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

those general practitioners with a special interest in practice organization.

Concentration of staff and equipment at central premises argues the case for patients travelling to them and there has been an undoubted fall in the amount of home visiting. It seems absurd to ask patients to travel long distances to their doctors when nearer surgeries are available. Transport costs rise relentlessly and so do traffic jams; mothers with small children particularly value local services. Doctors, health visitors, and nurses all gain by becoming more than familiar with problems and services that are available in their local 'patch'. The manifest absurdity of seeing several doctors visiting the same street on the same day is traditionally cited as an example of a reason for rationalization. Furthermore, there have been worrying suggestions that patients living at a distance from their doctor may be inhibited from consulting (Cobb and Baldwin, 1976), while in many country areas and on some housing estates geographical considerations may override the patient's right to choose.

In any case, if catchment areas and zoning are right for primary education, why not for primary medical care?

Medical geography

Against this formidable array of arguments no strong and consistent policy has so far emerged. The issue of consumer choice only recently began to emerge in the public services and at present the patient's voice is relatively silent about his right to choose a doctor.

As general practice becomes increasingly concerned with the environment, so environmental sciences begin to illuminate our understanding of general practice. Geographers are now beginning to apply their skills of spatial analysis to the problem of organization of general practice, and we publish this month an article by Phillips (p. 688), a geographer who is reporting the results of research in South Wales.

Phillips' approach has been to analyse not just what patients say, but what they do. He has plotted, like others before him, the relationship between a sample of patients and the distance they have to travel to their doctors. His findings do not fit the current fashion of centralizing general medical services and, by implication, restricting choice of doctor. He found that, "surprisingly large proportions of respondents in all sites were bypassing their nearest or second nearest surgeries to travel considerable distances to the doctor." Fifty-six per cent of Blaen-y-Maes respondents and 39 per cent of those from Foresthall were going more than two miles to their doctor's surgery.

He found one important factor to be the previous residential history and, what will not be surprising to many general practitioners, that the personal relationship established over the years between doctor and patient sometimes "since childhood" was valued so much that patients, even after they had moved some distance away, were prepared to travel to a doctor whom they knew and had come to trust. "To date the selection of a general practice remains a personal choice. The desire to maintain a link with the doctor known to the family 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."

Choice of doctor

These findings seem important although, since the study was carried out on only 400 patients, there is a need for further research on many different districts before more general conclusions can be drawn. Nevertheless, at a time when general practice is becoming increasingly conscious of the rights of patients, and when South Wales itself has a particularly distinguished record in encouraging patients to express their views (Wilson, 1975), Phillips' finding (Table 1) that over 40 per cent of patients of all social classes in each of his four districts were travelling to a third or more distant practice, and that of those patients of lower social class over a third were travelling more than two miles past nearer general practices, merits attention.

At a time when there is much comment about uptake of health services (DHSS & CPAG, 1978), especially by patients in lower social classes, this personal choice is all the more instructive. These patients are exercising consumer choice in a striking way.

In terms of market forces, are practitioners perhaps reacting in a way characteristic of monopolies? Are they exploiting a position of relative strength vis-a-vis the consumers by progressively putting their own interests first and limiting the areas they are prepared to serve? Catchment areas have coincided closely with reduced competition for patients.

Unsatisfactory uptake and access to medical services, especially from patients in the lower social classes, is one of the principal problems of British medicine. When over a third of such patients make a positive decision and choose general practitioners other than those nearest to them, this is particularly important. Voting with the feet is an effective form of non-verbal communication.

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