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A study was initiated to assess the effectiveness of broadcast television in the post-medical education of practicing doctors in Britain. High quality programs presenting new medical knowledge were broadcast in an effort to promote continuing education of general practitioners working away from centers of medical sciences. Studies using mailed questionnaires and interviews to assess the breadth and reaction of the viewing audience revealed that a remarkably low number of doctors (7% to 21%) tuned in the programs. Reactions from sample panels of viewers tended to be unspecific. Although the study is small, sporadic and not statistically significant, making it impossible to draw conclusions about defects in particular programs, the overall conclusion is that the programs were not having a serious educational impact. (BB)

ASSOCIATION FOR THE STUDY OF MEDICAL EDUCATION

REPORT ON RESEARCH INTO THE EFFECTIVENESS OF MEDICAL TELEVISION PROGRAMMES, FEBRUARY, 1966 - JULY, 1967

February, 1968

Foreword

The United Kingdom is in advance of other European countries in the field of broadcast television programmes for post-graduate education of general practitioners. Two separate series, on B.B.C. and Independent Television, have provided a remarkable coverage of advances in medical knowledge and techniques for family doctors to view in their own homes for nearly five years. The quality of these programmes stands up well to those produced elsewhere, particularly in North America, as the award of the first three places to British programmes in a recent Canadian Festival goes to prove. It is much less certain to what extent such broadcasts are in fact viewed or valued by doctors or what influence they may have on current medical practice. Attempts to evaluate these factors have been made in America, notably by McGuinness and his colleagues and by others. In this country Cameron and Bell and Shaw have made some assessment of the reception of the local programmes and Cameron has also attempted to prove some effect on the individual doctor's knowledge. Factors of time, expense and experience in this field of investigation make it difficult for the medical teachers who produce the programme also to carry out effective research. The appointment of two Research Fellows, attached to A.S.M.E. and to the University of Glasgow and financed by the respective authorities of the Ministry of Health in England and the Home and Health Department in Scotland, was a welcome addition to the situation as regards manpower and finance. This has permitted further and more detailed investigation of medical viewing habits and of the practitioners' views on programme content. Both in England and in Scotland, however, the researchers have met a number of difficulties. The first has been the relatively small number of regular viewers and associated with this the poor response to all postal questionnaires. The number of research personnel available has not permitted a large series of personal interviews but where these have been carried out the chief feature is a general apathy or at best a very limited enthusiasm. A second difficulty has been the lack of available 16 mm film copies of the B.B.C. programmes which made captive audience assessment impossible; other troubles beset attempts to organise viewing groups for the Scottish films. Finally, the techniques of assessing changes of attitude in response to viewing television are highly specialised and not fully developed; nor were the researchers experienced in these newer techniques. Nevertheless, before his departure to another

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post, Mr. Barkla had designed a trial which might have given some indication of whether or not doctors were acquiring and using new information from these programmes.

The work presented here is complete enough in itself; but before the evaluation of effectiveness and possible change of attitude in doctors is made, very careful study should be made of the scope, nature and technique of the research in collaboration with others working in this and parallel fields.

The Association for the Study of Medical Education is most grateful to the Ministry for making funds available for the present study and to Mr. Barkla for his work in carrying it out and regrets that it has not proved possible to include evaluation studies in the present work.

The research as presented here is in several parts:-

1. Exploratory Studies to investigate transmission times and means of making contact with the doctors. This work revealed disappointingly small numbers of viewers which had implications for further work. However, it allowed the researchers to plan a number of approaches (pp 3).
2. Final Study: four approaches were planned:-
   a) Use of pairs of films with invited audiences.
      This proved unhelpful for a number of reasons (pp 4.2.).
   b) Use of lunch-time viewing groups to assess acquisition of information. This was not in fact used (pp 4.3.).
   c) To obtain further information from sample panels of home viewers.
      This forms the chief part of the report (pp 4.4.).
   d) To examine retention of factual material in the programmes. This work was carefully designed and prectitioners selected according to the design of the experiment. Mr. Barkla's departure and the passage of time between viewing and the final questioning led us to abandon this particular experiment although the plan is included in the report in some detail as it could be used for any future study.

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REPORT ON RESEARCH INTO THE EFFECTIVENESS OF MEDICAL TELEVISION PROGRAMMES, FEBRUARY, 1966 - JULY, 1967

EXPLORATORY STUDIES:

At the outset of the research, it was hoped to discover how far open-circuit medical television programmes were interesting, comprehensible, memorable and influential to doctors. The research was to be concerned both with the B.B.C. series 'MEDICINE TODAY' and the I.T.V. series 'POSTGRADUATE MEDICINE'with particular reference to the response of general practitioners to the broadcasts. Previous work carried out by A.S.M.E. with the help of Messrs. Smith, Kline & French Ltd. had suggested that each programme was watched and liked by a substantial proportion of G.P.'s and that they tended to watch several programmes in a series. But few detailed comments were available to supplement this and moreover it was recognised that the sample was drawn from a self-selected population (those who had returned a card to A.S.M.E. saying that they had access to BBC-2) which might have been unrepresentative of doctors in general. Because of the concern of A.S.M.E. and others that the programmes should benefit the professionally isolated doctor, it was considered that the first step in the research must be to establish contact with an 'unselected' group of doctors and carry out an exploratory study of their experience with medical television broadcasts.

1. Compiling the List of Broadcasts

1.1. The dates of transmission of B.B.C. programmes were known but their implications were not entirely clear because of the successive extensions of the areas receiving BBC-2; these extensions usually go through a pilot stage before becoming fully operational and there are additional changes in their boundaries subsequently. The original dates of transmission of I.T.V. programmes by Scottish Television Ltd. were also known but it proved unexpectedly difficult to discover the full extent and dates of their re-transmission by other programme companies.

1.2. A list of transmissions, including re-transmissions up to the end of May 1966, was produced in June and information was also sought about future plans. This was not always available, partly because of the short notice at which re-transmissions can be arranged and, although our information now seems reasonably good, it is not absolutely reliable. For instance, we heard accidentally of one large company's intention to re-transmit the I.T.V. Autumn 1966 programmes a few days before re-transmission began.

2. Making Contact with Doctors

2.1. At the outset it was believed that doctors would be unwilling to be interviewed. So a survey of most of the N.H.S. G.P.'s in the Sevenoaks area was carried out in June to examine the problem and to seek ways of overcoming it.

2.2. The outstanding points that emerged were:

a) that there was hardly any objection to being interviewed even at some length.

b) that the method was inefficient, not merely because of the time needed for arranging appointments but because so many doctors had seen so few programmes,

c) that part of the non-viewing was due to lack of publicity and lack of access to BBC-2,

d) doctors who had seen one programme were not usually avid for the next but hardly any specific criticisms could be got out of them,

e) it was as if each doctor believed that the series was probably very good for other doctors.

2.3. The current I.T.V. programmes were not available in the Sevenoaks area and members of the Glasgow and Newcastle Postgraduate Medical Boards felt that it would be useful to carry out a similar exploratory survey in their areas where the I.T.V. programmes had been extensively publicised to G.P.'s by circulars.

2.4. This survey was made by post, addressed to a random sample of about 8% of the N.H.S. G.P.'s in each area but the communication was made as personal as possible in the hope of retaining a good response

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rate; it succeeded fairly well. The methods and results are briefly described in a report to the Research Sub-Committee entitled Summer 1966 Survey of Postgraduate Medical Television Programmes, written by Miss Arlene Smith (for Glasgow Postgraduate Medical Board) and myself.

2.5. The results were reasonably concordant with those of the Sevenoaks survey and more definitely quantifiable. The main points were:

(1) Only about 6% of G.P.'s had seen half the available programmes or more than half; a further 15% had seen more than a third.

(2) Each programme in the I.T.V. series was seen by between about 7% and about 21% of G.P.'s (median about 15%). The corresponding figures for B.B.C. programmes were lower but they had not been publicised at all.

(3) A consequence of these points is that any particular pair of programmes could be compared by only 2 - 5% of the doctors, including a disproportionate number of the few heavy viewers.

(4) Hardly any specific comments on the programmes were made.

