Counselling in the European Economic Community

JOHN COHEN, MRCGP
General Practitioner, London

SUMMARY. Counselling is becoming increasingly important in modern general practice and the relationship between counsellors and general practitioners varies in different places and in different countries. Through a Stanning Overseas Fellowship I had the opportunity of examining this relationship in several countries in Europe in order to compare and contrast arrangements.

Introduction

MANY patients seen in general practice are not suffering from physical illness. Estimates of the incidence of psychosomatic illness vary from 30 to 40 per cent of the patients presenting. Despite high increases in costs and manpower, the consultation rates for illness are maintained or increased but morbidity is not significantly altered (Office of Health Economics, 1974). There has thus been a tendency to diagnose and treat the presenting complaint—the patient has demanded and the doctor, perhaps sometimes unwillingly, has acceded. Thus, in 1975 the proportion of the British National Health Service drug bill for 10 central nervous system drugs was £45,940,000.

On the whole, doctors agree that with increasing awareness many of the presenting problems cover hidden problems which require exploration. This is quite feasible even if consultation times are usually no more than six to 10 minutes; a long interview or several short interviews can be used (Balint and Norell, 1973). It is often difficult because the doctor has to abandon his usual role of listening to symptoms, examining the body, making a diagnosis, and offering treatment and advice. Instead, he has to help the patient to define the problem, to consider alternative solutions, and finally make a decision.

The increasing workload in general practice imposed by psychological and social problems stems from the increasing demands by people to be happy, healthy, and to live without pain, stress, or disability. They feel these goals are obtainable through the medical profession who have tended to over-emphasize the technological triumphs of modern medicine (Wadsworth *et al.*, 1971; Dunnell and Cartwright, 1972). Illness has become much more socially acceptable and the doctor can offer relief in the form of sick-notes and tablets (Office of Health Economics, 1975).

With the decline in religious values, increased social and geographic mobility leading to breakdown of family relationships, the great increase in female independence and autonomy, far greater expectations of personal relationships, increased longevity, earlier marriage, continuous housing problems, and the introduction of Legal Aid (Office of Health Economics, 1975), it is perhaps not surprising that many people turn to the general practitioner who has to his credit four As: Availability, Approachability, Acceptability, and Adaptability. In the NHS he is also free of charge!

Considering the burden it is not surprising that many general practitioners prefer to refer non-physical problems to colleagues or appropriate agencies, or merely offer a prescription and brief advice.

The Balint Society, created from the seminars begun in 1950 at the Tavistock Clinic by Dr Michael Balint, sought to examine these problems, but although a considerable number of general practitioners have benefited greatly from these seminars, possibly only five per cent of all general practitioners have ever actually attended (Balint, 1957).

Only five to 10 per cent of general practitioners have an attached social worker (Irvine and Jeffreys, 1971) and few have a professional relationship with other agencies such as the Marriage Guidance Council. While many are glad to use volunteers such as vicars, patients with special skills, and patients' associations, for problems such as: "Peter cannot find a job he really likes," "Mary is always 'off sick' ", "Gary is not getting on with his studies", "George and Barbara have sexual difficulties", and "Maurice is a homosexual—he does not mind but his wife does!", general practitioners struggle on with helpfulness, encouragement, simple psycho-

Table 1.

Country	Size (square km)	Population to nearest million (people/sq. km.)	Type of health care system and remuneration of general practitioners	Number of qualified doctors
Belgium	30,513	10,000,000 (327/sq. km)	Compulsory insurance via State and para-state mutual funds for most of the population and private insurance for rest. Patient pays doctor directly and recovers fees from funds	15,000
Denmark	43,074	5,065,000 (117/sq. km)	Fully comprehensive health service insurance system covering 90 per cent of the population. Contributions received from employer and employee in proportion to wages/salary. No payment by patient for health care. Remuneration of doctors by capitation fee and item of service payment. Some general practitioners also carry out specialist examinations and have special responsibility for preventive care—no hospital outpatient departments. Small private practice sector	9,500
Eire	70,282	3,127,000 (44/sq. km)	Total health services provided by central government under compulsory insurance scheme for employees (two thirds). Free care for agricultural workers and poor people. Also, small voluntary health insurance scheme. Most rural general practitioners paid by local authority; rest paid directly by patients	3,600
Federal Republic of Germany	248,620	61,648,000 (248/sq. km)	Ninety per cent of population covered by social health insurance administered by sick funds controlled by government but organized by local authorities in each state. Doctors belong to an association which negotiates item-of-service payments with the insurance fund. Contribution to sick fund from employer and employee. Some contribution to all prescribing and treatment by sick funds	125,000
France	547,026	51,000,000 (94.5/sq. km)	Compulsory health insurance schemes organized on regional basis cover 90 per cent of population—contributions from employer and employee. Patient pays the doctor and receives about 80 per cent of the fee and pays 20 per cent of hospital costs. Most doctors single-handed—only 12 per cent in groups	86,000
Italy	301,260	56,014,000 (186/sq. km)	Health Services provided by para-state sick funds like government corporations responsible to appropriate Minister—compulsory membership for all employed persons. Contributions from employees and employers. Benefits vary but most medical care free. Some doctors paid for each consultation, others salaried. Any may practice privately	107,000 (160,000 medical students in training: 18,000 at Rome University producing 16,000 doctors a year)
Luxembourg	2,586	358,000 (138/sq. km)	Health service under Code of Social Assistance for workers and dependants. Other funds for other groups in self-financing schemes. Payment direct to doctors. About 75 per cent recovered from Sick Fund. Hospital free for up to six months. Some control on drug prescribing	403
Netherlands	33,811	13,060,000 (384/sq. km)	Compulsory health scheme covering all employees and others by arrangement. Contributions by employer and employee, central government making up any deficit. All services given free. Doctors' remuneraion on basis of capitation fee. Twenty per cent of population are entirely private patients. Most doctors single-handed, rest in small groups	18,000
United Kingdom	244,019	55,000,000 (229/sq. km)	NHS cover population of Gt. Britain and N. Ireland Services provided mainly by central government. Contributions from most people of working age. Services free to patients at time of use. Doctor paid later. Three per cent patients registered also with Private Health Care Plan	80,000

