general the respondents were very positive about their role in preventive care and health promotion and most disagreed with negative statements about the value of lifestyle advice.

Problems and how to overcome them

In open-ended questions the respondents were asked to describe difficulties they had encountered or anticipated encountering developing prevention in practice, and 82.5% mentioned at least one. Lack of time was the most common problem (49.8%); 16.2% said they felt their patients were not really interested in lifestyle advice and 11.8% admitted to a lack of interest on their own part. Other barriers mentioned were the lack of financial incentive (15.9%); too few practice staff (10.5%); inadequate records and registers (10.1%); inadequate premises (6.4%) and the lack of a computer (4.3%). Other comments indicated disagreement between practice partners over the importance of preventive care and health promotion.

A variety of ideas were expressed about ways in which the problems could be overcome. These included financial incentives (22.6%); smaller list sizes (21.0%); more staff (18.6%); and a practice computer (10.7%). The need to prolong consultations was only mentioned by 3.0% of respondents. A number of respondents felt that other agencies, including schools and the media could do more to promote health and some felt that practice nurses should become more involved in preventive care.

Discussion

The high response rate achieved by this survey means that we can be fairly confident that it reflects the views of general practitioners in the Oxford regional health authority. However, there are important limitations to the methods adopted here which must be taken into account when interpreting the results. A survey such as this, based on self-reports of activity, is likely to produce an over-estimate of the level of preventive care in general practice. Paradoxically, the use of a structured questionnaire may also underestimate activity since it may exclude responses which do not fit into the precoded options. We attempted to overcome this difficulty by including some open-ended questions, but we had no means of validating the responses. For these reasons, the results are perhaps most interesting as a measure of what the respondents did not claim to be doing.

While the respondents to this survey had a very positive attitude to prevention, this was largely seen as individual doctor initiated care. There was far less commitment to identifying needs for prevention in the whole of the practice population. This is the approach that has been advocated as necessary to make a significant impact on public health⁹⁻¹¹ and is implicit in the proposals outlined in the new contract.¹

The first working party report on health and prevention in primary care from the Royal College of General Practitioners¹² described three spheres in which preventive activities could take place: with patients during consultations; within the registered practice population and within the local community. Within the consultation the large majority of our respondents said they would raise lifestyle issues in the presence of a relevant history or as part of a health check, but taking a smoking history or recording a blood pressure were the only activities reportedly carried out as a matter of routine. Cervical screening was the only item of preventive care which the majority of doctors were aiming to provide on a universal basis and for which they claimed to keep adequate record systems to enable them to monitor progress. Respondents tended to play down the influence of socioeconomic factors in the spectrum of risk factors for cor-

Table 5. Extent of agreement with statements about preventive care and health promotion.

Statements about preventive care ^a	% of GPs who:			
	Agree strongly	Agree somewhat	Disagree somewhat	Disagree strongly
GPs are ideally placed to give health education	72.0	23.0	2.8	2.2
Helping people to understand their body is important	58.1	34.3	4.1	3.5
Preventive care needs good records and recall systems	50.6	35.4	10.7	3.3
Government should take more responsibility for promoting health	47.7	43.4	7.6	1.3
Health authorities should provide more assistance to GPs for preventive care	35.8	50.2	11.8	2.2
GPs should put preventive health on the political agenda	32.9	47.5	15.2	4.4
GPs should take a leading role in prevention in the community	30.1	50.0	16.4	3.5
GPs have insufficient time to practice prevention	17.3	45.7	22.0	15.0
GPs do not have enough training in health promotion	11.4	57.1	25.5	6.0
Nurses are more appropriate people to promote health	8.0	41.9	42.9	7.2
GPs can do little to change people's lifestyles	3.0	31.7	52.3	13.0
Patients find health education boring	2.8	35.6	39.3	22.3
Patients take little notice of what a GP says about lifestyle	1.5	29.7	49.6	19.2
Health education may be irrelevant to patient's presenting problem	1.8	21.8	43.8	32.6
Evidence relating diet to health is too uncertain	1.6	16.2	46.2	36.0
Giving detailed explanations worries patients	1.7	15.2	43.7	39.4
Health education is boring	2.3	19.1	40.8	37.8
Health education is guilt-inducing	0.5	17.5	44.9	37.1
GPs should not interfere with people's lives	1.3	6.6	25.7	66.4

^a Table shows condensed versions of statements.

onary heart disease, although the majority agreed with statements indicating a need to see health promotion in a wider political context. This pattern of opportunistic enquiry being confined to 'clinical' topics is similar to the findings of other studies.^{13,14}

Respondents appeared confident that giving lifestyle advice was likely to be effective in preventing deaths from coronary heart disease and cancer, a level of optimistic enthusiasm which has been found in other studies.¹⁵⁻¹⁷ Despite this enthusiasm, findings from patient surveys have shown that many of those in high risk groups have not been targeted for advice by their general practitioners.¹⁸⁻²⁰ The integration of the individual oriented model of prevention which has been prevalent in general practice with the population oriented public health model has not yet occurred.²¹

Our results show that before the imposition of their new contract general practitioners were enthusiastic about offering preventive care and lifestyle advice, although they were not claiming to reach the whole of their practice population on a systematic basis. They reported a number of difficulties including lack of time, lack of financial incentive and lack of resources such as computers. The new contract has not addressed the most commonly perceived barrier to the further development of preventive care in general practice, namely lack of time, but by offering financial incentives and assistance with the costs of computerization, the government may have alleviated some of the problems. It remains to be seen whether these measures will produce the desired result.

Appendix 1. Sample question.

Under what circumstances do you enquire about patients' drinking habits? (Tick all that apply).

- When patient asks for advice about drinking
- When patient presents for 'health check'
- When patient presents with anxiety or depression
- When patient has clinical signs or symptoms (incl. injuries arising from accidents) which might be related to alcohol consumption
- When patient has social or marital problem
- When patient has upset stomach with no obvious cause
- When patient's breath smells of alcohol
- Routinely with most adult patients
- Other (please specify)

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