Can general practitioners counsel?

NANCY ROWLAND
JILL IRVING
ALAN MAYNARD

SUMMARY. It has been suggested that general practitioners are in a prime position to counsel patients presenting with psychosocial problems. While many doctors use counselling skills in their consultations few have received training in counselling and the difference between the use of counselling skills and the process of counselling is not always understood. This paper examines the differences between counselling and counselling skills and compares the role of doctors and counsellors. It is concluded that there is a need for trained counsellors to work alongside general practitioners and that this is of benefit to patients and all members of the primary care team.

Introduction

As many as 30% of patients present in general practice with problems that are primarily emotional in origin. While doctors are increasingly aware of the dangers of medicalizing a patient's complex practical, social and emotional problems by treating them symptomatically, many are familiar with the patient who never seems to get better, or the patient who leaves the doctor with a sense that the real purpose of the consultation has not been resolved. In such cases counselling may be appropriate as it aims to help an individual identify, understand and come to terms with underlying difficulties and find ways of coping more effectively.

Many general practitioners use counselling skills during the course of their work, albeit often unconsciously. Some people have a flair for doing and saying the right thing at the right time; doctors who possess this quality often find they release a flood of confidences reflecting underlying psychosocial problems which can leave them uncertain as to how to proceed.

While communication skills are currently being taught in most professions that demand good interpersonal relations, the majority of general practitioners have developed counselling techniques through experience rather than formal training. This raises questions about the nature of counselling, its procedure and principles.

Counselling skills

Most counsellors would distinguish between the use of counselling skills and the activity or process of counselling. Counselling skills consist of certain communicative behaviours by which one person may elicit certain responses in another. Fundamental to the counselling process are the core skills of listening, empathising and reflecting. Further skills include problem clarification, accurate understanding, summarising and confrontation. Counselling skills have a wide applicability and can be used in a variety of professional settings.

Counselling

Defining counselling as opposed to listing counselling skills is more complicated. According to the British Association for Counselling 'People became engaged in counselling when a person, occupying regularly or temporarily the role of the counsellor offers or explicitly agrees to offer time, attention and respect to another person or persons temporarily in the role of the client. The task of counselling is to give the client an opportunity to explore, discover and clarify ways of living more resourcefully and towards greater well being.'

Counsellor training and supervision

Although some people's personality and life experience make them well suited to counselling, the counselling process involves more than offering tea and sympathy or a shoulder to cry on. Those committed to counselling need to learn as much as they can about the factors involved in the process; training and continuing supervision are important for a counsellor to be effective. At best, training ensures the acquisition of theoretical knowledge (for example, counselling theory, developmental psychology), the examination of one's own inner life (emotional reactions, values, attitudes and prejudices) and the development of skills to facilitate change (motivational interviewing techniques, the use of silence, interpretation). Supervision facilitates the integration of these elements in the counsellor's emotional and behavioural set. Supervision is a form of consultation with a peer, which involves a continuing process of learning and an opportunity for counsellors to reflect on their work and some of the feelings engendered by it. The majority of counsellors find this kind of consultation essential and continue to use it even after years of experience.

Who should counsel? The general practitioner's role

Since Balint's seminal work on doctor–patient interactions general practitioners have been aware that patients can be helped by the use of counselling techniques. Exploring the patient's beliefs, emotions and concerns, in addition to specifying the nature and history of the presenting problem has been shown to facilitate diagnostic skills and to increase patient cooperation in following advice, leading to improved patient care.

Although counselling skills help the general practitioner in his clinical consultation, the focus of the general practitioner's work is different from that of the counsellor. The aim and function of counselling is for the client to help himself; to clarify his difficulties and attempt to resolve them. Rather than giving advice, reassurance or medication, the counsellor systematically attempts to avoid long term dependency. The general practitioner's role, however, is that of a specialist, with expertise and knowledge not generally available to the patient. His job is to listen to the patient, attempt to diagnose any disorder and to prescribe treatment to ease or cure. He is seen as an authoritative helper who defines and resolves the problem, directs the course of treatment and gives advice and support. Although the outcome of patient care is likely to be improved if the doctor actively involves the patient in his treatment through discussion and explanation, the relationship between doctor and patient is unlikely to be purely that of counsellor and counsellor, since the doctor will frequently be called upon to give practical help, which would be inappropriate in the counselling relationship.
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The doctor—patient relationship

It has often been said that general practitioners are in a good position to counsel their patients, many of whom they have known for many years. However, patient attitudes may be the first barrier to the doctor counselling the patient, as the patient’s expectations of the general practitioner may be solely of the doctor as dispenser. Presenting with a somatic complaint and expecting a somatic diagnosis, the patient may resist a cure that only involves talking and may feel neglected unless he leaves with a prescription.

While somatization may become less frequent as the patient comes to know and trust his general practitioner, internal conflicts may arise if the patient feels that unhappiness or anxiety are not appropriate symptoms in the surgery. Indeed, there is an expectation that doctors would prefer to hear about physical symptoms rather than psychological problems. Thus, the dual role of doctor/counsellor, with all its connotations, can be a difficult one for both the patient and the practitioner.

Whereas counselling aims to foster autonomy and the independent decision making power of clients, patients often experience feelings of dependency on their doctor, a consequence perhaps of their having been patients since childhood. This often means that the 'unfinished business' of childhood gets projected onto the doctor/counsellor relationship thus complicating counselling.

