General practitioners and marriage guidance counselling

D. G. NEILSON, B.Sc., Ph.D.
Assistant Counselling Tutor, Scottish Marriage Guidance Council

J. D. E. KNOX, M.D., F.R.C.P.ED., F.R.C.G.P.
Professor of General Practice, University of Dundee

This article compares the attitudes of a group of established general practitioners (20 in number), attending a refresher course, with the views expressed by a group of local, younger, trainee general practitioners (ten in number), taking part in a day-release scheme, with reference to involvement with one paramedical agency, the Marriage Guidance Council. In each case, we conducted the exercise jointly. The Assistant Tutor, Dundee Marriage Guidance Council, was *not* introduced as such to the groups before their discussions. The doctors on both courses were first split into two sub-groups, and were then each given a printed fictitious case history which they were asked to discuss (appendix 1).

It became clear from the discussions of both groups that only two of the experienced general practitioners (who were drawn from Scotland and England) and one of the trainees (who were more locally based) had any real knowledge of, or had had any direct contact with, any marriage guidance counsellor. On the whole, these three doctors expressed favourable comments on the training and skill of counsellors, although one had been surprised to find unmarried people acting as counsellors (this is not common in Scotland).

The term ' psychiatric adviser ' puzzled both groups—the trainees felt that this could be a psychiatrist but reserved judgement until the end when they could ask for more information. On the other hand, the group of experienced doctors assumed that this person would not be a doctor but might be a ' paramedical ', e.g.: a psychiatric social worker. There appeared to be no real knowledge of the supporting service given to marriage guidance counsellors in the form of case conferences by consultant psychiatrists—many of senior status.

Experienced doctors

Apart from this lack of factual information, the groups reacted to their tasks quite differently. The group of experienced doctors read, at times, much more into the case sheet, e.g.: they felt and expressed annoyance that the client had not come first of all to the general practitioner with his problem—or that at the very least the counsellor had not taken the general practitioner into his confidence much earlier.

Out of this grew a group phantasy that the counsellor had built up the whole situation until it had got out of hand. Moreover, as the counsellor was not medically qualified, he should not be tackling this type of problem (psychosexual) and indeed general practitioners should not associate themselves in management with such non-medical persons.

However, they did feel that they would have to see the patient—the diagnosis of suicidal risk might be justified—but in no way did this group see the counsellor as a partner in any discussion about the patient—rather as someone to be got out of the way. Some doctors felt that they would consult the partner whose patient was under discussion; others expressed the view that the doctor would not wish to be disturbed if he happened to be the off-duty partner.

Many of the group also felt that they would see the patient's wife and discussed where and when they would do this, before one of their number pointed out that she might not be a patient registered with the practice (indeed, as happens in several such situations of marital breakdown, she could well no longer be in the district).

Trainees

The trainees, although at first expressing some resentment that the doctor had not been consulted earlier, finally concluded that the patient was the type of person who found personal relationships difficult and might not have got on well with his general practitioner. The case

history was vague enough to allow for the fact that the partner might have been consulted by the counsellor at an earlier date.

This group also felt that suicidal risk was difficult to assess and that in some cases a lay person could be as aware of the danger as a medically qualified person.

At first, this group also felt that a psychosexual problem was not one that a marriage guidance counsellor should tackle, but then modified this by reflecting that they did not know from the case history who had made the diagnosis and that in practice a counsellor would probably see as many sexual problems as a general practitioner. This group appeared to work through their early hostility towards the counsellor much more rapidly than the first group who maintained it to the end, and hence were to a large extent blinded by it to the wider facts and needs of the client.

The Marriage Guidance Counsellor

The problem of confidentiality was also raised by both groups—the doctors were sure of their own ethical and legal position, but were uncertain how free a counsellor was to give them information about a client. It was later explained by the Marriage Guidance Tutor that a counsellor would in the normal way talk to a third party only with the consent of the client.

After the groups had had a chance to present and discuss their deliberations, the Marriage Guidance Counsellor was introduced as such. Both groups reacted with a certain amount of embarrassment, which was much less marked among the trainees.

In conclusion, the case which was deliberately presented in such a way as to create hostility, taught both groups how they might react to such in real life. The difference in attitudes of the two groups may reflect changes taking place in medical school curricula, with more emphasis now being placed on the teaching of general practice, medical interviewing, and working with other agencies, both statutory and voluntary.

