

Family doctors and health promotion: Do we practise what we preach?

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Abstract

Introduction: A survey on 'Attitudes and Knowledge of General Practitioners (GPs) in Prevention and Health Promotion' was carried out in 2000 by EUROPREV (European Network for Prevention and Health Promotion in General Practice / Family Medicine).

Method: All local general practitioners (GPs) known to the Malta College of Family Doctors were mailed a questionnaire to elicit beliefs and attitudes in practice, possible barriers in implementing preventive activities, and their personal health behaviour.

Results: The response rate was 50% (156 replies out of 313). A difference was found between GPs' beliefs that certain preventive and health promotion activities should be done and their actually doing them in clinical practice. Forty-nine percent found some or great difficulty in carrying out such activities, mainly due to heavy workload and lack of time, problems in patients' accessibility to these activities, and patients' doubts about their effectiveness. Discrepancies were revealed between GPs' health promotion beliefs and their own personal behaviour.

Discussion: As this study is based on GPs' self-reporting of activities, more objective evidence is needed through audit of properly-kept medical records. A practical protocol of health promotion activities needs to be devised for, and distributed to, family doctors. Health promotion activities may be facilitated by reduction of doctors' workload through patient registration and an appointment system. As doctors seem to prefer ordering investigations to giving verbal advice, other healthcare professionals could provide the latter. GPs should set an example to their patients by adopting a healthy lifestyle to reinforce their advice regarding health promotion.

Keywords

Family practice, health promotion, health knowledge, attitudes, practice, health behavior

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Introduction

Health promotion was defined in 1986 by the Ottawa Charter for Health Promotion as "the process of enabling people to increase control over, and to improve, their health".¹ An orientation towards health promotion, health education, and the prevention of disease and ill-health should be the main goal of primary care services.² As each patient sees his/her family doctor / general practitioner (GP) four times a year on average, the latter has ample opportunities to practice preventive medicine in daily practice.³ In fact, one of the core competences of the family doctor is the promotion of health and well being by applying the appropriate strategies.⁴

Research in the UK has revealed a positive attitude of GPs towards health promotion despite their increasing workload.⁵ However, an Australian study suggested that, for preventive counselling protocols to be translated into routine practice, sufficient investment in time and adequate generation of interest are required.⁶ Moreover, Canadian family doctors perceived difficulties in communication skills and "a feeling of powerlessness" as barriers to the implementation of prevention in clinical practice.⁷ Further studies from the UK have recommended that, for health promotion programmes in general practice to succeed, consideration must be given to the view of the patient⁸, while a regular review of the attitudes of health professionals needs to be undertaken.⁹

Rationale & Purpose of Study

The European Network for Prevention and Health Promotion in General Practice / Family Medicine - EUROPREV (<http://www.europrev.org>) is a network organisation within WONCA (World Organisation of Family Doctors) Region Europe – The European Society of General Practice / Family Medicine. EUROPREV was set up in 1997 with the aim of promoting evidence-based prevention and health promotion in general practice through the encouragement of multicentre research and educational programmes.¹⁰

Table 1: GPs' professional characteristics (working and teaching activities)

Working and teaching activities	Percentage
Work in: Primary health centre	16%
Solo practice	58%
Public centre	19%
Private centre	55%
Postgraduate teaching activities	26%

The objectives of the EUROPREV Survey on the Attitudes and Knowledge of GPs in Prevention and Health Promotion¹¹ carried out in 2000 were to:

- Describe the knowledge and attitudes of European GPs in implementing evidence-based preventive and health promotion recommendations in primary care;
- Describe GPs' perceived barriers in implementing these recommendations;
- Assess how GPs' own health behaviours affect their work with patients.

Methods

The survey took the form of a questionnaire developed in English, pre-tested in each participating country (being translated to the local language where necessary), and posted in 2000 to a sample of GPs in 11 European countries. In Malta it was sent in the original English, together with a stamped addressed return envelope, to all Maltese GPs as listed in a Family Doctor Directory compiled by the Malta College of Family Doctors (MCFD). Due to the small number of GPs in Malta, the questionnaire was sent to the whole GP population in order to have sufficient power to detect a meaningful result. Non-respondents were sent a reminder by post. The returned questionnaires were sent for data entry and analysis (including back translation as necessary) to the EUROPREV centre in Barcelona, Spain.