A further complication may occur through the mixing of social and professional contacts which is often inevitable if a general practitioner lives in the same locality as his patient. Counselling addresses the private and often messy parts of our lives and it may be difficult for a doctor, who meets his patient socially, or whose children attend the same school, to counsel effectively. As a rule the counsellor does not allow the counselling relationship to be compromised by any other relationship such as friendship.

Practical constraints

Time — or lack of it — is an important factor in any busy surgery. The average consultation is six minutes, whereas a counselling session usually lasts between 30 and 50 minutes. While the repeated shorter interview in general practice may be equally effective and more digestible for patients, the danger is that it may be insufficient for an unhurried discussion of the important issues, may become superficial, and may never progress towards meeting the patient’s needs.

There is some research to show that without taking extra time, general practitioners can offer brief counselling instead of prescribing benzodiazepines. ‘Such counselling need not be intensive or specially skilled ... anxiety may often be reduced to tolerable levels by means of explanation, exploration of feelings, reassurance and encouragement’. Whether using counselling skills as described by Gath and Catalan, or offering counselling in the formal sense, it is doubtful whether general practitioners can satisfy the demands of the community for counselling without adversely affecting the time needed for clinical work. This is not to create an artificial division into emotional and physical illness, but to emphasize the place of differing skills and knowledge in providing patient care. However great their therapeutic skills and interest may be, counselling by general practitioners may not be the most efficient or cost effective use of practice time.

There are other practical constraints for general practitioners who want to counsel; the number and frequency of interruptions in the consulting room by staff and telephone, the seating arrangements and the degree of privacy — conversations which can be overheard from the outside are doomed from the start. A quiet room, uncluttered by bureaucratic paraphernalia and without interruptions may be difficult for a general practitioner to organize.

Doctors and counselling

In general, students selected for medical training are usually not selected for their counselling potential, nor does their education produce a professional whose orientation is that of the counsellor. Medical training is designed to produce doctors, not counsellors. One by-product of medical training and practice can be an arrogance and distance which are at odds with a counselling approach.

Nonetheless, doctors tend to be doctor centered or patient centered and while patients will gravitate to the doctor in the surgery who best meets their needs, counselling in general practice demands empathy with the patient, considerable listening skills and an ability to share and discuss information and decisions: offering and sustaining a relationship of non-possessive warmth to 2500 people for years on end is a considerable intellectual and emotional challenge for physicians in primary care. Some doctors who have tried to offer psychotherapeutic assistance in general practice find their family life suffers.

Counselling, like medicine, is often stressful work and the effective counsellor has to be able to listen to the client’s problem without over-defending or over-identifying. Supervision enables counsellors to have some sort of clinical overview of a ‘case’, identifying personal feelings and professional bias which may be hindering rather than helping the client. Lack of availability as well as lack of time may hinder general practitioners from counselling under adequate supervision.

For the general practitioner committed to counselling these problems may not be insurmountable but they highlight the differences between the role of the general practitioner and counsellor.

Differences between counselling and general practice

Counselling offers an alternative form of therapy for the ‘life problems’ presented in general practice. It requires a new technique for doctors, involving a shift from the authoritarian model of ‘distance, diagnosis and reassurance’. Most general practitioners see themselves as the professionals who should be helping their clients but it is questionable whether expertise in the use of counselling skills and the process of counselling as a therapeutic intervention is fully appreciated or understood.

There is, of course, some overlap between counselling and general practice. There may be brief counselling episodes within the normal framework of a consultation, perhaps to establish the areas in which the general practitioner should offer advice. Moreover, the clinical consultation is ideally conducted in an atmosphere not too different from that of counselling — the general practitioner sharing with the patient the task of solving a problem, bringing his expertise as a resource as they work together on the problem.

Benefits of counsellor attachments to the primary care team

Counselling is an effective form of therapy for the psychosocial problems presented in general practice. Given the nature and extent of these problems it is improbable that general practitioners can fully satisfy the demand for counselling services. Moreover, whereas some general practitioners are interested in the psychological aspect of their work, others are not, and it is likely that the patients in the care of the latter would benefit from a counsellor attachment.

Doctors who use counsellor services are enthusiastic about
the expertise they bring to the team, particularly in helping them distinguish between problems that can be dealt with at source, and those which require more specialized counselling. The presence of a trained practice counsellor has been shown to facilitate the general practitioner’s work with patients, leading to the early identification of the patient’s problem, fewer inappropriate referrals and investigations, and a reduction in consultation time and in the prescription of drugs. 

Counsellors in general practice tend to be ‘generalists’, although like other members of the primary care team, they may have areas of special interest and expertise. Carefully set up counsellor attachment schemes with clear lines of communication between team members can heighten general awareness of the psychological aspects of the patient’s presenting problem and encourage team members to develop their own counselling skills. Further benefits include an increase in sharing of skills among primary care professionals, suggesting enhanced knowledge of each member’s special skills, discussion of case management and ease of referral, all of which contribute to the expansion and quality of patient care.

Conclusion

It has been suggested that there is a need for general practice to accept a wider range of health professionals working within it and there are indications that the government might be prepared to make money available to remunerate them. Given the benefits of counsellor attachment schemes, it is essential to move beyond practitioner flail to guarantee reliable standards of care. The British Association for Counselling encourages counsellor accreditation, recommending that counsellors meet recognized standards of training and supervision and accept a code of practice and ethics. It might be suggested that only those satisfying such standards call themselves counsellors — this is perhaps the final consideration when asking if general practitioners can counsel.

References


Address for correspondence

Nancy Rowland, Centre for Health Economics, University of York, Heusington, York YO1 5DD.