About half the doctors of the first group (established principals in general practice) felt that they had learned much from the group work—the others projected their own embarrassment over their expressed attitudes and said that it had been much too traumatic for the Marriage Guidance Counsellor (the tutor) and hence the experiment should certainly not be repeated. By contrast, the trainees all felt that the learning experience had been well worthwhile and could be repeated for the benefit of their successors.

For the Marriage Guidance Councils, these experiments reflect a lack of communication with general practitioners in general, and hence a need for greater publicity about the scope of the services offered.

These include confidential counselling at marriage guidance premises of anyone with personal relationship problems, but in particular of those persons with difficulties within a marital relationship. Although counsellors prefer to see both partners of a marriage, this is not a prerequisite. Most councils also have counsellors whose special talents lie in the field of youth counselling and who will conduct, in addition to personal interviews, group discussions, e.g. with engaged couples. Counsellors are also willing to work in close collaboration with general practitioners and in some areas counsellors have been attached to health centres.

The teaching and learning here described have implications for vocational training for general practice. While local initiative may successfully develop active co-operation in the routine service setting (Marsh and Barr, 1975) even more might be achieved by including training like this in day-release courses.

REFERENCE

Marsh, G. N. & Barr, J. (1975). *Journal of The Royal College of General Practitioners*, **25**, 73-75.

APPENDIX 1—" OTHER PEOPLE'S PROBLEMS! "

You are a doctor in a group partnership of four. It is your night ' on call ' and about 2100 hours your 'phone rings.

A complete stranger introduces himself as Mr X of the local Marriage Guidance Council. " I have with me Mr John Y " he says, " one of your partner's patients ". You dimly recall a rather tense individual of that name, a man in his 30s, but he is not a patient you have seen recently.

" I'm worried about his mental state ", continues Mr X " and I really feel he ought to see a psychiatrist tonight—be admitted I mean ".

It transpires that during the two months the marriage guidance counsellor has been involved with him the basic problem is psychosexual, Mr Y being unable to relate properly at this level with his wife. During these two months, Mr X has noted a deterioration, and tonight he has had to tell John Y that his wife intends to seek a divorce—the marriage of eight years has failed. Unfortunately, yesterday, John Y's firm has paid him off, " and to crown it all ", adds Mr X, " there's some possibility of a duodenal ulcer, so the doctor at casualty told him last week when he referred himself there because of abdominal pain."

Mr X goes on to say, " and earlier this week he says he was sent home by the factory doctor with 'flu, but this was associated with John Y ' taking some tablets ' which he didn't disclose at the time.

" So you see, doctor, I'm worried about John. In my opinion he needs more skilled psychiatric help—if you like I can phone our psychiatric adviser with whom I have already discussed this case ".

1. Discuss your feelings about these demands being made on you by a lay person
2. How valid is the implicit assumption of suicidal risk here?
3. Are ethical and legal issues involved—if so, what are they?
4. What actions might you take, and why?
5. What long-term help might be mobilised for the basic problem?

NUFFIELD FOUNDATION GRANTS

In 1973 the Foundation made its largest medical grant for some years: a capital sum of £88,550 to provide for the addition of a day hospital to the 25-bed St. Luke's Nursing Home in Sheffield. This nursing home has been established by Professor Eric Wilkes, in association with Sheffield University, for the care of patients of all ages who are incurably ill and may be in the terminal phase of illness. The grant recalls the Foundation's earlier grant to Dr Cicely Saunders to assist in building the now world-renowned St. Christopher's Hospice for terminal cases. It was the example set by Dr Saunders which first focused long-overdue attention on how to provide acceptably for the psychological and social, as well as the medical needs of the incurably ill and dying—matters with which western civilization has generally shown itself to be ill equipped to deal.

Professor Wilkes's day hospital will be providing a kind of care for chronically sick people which is specifically aimed at rehabilitating them and restoring their independence to the greatest possible extent, even in the final stages of illness. The day hospital, like St. Luke's Nursing Home, will be used for teaching undergraduates from Sheffield medical school—a considerable innovation in medical education, for the day-to-day management of chronic illness does not usually find a place in the curriculum. Again like St. Luke's, the day hospital's full range of educational functions will be very wide, including among its students not only medical practitioners and nurses and nursing auxiliaries but all kinds of social workers and the relatives and friends of the patients themselves.

REFERENCE

Nuffield Foundation (1974). *Yearbook for 1973.*

HOPE OF THE YEAR

It is hoped that the reorganisation in 1974 will alleviate the shortage of social workers.

REFERENCE

Hospital Advisory Service (1974). Annual Report to the Secretaries of State for 1973, p. 15. London: H.M.S.O.