We have discussed how much of the family doctor's work is taken up by psychological disorders, many of them on the fringe of normality, and how well he is placed for their prevention, diagnosis, and management. We have pointed out how much good in this field every general practitioner can do himself, and on other occasions how much he and his patients benefit when he co-operates, in a team, with his many potential helpers from the social services. We have shown how advantageous it may be for a group of doctors to have one partner who, though still primarily in general practice, has been specially trained and experienced in this branch of medicine, and how much he can teach his colleagues. With increasing understanding by all general practitioners, and by the public, of the significance of anxiety and stress in health and disease, and with advances in knowledge and skill of succeeding generations of family doctors, the average standard of work in this field should be very much higher in twenty years' time than it is to-day.

Recommendations

We recommend that:

1. In the undergraduate medical curriculum greater emphasis should be laid on normal psychology and on psychological medicine.
2. In qualifying examinations there should more often be a compulsory written question (or its equivalent in the clinical or oral) on the psychological aspect of medicine, and one of the examiners should be interested in this subject.
3. More postgraduate training of general practitioners in psychological medicine should be arranged in all areas.
4. In helping their patients with psychological illnesses more opportunities should be taken by family doctors

to develop team-work with the ancillary services, to all of which they should have free access; and the Ministry of Health should give more encouragement, and assistance, towards linking general practice with the social services.

5. The Ministry of Health and other appropriate bodies should investigate the possibility of giving more opportunities, and recognition, to general practitioners with a special interest in psychological medicine who have had training and experience in it.

6. In the future development of the National Health Service the fundamental role of the general practitioner, in psychological medicine as in other branches of medicine, should be recognized.

Grateful acknowledgment is made to the 37 psychiatrists and other consultants who have helped the working party in the preparation of this report; to the heads of the psychological departments of all the teaching hospitals in the United Kingdom and Eire, and of some in the Commonwealth; to the members of Council of the College of General Practitioners; and to the following practitioners who have expressed a special interest in psychological medicine and who have given much helpful advice: Drs. F. A. Bevan, T. S. Beveridge, F. M. Brook, J. F. Burdon, J. M. Clow, E. G. Cohen, D. Craddock, W. V. Cruden, J. A. Currie, B. J. Foster, A. Fry, R. N. R. Grant, E. C. Hamlyn, Marjory C. Hogg, P. Hopkins, C. E. Langley, M. J. Linnett, F. A. Lodge, E. V. Mackay, A. U. MacKinnon, M. Marcus, A. Model, J. G. Ollerenshaw, H. S. Pasmore, Jean W. D. Pasmore, R. A. B. Rorie, P. Rowntree, J. A. Taylor, H. E. Thorn, D. Iona Troup, and J. Whitby. The particular thanks of the working party are due to Mrs. D. I. Phillips, who has most patiently undertaken the typing and circulating of many drafts of this report.

REFERENCES

- Balint, M. (1957). *The Doctor, His Patient, and the Illness*. Pitman Press.
 Bomford, R. R. (1958). *J. Coll. gen. Pract.*, 1, No. 2, Suppl., p. 10.
 College of General Practitioners (1957). *Practitioner*, 179, Suppl., p. 21.
 General Medical Council (1957). *Recommendations as to the Medical Curriculum*, pp. 10 and 11.
 Hopkins, P. (1956). *Lancet*, 2, 455.
 Paulett, J. D. (1956). *Ibid.*, 2, 37.
 Pemberton, J. (1949). *Brit. med. J.*, 1, 306.

THE PHYSICIAN AND HEALTH EDUCATION

BY

GUY W. STEUART, M.A., M.Ed., M.P.H.

Senior Lecturer, Department of Social, Preventive, and Family Medicine, University of Natal; Organizer, Health Education, Institute of Family and Community Health, Durban

The clinical situation, with its intimate doctor-patient relationship, is a peculiarly appropriate one for health education. Yet it is probably true to say that the physician has not adequately exploited his unusual educational opportunities. There are still far too many people who make relatively frequent use of their doctors but who remain with little knowledge and insight into their own states of health or those of their children. The numbers are legion indeed of those who have done little more than acquire a few esoteric terms to spice their conversations and impress their friends.

