HEALTH EDUCATION

The role of the Family Physician

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A paper presented at the 11th International Conference on Health Education.

Throughout the world there exist widely different needs in the field of Health Education. On different stages different players each have their own specific roles. In this paper the stage and the players are Australian. The time — contemporary.

For some it might seem that this is a topic barely worth discussion, but for either of two quite disparate reasons.

One group will hold the view that physicians have a place in the centre of health education, of right the Rons Et Origo of all pertaining to health.

The other maintains that physicians relate to disease only, have no place and profess no interest in a subject for which they have had no formal training, that the main body of Family Physicians, being sickness orientated, percieve an ecomic threat in health education.

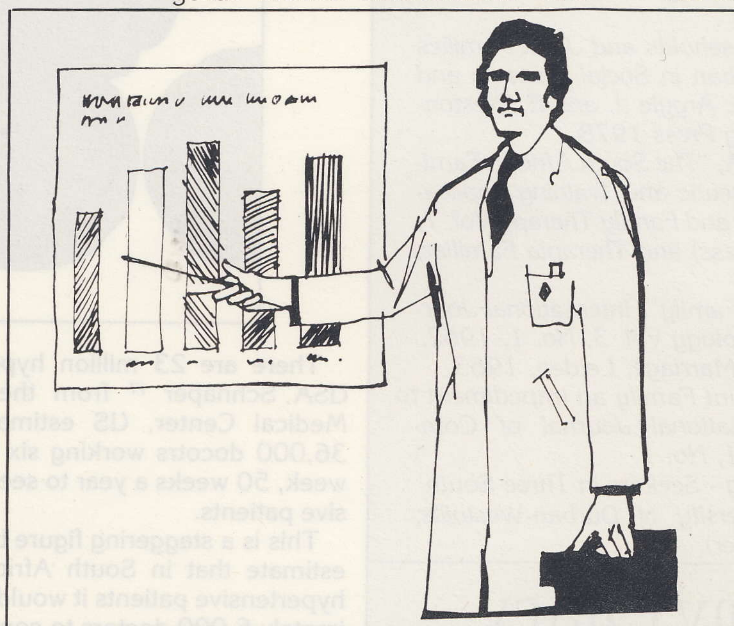
Like many entirely polarised viewpoints, neither are accurate, though they both have a basis of truth.

As a Family Physician, I detect an attitude that suspects the reasons for my involvement, wondering why I'm not busy treating the sick, and earning dollars under a free enterprise 'illth' system.

The obvious reason is the current oversupply of physicians in Australia and the spill of 'specialists manques' has been dumped on family medicine, that I have a pain in my hip pocket and have gone into health education to make up the deficit.

There is of course a parallel view that might regard health educators as failed physicians desperately trying to make up leeway — at least according to recent quasi-authoritative utterances from on high.

The new breed of bewhiskered males and levied young ladies of the genus "eruditor vivax sanitatis" occasionally seems to discount 20 or 30 years of experience of patient contact,as the average Family Physician's curricula vitae lack, unlike theirs, a major in psychology, sociology or communications.



What of the physician — affluent in his imported sedan, aloof, operating in an atmosphere of authority, concerned only with the immediate win or no-win situation. Needed, but no longer 'beloved' family doctor, having no interest other than that of treating the obvious disease process and with no concern for the social processes at work to produce disease.

Both of these are deliberate caricatures, but like caricatures in general, possess a basis of fact.

In the past Family Physicians have had little public involvement in health education and have not been obviously concerned with Preventive Medicine, though in fact they practise both functions daily.

The discipline of Health Education has practitioners originating from outside the field of medical science and rarely integrates eith the health care team in the field. This probably relates to their funding, which also determines their terms of reference – from Government or quasi-governmental bodies. Essentially, health educators have little or no contact with private fee for service practitioners. When did you last meet in a private doctor's rooms?

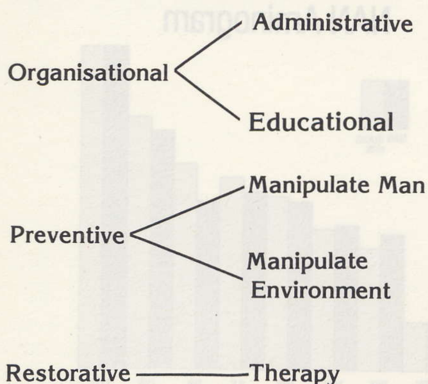
Indeed the only comfortable contact with medical practice that health education has is within the ambit of Health Departments, Community Health Centres, Child Health and Family Planning Clinics and University and Hospital Departments of Community Medicine — those that employ only salaried practitioners.