(5) There was no sign of association - either positive or negative - between watching programmes and attendance at clinical meetings or courses.

3. The Implications of the Exploratory Studies for Further Work

3.1. These results offered no very good basis for prediction because almost every aspect of the situation was subject to change and several important aspects did in fact change; publicity for B.B.C. programmes and brochures (a sort of pre-script) about the I.T.V. programmes was issued; and I.T.V. programmes were linked more closely in content and transmitted at weekly instead of monthly intervals.

3.2. All these things might have led to large increases in the number of doctors viewing each programme and to more regular viewing by individual doctors. On the other hand, they might not, and it would have been unreasonable to ignore the preliminary findings in planning more definitive research.

3.3. If the audience for the average programme were about 15% of G.P.'s it might still be a worthwhile one (it would be altogether about 3,500 for B.B.C. programmes and 400 or more for I.T.V. programmes, depending on how widely they were retransmitted) but it would be too small to yield useful detailed information about particular programmes by random sampling of unselected G.P.'s.

3.4. We should have had to contact something like 600 G.P.'s to be reasonably sure of finding twenty who were able and willing to make comparative comments on any particular pair of programmes.

3.5. There were other issues which, it was suggested, could be tackled by a simple questionnaire, e.g. whether brochures or postscripts are useful and whether weekly broadcasts are more convenient than monthly ones. The questions were not as simple as they looked because doctors' experience of them was set in a very small range of contexts and so simple answers to them were unlikely to be really decisive.

Under these circumstances it seemed necessary to reduce the emphasis on statistical reliability for the sake of discovering material that could actually be used by the producers of the programmes. The first expression of the new aim (in the proposals submitted to the Research Sub-Committee in September 1966) was 'to study a sample of regular G.P. viewers ..... with a view to tailoring later programmes more closely to (their) needs.' But the phrase 'regular viewers' seemed in the light of the summer survey to be unsatisfactory since genuinely regular viewers were so few. It seemed better to say: "to study samples of G.P.'s who can discuss two or more programmes comparatively".

4. FINAL STUDY

4.1. This section deals only with the work involving doctors in England (except the Tyne-Tees area) and Wales. Similar work in Scotland and the Tyne-Tees area is reported separately by Miss A.J. Smith of Glasgow University. Four approaches were made to the problem of eliciting comparative evidence about programmes:

4.2. To use pairs of films of earlier programmes with invited audiences, followed by questionnaires and discussion.

For most of the programmes in the B.B.C. series, no films were available. It was difficult to justify the very high cost of having them specially made since at least four, and perhaps more, would have been needed to permit even the most tentative generalisations.

4.2.i. After some delay it was possible to select a number of films from the I.T.V. series suitable for use with invited audiences in S.E. England. Two meetings were held on these lines but they were not very satisfactory for several reasons.

4.2.ii. Very few doctors were present on either occasion.

4.2.iii. The proceedings were delayed because some of the audience had to arrive late - and since they were evening meetings, delay made them end unacceptably late.

4.2.iv. Discussion of the films did produce some useful points and it showed clearly how diverse the audience was but on the whole it was surprisingly unspecific; and, even more surprisingly, a good deal of it was not really about the films at all.

4.2.v. Structured open-ended questionnaires had been prepared for use at these meetings. On one occasion there was no time to use them and, on the other, they were filled up rather vaguely by most of those present.

4.3. To observe existing groups of doctors who meet regularly to watch BBC-2 transmission at lunch-time. (No groups have been found that watch the late night transmissions).

4.3.i. This would doubtless have given more stable responses than we could expect to get from groups invited specially and unfamiliar with the series. Unfortunately few such groups could be located and those that did exist seemed to be small and to have no time at all immediately after the programme for discussion.

4.3.ii. It is known that several large and apparently successful viewing groups now exist to which a consultant is invited to comment on the programme and answer questions. That of course makes it practically impossible to use the group in evaluating the effect of the programme itself though it is probably most valuable from the point of view of teaching.

4.4. <u>To elicit observations on the programmes from a sample of those watching at home</u>, because it can be assumed that viewing alone at home is a substantially different experience from viewing in a group.

4.4.i. For this survey, a semi-random sample of 225 G.P.'s on the Medical Mailing Company's list and a random sample of 225 doctors receiving A.S.M.E. Postscripts was invited, in advance of the Autumn 1966 and Winter 1967 programmes, to offer comments on at least two of those programmes at the end of the series.

4.4.ii. About one in five of the Medical Mailing Company sample and about two in five of the A.S.M.E. sample accepted the invitation and thus constituted two 'panel' groups.

4.4.iii. Immediately before the last programme (the sixth) in the series they were asked for their comments on specially prepared open-ended comment sheets.

4.4.iv. The same request (with an appropriately different introduction) was sent at the same time to a further 72 G.P.'s on the Medical Mailing Company's list.

and 4.4.v. A further 75 doctors receiving A.S.M.E. Postscripts who had <u>not</u> been invited to join the panel; these constituted two 'sample' groups.

4.5. The different groups could be described as:

A. Doctors who were already more or less regular viewers and interested enough to want to comment (the A.S.M.E. list panel).

B. Doctors who were willing to become more or less regular viewers and interested enough to want to comment (the Medical Mailing Company list panel).

C & D. (the two sample groups).
Doctors representing the populations from which Groups A and B respectively had come, offering some check on the bias induced by the self-selection of Groups A and B and on the bias induced in Groups A and B by watching programmes in the knowledge that they were going to comment on them.

4.6. This survey is fully described below.

4.7. It is impossible to say definitely whether respondents failed to comment because they couldn't or because they wouldn't. But there is some indication that their own view, on the whole, was that the programmes had been welcome and useful refreshers but had not taught them much new. Even if that were true, it is still disappointing that they said so little about the different modes of presentation that were used in the different programmes.

4.8. To examine the retention of factual material in the programmes, mainly among those who had watched them at home. This was undertaken after the previous study in the hope of determining what, or whether, viewers were in fact learning from the programmes, whatever their own opinion on that point. The plan was essentially to compare the scores of doctors who had watched a particular programme with the scores of doctors who had not watched it on a questionnaire of 24 'yes or no' factual items based on material in the programme. Dr. J.F. Stokes prepared such questionnaires for most of the 1966 programmes.

4.9. The questionnaire was to be administered by trained interviewers employed by M.A.P.S. Ltd., a research company and accustomed to interviewing doctors, and it was hoped that in face-to-face interviews doctors might also make more specific comments about programmes than they were willing to put in writing in postal surveys.

4.10. It could safely be assumed that substantial variations in scores would occur because of differences between doctors and differences between topics in prior knowledge of the topic. So it was considered essential to use a rather strong quasi-experimental design for the survey; namely to concentrate on four programmes, collecting scores only from those who had seen 1 and 2 but not 3 or 4, those who had seen 1 and 3 but not 2 or 4, and so on.

4.11. That design demanded a first stage to identify the doctors who had seen particular programmes and to see whether any set of four programmes had enough viewers of each of its six pairs living in a reasonably compact area. This first stage was carried out by a simple postal enquiry in June 1967.

4.12. The work is fully described in the report to the Research Sub-Committee entitled: Retention Study of Medicine Today programmes.

4.13. The main point that emerged from the first stage was that no set of four programmes had enough viewers to sustain the original design; the best set had about two-thirds of the required minimum in its worst pairs.

4.14. The minimum had been set at 30 interviews which would probably need about 35 initial contacts. The minimum was of necessity arbitrary, since we could not know in advance what the distributions of scores on the questionnaires would be. This shortfall does not imply that the extent of viewing was less than the previous survey had led us to expect.

4.15. The postal enquiry was sent to all N.H.S. G.P.'s on the Medical Mailing Company's list in London, Middlesex, Surrey and Essex (about 4,000).

4.16. Assuming that about 25% were on the A.S.M.E. list and assuming viewing patterns and response rates similar to what we had found in the previous survey, it was possible but by no means certain that we would find enough viewers to fit the research design.

4.17. It would have been possible to supplement the number of interviews on each programme by approaching, in addition to those who had seen two of the four programmes, those who had seen one or three, although that would have been a rather weaker design.