The Patient's Viewpoint and Physician's Role

To consult his doctor is, on the part of the patient, usually a decision of surrender. Even with mild complaints he feels that he can no longer carry on alone. Under a threat to his security, his immediate need is not to think for himself but rather to confide in someone who will take over a responsibility he can no longer bear.

The greater his anxiety, the more receptive is he likely to be to an authority and decisiveness that offers to restore

something of certainty and orderliness to his life. Thus, although in one sense he is highly susceptible to suggestion, he is also, paradoxically enough, rather ineducable because the fundamental understanding and insight that marks sound education is not what he primarily wants.

He is seeking essentially a short-cut solution to his problem. His dominating motive is to hand over his troubles to an expert in whom he has some measure of faith. But of this expert's hidden store of skills he has little comprehension, and within limits he is emotionally set for an uncritical acceptance of what he is told.

To this extent he is in psychological continuity with all the patients of medical history who have endowed their healers with magical powers.

The physician thus finds himself in a mould, pre-cast by his patients and by society, and he would be more than human if he did not find the proffered role somewhat tempting. Not only does he himself find it satisfying in the shortest possible time to establish an unequivocal diagnosis and a clear regimen, but it is certainly demanded by his patients.

The physician's conclusions may be medically quite valid, but while he retains too much of the aura of authority he limits more than he need the patient's understanding both of his diagnosis and of his therapy. The patient comes away with that mysterious justification for his future behaviour, both rational and irrational, significantly called "doctor's orders." Thus, once he has had his complaint labelled and has been told to take a tablet at certain times, to change his diet, or to rest more often, this may mean little more to him than the anxiety-relieving rituals of magic to a primitive.

Thus, with the physician in an active dominating role and the patient in a passive dependent one, we have a contradiction of the best educational situations where the learner actively and intelligently participates in solving his own problems and meeting his own needs.

Moreover, the somewhat undignified dependence of the patient often means that, as he recovers and his feeling of independence is restored, while gaining a greater respect for himself, he tends to lose it for his regimen. It is therefore not uncommon to find the patient, in his final stages of recovery, avoiding desirable contact with his doctor and neglecting the advice he received.

The result is that considerable numbers of patients resume their daily rounds as before, having received only a short didactic training in a limited mechanical procedure that has little meaning for them.

Why Educate the Patient?

Of course, we may well ask why the patient should receive a broader guidance and education. After all, he presents a complaint to his doctor and at least his immediate need is met when this is ameliorated.

But it is hard to conceive even of a frankly curative service as being desirably concerned only with cures. Such a feat of purism would be difficult to defend. Curative services may begin with cures, but they surely should not end with them. They are intimately concerned with the future of the patient in respect both of the prevention of disease in the future as well as of the positive promotion of his health. In these respects, at least, the patient has a heavy personal responsibility which he cannot adequately fulfil without education.

Moreover, it is no longer possible for us to take refuge in a theory that with medical advances there shall be revealed more highly specific aetiologies that will enable the physician to treat and prevent disease through technical acts of extraordinary precision with less and less need for personal guidance of the patient.

It is a naive conception indeed that the function of science is primarily to simplify. On the contrary, its function of revealing new possibilities and of vastly complicating our vision of things is of at least equal importance. There is hardly room to-day for beliefs like those of Crookshank's (1920) ingenuous police surgeon, who declared that "bullets are the cause of war, as of murder."

In point of fact, recent advances in medicine have increased immeasurably the stature of emotional, behavioural, and social factors in the aetiology of disease and the maintenance of health. The vital role of human relationships; of emotional adjustment; of habits of sanitation, diet, smoking, drinking, sleep, work, rest, and exercise; of attitudes to and the use made of health and medical services—indeed, of the total pattern of the individual's daily life—has acquired a significance impossible to ignore.

The individual's personal influence on his own health is therefore of unusual importance. He can receive only limited help from the physician who remains narrowly preoccupied with the physical and biochemical aspects of disease and with the immediate technically expert acts he can perform on behalf of his patient. Such an approach misses one of the greatest potentialities of the clinical situation in guiding and educating the patient in his own care.

In the words of Delore (quoted by Mackintosh, 1953): "Over and above each technical act there is a corresponding educational function which doubles the value of the act, prolongs it, increases its efficiency and endows it with real human and social value."

It seems high time, then, that we take more vigorous action to fashion the physician's role in a form more consonant with his possible educational function.

