DIFFUSION OF A MINIMAL CONTACT SMOKING CESSATION PROGRAM FOR DUTCH GENERAL PRACTITIONERS

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In 1994 a minimal contact smoking cessation program for Dutch general practitioners (GP) was disseminated nation-wide, aiming at a 15% implementation rate among all dutch GPs. A feasibility study showed that the program is easily applicable in daily routine. Evaluation of program effectiveness in a randomized controlled trial ($n = 518$) showed at twelve months a self-reported quit rate of 13.3% in the intervention group and 7% in the control group (Odds $R = 1.84$; $p < 0.04$; 95% CI = 1.02–3.31), including non-respondents as smokers in the analysis.

The implementation process is guided by a systematic diffusion strategy. Central elements of this strategy are: locally organized continuous medical education (CME), involvement of peers at all levels and of local opinion leaders, and continued attention for the program in regular meetings of local GP units. Twelve months after the dissemination a survey among a representative cohort of 550 GPs showed that the rate of GPs using the program regularly was increased from 1.5% at baseline to 6.5%. Only 8 GPs (1.5%) reported to have received CME in that period, indicating on the one hand a slowly progressing diffusion process, but on the other hand a large potential 'sleeper' effect. This is confirmed by the fact that in this second implementation year several CME-activities are scheduled, by which almost 800 GPs (12% of all Dutch GPs) may be reached directly. Adoption of the program is therefore expected to increase considerably during the second implementation year.

THE ANXIETY OF THE PHYSICIAN AT THE BEDSIDE OF DYING PEOPLE

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The aim of this lecture is the analysis of the doctor's anxiety concerning death and dying. Part of this anxiety is originated from the doctor's own fear of death. Studying this we are seeking answers to the following questions:

- What components are included in the fear of death?
- What kind of processes have contributed to the increase of this fear in the XXth century?
- What kind of cultural consequences do these processes have?

The other component of the physician's anxiety is resulted from the specifications of the client-doctor relationship. The analysis of this componene raises the following questions:

- What are those elements of the physician's anxiety which increases his/her own fear of death?
- What kind of influence does it have on the client-doctor relationship?

Finally we are discussing those possibilities and methods which can make the elaboration of the physician's anxiety possible.

PSYCHIATRIC MORBIDITY AMONGST PARTNERS OF CANCER PATIENTS—THE IMPLICATIONS FOR AN INTERVENTION STUDY

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In a retrospective study 168 partners of cancer patients were interviewed, by trained interviewers, 2 years after the patient's cancer diagnosis. Standardised psychiatric interviews were carried out to assess the partners' experience of psychiatric morbidity over the 2 year period and DSM III diagnostic criteria were used.

Twenty (12%) of the sample experienced an episode of anxiety and/or depression at some time during the two years and prevalence was significantly higher amongst female partners ($p < 0.001$). Partners were almost three times more likely to develop an affective disorder if the patient had experienced a similar disorder since diagnosis and in all but one of these cases the partner's psychiatric illness developed concurrently with, or following, the patient's affective disorder. Almost half of the partners 8/20 (40%) failed to seek professional help for their illness.

Psychiatric morbidity in partners was related to satisfaction with information about the cancer illness ($p = 0.06$) and its treatment ($p = 0.04$). It was also significantly related to the number and severity of unresolved concerns but not to the degree of confiding about the illness.

In the light of these results, a way of targeting and intervening with partners will be discussed.