INVITED COMMENTARY

TRAINING GENERAL PRACTITIONERS*

BRIAN R. McAVOY

Department of Primary Health Care, School of Health Sciences, University of Newcastle upon Tyne, Newcastle upon Tyne NE2 4HH, UK

(Received 25 July 1996; in revised form 28 August 1996)

Abstract — Nationally there is no standardized system for the education and training of general practitioners (GPs) within the UK in relation to prevention, early detection and management of alcohol problems. A number of surveys over the past 20 years have confirmed GPs' role legitimacy concerning working with excessive drinkers, but identified a lack of role adequacy and role support for this work. However, there are considerable constraints present in current UK general practice which limit opportunities for education and training of GPs. A possible way ahead may be to encourage general practitioners to utilize a screening and early intervention programme, coupled with ongoing support and imaginative use of other primary health care workers, community workers and the secondary services.

INTRODUCTION

Training general practitioners (GPs), particularly in the field of alcohol-related problems, is not an easy task. Indeed, the process has been equated with that of 'herding cats' (S. Cohen, personal communication). This paper has three purposes: (1) to review what we know about GPs' attitudes to and experience of education and training relating to alcohol problems; (2) to describe some of the constraints of current UK general practice; (3) to present some preliminary results from a WHO study which may offer a way ahead.

SURVEYS OF GENERAL PRACTITIONERS

Over the past 20 years, there have been a number of studies to ascertain GPs' attitudes to and opinions on detection and management of patients with alcohol problems. The earliest work was probably the Maudsley Alcohol Pilot Project (MAPP), which in the late 1970s claimed that the main reason many problem drinkers went undetected was that health professionals did not have the necessary skills to identify them (Shaw et al., 1978).

In 1984, a postal questionnaire study (Anderson, 1985) of 467 GPs in Oxfordshire and Berkshire elicited that nine-tenths thought that they had a legitimate role in working with patients with drinking problems, but less than half thought that they were adequately equipped to perform this role. Only two-fifths felt motivated to work with drinkers, less than one-third were satisfied with the way in which they worked with drinkers, and fewer than one in ten obtained work satisfaction from working with drinkers.

A postal questionnaire survey of 1291 GPs in the Oxford region in 1994 (Coulter and Schofield, 1991) revealed that GPs' attitudes to their role in prevention and health promotion were very positive and a large majority claimed to discuss health-related topics with their patients when indicated. Twenty-six per cent said they discussed alcohol intake as a matter of routine with all their adult patients.

A postal questionnaire study of GPs in England and Wales in 1994 (J. Strang, personal communication) suggests that there has been an increase in role legitimacy since the MAPP research but that,
despite all the efforts that have gone into educating and training the medical profession to detect and intervene with excessive drinkers, general practitioners still lack role adequacy and role support for work in this area.

These findings are consistent with the most recently performed questionnaire survey, conducted at the end of 1995 and beginning of 1996, as part of a WHO Collaborative Study. Phase I of the study involves the development of a valid and reliable screening instrument for the identification of hazardous and harmful alcohol consumption — the AUDIT, the Alcohol Use Disorders Identification Test (Saunders et al., 1993). Phase II is a randomized control trial of three methods of brief intervention for hazardous and harmful alcohol consumption (Babor and Grant, 1992). Phase III, which involves 14 countries, is a controlled trial of methods to encourage uptake and utilization by GPs of early intervention against excessive alcohol consumption (see Saunders et al., 1992).

There are three strands to Phase III of the study. The first is a questionnaire survey of GPs, the second a survey of GPs and key stakeholders and decision makers in the health care system and the third a randomized controlled trial of methods to encourage uptake and utilization by GPs of an early intervention package. This study will provide important information on effective strategies for increasing GP involvement in early intervention for hazardous and harmful drinking problems. It will be the first study in Britain to examine systematically the development and marketing of such strategies in primary care and is likely to have generalizable applications to other treatment innovations in general practice.

The aim of the Strand 1 study is to assess and document GPs’ knowledge, current practices and opinions on early alcohol intervention, preventive medicine and the treatment of established alcohol dependence, and how they perceive their roles in providing these interventions. It also seeks their views on barriers and potential incentives to provide early intervention. The questionnaire was piloted in eight countries. As the UK component of the WHO Strand 1 study, a random sample of 430 GPs was drawn from the Family Health Services Authority (FHSA) lists in Leicestershire, Derbyshire and Nottinghamshire, one GP from every practice. A covering letter was sent with a pre-paid envelope and there was a reminder telephone call to all non-respondents after 2 weeks, with two further questionnaires being sent out.

