Medicine and the Media

General practitioners' use of written materials during consultations

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Russell *et al* have shown that the compliance of patients can be enhanced by general practitioners' providing them with written materials.¹ We examined what educational materials for patients were used by general practitioners and where the materials came from.

Methods and results

A total of 236 general practitioners (a one in three sample of doctors on the lists of South and Mid-Glamorgan and Gwent family practitioner committees) were randomly selected for inclusion in the study. Altogether 106 agreed to be interviewed, and we used a semistructured questionnaire to ask them about which educational materials they used for their patients, what they thought of them, and where they got them from. A short questionnaire was posted to the remaining 130 general practitioners, and replies were received from 71 (55%); 70 questionnaires were satisfactorily completed. To maximise the rate of response complete anonymity was promised. The overall rate of response was 75%.

Table I shows the educational aids for patients used regularly by all the respondents during routine consultations. Diet sheets were the most popular aids, being used by 90% of the doctors. Overall 88% of general practitioners regularly used diagrams drawn by hand to explain various topics to their patients, and many of the doctors interviewed had freehand drawings of the ear or the female genital tract easily available. Leaflets were dispensed regularly by 61% of the doctors during routine consultations.

All the general practitioners interviewed had used educational material for patients during consultations. Sixty had used diagrams drawn by hand, 47 diet sheets, and 43 leaflets during the week before the interview. Eighty one doctors displayed educational leaflets for their patients in the practice. Most of the doctors were concerned that they had little control in the use of these leaflets and found that supplies disappeared rapidly without their knowing what had happened to them.

Eighty three of the general practitioners interviewed had provided patients with prepared leaflets on specific topics during consultations, but 54 expressed reservations about their value—mainly that they might disrupt the doctor-patient relationship. They suspected that patients might consider the leaflets to be a substitute for explanation by the doctor or that the patients might misinterpret the leaflets' contents. No correlation was found between the types of aids used and the doctors' experience (taken as the time since qualification).

None of the doctors interviewed had prepared any written materials themselves, although a few had considered doing so and some had photocopied information from sources that they had found useful. Written materials were used to reinforce oral advice about many topics: 86 doctors used materials on disease processes, 40 leaflets containing advice on

modification of lifestyle, 12 material on family planning, and seven material on preventive care (screening, immunisation, and antenatal care).

All the general practitioners received their educational materials for patients from many sources (table II), the most popular source of written materials (as well as of plastic models, preprinted diagrams, and so on) being the pharmaceutical companies. Many of the doctors who were

TABLE I—Numbers (percentages) of general practitioners using various health educational aids during routine consultations

Health educational aid	Doctors interviewed (n=106)	Doctors returning postal questionnaire (n=70)	Total (n=176)
Diet sheets	91 (86)	67 (96)	158 (90)
Diagrams drawn by hand	101 (95)	53 (76)*	154 (88)
Leaflets	74 (70)	33 (47)*	107 (61)
Preprinted diagrams	63 (59)	13 (19)*	76 (43)
Patient Counselling Compendium	29 (27)	8 (11)	37 (21)
Family Doctor booklets	18 (17)	10 (14)	28 (16)

*Significant difference between replies to administered and postal questionnaires ($p < 0.01$).

TABLE II—Sources of educational material for patients used by general practitioners. Values are numbers (percentages) of general practitioners

Source	Doctors interviewed (n=106)	Doctors returning postal questionnaire (n=70)	Total (n=176)
Pharmaceutical companies	67 (63)	44 (63)	111 (63)
Health Education Authority	32 (30)	8 (11)*	40 (23)
Hospitals	7 (7)	5 (7)	12 (7)
Non-commercial groups (self help groups)	5 (5)	5 (7)	10 (6)
Textbooks	2 (2)		2 (1)
Other sources	14 (13)	10 (14)	24 (14)

*Significant difference between replies to administered and postal questionnaires ($p < 0.01$).

interviewed expressed reservations about using materials from pharmaceutical companies as they disliked the idea of promoting a specific product and often felt compelled to prescribe the drug mentioned in a particular leaflet. Only 26 of them knew that they could obtain educational materials for patients from local health education units; the 80 others had not had any contact with these offices.