The questionnaire consisted of the following items:

- Demographic and professional data (10 questions);
- Two clinical scenarios with a list of different preventive and health promotion activities and two different columns for responses - beliefs and attitudes in practice (34 questions);
- Items related to barriers in implementing preventive activities (6 questions);
- Items concerning personal health behaviour (21 for male GPs and 25 for female GPs).

Ethical considerations

Although no consent forms were used, participants were informed that they would be part of a voluntary research study that would assist EUROPREV to discover the attitudes and knowledge of GPs in prevention and health promotion at the European level, which also would be useful for comparison between countries. Participants were assured that the information provided in the questionnaire would be held in the strictest confidence, and that data would not be analysed individually. As the study was carried out on a European level, research ethics permission was not sought at the national level.

Results

The questionnaires sent out to all family doctors known to the MCFD had a response rate of 50% (156 out of 313). The ages of the respondents varied from 28 to 81 years, with a mean of 45. The male / female ratio was of 74% / 26%. Details of the GPs' professional characteristics (working and teaching activities) are shown in Table 1.

Quantitative Results

GPs were presented with the two clinical scenarios of a 52-year-old male presenting with a trivial cough and a

Table 2: Examinations done / investigations ordered by GPs in reaction to clinical scenarios (52-year-old male presenting with a trivial cough and a 57-year-old female with a trivial dermatological problem)

Examination/investigation	Should it be done? (yes, %)		Do I do it? (yes, %)	
	male patient	female patient	male patient	female patient
Blood pressure	99%	95%	88%	81%
Glucose level	80%	88%	80%	78%
Cholesterol level	73%	76%	74%	75%
Faeces for Occult Blood	23%	22%	21%	20%
Chest X-ray (male patient)	52%		44%	
Digital rectal examination (male patient)	43%		45%	
Cervical cytology (female patient)		77%		64%
Clinical examination of breasts (female patient)		88%		73%

Table 3: Advice given / estimation done by GPs in reaction to clinical scenarios (52-year-old male presenting with a trivial cough and a 57-year-old female with a trivial dermatological problem)

Advice/examination	Should it be done? (yes, %)		Do I do it? (yes, %)	
	male patient	female patient	male patient	female patient
Advise quit smoking	99%	95%	66%	61%
Advise less alcohol consumption	97%	95%	62%	60%
Advise physical exercise	97%	95%	62%	59%
Advise weight loss	97%	95%	61%	60%
Estimate Body Mass Index (kg/m ²)	58%	59%	39%	37%

57-year-old female with a trivial dermatological problem. Both patients were visiting the doctor for the first time and had no previous 'check-ups' or tests, no known risk factors and no personal or family history of major disease. The GPs' reactions to the scenarios (what they think should be done and what they do in practice) are shown in Table 2 (examinations done and investigations ordered) and Table 3 (advice given and estimations done).

When asked about their attitudes to general activities of prevention/health promotion, nearly half the GPs found some (44.5%) or great (4.5%) difficulty with such activities, while 30.3% and 20.7% had no difficulty or very little difficulty respectively. Table 4 lists the barriers perceived by the doctors to the implementation of such activities. Their attitudes regarding the specific activities of quitting smoking, alcohol reduction, maintenance of weight and regular exercise are shown in Table 5.

Regarding their own health behaviour, 15% of GPs stated that they smoked on a daily basis (cigarettes: 12%, cigar/pipe: 3%), and 29% admitted they were former smokers. While 37% of GPs reported that they do not drink alcohol, 25% consume 1-2 drinks a week, 31% 3-14 drinks/week and only 6% drink 15 units or more (with 1 drink or unit consisting of 100ml wine, 200ml beer or 25ml whisky). On the other hand, 37% of GPs exercise regularly (daily or 2-3 times a week), 39% exercise rarely (just once a month or week), while 24% of GPs never exercise at all.

The doctors were asked how frequently they had their own blood pressure and serum cholesterol measured (Table 6) and about self-screening procedures and vaccinations

(Table 7). The questionnaire also requested respondents to provide their weight and height, with the mean values for females being 63kg and 1.61m, and for males 79kg and 1.72m. Using the formula BMI=kg/m², the mean body mass index (BMI) for the female GP at 24 fell within normal limits (normal range: 20-24.9), while the male GP, with a BMI of 27, was found to be overweight (overweight range: 25-29.9).