4.18. However, misgivings had arisen earlier among officers of A.S.H.E. about the study on the grounds that programmes were not really intended to convey factual information and, even if they were, doctors could not be expected to retain any such information for more than a few months. These misgivings now recurred and the retention study was stopped, pending a review by the A.S.M.E. Council to be held in September, 1967.

Report on Final Study on a Sample of Lone-Viewing General Practitioners (v. Para. 4.4. above)

Although the original aim of the research included the idea that medical television programmes might reach more doctors (and, in particular, more isolated doctors) if they were altered in some way, preliminary research indicated that non-viewing doctors were so many and so diverse that any such alteration would be hard to plan. Non-viewing doctors were also very inarticulate about why they were not viewing, apart from the undisputed facts that transmissions were at inconvenient times and not well publicised.

In September 1966, the Research Sub-Committee of the A.S.M.E. Television Section therefore decided to undertake a study of the satisfied minority of 'regular viewers' to see what they were gaining from the programmes and whether they could be made even more satisfied. It was decided to ask doctors for detailed written comments, prompted by rather broad questions sent by post and to follow these up by personal interviews with a smaller number of respondents.

Essential to this plan was to find a large number of doctors who were interested enough, not only to have watched programmes but to write about them. One way was to invite a group of those who were (at their own written request) receiving A.S.M.E. Postscripts, to commit themselves in advance to watching certain programmes knowing that they would subsequently be asked for comments on them. Such a group might be excessively keen, so they were supplemented in two ways; firstly, by inviting a more or less random selection of G.P.'s to commit themselves in the same way and, secondly, by asking, after the programmes, for comments from two similar groups of doctors who had not been invited in advance to watch. These were the four groups:

1. Doctors receiving A.S.M.E. Postscripts, committed to watching, then asked for comments.
2. Randomly selected G.P.'s, committed to watching, then asked for comments.
3. Doctors receiving A.S.M.E. Postscripts, asked without warning for comments.
4. Randomly selected G.P.'s, asked without warning for comments.

It was expected that Group 1 would produce most responses and Group 4 fewest but the main point was to see whether those in Group 4 who were regular viewers were obviously different from those in the other three groups.

This report deals with doctors in England outside the Tyne-Tees Television area, together with very small numbers in Wales and Ireland. Apart from a few living in the TWW area, these doctors could receive only the B.B.C. series 'MEDICINE TODAY' in their homes and this report deals only with that series.

Procedures

The Original Samples

The four groups were constituted out of two original lists:

(i) A list, owned by A.S.M.E., of all the doctors to whom Postscript was sent. Any doctors could be put on that list simply by writing to ask for Postscripts to be sent to him or her. The list had grown gradually since the first programmes (on BBC-2 only). It had been pruned shortly before this research began but still contained a large proportion who had jointed it before BBC-1 transmissions began. After pruning it stood at about 3,600 but grew rapidly with the spread BBC-2 to over 8,000 in March 1967, of whom about two-thirds were G.P.'s and the rest were in hospital jobs or public health etc.

(ii) A list, owned by the Medical Mailing Co. Ltd., of all N.H.S. G.P.'s in the United Kingdom, arranged by counties, and intended primarily for postal advertising campaigns. It stands at about 23,000.

No list of names and addresses remains complete or accurate for long but both these lists were claimed to be up-to-date and in fact not many errors have come to light in either of them.

Previous work had suggested that about one-fifth of G.P.'s selected at random and presumably a larger proportion of those receiving Postscripts could be regarded as regular viewers - on the rather lenient criterion of having watched at least two programmes out of six - and expected to reply to a postal enquiry. In addition, it was thought that some others might be induced to become regular viewers by the direct invitation to take part in the enquiry. So it seemed likely that 300 doctors from each of the two lists would provide an adequate number of replies, especially if three quarters of them were invited to take part in advance of the programmes.

In principle, both groups should be random samples from the corresponding total list but that is not a simple requirement. In the circumstances we decided to ignore it.

The sample from the A.S.M.E. Postscript list was drawn simply by taking every 12th name up to a total of 300. As the list was in order of accession this is probably a fair approximation to randomness.

The sample from the Medical Mailing Company's list was stratified in an effort to see that different areas and practices were represented. It included 30 G.P.'s from each of the following counties: Middlesex (1 in 16), Buckinghamshire, Norfolk, Suffolk, Northamptonshire, Leicestershire, Somerset and Dorset and 60 from Cheshire (1 in 9). The sampling fraction was about 1 in 7 except where stated otherwise and the names were simply taken as they came from the beginning of an alphabetical list. This tended to over-represent family partnerships but I do not think that had any perceptible effect on the result.

All the G.P.'s on the A.S.M.E. Postscript list should also be on the Medical Mailing Company list so there was a chance that a particular doctor would be drawn in both samples. In fact only two or three were in both and they were counted as members of the A.S.M.E. list. In addition, some members of the sample from the Medical Mailing Company list might also have been on the A.S.M.E. Postscript list without having been drawn in the sample from it. The indications are that very few, if any, were actually in that position. The overlap was so small because most people on the A.S.M.E. Postscript list at that time lived in Greater London.

The two entire samples were divided into quarters, keeping members of family partnerships together. Three quarters of each were sent an invitation to join in the enquiry by returning a card stating their willingness to watch at least two of the next six programmes and subsequently comment on them. These groups will be referred to as'the A.S.M.E. panel' and 'the Medical Mailing Co. panel'. The fourth quarters were retained and were sent a request for comments at the end of the series. These groups will be referred to as 'the A.S.M.E. sample' and 'the Medical Mailing Co. sample'.

The Panel

The form of the invitation to the A.S.M.E. and Medical Mailing Co. panels is given in Appendix I. The intention was to word it so as to attract the largest possible number of acceptances and to see that those who accepted had adequate information about programme times. (The A.S.M.E. panel, but not the Medical Mailing Co. panel, would also have notice of successive programmes on each issue of Postscript. In addition, a publicity card was distributed by A.S.M.E. through executive councils to many, perhaps most, N.H.S. G.P.'s in England and Wales but it announced only three programmes - the second, third and fourth of this series).

It was thought that doctors were apt to throw away any communication that looked like a circular. The invitations to join the panel were sent in 5½" x 4¾" white envelopes with names and addresses typed, not machine-printed, and franked in three different ways; one-third with an ordinary 3d. stamp, one with an Isle of Man 3d. stamp and one by the London University Institute of Education franking machine. It made no substantial difference to the response rate.

The reply cards were sent unstamped but we have no positive reason for supposing that reduced the response rate. Nearly a fifth of the returned cards arrived back unstamped or understamped.

The invitations were sent out six days before the first transmission (on BBC-2; 13 days before the first on BBC-1). Nine-tenths of the acceptances were received before the first BBC-1 transmission and practically all the rest were received within three days after it.

The Request for Comments

The main practical questions were: how soon after the programmes should comments be sought? What sort of prompting should be given to show what sort of comments were wanted?

There is no ideal interval after which comments are most meaningful. Soon after the time of the transmission, comments will reflect the quality of the communication - how much of it is taken in. Later, comments will reflect the clarity and importance of its content - how much of it is remembered. We decided to send the request for comments, on all programmes, to all respondents, immediately before the last programme in the series.

The aim of the request was to elicit as many and as specific comments as possible on the content and style of the programmes. We did not know whether doctors would be put off by detailed headings or whether more general headings would fail to stimulate comment at all. So two versions of the comment sheet were drawn up, one more open, one more structured, and ten members of the sample were chosen at random and sent one or other version, immediately before the fifth programme in the series. From their replies it was clear that the open form would elicit only vague comments.

Stamped addressed envelopes were sent with all the requests, which were posted in white envelopes with names and addresses typed and franked by the Institute of Education machine.

Reminder letters were sent, with duplicate comment sheets and stamped addressed envelopes, to all those who had not replied three weeks later.

RESULTS

A. Response Rates, Biases, etc.

A.1. Of the 225 people on the A.S.M.E. list who were invited to join the panel, 85 (38%) accepted. Of the 225 on the Medical Mailing Co. list who were invited, 46 (20%) accepted.