Number of primary care physicians/ general practitioners	Number of medical schools	Number of Balint-type groups	Types of counselling services	Degree of co-operation with general practitioners
5,300 (1: 1,750)	11	>20	A few group practices have social workers' attachments and others meet psychiatrist weekly. Local authority, religious and non-religious, university and private counselling agencies. Also UK Marriage Guidance Council equivalent	Limited. More involvement from group practices and urban areas
2,600 (1: 2,200)	3	Not known	One third of general practitioners work in groups, with social workers to explain state benefits. Local authority counselling services, sometimes only for families with children. Comprehensive university service. Special agencies in Copenhagen. Some co-operation between general practitioners and psychiatrists	Good co-operation in general, especially in group practices and in towns
1,500	5	0	Independent and isolated general practice in the main except in towns where the main counselling services are provided by the Catholic Church and by parish priests. In major cities local authority and university counselling services are being developed	Limited to a few town practices
24,500 registered general practitioners 51,000 independent practitioners (1: 2,500 for all primary care physicians)	27	>20	Local authorities provide social work and counselling services. Services in some universities. Less than 15 per cent of referrals are from other agencies. Contact with general practitioners very limited. Psychiatric services patchy and poor in some rural areas. Many general practitioners do not see psychological disorders as part of this work except to exclude physical disease	Minimal—problem exists of acceptance and recognition of psychological disorders
25,000 (1: 1,800)	38	>20	Rural general practitioner and parish priest provides much of service in rural area. University counselling service exists in most centres and is especially well organized in Paris (Bureau d'Aide Universitaire). Voluntary services include church, and non-church	Poor, except in some urban areas where doctors work in groups
35,000 (in general practice)	24	<20	Family and rural life supportive in South; counselling services in North. Psychological, marital advice in towns. Some careers advisers; few adequately trained social workers. Centres recommended since 1975 to co-ordinate social, psychological, family planning services. General practitioners slow to co-operate	Poor, as doctors tend to work in isolation and with little additional help
Not known	0	Not known	Limited services. In Luxembourg services provided by local authorities and Catholic church	None known
6,500 (1: 1,750)	8	>30	Some general practitioners in groups have psychologist or social worker attachments but most are single-handed. Counselling services exist in most towns and universities. Telephone crisis service. Agencies for young people and marital, drugs, pregnancy, maladjustment, mental handicap problems	Good, especially in towns and cities and for group practices other workers
23,000 (1: 2,300)	32 (12 London)	<20	Many general practitioners and all universities offer counselling services. Marriage Guidance Council, religious services, and specialized agencies in most major towns	Good in most places, especially in more recently trained doctors

therapeutic skills, and an occasional prescription.

As a member of a Balint seminar, I looked at these problems to see if there was a national answer. Almost every university in the UK had a counsellor to whom students could go to talk about their problems—were the problems of my patients so different from the students? I decided not, and so for several years I have had a counsellor working in the practice (Cohen and Halpern, 1978).

In 1975 I obtained a Stanning Overseas Fellowship of the Royal College of General Practitioners to enable me to investigate and compare counselling services in the countries of the European Economic Community. The results are shown in Table 1.

It is clear from this study that every country in the European Economic Community maintains a counselling service for people with personal or family problems from childhood to old age, which includes adolescent guidance, occupational guidance, marital counselling, family counselling, and services for the older age group, but in every country they are differently organized and financed, often having developed initially without government help.

Since needs differ from country to country, the resulting agencies also differ and are provided by local authorities, religious organizations, and various voluntary organizations.

Differences are compounded by different systems of providing health care and of paying doctors. They have therefore become more integrated within the medical profession in those countries where a fee for services is not part of the contract, as in the UK, Holland, and Denmark. In countries such as France, Belgium, Germany, and Italy, where doctors are paid directly for their services, such organizations generally have a poor relationship with the profession.

Also, in each country doctors work with different types of assistance and paramedical staff and it is confusing that what is meant by a social worker, health visitor, or practice nurse in one country may mean something quite different in another.

The amount of general practitioner training also varies from country to country, especially in relation to the non-physical aspects of general practice and postgraduate education. Even in those countries where counselling services have a low rate of co-operation with general practitioners, there are nevertheless signs of an increasing involvement. Seminars are held for general practitioners, psychologists, social workers, psychiatric social workers, health visitors, and counsellors in most countries in Europe.

With the increasing development of universal health care, the need for co-operation between the caring professions is likely to grow and as doctors increasingly work in groups it will be reasonable to expect them to use the skills of other professions, a fact which is gaining recognition at both the undergraduate and postgraduate levels of training.

All the caring professions except general practice hold regular case discussion groups and only now is their value coming to be recognized by doctors, as in the Balint seminars. For this reason the tendency towards inter-professional co-operation in training and education is likely to continue. International co-operation by meetings, exchanges, visits, and seminars will increase understanding but agreement on terminology, procedure, and training will be needed before greater cohesion can be obtained.

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