Table 4: Barriers perceived by GPs to their implementation of prevention / health promotion activities

Rank	Perceived barriers to implementation	Percentage*
1	Heavy work load and lack of time	56%
2	Problems in patients' accessibility to these activities	39%
3	Patients have doubts about effectiveness of activities	31%
4	Insufficient personal training in prevention and health promotion	24%
5	No reimbursement for prevention and health promotion activities	22%
6	Lack of consensus (discrepancies in recommendations)	21%
7	Lack of clarity on which professional in primary care is responsible for carrying out these activities	20%

* of all questionnaires returned

Table 5: GPs' attitudes regarding certain specific activities of prevention / health promotion

Activity	Tobacco reduction	Alcohol reduction	Maintain weight	Regular exercise	Mean percentages
Felt very effective	5%	3%	1%	5%	3.5%
Reasonably effective	46%	53%	63%	68%	57.5%
Minimally effective	49%	42%	35%	26%	38%
Not effective	0%	2%	1%	1%	1%

It is to be noted that the Maltese results were not statistically analysed on their own within this study, but as part of the pooled European data by the Europe-wide study¹¹, which also compared results across other survey centres. Also results were not compiled by age of respondent, and the basic characteristics of respondents were not compared with those of the Maltese GP population.

Qualitative Results

The questionnaire also gave family doctors the opportunity to make any comments. Two of these (below) regarded the influence of the patient when deciding on activities of prevention and health promotion:

- “The questions and investigations advised very often depend on how ready the patient is to take this opportunity to perform a check-up. Some patients just want the present problem solved and would not be receptive for any other advice or suggestions re further check-ups” (female GP, 30 years old).
- “The above screening and advisory preventive measures are offered to such a patient but are only carried out by me if the patient agrees to having them done. Further attempts are made discreetly when the patient returns on subsequent visits (without of course any ‘nagging’ or annoying of the patient) if he still has not done them” (male GP, 31 years old).

Another two GPs commented (below) on how such activities were affected by certain circumstances, namely doctor-patient relationship, continuity of care and prevention/health promotion protocols:

- “I work solely in the public primary health care department where patients are not registered with a particular doctor, there is no appointment system and the workload is heavy. As a result, there is no true doctor-patient relationship and no continuity of care with follow-up of the same patient. This makes prevention and health promotion very difficult” (female GP, 34 years old).
- “This questionnaire has served to open my eyes as to how poor my health promotion activities are in my

Table 6: Frequency of measurement of own blood pressure and serum total cholesterol by GPs

Frequency of measurement	Blood pressure	Se total cholesterol
Once a year	74%	37%
Once every 2 yrs	10%	13%
Every 3-5 yrs	10%	19%
More than every 5 yrs	4%	12%
Never	2%	19%

practice. Thank you. May I suggest that the organisers of this questionnaire devise a practical protocol (what to do, when to do it, and how often) in health promotion activities for the GP and distribute it” (male GP, 40 years old).

Discussion

From the reactions to the two clinical scenarios, differences emerged between GPs’ beliefs that certain health promotion activities should be done and their actually doing them in clinical practice. While the mean difference between belief and practice with regard to examinations done or investigations ordered was of just 3%, the mean difference for advice given or estimations done was of 32%. Thus doctors find it over ten times more difficult to give advice or do related estimations than to perform examinations or investigations. Such provision of advice on health promotion and disease prevention may be facilitated if GPs had access to guidelines (high in quality, low in quantity) and specially-written handouts for patients, which are specifically developed to assist GPs in their busy practices.^{10,12} An example of such a guideline is one on healthy diet in primary care developed by EUROPREV.¹³

In fact, nearly half of GPs found some or a lot of difficulty in carrying out preventive/health promotion activities. Moreover, as much as 39% of GPs felt minimally or not effective in the specific activities of quitting smoking, alcohol reduction, maintenance of weight and regular exercise. While problems involving patients (accessibility to activities - 39%, doubts about effectiveness - 31%) were mentioned among several barriers to implementation, the biggest obstacle identified by 56% of the respondents was doctors’ heavy workload and lack of time. A possible solution to this problem would be the involvement of other health care professionals (e.g. nurses trained in the subject) to assist in advising patients about desirable prevention/health promotion practices.¹⁰

Table 7: Self-screening procedures and vaccinations undergone by GPs

Underwent screening procedure / vaccination	Yes
Test for faecal occult blood	7%
Digital rectal examination (males)	19%
Clinical breast examination (females)	83%
Cervical cytology (females)	83%
Rubella (females)	91%
Tetanus	89%
Hepatitis B	84%
Influenza	62%