A.2. Comment sheets were returned as follows (including those returned only after reminders had been sent):

Panel, ASME Postscript list	72(85%)	returned	out	of	85	sent.
Panel, Medical Mailing Co. list	40(87%)	"	"	"	46	"
Sample, ASME Postscript list	61(81%)	"	"	"	75	"
Sample, Medical Mailing Co. list	57(79%)	"	"	"	72	"

A.3. These responses are slightly higher than they look because the actual sample, and possibly also the panel, were slightly attenuated by removals that took place after the lists were compiled. The replies from the two sample groups may therefore be regarded as reasonably representative of the populations from which they were drawn. Even if there are respondent biases (e.g. if non-respondents tend to be non-viewers) they are not likely to make much difference to the results actually obtained.

A.4. But of course the original groups were self-selected or selected by me, or both, and even the sample group from the Medical Mailing Co. list may not be closely representative of English G.P.'s in general; for instance, it may be short of doctors who live in conurbations.

A.5. The panel groups were constituted from the same original lists as the sample groups and it was hoped that the panels and samples would not differ substantially except in the quantity and quality of comments on programmes.

A.6. There was no indication that the panels were biased in respect of the age or qualifications of members, or their location, or the proportions of them who were in single-handed practice, or (from the A.S.M.E. list) not in general practice. There was not much difference in the numbers of programmes they had seen. Table I gives the absolute number of doctors who had seen a given number of programmes. But the sample was only one-third of the size of the group invited to join the panel: Table I shows also in brackets - the numbers we could expect in a sample of 225 instead of 75.

A.7. It looks as though the invitation to join the panel was fairly successful in recruiting those who would in any case have viewed two or more programmes and excluding those who would not and it seems also to have induced a few people to watch more than they otherwise would have done.

Table I

	No. of respondents who saw the given no. of B.B.C. programmes						
	0	1	2	3	4	5	6
ASME Postscript List Panel	18	8	6	13	9	10	8
Sample of 225	(93)	(18)	(15)	(18)	(12)	(18)	(9)
Actual sample	31	6	5	6	4	6	3
Medical Mailing Co. List Panel	10	6	6	8	5	3	2
Sample of 225	(141)	(15)	(12)	(0)	(3)	(0)	(0)
Actual sample	47*	5	4	0	1	0	0

* Of these 47, nine said they have no TV at all.

A.8. But there are very sharp differences between the groups in the numbers of doctors who offered any comments on the programmes they had seen: see Table 2.

Table 2

Group	Respondents who offered comments No.	(% of Respondents)	Mean no. of programmes commented on (by each who commented)
ASME Postscript List			
Panel	38	53%	1.66
Sample	12	20%	1.67
Medical Mailing Co. List			
Panel	17	42%	1.53
Sample	4	7%	1.25

A.9. There are also some differences between the groups in the numbers of viewers for particular programmes. That can partly be accounted for in terms of the different prior information they had about programmes. The Medical Mailing Co. list sample had only the ASME card, received before the second or third programme, and my request for comments, received before the sixth. At the other extreme, the A.S.M.E. Postscript list panel had my invitation to the panel, received before the first programme, the Postscripts, which gave reminders of the dates of the first four programmes (subsequent Postscripts were sent out too late), the A.S.M.E. card and my request for comments. Table 3 gives the numbers of respondents who saw a given programme.

Table 3

Programme	No. of respondents who saw the programme				Total
	A.S.M.E. Postscript		Medical Mailing Co.		
	Panel	Sample	Panel	Sample	
1. Airways obstruction; carbohydrate intolerance	46	19	14	0	79
2. Autoimmunity and common diseases	28	16	20	2	66
3. Schizophrenia; painful shoulder	38	17	16	5	76
4. Early hypertension; myocardial infarct	26	20	17	5	68
5. Anxiety	27	15	13	1	56
6. Genetic Counselling: Oestrogens & Progestogens	28	11	9	4	52

A.10. There was no apparent substantial difference between the replies of those who replied quickly and those who needed a reminder letter but the proportion of additional replies after reminders was greater from the A.S.M.E. list than from the Medical Mailing Co. list and greater from the panel groups than from the sample groups. Altogether, about a third of the replies were sent after a reminder.

A.11. The only thing that seemed an important prior distinction between panel and sample groups was that members of the panel groups claimed more previous experience of watching 'MEDICINE TODAY'. Table 4 shows the percentages of respondents in each who claimed to have seen the given number of programmes before September 1966.

Table 4

Group	Percentage of respondents who saw the given number of B.B.C. programmes before September 1966 – None or no answer	1-4 or unstated number	5 or more	
ASME List				
Panel	26%	40%	33%	(99%)
Sample	25%	57%	18%	(100%)
Medical Mailing List				
Panel	40%	45%	15%	(100%)
Sample	73%	21%	5%	(99%)

A.12. It is surprising to find people on the A.S.M.E. list who claim to have seen no programmes but no less than 18% of the A.S.M.E. sample stated positively that they had not.

A.13. The number of programmes previously seen was related to the number seen in the present series. That was to be expected in the sample groups but it was true of the panel groups as well; Table 5 shows the number of respondents in the two panel groups, combined, who saw the given numbers of programmes.

Table 5

Number of programmes seen in the present series	Number of respondents who saw the given number of programmes before September 1966	
	0-4 or unstated	5 or more
0-2	50	4
3-6	32	26

A.14. Since the sample and panel groups do not seem to differ much, they are combined in subsequent analyses.

A.15. It has been suggested that viewers might include a disproportionately large number of up-to-date doctors or doctors who are not in general practice.
Table 6 shows the percentages of the respondents who qualified during a given period who watched the given number of programmes.

Table 6

Period of Qualification*	Actual number of respondents who qualified during this period	Percentage of respondents who saw the given number of programmes in present series		
		0 or 1	1 or 2	3-6
In or before 1939	61	45%	20%	36% (101%)
1940-49	65	40%	21%	38% (99%)
In or after 1950	103	50%	19%	30% (99%)

*'Qualification' means first medical degree or equivalent as recorded in the Medical Directory; where two qualifications were taken, the later is counted.

Table 7 shows the percentages of the G.P. and non G.P. respondents on the A.S.M.E. Postscript list who watched the given number of programmes.

Table 7

	Actual Number	Percentage of respondents who saw the given number of programmes in the present series			
		0	1 or 2	3-6	
In general practice	85	34%	17%	49%	(100%)
Not in general practice	47	42%	21%	36%	(99%)

A.16. It has been suggested that doctors who watch at lunchtime (BBC-2) may be more regular viewers than those who watch at night (BBC-1). Table 8 shows the percentages of the respondents who watched the given numbers of programmes who had watched at either transmission time.

Table 8

	Percentage of respondents who saw the given number of programmes at the given time	
	1 or 2	3 - 6
Seen mostly at night	74%	71%
Seen mostly at lunchtime	11% (85%; some did not answer)	28% (99%)

B. Views about Future Programmes

B.1. The comment sheet headed 'General Comments' included questions about the spacing of broadcasts and the number of topics to be covered in them. Most of the respondents who had actually seen programmes in the present series, and about a third of those who had not, expressed opinions.

B.2. On spacing, there was a majority in favour of the present pattern of broadcasts spread over the whole year, once a month, and the majority was greatest among those who had seen 3 - 6 programmes in the present series. But even among these, a quarter preferred broadcasts concentrated into two or three short terms, once a week.

B.3. On the number of topics, about 45% of those who had watched programmes were in favour of broadcasts consisting of a single item and about 30% were in favour of separate broadcasts, each made up of two or three short items. There was hardly any support for a series on a single theme or on connected topics (which is the ITV pattern).

B.4. Specific suggestions of topics for future programmes were invited and were given by 53% of those who had seen 3 - 6 programmes, 35% of those who had seen one or two and 12% of those who had seen none. Some of the suggestions were rather ambitious, e.g. a programme to show consultants what general practice is like and a programme demonstrating that many conditions cure themselves if left alone. All the specific suggestions are listed in Appendix 2.

C. Comments about the Programmes in the Present Series

C.1. The main purpose of the survey was to provide an opportunity for doctors who had seen more than one programme to make specific and spontaneous comments on their content and presentation. But the comments made were few and mostly unspecific. They were too few to be considered as a representative cross-section of opinions; at best they may indicate the range of opinions that is to be found.

