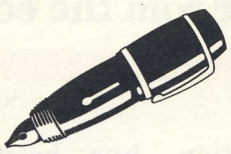

From the editor • Van die redakteur

"Telling" patients

"I talk to my patients. I explain the diagnosis and management to them ..." is often a response when patient-centredness is discussed. There is no doubt that this is appreciated by many of our patients. They listen reverently and even act on our advice. If we count those who do not listen, the bottom drops out of our confidence. Medical students also seem to pick up early on in their careers their compulsion to teach patients at all costs as a sign of really caring for patients.

A malnourished child, whom I have never seen, shook my confidence in this business of giving advice. Glatthaar[1] in a study on home-based nutrition education, randomly allocated mothers and their undermass children to two groups. The experimental group was given personalised nutrition education in their own kitchens; the control group none. Both groups were interviewed for nutrition knowledge at the beginning, weighed every three months and interviewed again at the end of one year.

One of the control children was doing particularly badly. While making a video recording of the project, this child's home was visited to get an example of poor progress in a control child from a slum. To our great surprise the child had a large growth spurt following the filming.

Analysis after one year showed no statistical difference in the catch-up growth of the children from the nutrition education and the no-education group. Nutrition knowledge however did show a statistically significant improvement in the experimental group. So what?

Before speculating about possible reasons for this, it is perhaps good to recognise our ignorance. We still know very little about motivating people to change living patterns.

The experiment could have failed to show a difference due to the Hawthorne or placebo effect. That is the experiment itself influenced the behaviour of the control mothers. The initial obtaining of consent, the entry questionnaire and the three monthly weighing could have been enough to motivate the changes. As in the case of the child that was filmed, the increased interest in the child could have had its own message. Did the mother perhaps understand that her child is also valued by others? Thereafter, in valuing it more herself, she helped the child to break through the barrier to catch up on lost growth. All this remains conjecture. We must work hard for a better understanding of the issues involved. So many who are "told" to change do not. Others who were never "told", do change for the better. Why?

Stott[2] talks of a cascade of antecedants to human behaviour or behaviour change. "Telling" and information is only one of the many factors in the cascade. There are previous life experiences, beliefs, feelings and obstacles, to name a few, that are all interconnected. Each weighs differently in every interaction between a doctor and a patient. One thing is now clear there is no straight line effect from ignorance via information to appropriate action. Information can only help if the other factors in the complex system cooperate to fascilitate life style changes. Each of us know people who suffer from the effects of smoking and are intellectually convinced that it is harmful but still continue to smoke. Not all those who are persuaded of the value of seat belts, wear them, even under the threat of a fine.

Another approach, one of sharing ideas between doctor and patient in the consulta-

tion, has been studied by Tucket and colleagues[3]. They talk about **Meetings between experts.** They studied a thousand general practice consultations in the UK. They "found that consultations in which there was evidence that a doctor had inhibited or evaded a patient's ideas, were less likely to result in a patient being committed (to what their doctor said about treatment) than in those in which there was no such evidence". They recommend that, "A change in the medical ethos which so easily devalues patients' contributions, will be one of the first steps necessary if communication between doctors and patients is to be improved".

To progress on the road to motivate people towards healthier living it seems that there will have to be less "telling" and more mutuality in the consultation. We will need more listening, and respect of one another as experts.

Sam Fehrsen

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1. Glatthaar II, Fehrsen GS, Irwig LM and Reinach SG. Protein Energy Malnutrition: the Role of Nutrition Education in Rehabilitation. *Human Nutrition: Clinical Nutrition.* 1986; **40c:** 271-85.
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3. Tuckett D, Boulton M, Olson C and Williams A. Meetings between experts. London: Tavistock Publications, 1985.

Guest Editorial

Our Vocation and Responsibility

There must be very few doctors today who do not realise that the rate of accumulation and obsolescence of medical knowledge and skills is now so great that not only does everyone require vocational training but that education must continue throughout the whole of our professional lives.

While most doctors understand their unmet needs as can be seen by the growing membership of the Academy, by no means all who have benefited from the efforts of those in the Academy have joined.

As Philip Rhodes[1], Professor of Postgraduate medicine has stated:

The leaders of the general practitioners to their lasting credit turned to the old friend of education as the remedy. They defined the nature and content of general practice, with especial emphasis on the consultation. On these preliminaries they were able to define desirable standards and then to assess them, by introducing vocational training and more formally by the examination for membership of the Royal College of General Practitioners.

The results have been astonishing in the improvement of general practice, with sanctions re-inforced in 1979 by the Vocational Training Act.

The role of education in the furtherance of general practice has been triumphantly vindicated and should be recognised for being so. It has shown the interaction of education with standards of service over the course of only 30 years or so. From being the Cinderella of medicine, general practice now attracts from among the best graduates, who are technically competent in a narrow medical sense, but in addition know of and consider the contexts in which their branch of medicine is practised. They begin to appreciate the nature of the interactions between general practice and the various types of societies in which it operates. These have various nuances of psychology, sociology and ethical and moral values, as well as political ones.

Consequently, as in other countries if those in family practice/primary care wish it to be relevant, significant, meaningful and satisfying, they, like their overseas colleagues, should be members of their vocational academic body.

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1. Rhodes P: Educating the Doctor. Postgraduate, Vocational and Continuing Education. Br Med J 1985; **290:** 1808.