Desirable Steps

To achieve this end there are perhaps two major aspects of patient management that require attention. The first is the need for the physician to develop and exploit a more

psychiatric type of relationship than is at present current. This would include greater opportunities for self-expression by the patient and consequently a more passive and permissive role for the doctor, in which his interventions were not only explanatory but suggestive and co-operative rather than didactic and authoritarian. In such a clinical context his guidance could be more closely related to the felt and expressed needs of his patient. This would enable him to build on the essential foundation of the patient's interpretation of his own problem and not so much on a discrete medical interpretation meaningful only to himself. It would enable him to adapt his guidance more easily to the individual patient's peculiar habits, attitudes, feelings, and knowledge as well as to the particular degree of that patient's emotional rigidity and resistance to change.

Secondly, the physician should be more actively aware of the need to salvage the patient's capacity for independence and to build up his self-reliance and confidence. This is not to say that when the patient appeals for help the physician should throw him back on his own resources, but rather that as early as possible the physician should encourage the patient to feel that he has control over his own destiny and that he has an intelligent role to play in his treatment and in the future care of his own health.

It is in such a context that the patient may be given information to the extent that his motivation and understanding permits—which is somewhat further than most doctors are inclined to assume for most patients. This is, of course, not an entirely easy proposition, for what profession is there whose public prestige is more enhanced by the full-dress regalia of its technical jargon? Indeed, it is probably a need of most physicians that they learn to express medical principles in terms which are both accurate and comprehensible to the increasingly well-educated public of modern times.

If these suggestions are valid it is apparent that the problem of educating the patient is not a matter of simple accretion of an extra element, but rather of a reorientation of the whole clinical situation and of the doctor-patient relationship.

Possible Objections

There are naturally certain objections which may be raised. It might, for example, be said that the busy medical practitioner is at present hard pressed enough—too hard pressed, perhaps—to give each of his patients sufficient time. He would therefore be unlikely to welcome the introduction of procedures which may considerably lengthen his clinical contact with the patient.

To counter this it may not be unreasonable to claim that in many practices short-term palliative treatment, on the one hand, and pressure from numbers of patients whose care and guidance have not been thorough enough in the past on the other, are parts of the same vicious circle.

But even if this was not wholly true, the fact remains that education and guidance techniques are clinical skills like any others. As such they require careful teaching and considerable experience. While the application of the principles by a beginner may appreciably lengthen his clinical contacts, we have no reliable estimate of the short-term, let alone the long-term, implications for time, once the practitioner is really skilled.

Each physician must remain the judge of what he can best do under the circumstances and demands of his practice. In the last resort, however, there is no blinking the fact that some balance (in spite of periodic changes in the centre of gravity) must be found between the needs of time economy and the needs of optimal medical efficiency.

Another objection might be that education of the patient frequently means giving him information which he will misinterpret or which may affect his clinical condition adversely. It is quite obvious that this again is a matter to be decided by the physician with each patient, and is a vital and intrinsic part of his clinical judgment. But in the long run it is hard to defend the withholding of information outside of the exceptional case. Quite apart

from the critical question of whether it is morally defensible, there are essentially practical reasons.

To-day, when people have reached an unprecedented level of literacy and education, and have an almost unlimited access to a wide variety of sources of information about health and disease, this whole objection loses force. Whether we like it or not, patients are going to have their questions answered with varying degrees of accuracy by friends and relatives, by quacks of all kinds, by articles in newspapers and popular magazines, and by commercial advertisements.

It is therefore clearly in the interest both of the physician and of his patient that the latter should not leave his doctor with questions he would like to have asked but did not, or with answers that did not satisfy him. It seems an elementary insistence that the patient is entitled to know all his doctor can tell him and that his doctor is the best person to tell him.

Medical Education

The ultimate solution of the problem, as of many others affecting modern medicine, probably lies in the field of basic medical education. There is to-day a clearly discernible increase in appreciation of the fundamental need of medicine to be systematically moulded into a more human and social discipline and to widen its interest in diseases to include the people and communities that suffer from them.

Medical education may, after all, be designed to produce physicians who not only have the technical knowledge and skills of their craft, who not only see health and disease as a by-product of personal and social life, but who are at once humane and imaginative educators as well.