C.2. There were a few general comments, principally that proprietary names of drugs should be given and that diagrams and tables should remain longer on the screen to help viewers to take them in.

C.3. There were also some complaints about the patronising manner of some presenters and the artificiality of some 'discussion' items.

C.4. The most common comment by far was that the evening transmissions are too late. It is worth remarking that even people who had A.S.M.E. Postscripts and had undertaken to watch frequently forgot to do so and of those who did remember to watch, quite a few went to sleep during programmes. (Comments on specific programmes are detailed in Appendix III).

CONCLUSIONS

From data as meagre as this survey provided, it is impossible to draw conclusions about the merits or defects of particular programmes. Evidently, either we used an inappropriate method of asking questions or viewers consciously remember very little of what they have seen. We believe there is some truth in both propositions. The task we asked respondents to undertake was not an impossible one in principle - a handful of them performed it adequately - but it was in some sense 'too much' for most people. What we know of doctors' opinions of the times of transmission makes it understandable if not much is remembered; much of the audience is very tired. A number of respondents complained that the questions should not have been sent so long after the transmissions but there were no obvious differences in the quality of comments between the last programme, where the interval was nil, and the first, where the interval was six months.

There remain two hopeful possibilities, not testable in this survey: (i) viewers may remember more of the programmes than they are aware of, (ii) viewers may find the programmes valuable in various ways without learning new material from them.

6. RETENTION STUDY OF 'MEDICINE TODAY' PROGRAMMES (see Para. 4.8. above)

Because of the small number of comments received in the Autumn 1966 survey of 'regular viewers', it was decided to examine the possibility that doctors were gaining information from the programmes without realising it.

6.1. That requires us to ask both viewers and non-viewers questions based on material in a programme.

6.2. Viewers are learning, regardless of whether they realise it or not, if on average they are better able to answer these factual questions than non-viewers.

6.3. Dr. J.F. Stokes, who had seen most of the programmes and had B.B.C. scripts and transcripts and A.S.M.E. Postscripts for each programme, constructed questionnaires consisting of 24 'yes or no' items for nine of the twelve programmes transmitted during 1966. As Examples, two of these questionnaires are given in Appendix I.

7. PROCEDURES

7.1. We could not approach viewers and non-viewers at random because we expected large variations in scores on the questionnaire attributable to causes other than watching the programme. There were also expected to be practical difficulties due to the small numbers of viewers.

7.2. To cope with the differences between doctors and between topics it is necessary to set up a balanced table of scores, allowing comparisons for each doctor between scores on programmes seen and scores on programmes not seen and for each topic between scores made by viewers and scores made by non-viewers. To get enough response and to make sure they are produced without cheating, it is necessary to administer the questionnaires in a face-to-face interview. These requirements make the operation expensive.

7.3. It was assumed that interviews should be kept as short as possible and it seemed likely that questionnaires on four programmes could be answered in ten minutes or less. That permitted a research design concentrated on four programmes

/and .....

and interviews with doctors who had seen two, and only two of them, yielding six balanced sets of scores, namely:

From doctors who had seen

1. the 1st and 2nd programmes, but not the 3rd or 4th.
2. the 1st and 3rd programmes, but not the 2nd or 4th.
3. the 1st and 4th programmes, but not the 2nd or 3rd.
4. the 2nd and 3rd programmes, but not the 1st or 4th.
5. the 2nd and 4th programmes, but not the 1st or 3rd.
6. the 3rd and 4th programmes, but not the 1st or 2nd.

7.4. It was impossible to be certain how many interviews would be needed in each set to achieve statistically significant results because we could not know how scores on the questionnaires would be distributed but it seemed unlikely that less than 30 interviews per set would be adequate.

7.5. It was estimated that a total of 200 interviews could be carried out in the Greater London area at a cost of £900 by trained interviewers employed by M.A.P.S. Ltd., a research company, and accustomed to interviewing doctors.

7.6. It was necessary to identify in advance the doctors who had seen particular programmes and to see whether any four programmes had in fact had enough viewers in the Greater London area to fit the proposed research design.

7.7. It would have been far too dear to do that by face-to-face interviews, or even by the postal survey techniques used in the earlier surveys, with stamped reply envelopes and reminders to non-respondents.

7.8. The only feasible method was a postal enquiry using business reply envelopes and relying on the first response without reminder. Previous experience indicated that that might be expected to yield about two thirds of the accessible responses.

7.9. The letter of enquiry was facsimile-printed and machine-addressed to all N.H.S. G.P.'s on the Medical Mailing Company's list for London (postal addresses), Middlesex, Surrey and Essex; about 4,000 doctors in all. A copy is attached as Appendix II. Reply-paid envelopes addressed to

M.A.P.S. Ltd. were inserted and the letters were posted in 9" x 4" white envelopes overprinted 'University of London Institute of Education', machine-addressed and machine-franked at the 3d. rate by the Medical Mailing Company. They were posted on 12th June 1967.

7.10. The plan for the second stage was that replies to the first stage should be counted to select four programmes that fitted the design and that M.A.P.S. Ltd. interviewers would visit the chosen doctors after making appointments by telephone to administer the questionnaires corresponding to those four programmes. These contacts were to be carefully introduced because nothing in the first postal enquiry had suggested that any further approach would be made.

7.11. The interviewers were to check by showing stills from the programme, whether the respondent had in fact seen the programmes he claimed to have seen.

7.12. They were also to give him opportunities for unforced comment on their content and presentation.

7.13. Poor scores made by viewers might have arisen from not learning from a programme rather than from forgetting what had been learned so it was proposed to make videotape copies of the four selected programmes and show pairs of them to invited groups of doctors who would then, or at controlled intervals subsequently, answer the questionnaires.

7.14. While not strictly comparable with viewers at home, these groups could show points in the programmes that were not being adequately communicated to audiences and they could also be used to check the effects of different intervals since transmission which would otherwise be an uncontrollable variable.

7.15. The detailed arrangements for the second stage had not been fixed when the research was stopped.

8. RESULTS

Three weeks after the mailing of the postal enquiry there had been nearly 800 replies, not counting about 100 who returned the form although they had seen no programmes. Table 1 shows the numbers of programmes seen by respondents.

No. of Programmes seen	No. of Respondents	% of Respondents
1 or 2	223	28%
3 or 4	198	25%
5 or 6	140	18%
7 or 8	90	11%
9 or 10	62	8%
11 or 12	43	5%
13 or 14	22	3%
15 or 16	11	1%

8.1. Thus 23% claimed to have seen half the programmes or more.

They are referred to as 'regular viewers' in Table 2 which shows the numbers who saw each programme.

Table 2

Programme	Number of regular viewers who saw it	Total number of viewers who saw it
Diabetic foot; diabetic retinopathy (Jan-Feb 66)	103	196
Is it piles? (Feb-Mar 66)	107	198
Sub-acute glaucoma; rhesus isoimmunity (Mar 66)	99	185
Babies who ruminate; pertussis without whoop; urinary tract infection (April 66)	96	176
Systolic murmurs; ileostomy; hoarseness (May 66)	101	182
Iron deficiency (Jun 66)	132	239
Depression (July 66)	145	358
Airways obstruction; carbohydrate intolerance (Oct 66)	102	193
Autoimmunity and common diseases (Nov 66)	108	222
Schizophrenia in the community; painful shoulder (Nov-Dec 66)	148	392
Early hypertension; intensive care of myocardial infarction (Dec 66-Jan 67)	132	326
Anxiety (Jan-Feb 67)	120	240
Genetic counselling; oestrogens and progestogens (Feb-Mar 67)	95	189
Renal failure (Mar-Apr 67)	137	299
Osteoporosis (Apr-May 67)	122	275
Inspection of new-born baby (May 67)	116	318

8.2. Of the transmissions during 1966, for which questionnaires had already been prepared, the most promising set of four consists of the programmes for June, July, November-December and December-January. As it did not yield satisfactory numbers, sets including one or two of the 1967 programmes (March-April or May, or both) were also examined. Table 3 shows the numbers of respondents who had seen the given combination of programmes for four sets of programmes. To be reasonably sure of getting 30 interviews, we need about 35 names for each combination.

