# *Medicine and the Media*

## Effect of a public campaign about malignant melanoma on general practitioner workload in Southampton

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In 1982 a colleague and I published data which suggested that a local public campaign about breast cancer had not caused a pronounced increase in the workload of general practitioners in Southampton.[1] In July 1987 a public campaign about early detection of malignant melanoma was launched by the Cancer Research Campaign. Publicity was targeted at seven health districts including Southampton. This provided another opportunity to assess the impact of a public campaign on general practitioner workload in Southampton. In both campaigns local television, radio, and press were used, and posters and leaflets were widely distributed. The melanoma campaign was also reported by the national media and press.

### Survey

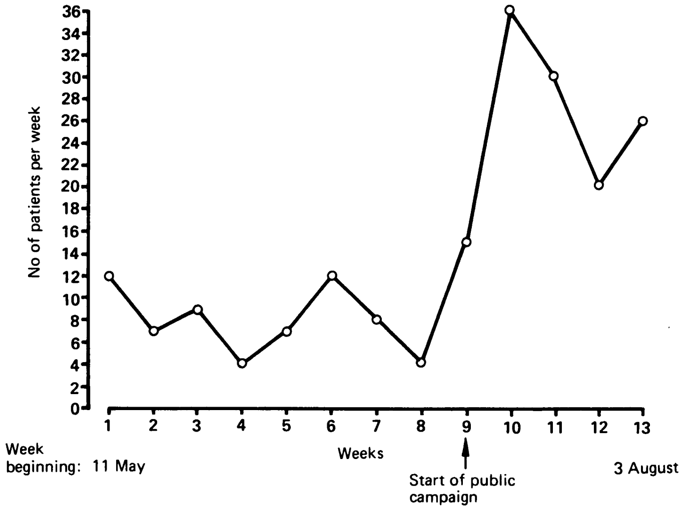
Twenty nine volunteer general practitioners from 18 (26%) of the 68 general practices in the Southampton Health Authority kept a record of patients who consulted them about pigmented lesions. The start date for keeping a record was staggered, as I visited each practitioner personally, but all 29 doctors participated from 11 May to 7 August. The period before the start of the public campaign (11 May-7 July) was 42 weekdays compared with a postcampaign period (8 July-7 August) of 23 weekdays.

The doctors recorded 70 patients before the campaign and 122 after the campaign. The median number of patients consulting 29 doctors was, therefore, 2·00 per day before the campaign and 4·00 per day after the campaign. This difference was significant (Mann-Whitney U test $p<0·001$; estimate of difference between medians$=-3$; 95% confidence interval $-4$ to $-2$). The figure shows the number of patients consulting the 29 doctors during each five day week over the entire period. Seventy three (38%) of the patients were men and 117 (62%) women (sex not recorded for two patients); 66 (40%) were under 45 years of age and 99 (60%) were 45 or over (age not recorded for 27 patients).

Sixty eight (63%) patients in the postcampaign period had delayed consulting their doctor for six months or more compared with 31 (48%) in the precampaign period. This difference just failed to be significant (Fisher's exact test (two tail) $p=0·0883$). The proportion of patients who were either reassured, seen again, or treated by the general practitioners increased significantly from 47% in the precampaign period to 63% in the postcampaign period, with a corresponding 16% fall in the proportion who were referred to hospital (Fisher's exact test (two tail) $p=0·046$).

### Comment

The prospective records kept by 29 general practitioners suggest that there was a pronounced increase in workload at the start of a publicity campaign about early detection of malignant melanoma.



Number of patients consulting 29 general practitioners over the study period.

The alternative explanation is that the increase was due to a change in doctors' recording behaviour when the publicity began. Support for a "real" increase in the number of patients consulting with pigmented lesions after the launch of the campaign came from a local skin forum held in October. The 40-50 Southampton general practitioners at the forum said that their workload of patients with pigmented lesions had increased. If the effect was a real one it resulted not only in greater numbers of patients consulting but also in a tendency for general practitioners to manage a larger proportion of patients. In contrast, the earlier publicity campaign about breast cancer caused almost no change in the proportion of women with breast symptoms who were referred to hospital or managed by the doctors.[1]

There may be many reasons for the different effects on the workload of general practitioners of two similar campaigns. The campaign about melanoma, although targeted locally, had received an extra "boost" from the national media and may have reached more people. Also, breast cancer is an emotive subject and very frightening to many women. Malignant melanoma, although serious, is a less well known form of cancer[2] and therefore may not raise anxieties and discourage reporting of symptoms to the same extent.

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### References

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LAST MARCH in an unprecedented concerted blitz the BBC and ITV television broadcast 14 separate programmes on AIDS. Around the same time regular advertisements pushed messages that AIDS kills, it's everyone's problem, and wear condoms. Similar messages were emblazoned over billboards and occupied prominent positions in national newspapers. An informative leaflet about AIDS was sent to every home in Britain. The cost of this publicity was £7·5m, but what did it achieve? Are blunderbuss tactics the best way to put across sensitive health education messages? These questions were addressed at a recent meeting organised by the Social Research Society.