Discussion

Some form of written educational aid for patients had been used by all the general practitioners studied. Diet sheets were the most popular and were often supplied in response to patients' requests. Unlike the other educational aids, dietary information often promoted feedback from patients at subsequent consultations, which probably accounts for its popularity with doctors.

Diagrams they had drawn themselves were used by 88% of the doctors, usually to illustrate relevant anatomy during explanations

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of disease processes. These diagrams were popular with doctors as they could make them personal and adapt them to each patient's needs. Doctors often commented that blank sheets of paper were their most useful aid for health education. They often used notepads containing paper endorsed with a drug advertisement.

Most (78%) of the general practitioners interviewed had provided patients with prepared leaflets on specific topics during consultations, but half of them expressed reservations about their value. Most general practitioners value the one to one relationship with their patients; they therefore view with suspicion anything that might alter their consulting pattern and disturb this relationship. The general impression, expressed by doctors in this study, that patients adopt an attitude of passive acceptance when being given a leaflet caused many doctors to doubt whether publications were appreciated by patients. Most of the doctors studied did not record in their notes when patients had been given a leaflet.

Written materials used by general practitioners were obtained from various sources but most commonly pharmaceutical companies. Although doctors preferred the style and impartiality of leaflets produced by non-commercial organisations, the advantages of these publications were outweighed by the greater effort needed to obtain them. Availability of supplies was probably the most

important criterion influencing their use by general practitioners. Representatives of pharmaceutical companies visit practices regularly and promote and then deliver supplies personally, often arranging to replenish stocks. This servicing of practices by pharmaceutical companies was an important factor in the selection of materials by doctors: health education units existed in the area studied, but doctors knew little about them.

Most leaflets used by the general practitioners explained diseases rather than advising on modifying lifestyle to improve general health. This may suggest that many general practitioners think that they primarily provide curative rather than preventive care for their patients.

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Reference

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For Debate . . .

A licence for breast cancer screening?

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Abstract

It is unrealistic to expect that the best results which have been reported from some research programmes will be equalled after the introduction of a nationwide breast screening service in Britain. Stringent methods of quality control will be needed or potential benefits will not be realised. Despite the disadvantages an effective method of accreditation may be the only way to contain the cost to both healthy women and the National Health Service.

Introduction

The critical question about breast cancer screening is no longer whether early detection and treatment can prolong life. This has been answered. Two new questions now arise. How far can the quality of the screening process that has already been achieved in some research programmes be maintained in community hospitals, and what will be the cost to normal healthy women? Results from Sweden have shown that the mortality from breast cancer can be reduced by screening women over 50 years of age with single view

mammography alone.¹ These results, however, were achieved in specialist centres by staff who have been dedicated to screening for many years and in a country where the population is renowned for its compliance and the health service for its staffing levels. Over 90% of Swedes take part in elections, and there are 4.5 times as many radiologists per person in Sweden than in the United Kingdom. No country yet has a nationwide screening service for breast cancer, but we can learn from others about what happens when mammography screening is carried out widely. From West Germany, where over 2.5 million mammograms are performed yearly using 10 times as many mammographic installations as are available in the National Health Service, it can be learnt that results from specialist centres are not reproduced. The number of breast cancers that are diagnosed in West Germany is increasing,² but mammography has had no detectable effect on mortality from breast cancer.^{3,4} From the United States it can be learnt that when screening became widespread between 1970 and 1975 no discernible benefit resulted, but the mastectomy rate increased to double that in UK. More women were diagnosed and treated for cancer because the pathological criteria for making a diagnosis became more relaxed.⁵ Without careful control mammographic screening is detrimental. From France, where twice as many radiographs are exposed per person than in Britain, and from other Western countries which spend more on health care and have more advanced infrastructures of conventional mammography than Britain it can be learnt that a nationwide screening programme is not yet justified. An expansion of mammographic facilities is indicated, but planning a nationwide screening programme is overambitious at this time. Starting a nationwide screening programme within three years, as the government plans to do, could contain the seeds of disaster unless the skill, application, and interest of specialist centres can be matched.

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