Table 3

Programme number in its set	A	B	C	D
1	Jun 66	Jul 66	Jul 66	Nov-Dec 66
2	Jul 66	Nov-Dec 66	Nov-Dec 66	Dec 66-Jan 67
3	Nov-Dec 66	Dec 66-Jan 67	Dec 66-Jan 67	Mar-Apr 67
4	Dec 66-Jan 67	Mar-Apr 67	May 67	May 67

Combinations of programmes seen	Number of respondents who saw the given combination			
1 & 2, not 3 or 4	15	77	74	39
1 & 3, not 2 or 4	11	28	30	30
1 & 4, not 2 or 3	22	16	21	44
2 & 3, not 1 or 4	67	27	30	32
2 & 4, not 1 or 3	29	23	34	26
3 & 4, not 1 or 2	34	35	31	24

Programme Number	Total number of respondents who saw the given programme			
1	48	121	125	113
2	111	127	138	97
3	112	90	91	86
4	85	74	86	94

8.3. Obviously none of these sets is satisfactory and the work could only be continued if the numbers were supplemented by interviewing also some doctors who had seen oneor three of the four programmes. That would not be quite so straightforward to analyse but could be done.

9. NOTE ON THE NUMBERS OF RESPONSES

This survey is not strictly comparable with my earlier ones and, like them, it was not intended to provide an estimate of total audiences. However, the number of returns was large enough to warrant some remarks on this.

9.1. The responses were not inconsistent with previous surveys so that if we add 50% to the numbers in Tables 1 and 2 we can regard them as reasonable rough estimates of the total audiences in the area surveyed.

9.2. Thus the estimated median audience over this period was about 350 or between 9% and 11% of all N.H.S. G.P.'s in the area (the exact figure depends on how we categorise non-respondents).

9.3. There are about 270 G.P.'s who watched half the programmes or more; between 7% and 8% of the total.

9.4. There are some signs that both these proportions are rising; the estimated median audience over the last six programmes was about 430. But caution is needed in interpreting these figures.

9.5. Some of the apparent increase may be because earlier programmes were seen but are now totally forgotten.

9.6. There is also a very wide variation in the size of audience from one programme to another; one of the largest audiences was in July 1966 and one of the smallest in February-March 1967.

9.7. Some of these features are hard to account for in terms of the publicity given or the attractiveness of the titles.

10. Conclusion

The very high degree of co-operation this work has received from doctors, coupled with the very low yield of hard information it has produced about their viewing, makes it look as though the programmes are not having much serious educational impact. But I think it would be wrong to take it for granted that the retention study would have yielded no more than the earlier work; there is every reason to suppose that a face-to-face interview would be more productive than a postal survey. It would also be a mistake to treat lightly the claim that the programmes act as a 'refresher'. Admittedly there is no evidence that they are watched predominantly by the more isolated doctors but the job imposes on every general practitioner a great deal of professional isolation and there are not too many opportunities for dealing with it.

At any rate, there are many hundreds of general practitioners who watch half, or more than half, of the programmes in the Medicine Today series. There is no indication that they are watching merely as critics; most of them clearly feel that they gain <u>something</u> from watching.

APPENDICES

Appendix I

Invitation to join the panel.
Letter to panel members, accompanying comment sheet.
Letter to sample members, accompanying comment sheet.
Comment sheet.

Appendix II

Suggested topics for future medical television programmes.

Appendix III

Comments on particular programmes.

Appendix IV

Sample question papers.

Appendix I

ASSOCIATION FOR THE STUDY OF MEDICAL EDUCATION
in collaboration with
UNIVERSITY OF LONDON INSTITUTE OF EDUCATION
and
UNIVERSITY OF GLASGOW TELEVISION SERVICE

September 1966

Dear Doctor:

This letter may concern you if you are interested in the development of television programmes for doctors. If not, please accept our apologies for troubling you.

If you are interested, you will probably know of the BBC series Medicine Today and the ITV series Postgraduate Medicine. Details of forthcoming programmes are given overleaf. If you think there is a good chance that you will actually see at least two BBC or two ITV programmes, we would like to invite you to take part in a survey of medical television, intended to help the producers to make programmes more attuned to the needs of the doctors who watch them.

If you return the enclosed card, we shall write to you at the end of this group of programmes, asking for your observations on those you have seen. You are in no way committed to replying at that stage if you prefer not to, and of course we realise that you may be unexpectedly prevented from watching programmes you had intended to see. But naturally, the more programmes you can discuss, the more closely your wishes can be conveyed to the producers.

You may have been invited to join a group of doctors meeting at a postgraduate centre to watch these programmes, or you yourself may have arranged to watch them with other doctors living near you. Your participation in this survey will be equally welcome and valuable, whether you take part in any such group or not.

We hope this survey will prove useful to you; we will do what we can to make it so.

(Signed) Arlene J. Smith

Miss A.J. Smith MA
UNIVERSITY OF GLASGOW TELEVISION SERVICE
Southpark House, The University,
Glasgow W.2.

(Signed) David Barkla

Mr. D.M. Barkla B Sc
UNIVERSITY OF LONDON INSTITUTE OF EDUCATION
Malet Street,
London, W.C.1.

All dates and times should be checked with Radio Times or TV Times

ITV PROGRAMMES: POSTGRADUATE MEDICINE

(Only available on Scottish TV, Tyne-Tees TV, and Grampian TV)

	Scottish & Grampian		Tyne-Tees	
	Mondays 11.20 p.m.	Wednesdays 1.10 p.m.	Tuesdays 1.15 p.m.	Thursdays 11.45 p.m.
Maternal and paediatric care:				
1. Aspects of ante-natal care	7 Nov	9 Nov	8 Nov	10 Nov
2. Paediatric problems	14 Nov	16 Nov	15 Nov	17 Nov
3. The acute abdomen in childhood	21 Nov	23 Nov	22 Nov	24 Nov
The comatose patient:				
1. Acute poisoning	28 Nov	30 Nov	29 Nov	1 Dec
2. Head injuries	5 Dec	7 Dec	6 Dec	8 Dec
3. Uraemia	12 Dec	14 Dec	13 Dec	15 Dec

BBC PROGRAMMES: MEDICINE TODAY

(Available on BBC-1 & BBC-2)

	BBC-2 Tuesdays 1.15 p.m.	BBC-1 Tuesdays 11.00 p.m.
Acute airways obstruction, and differential diagnosis of chronic bronchitis and emphysema Carbohydrate intolerance: a new interpretation of some well-known facts	4 Oct	11 Oct
The concept of autoimmunity and common diseases	1 Nov	8 Nov
Management of schizophrenia in the community Examination of the painful shoulder	29 Nov	6 Dec
Early management of hypertension Recent advances in treatment of coronary thrombosis	27 Dec	3 Jan 67
Anxiety	31 Jan 67	7 Feb 67
Genetic counselling Recent work on oestrogens and oral contraception	28 Feb 67	7 Mar 67

APPENDIX I Continued

ASSOCIATION FOR THE STUDY OF MEDICAL EDUCATION
in collaboration with
UNIVERSITY OF LONDON INSTITUTE OF EDUCATION
and
UNIVERSITY OF GLASGOW TELEVISION SERVICE

February 1967

Survey of Medical Television Programmes

We were very pleased that you agreed to take part in our survey. The autumn and winter programmes are nearly over, and we are now writing to ask for your comments on them.

This is a problem, because there is so much one could say, that one is tempted to give up, and make some vague remark like 'good' or 'useful'. We think it may help you in making incisive comments, if you compare two particular programmes you saw - the best and the worst, unless you find it impossible to make that judgement. So there are separate comment sheets for two particular programmes, following another sheet for more general comments.

The comment sheets are divided into sections that may help you in crystallising your impressions. But if you find them unsatisfactory, please do not hesitate to let us know, or use whatever categories you think most suitable.

Thank you for your co-operation.

Yours sincerely,

(Signed) Arlene J. Smith
Miss A.J. Smith MA
UNIVERSITY OF GLASGOW TELEVISION SERVICE
Southpark House, The University,
Glasgow W.2.

