Is counselling the key?

The Royal College of General Practitioners regards counselling as an essential part of the process of many consultations in modern family practice.

RCGP (1976).

THE role of the doctor in primitive societies is almost invariably associated with higher than average status. Such doctors are often thought to have magical powers and are usually accorded numerous privileges. In today's society there is much discussion about the role and status of the doctor whose position is felt by some doctors to have been eroded inappropriately, whilst many others think that the change in balance between doctor and patient is a healthy development.

Constant refinement and analysis of the doctor/patient relationship has revealed that the doctor retains many privileges, including in material terms an income in the first percentile of the population and various legal privileges endorsed by Acts of Parliament. More important in practice is that patients naturally transfer to their doctors their own hopes of a cure. We all hope that the doctor will cure our own diseases.

Given the doctor's great technical knowledge and understanding of the patient and his or her disease, there is a natural tendency for doctors to instruct or to order. The phrase 'doctors' orders' has become commonplace.

Nevertheless, as Lindsey Batten in the 1960 James Mackenzie Lecture argued, in general practice the authoritarian mode, while comfortable, is less attractive, and may be less effective. What seems to be needed is an alternative model in which the patient, instead of being seen as the bottom rung of some extensive bureaucratic hierarchy, is restored to a position of equality and helped with dignity.

Definition

The concept of counselling fits these ideas and is particularly relevant to general medical practice. It can be defined as giving information, explanation, and a satisfactory opportunity for discussion and some, but not all, include the giving of advice. There can be little argument about the importance of patients being provided with adequate information, and numerous surveys have shown in a variety of conditions and diseases that patients often do leave doctors without having obtained the information which they need and are often dissatisfied because of this. Explanation can be regarded as an extension of information giving or sharing, but has the connotation of a to-and-fro dialogue designed to meet the needs of a particular patient.

Discussion, by definition, demands involvement by the patient, and in the ideal process of counselling there is a sharing between two people of the relevant information.

There are two schools of thought about whether or not advice by the counsellor is or is not desirable, or possible. One school believes that the process of counselling should be non-directive, in which the counsellor is careful to avoid any personal indication of the appropriate action and should be scrupulously neutral to ensure that the patient really does decide the issue himself.

The other school of thought believes that in a warm relationship between two people it is just not possible for the counsellor to hide his or her own feelings, and that the scrupulousness should refer to the way in which these are presented and revealed to avoid any covert manipulation or pressure on the client to conform. This school of thought believes that a counsellor who can talk about his or her own feelings about the problem will assist the patient and will assist the patient/professional relationship.

Aim

The aim of this process is to help the patient help himself. It is designed to build the patient up to use the additional information and to decide for himself or herself the appropriate action. Patients who are counselled may find the process more difficult than simply being told what to do, but the attempt by the counsellor is to help the client to grow by facing the issues and resolving them.

Counselling is thus much about feelings. The counsellor needs to be interested in the patient as a person and to be able to accept him or her as an individual, to be treated with equality and dignity, regardless of the particular problem presented to him. Counselling is thus a natural approach for the generalist.

Good counsellors have to have balanced personalities themselves to be able to share their patients' unhappy and confused feelings without breaking under the strain. Counselling is a process for the mature adult and its skills are often underestimated and underrated.

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Conditions

It follows that there are several conditions necessary for counselling. First, there must be adequate time. In many disciplines the classic psychoanalytical hour is still put aside and many counselling organizations still recommend this. In general practice, however, the repeated shorter interview is more usual and may be equally effective. Indeed, there is a possibility that shorter sessions may be more digestible for patients and enable them to evolve towards decisions at their own pace. An hour-long intensive interview can leave a disturbing effect on the patient. The danger, however, of the short interview is that it may be insufficient for an unhurried discussion of the important issues, may become superficial, and may never progress logically towards the patient's needs. There are other implications for general practitioners who wish 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 outside are doomed from the start. Waydenfeld and Waydenfeld today write a report of counselling in general practice (p. 671) and Short describes a seating arrangement more conductive to counselling (p. 687).

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 about two and a half thousand different people for years on end is a considerable intellectual and emotional challenge for physicians in primary care. It is for these reasons that growing attention is being paid to offering vocational trainees such an approach and one useful training technique is the interactive small group discussion. This does, however, demand leaders experienced in listening carefully for long periods.

Thus, for British general practitioners, counselling has emerged as a procedure requiring both new techniques and new attitudes. The implications for discouraging inappropriate doctor activity such as excessive prescribing, investigation and referral, are far reaching.

The concept of counselling thus integrates many of the great themes of modern general practice. First, it is a natural approach for generalists who deal with a wide range of personal problems; secondly, it is a logical philosophy for those primarily interested in people rather than diseases and it fits in well with current ideas about patient participation (Graffy, 1980; Wood and Metcalfe, 1980). Finally, it systematically seeks to avoid patient dependency and it reduces the risk of adverse effects following undue doctor activity and intervention.

In searching for the framework for the future of general practice, many are now asking: is counselling the key?

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Catchment areas for general practice?

"To date, the selection of a general practice remains a personal choice. The desire to maintain a link with a doctor known to the family and to the respondents for a long time appears to be stronger than wishes to minimize distances travelled to the practice premises. Accessibility to a surgery may be only a secondary consideration to a person who wishes to retain contact with a previous family doctor."

Phillips (1980)

IN the early years of the twentieth century the British Medical Association, when negotiating with government for the first time about the terms and conditions for the entry of general practitioners into a state medical service, laid down a fundamental principle that all patients should have a free choice of doctor. This stand came many years before the formal provision of a voice for consumers in health services and is an interesting illustration of patients and profession working in harmony.

Since 1950, however, public and professional policy has encouraged general practitioners to move into group practice. The number of groups and the size of group practices have been rising steadily (DHSS, 1977). With the steady fall in the number of single-handed practitioners, the number of separate general practices has obviously fallen, and with it the range of choice for patients.

Simultaneously, there have been many pressures leading to general practitioners drawing their practice boundaries rather more tightly than in the past. There are powerful arguments for restricted boundaries, for fewer practices, and for a rationalization in the use of medical services. Such arguments naturally appeal to