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Prevention and health promotion in clinical practice: the views of general practitioners in Europe

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Abstract

Background. Disease prevention and health promotion are important tasks in the daily practice of all general practitioners (GPs). The objective of this study was to explore the knowledge and attitudes of European GPs in implementing evidence-based health promotion and disease prevention recommendations in primary care, to describe GPs' perceived barriers to implementing these recommendations and to assess how GPs' own health behaviors affect their work with their patients.

Methods. A postal multinational survey was carried out from June to December 2000 in a random sample of GPs listed from national colleges of each country.

Results. Eleven European countries participated in the study, giving a total of 2082 GPs. Although GPs believe they should advise preventive and health promotion activities, in practice, they are less likely to do so. About 56.02% of the GPs answered that carrying-out prevention and health promotion activities are difficult. The two most important barriers reported were heavy workload/lack of time and no reimbursement. Associations between personal health behaviour and attitudes to health promotion or activities in prevention were found. GPs who smoked felt less effective in helping patients to reduce tobacco consumption than non-smoking GPs (39.34% versus 48.18%, $P < 0.01$). GPs who exercised felt that they were more effective in helping patients to practice regular physical exercise than sedentary GPs (59.14% versus 49.70%, $P < 0.01$).

Conclusions. Significant gaps between GP's knowledge and practices persist in the use of evidence-based recommendations for health promotion and disease prevention in primary care.

Keywords: Attitudes; Prevention; Health promotion; Clinical practice; General practice

Introduction

Disease prevention and health promotion are important tasks in the daily practice of all general practitioners (GPs). A recent suggested definition of general practice emphasizes the role of GPs in prevention, stating that 'the general practitioner engages with autonomous individuals across the fields of prevention, diagnosis, cure, care and palliation, using and integrating the sciences of biomedicine, medical psychology and medical sociology' [1].

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[1] EUROPREV (The European Network for Prevention and Health Promotion in General Practice/Family Medicine - www.europrev.org) is a network organisation within WONCA Region Europe – The European Society of General Practice/Family Medicine.

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Two thirds of the population visit their GP one or more times each year and 90% at least once in 5 years [2]. Therefore, GPs are in an excellent position to administer age- and sex-specific preventive and health promotion packages in an opportunistic manner, that is, when patients visit them for any reason. However, differences in the structure and organisation of practice in European countries are associated with a large variation in the degree of involvement of general practitioners in preventive activities [3]. The Canadian Task Force on the Periodic Health Examination [4] and the US Preventive Services Task Force [5], which are probably the most comprehensive preventive guidelines that have been published, recommend a very limited screening physical examination, relatively few screening laboratory tests and extensive risk-specific counselling. Nevertheless, studies carried out in the US have shown that family physicians perform extensive screening physical examination and many screening laboratory test of unknown effectiveness [6]. Moreover, a recent study has shown that less that half of all Americans receive some of the most valuable and effective preventive health services available to them [7]. Other countries have developed and evaluated their own guidelines, showing that there is an unequal level of performance depending on the preventive procedure and on the target population [8].

Previous research about the role of primary care physicians in prevention and health promotion has been concentrated on specific topics such as attitudes to and involvement in health promotion and lifestyle counselling [9], and perception of GPs in modifying behaviour [10].

The objective of this study was to explore the knowledge and attitudes of European GPs in implementing evidence-based, health promotion and disease prevention recommendations in primary care, to describe GPs' perceived barriers to implementing these recommendations, and to assess how GPs' own health behaviors affect their work with their patients.

Methods

Design

A postal survey was carried out using a pre-paid addressed envelope. We developed and pre-tested a questionnaire that included the following parts: the first with demographic and professional data (10 questions), the second one with two clinical scenarios comprising a list of different preventive and health promotion activities with two different columns for responses—beliefs and attitudes in practice (34 questions), a third part with items related with barriers in implementing preventive activities (6 questions) and the last part which included items concerning personal health behaviour (21 for GP males and 25 for GP females).

The questionnaire was translated and adapted from English into the different languages (except for Malta where English is an official language), being piloted with ten GPs in each country. A random sample of GPs from databases which listed GPs from national colleges of each country was selected.

Preliminary results of this survey, specifically those related to advising overweight and sedentary patients, have already been published as part of another project [11].

Sample size calculation

With an estimated true proportion of 0.5 (the most conservative estimation), the maximum acceptable difference of 0.05, and an alpha error of 0.05, the required sample size was calculated per country according to the number of GPs affiliated to each college, except for the case of Greece where GPs were randomly selected from a list of all GPs registered in the Greek national journal.

Assuming a minimum rate of participation of 50%, sample size was increased to compensate for anticipated loss. This was done by multiplying the sample size by the quantity $1/(1 - d)$, where d is the anticipated loss.

In some countries, as in the case of Malta, the questionnaire was sent to all the physicians, due to the small number of GPs listed. The survey instrument and an addressed stamped return envelope were mailed to all physicians from June to December 2000. Those who did not respond received follow-up mailings and/or telephone calls.

Statistical analysis

All the collected questionnaires were sent back to the coordinating and data management centre, assuring a centralised data entry and analysis. Mean and standard deviation for continuous variables and percentages for categorical variables were computed. Bivariate comparisons for categorical variables were performed using chi-square at the 0.05 level of significance. All analysis was performed using STATA programme (version 5.0).

Results

Eleven European countries participated in the study (Croatia, Estonia, Georgia, Greece, Ireland, Malta, Poland, Slovakia, Slovenia, Spain and Sweden), giving a total of 2082 GPs. The mean age was 44 years (SD 9.5, 23–84), and 60% were female. Table 1 shows sample size, age and sex characteristics of respondents by each individual country. The mean response rate was 54%, ranging from 50% in Malta to 65% in Croatia.

Professional characteristics requested in the first part of the questionnaire are shown in Table 2.