This study also revealed discrepancies between GPs' prevention and health promotion beliefs and their own personal behaviour. This was especially evident through their lack of exercise (63% exercised rarely or not at all), infrequent cholesterol checks (only half did so yearly or biannually), and high BMI in males (at 27 indicating an overweight problem). In the EUROPREV Europe-wide study, Brotons et al found that GPs who had their cholesterol measured at least once every 5 years measured that of their patients more often ($p < 0.01$), and that sedentary GPs advised sedentary patients to perform regular physical exercise less often than other GPs who exercised regularly ($p < 0.05$).¹¹ As such, the unhealthy behaviour of Maltese family doctors is likely to have a negative effect on their health promotion practices, with adverse consequences on the health of their patients.

The success of GPs' advice on prevention and health promotion relies in large part on the patient's decision to accept such advice by making it 'his or her own' and putting it into practice. A good relationship between the doctor and the patient is of course crucial here. The doctor-patient relationship, together with optimal continuity of care, both depend on sufficient periods being available for consultations to take place without the inconveniences of a heavy workload and / or a lack of time. The latter problems may be solved if patient registration is introduced and an appointment system is used to regulate the flow of clients seen by the family doctor (with appropriate arrangements being made for urgent cases to be seen without delay). Prevention and health promotion activities performed by the GP in clinical practice should be noted in the patient's medical record, not only for the sake of continuity of care, but to enable further studies on this topic to be based on documented activities rather than on doctors' beliefs and recollections.¹⁴⁻¹⁷

Limitations of study methods

Besides the above-mentioned limitation regarding the study having been based on GP recall rather than on documentation, another limitation could have been the reactivity of participants. Here the person filling the questionnaire would have wanted to leave a good impression by giving the researcher a reply the former thinks would have pleased the latter (the 'halo effect').

Despite the questionnaire having been sent to the whole population of GPs in Malta, a respondent bias could also have resulted from the 50% response rate. This might have caused an overestimation of the results, due to the likelihood that respondents to the questionnaire had a greater interest in prevention / health promotion activities than family

doctors in general. A comparative review of the baseline characteristics of participants and non-responders could have helped in this regard.

Concluding Recommendations

A practical protocol of health promotion activities needs to be devised for and distributed to family doctors to facilitate their prevention and health promotion activities, together with a reduction of doctors' workload through patient registration and an appointment system. Moreover, as doctors seem to prefer ordering investigations to giving verbal advice, other healthcare professionals could be trained to assist in providing the latter.

General practitioners should set an example to their patients by adopting a healthy lifestyle to reinforce their advice re prevention and health promotion. However, as this study is based on GPs' self-reporting of activities, more objective evidence is needed through audit of properly kept medical records. Further research is needed to expand on these issues.

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The 10th Anniversary of the Association of Surgeons of Malta

The Association of Surgeons of Malta celebrated the tenth anniversary of its foundation on 19th November 2005. A Surgical Update symposium was organized at the Medical School. The Association invited various speakers to give an update in their field of specialization.

Professor Godfrey LaFerla discussed topical subjects in General Surgery. Professor Joseph Azzopardi gave details on the changes affecting diabetic patients undergoing surgery with suggestions on their optimal management. Mr Alex Attard explained new techniques in Vascular Surgery and he was followed by a discussion of modern Orthopaedics by Mr Charles Grixti. Dr A Aquilina closed the session by discussing new concepts in Anaesthesia and Intensive Care.

A Gala dinner was held at the Corinthia San Gorg Hotel. The Association of Surgeons of Malta invited Dr Antonello Forgione from the prestigious Institut de Recherche contre les Cancres de l'Appareil Digestif (IRCAD) in Strasbourg, France. He gave a very interesting review of robotic surgery and discussed its impact on the future of Surgery. The President of the Association, Mr. Gordon Caruana-Dingli, discussed the history of the Association of Surgeons of Malta and explained the plans of the current committee for the future. He highlighted the challenges of post-graduate surgical training and announced the various bids that have been made by the Association for European Union Funding.



Mr G Caruana-Dingli presenting a commemorative plaque to the Dean of the Medical School Professor G LaFerla

The evening was rounded off by the presentation of a plaque to the Dean of the Medical School, Professor Godfrey Laferla. This plaque lists the previous presidents of the Association and it will be exhibited at the new Medical School at the Mater Dei Hospital.