(Signed) David Barkla
Mr. D.M. Barkla B Sc
UNIVERSITY OF LONDON INSTITUTE OF EDUCATION
Malet Street
London, W.C.1.

ASSOCIATION FOR THE STUDY OF MEDICAL EDUCATION
in collaboration with
UNIVERSITY OF LONDON INSTITUTE OF EDUCATION
and
UNIVERSITY OF GLASGOW TELEVISION SERVICE

February, 1967

Television Programmes for Doctors

We are sure you are very much aware of the problems of keeping reasonably up-to-date with medical knowledge at the same time as running a practice. The Association for the Study of Medical Education wants to see that the best possible help is available to doctors in this, and has asked us to examine one way of tackling the problem - the television programmes, 'Medicine Today' on B.B.C. and 'Postgraduate Medicine' on I.T.V.

We must obviously ask doctors about these programmes in order to find out anything useful; we are reluctant to add yet another task to any doctor's working day, but we can offer the hope that the time spent will be repaid later in the form of more useful and interesting programmes.

We have drawn your name at random from a list of doctors in your area, and we should be most grateful if you could spare a few minutes to answer the questions on the attached sheets and return them. (A stamped addressed envelope is enclosed.) We are especially interested in specific comments on particular programmes you have seen. It may help, in making incisive comments, if you compare two programmes you saw - the best and the worst, unless you find it impossible to make that judgement. So there are separate comment sheets for two particular programmes, following a sheet for more general comments.

If you have not seen any of the programmes listed, please indicate that under question 2, on the first sheet, and ignore the rest. Whether you have seen any programmes or not, your personal experience is an essential part of the whole situation, so we hope you will find it possible to send us your comments within the next week or so.

Thank you for your co-operation.

Yours sincerely,

(Signed) Arlene J. Smith
Miss A.J. Smith MA
UNIVERSITY OF GLASGOW TELEVISION SERVICE
Southpark House, The University,
Glasgow W.2.

(Signed) David Barkla
Mr. D.M. Barkla B Sc
UNIVERSITY OF LONDON INSTITUTE OF EDUCATION
Malet Street,
London W.C.1

GENERAL COMMENTS

N.B. Please put a tick in the boxes only when you find it applicable. E.g. in question 5, if you have no preference, leave all the boxes blank.

1. If you are in general practice, are you single-handed? Yes
or in partnership? Yes

If you are not in general practice, what type of practice or post have you?

.....

2. Had you watched television programmes for doctors before last September (1966)? Yes

If so, roughly how many programmes did you see?

BBC ..... ITV .....

If you have seen none since September 1966, was it -

- because they were at an inconvenient time? Yes
- because you didn't expect them to be worth watching Yes
- because you were unaware when they were on? Yes
- for some other reason? - If so, what?

3. Please tick each of the programmes you have seen since September 1966.

Medicine Today (BBC)

1. Acute airways obstruction, carbohydrate intolerance
2. The concept of autoimmunity and common diseases
3. Management of schizophrenia in the community; examination of the painful shoulder
4. Early management of hypertension; recent advances in treatment of coronary thrombosis
5. Anxiety
6. Genetic counselling; recent work on oestrogens and oral contraception.

Postgraduate Medicine (ITV)

1. Aspects of ante-natal care
2. Paediatric problems
3. The acute abdomen in childhood
4. Acute poisoning
5. Head injuries
6. Uraemia

Did the ITV Programme Notes -

- attract you to any prcgrammes? Yes
- put you off any programmes? Yes

Had you any special reasons for choosing those you watched?

If so, what? .....

.....

.....

Did you see them mostly at night-time? Yes

or at lunch-time? Yes

4. Do you prefer -

- broadcasts spread over the whole year, once a month? Yes
- broadcasts concentrated into two or three short 'terms', once a week? Yes

5. Do you prefer -

- separate broadcasts each made up of two or three short items? Yes
- separate broadcasts each consisting of a single item? Yes
- a series of broadcasts all on a single theme or on connected topics? Yes

6. Would you like to comment on more than two programmes? Yes
   - If so, would you like us to send you more comment sheets? Yes

7. Would you be willing (if it were practicable) for one of the research teams to visit you for further discussion? Yes

8. What suggestions would you like to make for topics of future broadcasts? .....
.....
.....
.....
.....
.....

COMMENTS ON A PARTICULAR PROGRAMME

Title of programme:
(if it included two items, please comment on both)

seen at night-time
seen at lunch-time

This programme was: the best
better than average
worse than average
the worst

1. Was it directly relevant to your practice? Yes
   Did it help you in diagnosis, or treatment, or giving information to patients? If so, how?
   .....
   .....
   If not, was it because the programme missed certain aspects altogether? Yes
   or because it dealt with them badly? Yes
2. If it was not related to your own practice, did you find it interesting -
   - theoretically? if so, how? .....
   - because it 'introduced' you to a particular doctor or doctors? - if so, who?
   .....
   - for other reasons? - if so, what? .....
3. Was the programme: a bit too fast? Yes
   a bit too slow? Yes
   a bit too hard to follow? Yes
   a bit too easy? Yes
   Did you find yourself dozing off? Yes
   or were you 'glued to the set?' Yes
4. Please mention any specific points that were -
   - particularly important .....
   ....
   - new to you .....
   .....
   - things you had forgotten or been unclear about, previously
   .....
   - so elementary as to annoy you .....
   .....
   - in your view doubtful or definitely wrong .....
   .....
   - missed out, though in your view they should have been included .....
   .....
   .....

5. Please mention any of the 'visual' presentations (patients, equipment, specimens, diagrams, tables, etc.) that were

- particularly well done .....

.....

- particularly badly done .....

6. Did you find the presenters

- fascinatingly good? if so why? .....
- unobtrusively good? Yes
- a bit dull? Yes
- irritating? if so why? .....

7. Was the programme on the whole better than you expected?

Yes

or was it disappointing?

Yes

8. Did you watch it in the company of another doctor? Yes

or with several doctors? - if so, how was the group brought together? .....

.....

Have you gained anything by discussing the programme with other doctors, or patients, or other non-medical people, or by reading the topic up after seeing the programme? if so, what? .....

.....

9. Did you have the BBC Postscript or ITV Programme Notes?

Yes

If so, please mention anything about it that was -

- particularly helpful .....

.....

- particularly unhelpful .....

.....

10. What other comments would you like to make about the programme?.....

.....

Appendix II

Suggested Topics for Medical Television Programmes

(Suggestions made by doctors contacted in the A.S.M.E. Survey of Autumn 1966 outside Scotland and the Tyne-Tees area. Suggestions made by two or three doctors are marked *, by more than three **. Suggestions made only by non-G.P.'s are so marked).

Items essentially to show G.P.'s how to do something

Diagnostic

* cervical smears

early diagnosis of lung cancer (non-GP).

'side-room pathology' e.g. Hb-meter.

Microscopic examination of urine and faeces

signs in common heart and lung conditions

regional examinations

tonometry

* neurological examination

indications for further investigation in cerebro-vascular disorders

examining drivers said to be drunk

health screening

Therapeutic

* handling emergencies: equipment needed

head injuries (non-GP)

stroke

resuscitation

burns and scalds

* 'acute abdomen'

* obstetric (pre-eclampsia, 2nd stage delay)

road accidents

* minor surgery

intravenous work

varicose vein and haemorrhoid injections

use of oxygen at home

* pudendal block

brietal

* manipulative procedures

* athletic injuries, sprains

orthopaedic exercises

hypnosis

Organisational

prescribing and dispensing
* use of lab. and radiologist
social services and the G.P.
* organisation and accounting in general practice.