The terms of reference are also obscure. Health Promotion — Health Education and Preventive Medicine. Are they all the same? Part of the same field but overlapping? or do Health Promotion and Health Education belong under Preventive Medicine? Grey areas generate problems.

Without embarking on the more esoteric techniques preferred by

those promotors of a discipline thirty years old and yet apparently anxious to establish 2,000 plus years of experience within that time framework: let's see where the two professionals integrate.

One conceptual framework of health care — to use the minimum jargon — divides health care into



Though there is much talk about the cost effectiveness of prevention by promotion and education, miniscule amounts are spent in these areas, the Commonwealth of Australia allocating less than 1/6000th of its annual budget for health promotion. The money goes to restorative medicine. In this area 80-90% of patient contact is with Family Physicians, but only 20-30% expenditure, the balance going to hi-tech hospital based medicine, with an estimated 50 cents in every dollar spent on those in the last year of their life.

This disparity between contact and cost in medicine serves to highlight the great potential of the Family Physician in this field.

Before examining the problems operative definitions need stating.

- **For Health Promotion** I use those of Green, (1979) "Any combination of related organisational, educative, economic and political interventions designed to facilitate behavioural and environmental changes conducive to health".
- **For Health Education,** the Joint American Committee on Health Education (1973) "Activities which increase the abilities of people to make informed decisions affecting their personal, family and community well-being."
- **For Preventive Medicine,** Medically indicated or prescribed action to either individuals or groups, where a threat to health exists, in order to prevent or arrest the development of disease. In these lie the key to the role of the Family Physician and his/her relation to health education — we operate when we perceive a threat to health.

The main problems are:

- The current discipline of Health Education has developed outside the framework of private medical practice, and with little reference to it, although private medicine is responsible for the major client contact.
- Physicians are currently perceived as, and too often see themselves as existing to treat established disease, rather than to prevent it, with certain standard exceptions: eg smear tests, immunisations.
- The points of contact between professional health educators and the mainstream of medicine are peripheral and intermittent, rather than central and continuous.
- The avowed stance of the upper echelons to Health Education, who apparently see their discipline as separate from the health care team.

What is the role of the Family Physician in health education, what is being done and what more can be done?

The physician who endeavours to build prevention into his practice, by saying every time he sees a patient, "Why did this condition occur? How can it be prevented?" becomes a health educator of the moment of maximum potential and, will find a whole field of new interest and reward.

Before considering this further, mention needs to be made of the "Iceberg of Disease Concept". Clinically recognisable or reported illness accounts for some 10% of disease. The peak of the iceberg is death and the lowest point below the surface is both the maximum of health, and the minimum of disease.

When the 'check-up', whether annual or intermittent, becomes no longer an insurance type examination, but rather a preventive maintenance schedule based on age-related mortality profiles, both the yield and satisfaction of medicine increase, and a whole new range of skills develop.

The physician who can train himself to look beyond each consultation, and produce a profile of his workload will not only learn much about his style of work, but of what he needs to learn about patient education and what his patients need to be taught. Contact with Health Educators of empathy and experience will more readily produce the correct answers in the most acceptable and effective way, by a combination of four key elements.

- The problem when recognised by those who see it first hand.
- The basic technical answer — both these provided by practising physicians.
- The cause of the problem.
- The presentation of the answer in the most communicable and acceptable way to the target group — based on the latest available Health Education methodology.

Thus Primary Physicians serve ideally as both determiners of need and resources of information for health education.

The potential role of the Family Physician in first contact health education cannot be understated in terms of either amount or effect. However imperfect the eruditors might consider the physicians' techniques to be, one thing must be remembered — the undeniable impact of information coming from the traditional authority at the most teachable moments of all — discomfort or pain, reinforced by the either/or choice — utilises the most powerful motivator of all — fear of illness or death.

Though arguably not the most cost effective method, or the most desirable, the sheer numbers of contacts endorse this paramount function, for example, the effects of British General Practitioners on smoking habits.

Consider the check-up as applied to the young professional, or university student. Vehicle accident, other accident and suicide are the main causes of death. The clinical examination though important, becomes perhaps secondary to the behavioural inquiry. Information on seat belt, hotted-up engine, alcohol and driving, other activities, interpersonal relationships, sexuality are

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