REFERENCES

- Crookshank, F. G. (1920). *Proc. roy. Soc. Med.*, 13, Sect. Epidem., 159.
Mackintosh, J. M. (1953). *Brit. Educ. J.*, 11, 174.

SOME POPULAR BELIEFS CONCERNING THE CAUSES OF CANCER

BY

ANN CARTWRIGHT, B.Sc.

AND

F. M. MARTIN, B.A., Ph.D.

*Lecturers, Department of Public Health and Social
Medicine, University of Edinburgh*

It is difficult to assess with any precision the present balance of medical opinion on the value of cancer education. A questionnaire circulated a few years ago by the British Empire Cancer Campaign drew replies from only one-quarter of the general practitioners to whom it was addressed, and of these slightly more than half expressed opposition to education of the public concerning cancer (Horder, 1953). More recently, however, it has been shown (Wakefield and Davison, 1958) that a carefully conducted local programme of cancer education can in practice gain the widespread approval of general practitioners. At the same time, the increasing volume of evidence tending to incriminate cigarette smoking as a major factor in the aetiology of cancer of the lung has stimulated the interest of many medical practitioners in the possibilities of education or propagandist activities directed towards a reduction in the incidence of what would appear to be an eminently preventable disease.

The planning of health education in this field, if its desirability be accepted, is likely to be the more effective if it takes account of the prevailing patterns of belief

and habit in the community. In this context, the findings of a recent inquiry, which throw some light on lay beliefs concerning the causes of cancer, with particular reference to the role of cigarette smoking, may perhaps be of interest.

The data presented here were obtained through interviews with a random sample of the adult population of the City of Edinburgh. The background of the inquiry, the sampling procedure, and the response rate have been described elsewhere (Cartwright, Martin, and Thomson, 1958). The inquiry was primarily concerned with popular beliefs concerning tuberculosis, but certain questions about cancer were included in the interview.

General Attitudes Concerning Cancer

Some indication of popular fears of cancer in comparison with other diseases is provided by replies to the opening questions of the interview, in which our subjects were asked what illness they thought was most dangerous for children under the age of 15, for adults under the age of 45, and for adults over that age. Only one person in a hundred mentioned cancer as the most dangerous disease for children, but a quarter and a third respectively thought it was the most dangerous illness for adults below and above the age of 45. In each of these last two groups cancer was the second most frequently mentioned disease; tuberculosis (29%) was specified slightly more frequently for younger, and heart disease (34%) slightly more frequently for older, adults.

There were, however, no indications, at any rate at the level of conscious awareness, of a widespread incidence of what is sometimes referred to as cancerphobia. Less than one-third of the people questioned said in reply to a specific inquiry that they were worried about their own health or the health of any member of their family, and of these the majority were concerned about some illness present at the time. Among those who expressed anxiety about an illness not actually present cancer was the disease most frequently mentioned, but even this was named only by one person in fifty.

When asked which of five selected causes of death was responsible for the greatest number of deaths, 35% of our subjects said heart disease, 32% street accidents, and 27% cancer. Only 5% cited lung tuberculosis and 1% poliomyelitis. Cancer was much more often specified by women (35%) than by men (18%). Asked to estimate whether death or recovery was the more probable outcome in each of the four diseases included in the previous list, the members of our sample were least optimistic about the prognosis for the cancer patient, with three-quarters thinking death the more likely outcome. One subject in five, however, thought that a person who had contracted cancer was more likely to recover than to die.

A somewhat higher proportion, nearly one-third, said they would rather not know if they had cancer, even though, in answer to a later question, only 9% thought the chances of recovery were not improved by early diagnosis. For lung tuberculosis people were apparently more convinced of the value of early diagnosis; only 2% thought it would not improve the chances of recovery, and only one in ten said they would rather not know if they had it.

Beliefs About the Causes of Cancer

In an attempt to discover the pattern of popular beliefs about the causes of cancer, we first asked a general question in which we did not suggest any possible cause. Replies have been classified into various groups in Table I.

The cause most frequently suggested was knocks, bumps, or bruises; then in descending order of frequency came smoking; air pollution, fumes or dirt; inheritance; and tiredness, worry, overstrain, or frustration. The popularity of the belief that trivial injuries may cause cancer provides an interesting example of the psychological process referred