Other Items with Particular Reference to General Practice

** evaluation of new drugs and their pharmacology, esp. steroids, diuretics, anti-depressants, oral contraceptives
dangers of: chloramphenicol, amphetiamines, sedatives
management of urinary infections in men and women (non-G.P.)
treatment of constipation, especially in old ladies
ophthalmic treatment in general practice
* geriatric management and terminal care at home
a programme to show consultants what general practice is like

Particular Conditions: Diagnosis & Treatment

neuroses and abnormal behaviour in patients and doctors
depression and anxiety
treatment of drug addiction (non-GP)
marriage guidance, sex problems
effectiveness of intrauterine contraceptive devices
mental subnormality (non-GP)
autistic child
child guidance
management of epilepsy (non-GP)
aphasia (non-GP)
disseminated sclerosis
motor neurone disease
differential diagnosis of carotid and vertebral artery syndromes
acroparaesthesia
arteriograms and myelograms in diagnosis of cerebral and other tumour (non-GP)
collagen diseases (non-GP)

rheumatoid arthritis
cervical arthritis
muscular dystrophy
knock-knee, pigeon toes, meaning and management
metatarsalgia
painful knee
sacroiliac strain
* lumbago, backstrain, prolapsed intervertebral disc and manipulation
headache (non-GP)
chest pain (non-GP)
** electrocardiography
indications for cardiac surgery
treatment of varicose veins (non-GP)
* haemophilia, coagulation defects and other bleeding disorders (non-GP)
differential diagnosis of anaemias
anaemia and iron balance (non-GP)
malabsorption (non-GP)
new advances in treatment of diabetes
thyroid diseases
thyroid function tests
obesity
** skin diseases and excrescences; differential diagnosis of skin rashes
industrial dermatitis (non-GP)
eczema
erythema multiforme and nodosum
* childhood infections
squint in childhood
eye diseases and injuries
different types of deafness
teething troubles - do they exist?
effects of dental sepsis (non-GP)
sore throat
catarrh
* bronchitis in infants; pros and cons of T and A
management of chronic bronchitis
* asthma (new advances in treatment)
acute respiratory failure (non-GP)
recurrent pulmonary emboli (non-GP)
treatment of peptic ulcers (non-GP)

acute renal failure (non-GP)

repeated dialysis v. renal transplantation (non-GP)

treatment of constipation, especially in old ladies (non-GP)

congenital abnormalities

* chromosome abnormalities, inherited and acquired (non-GP)

drug reactions (non-GP)

self-healing or self-limiting conditions (non-GP)

Basic Sciences etc.

nutrition (non-GP)

chemistry of digestion

enzymes and enzyme systems (non-GP)

new enzyme tests

metabolism (non-GP)

endocrinology (non-GP)

eyes

recent developments in social medicine (non-GP)

mental health; behaviour

space medicine

* medical electronics; possible use of computers (non-GP)

electron-micrcscope appearance of common bacteria and pathological tissues

radio-isotopes

Appendix III

Comments on Particular Programmes

It was not always easy to categorise the commence, since they were in respondents' own words. It would not have mattered if there had been more of them - in that case blurred categories would have been an acceptable price to pay for a wide range of unforced comments. But in this survey, two programmes (Autoimmunity and Anxiety) each received comments from only 8-10 doctors and the other four programmes each received comments from only 23-25 doctors. (Several doctors made comments on earlier programmes, some of them transmitted over 18 months ago; but no one programme received enough comments to warrant discussion here).

Acute Airways Obstruction; Carbohydrate Intolerance

The item on Airways Obstruction seemed popular as a 'refresher'. The only points mentioned by several respondents as new to them were: (i) the value of large initial doses of antibiotics (some claimed to have changed their doses); (ii) the dangers of oxygen therapy. The major distinction between obstructive bronchitis and emphysema was not often mentioned.

The item on carbohydrate intolerance was, by comparison, not so satisfactory (too short and not visual enough) but the whole concept was new to several.

Autoimmunity & Common Diseases

There was very little specific comment. Some found it baffling, others over-simple. Several said the concept was new to them.

Management of Schizophrenia in the Community: The Painful Shoulder

The item on Schizophrenia was not very well received; there were many comments that it was chatty, too short, omitted a lot, some thought it unrealistic. (But one mentioned that a patient with a schizoid spouse had been helped by it).

The painful shoulder item was well-liked but the only specific point mentioned was the scratch test. Several said it had helped them but some found it over-simplified (one said he subsequently found text-books confusing).

The Management of Early Hypertension; the Intensive Care of Myocardial Infarction

The item on Hypertension was liked as a refresher and some had not known of the improved prognosis in malignant Hypertension. But some seem to have thought the programme told them when not to treat Hypertension. No specific point was mentioned by more than one respondent.

There were different opinions about the clarity of the film of the intensive care unit but some had not known - and were reassured to discover - that such units exist. No specific point was mentioned more than once.

Anxiety

This was seen as patronising and not visual enough. Some thought it too elementary; others too limited in coverage and showing a technique inapplicable in general practice.

Genetic Counselling; Recent Work with Oestrogens & Progestogens

Several doctors had not known that genetic clinics exist and thought the programme would help in giving information to patients. Some thought the genetic explanations were too sketchy and the diagrams were not left visible for long enough.

Several felt the item on hormones was too bitty and omitted a lot and the interviewer's questions were inappropriate. It was more often seen as a refresher than as new.

Appendix IV

Sample Question Papers

25.1.66. **Diabetes**

Penetrating ulcers on the feet

A. may indicate the presence of diabetes mellitus
B. occur with some forms of venereal disease
C. do not arise in the absence of arteriosclerosis
D. are nearly always painful (A.B.)

Peripheral neuropathy

A. rarely interferes with temperature sensation
B. may be due to polyarteritis nodosa
C. produces a claw foot
D. may demand the surgical removal of toes (B.C.D.)

Ischaemia of a leg

A. produces loss of hair on the dorsum of the foot
B. is only rarely the result of arterial occlusion above the knee
C. demands protection of the feet against trauma
D. may result in severe burning pain in the foot which is worst on standing up in cold weather (A.C.)

The signs of diabetic retinopathy include

A. deep pigmentation of the macular area
B. a cobblestone pattern of exudates confined to the periphery of the retina
C. diffuse punctate haemorrhages
D. distortion and loss of retinal capillaries (C.D.)

Diabetes mellitus

A. should be diagnosed if the blood sugar is 140 mg./100 ml. two hours after taking 50 g. glucose
B. has a prevalence of less than 10% in England
C. does not run in families
D. is one of the three major causes of blindness in England (A.B.D.)

Diabetes mellitus should be suspected in cases of

A. proteinuria
B. boils
C. jaundice
D. intermittent claudication (A.B.D.)

22.3.66. Glaucoma & Rhesus Isoimmunity

Subacute closed-angle glaucoma

A. typically occurs after a visit to the cinema

B. is common in people who wear glasses for distance

C. causes flashes of light followed by intense headache

D. causes symptoms which disappear after a night's sleep (A.B.D.)

The aqueous humour of the eye

A. is secreted by the ciliary body

B. has difficulty in reaching the scleral veins when the pupil dilates

C. causes characteristic visual symptoms when it leaks in the cornea

D. is under a normal pressure of about 50 mm. Hg. (A.B.C.)

Glaucoma

A. is usually diagnosed on the patient's history

B. gives no visual symptoms unless the eyes are open

C. may be temporarily controlled by atrophine drops

D. is best treated by peripheral iridectomy, leaving a permanent communication between anterior and posterior chambers (A.B.D.)

Rhesus-negative women

A. constitute over 15% of the female population in Britain

B. have a 1/1000 chance of having a first child with haemolytic disease if they are married to an Rh positive husband

C. have no greater risk of bearing a child affected by haemolytic disease in the fourth than in the second pregnancy

D. nearly always have one affected child if they have more than one pregnancy (A.B.)

In rhesus iso-immunity

A. a homozygous rhesus-positive genotype will almost certainly father an affected and rhesus-positive child

B. a heterozygous rhesus-positive father is not necessarily a danger

C. the presence of antibodies in the mother implies that the child she is carrying is rhesus-positive

D. previous transfusion of the mother with compatible blood may help to protect the child at risk (A.B.)

A 30-week intrauterine baby with severe haemolytic disease

A. will produce bilirubin in liquor obtained by amniocentesis

B. is best treated by the induction of labour on Caesarean section, followed by exchange transfusion

C. may be given a better chance of survival by intrauterine intra-peritoneal blood transfusion

D. will not require exchange transfusion at birth if transfused in utero (A.B.C.)