The response rate to date is 68%, 76% of respondents were male and 78% worked in group practices; 50% of practices were urban, 16% rural and 34% mixed urban/rural. The mean age of respondents was 45 years, with the average number of years in practice being 13. As in previous studies, there was a strong expression of role legitimacy concerning working with excessive drinkers, with 57% prepared and 26% very prepared to counsel patients about reducing alcohol consumption. However, only 20% felt they were effective in helping patients reduce alcohol consumption, but 58% believed that given adequate information and training they could be effective or very effective.

These figures can perhaps be explained by the fact that 42% of respondents reported <4 h total postgraduate training, continuing medical education or clinical supervision on alcohol. The equivalent figure from an earlier study (Anderson, 1985) was 66%.

CONSTRAINTS OF CURRENT UK GENERAL PRACTICE

It is ironic that, at the very moment when politicians are proclaiming a primary-care-led National Health Service (NHS), there is widespread concern among GPs over job satisfaction, morale, autonomy, workload, bureaucracy, recruitment and retention (Olsen, 1996). The realities and difficulties faced by UK general practitioners today were starkly revealed during the Strand 1 questionnaire survey. After 2 weeks, the response rate was only 32% and so, following the protocol, non-respondents were telephoned. A total of 267 general practitioners were eventually contacted and their reasons for not having responded ascertained. Forty-six per cent stated that it was because: they were too busy; they did not answer questionnaires; they were not interested in research. Researchers certainly need to be aware of the constraints of service general practice (McAvoy and Kaner, 1996). In 1985–86 the average time spent on general medical services in a working week (excluding on-call) was 38 h. In 1989–90 this had risen to 41 h, and by 1992–93 to 43.5 h.
The most recent survey (British Medical Association, 1996), also revealed significant changes in recruitment and the patterns of working. Between 1988 and 1994 there has been a 15% decrease in the number of general practice registrars. Between 1990 and 1994, there has been a 50% increase in the number of GPs working three-quarters time, and nearly a five-fold increase in the number working half-time. GPs are clearly under enormous pressure and it seems to be increasing as we move towards a primary-care-led NHS.

THE WAY AHEAD?

Some of the information gleaned from the Strand 1 questionnaires relating to the disincentives GPs perceived for early alcohol interventions may help plan future approaches. Apart from the ever-present time constraints, 62% identified not being trained in alcohol counselling and 51% non-availability of suitable materials as important factors. These issues, particularly the latter, are being addressed in Strand 3 of the WHO Collaborative Study — a randomized, controlled trial of methods to encourage uptake and utilization by GPs of early intervention against excessive alcohol consumption.

The aim of the study is to investigate the most cost-effective marketing strategy to influence GPs to take up an early alcohol intervention programme (the DRINK-LESS programme, incorporating the AUDIT instrument), and thereafter the most cost-effective training and support strategy to encourage long-term utilization of the programme.

In the UK Strand 3 study, a sample of 729 GPs has been randomly selected, one per practice, from the FHSA lists in the Northern and Yorkshire Region. The study design involves two phases: uptake and utilization. The former involves three marketing strategies: direct mail (written information is posted to the GP), telemarketing (trained research staff encourage the GP by telephone to take up the programme) and personal marketing or academic detailing (trained research staff personally visit the GP and encourage use of the programme). The utilization phase involves three levels of training and support: none, training and training plus support. The study only began at the beginning of 1996, but preliminary results involving 278 GPs, ~40% of the total sample, are available. In terms of uptake of the programme, telemarketing has proved to be very successful, with 83% of the practitioners agreeing to be involved. Academic detailing resulted in a 79% uptake and direct mailing produced a response rate of only 18%. In all three marketing groups, ~50% of those who requested the programme have agreed to utilize it, but at this stage it is not known what level of support will be required to sustain this.

Clearly, the results of the completed study are needed before any firm conclusions can be drawn. However, there is anecdotal evidence that many GPs are using their practice nurses and other members of the primary health care team to provide support and advice for patients identified at risk, and this has been confirmed by preliminary results from a survey of 390 primary health care workers in Waltham Forest (E. Roman, personal communication). The evidence for the effectiveness of opportunistic brief interventions for non-treatment seeking populations is much stronger than that for brief interventions in specialist settings for those seeking help. Such applications should be restricted to those with less severe problems/dependence (Heather, 1995). Consequently, GPs will still need appropriate support from specialist services.

GENERAL CONCLUSIONS

GPs have a strong role legitimacy concerning working with excessive drinkers, but express a lack of role adequacy and role support for this work. There is a clear need for more postgraduate education and training, but currently constraints relating to workload and morale in UK general practice make this difficult to implement. Screening and early brief interventions look promising, and could offer a way ahead, especially if combined with ongoing support and imaginative use of other primary health care workers, community workers and appropriate specialist services.

Acknowledgement — Strand 1 of the WHO Collaborative study was funded by the Yorkshire Regional Health Authority and Strand 3 by the Alcohol Education and Research Council. Thanks also to Dr Peter Anderson, WHO Regional Office for Europe and all the collaborating investigators.
REFERENCES