The objectives of the campaign were, according to the Health Education Authority, to increase awareness, change attitudes, and modify behaviour. But the authority's strategy for assessing the impact of the campaign has been limited. It commissioned the British Market Research Bureau to conduct 30 minute face to face interviews with people in their own homes. About 4500 people (most aged 16 to 64) were interviewed between February 1986 and February 1987, and a similar number in the following year. The views of some 1000 homosexuals were also sought.

The overall results were not encouraging. On the plus side, it seems that the general public is now well informed about AIDS. Among sexually active heterosexuals over 16 with more than one partner a year, however, 42% said that they had had sex with someone they had only just met and only 29% said that they used condoms more often than before. Among homosexuals the data suggests that the annual number of partners is decreasing and more are practicing safer sex. A MORI poll taken after the television coverage produced similar results, as did a much more detailed study of homosexuals, Project Sigma, funded by the Medical Research Council and the Department of Health. Its findings also show that receptive anal intercourse is becoming less common among homosexuals and that they have adopted a wider, safer sexual repertoire. On the negative side, many men in established relationships "cheat" their regular partners and on such occasions seldom take precautions.

The obvious problem with these findings is that they are based on reported rather than actual behaviour, and there is no means of assessing how many of the reported changes have been caused by the publicity campaign. The prevailing opinion at the meeting was that peers influence behaviour and attitudes as much and probably more than publicity campaigns—and among homosexuals the changes in behaviour preceded the government's campaign. It is also clear that the campaign has decreased the general public's tolerance of homosexual behaviour and that this, in conjunction with the reaction to clause 28, has resulted in homosexuals becoming increasingly suspicious of any information perceived to come from government sources.

As the government's publicity campaign probably had little if any impact on the homosexual community and only a limited impact on heterosexual behaviour, what is the way forward? What messages should be pushed now, how, and by whom?

The consensus was that given good knowledge of HIV infection among the general public (and recognising that most homosexuals know far more about it than most doctors) what is needed now is information on specific topics. And this information must be consistent. Describing oral sex as risky at one moment and safe the next was cited as a good example of what *not* to do. Next, it was suggested, there should be a move to portray condoms not pragmatically as protective devices, but as desirable through suitably seductive advertisements. Information should also be made widely available to heterosexual couples on how they can diversify their sexual habits (as have homosexuals): vaginal sex should no longer be regarded as the main option.

But can a government organisation be seen to be pushing the fun element of safe sex and the desirability of sexual inventiveness? Regrettably, no, said the representative from the Health Education Authority: ministers were not likely to regard this as acceptable. Such messages were best put over by popular magazines, television soap writers, and agony aunts. And with refreshing honesty she admitted that if the authority is to get the best value out of its £10m a year it needs to collaborate with organisations that have "street cred," from whom information and advice will be believed and followed: the Terrence Higgins Trust, Body Positive, and genitourinary clinics are obvious examples.

All agreed that the best way to put up to date information and health education messages about HIV infection over to the maximum number of people at a realistic cost was to use all forms of media—popular magazines and radio networks in addition to newspapers and television. And on television the portrayal of realistic "role models" is preferable and probably much more effective than harsh authoritarian messages. Billboard advertisements were singled out as notably ineffective. By contrast there was much support for the informative leaflets sent out to homes. These have probably had the greatest impact of all, and a leaflet similar to the British one is to be distributed to every home in the United States between 26 May and 30 June.

Another important point to emerge from the meeting was that information must be targeted more specifically. Groups that need special consideration are 13 to 17 year olds and drug addicts, who are showing little evidence of adopting less high risk behaviour. Finally, the realities of AIDS and HIV infection must be kept alive in the minds of the public, for already there is evidence that concern is waning. To achieve this a steady stream of new information from a wider variety of non-judgemental, non-governmental sources is essential.

As for the data gatherers, they need to switch from the pursuit of quantity to qualitative analysis of the content of their interviews. And the Health Education Authority should perhaps question whether its current methods of evaluating trends are really cost effective.—TESSA RICHARDS, assistant editor, *BMJ*.

SICKLE CELL disease is now common in multiracial Britain. But for many years those with the disease, which has wide ranging presentations and complications, have felt isolated and inadequately supported by health professionals, some of whom have not been well informed about the disease. The Sickle Cell Society, which *Let's Talk Sickle* (£15 for sale or £5 a week to hire from the society, Green Lodge, Barratts Green Road, London NW10) portrays, is a charity that was formed nine years ago. The society aims at educating public and professionals about the disease and also offers support to sufferers and their families.

The video is aimed at health professionals—particularly at general practitioners, nurses, midwives, and social workers who run their own clinics or support groups for those with sickle cell disease—and at hospitals that run special clinics. The video is 20 minutes long and may be used in the waiting area for the special clinics. Its strength lies in the interviews with real patients talking about the effects of sickle cell disease on their lives: they say more than any professional can say in lectures or consultation with patients. I recommend it strongly as an adjunct to health education by professionals.—NELLIE ADJAYE, consultant community paediatrician, Maidstone.