Counselling in general practice

IN the 1950s, Michael Balint showed general practitioners the value of listening to their patients and tuning in to their feelings.[1] The emotional distress underlying many of our patients' complaints at once became more apparent. At first, the implication seemed to be that general practitioners would need to become psychotherapists for at least some of their patients, and a long interview was regarded as essential. Later, with the publication of *Six minutes for the patient,*[2] came a new realism: general practitioners did not have the time and did not really have the training to do long therapy sessions.

Family doctors were there to listen and to understand if they could, but only in the context of ordinary length consultations. A sensitive doctor with some training in communication skills (and today that means all of us) can often do a great deal in this way to help a distressed patient. But there will always be a considerable number of patients for whom this will not be enough. Both doctor and patient may realize that the new insight gained from a good 10 minute consultation needs to be followed up at greater length and in greater depth. Some general practitioners have always been prepared to go this extra mile with a few of their patients and have been willing to undertake more training. Most, despite their interest have, perhaps wisely, stopped short of the added commitment and the associated hazards.[3] The general psychiatric services have little to offer these patients who may feel that they have been stigmatized and their problem inappropriately medicalized by a psychiatric referral.[4] General practitioners now seem to be developing a pragmatic solution to this problem by employing counsellors to work with them in their practices.[5] Recent studies have shown that counsellors work in nearly a third of general practices in England and Wales.[6,7] The distribution of counsellors is patchy, seemingly dependent on the vagaries of family health services authority policies. There is some evidence to indicate that general practitioners are more likely to employ counsellors in the absence of a credible community mental health service.[7]

Counsellors work with patients with a wide variety of problems,[8] ranging from loss and bereavement to complex disorders such as phobias, obsessive-compulsive disorders, anxiety and depression. Counsellors with specialized skills see patients with relationship problems, psychosexual disorders and substance abuse. Others have become adept at treating patients with eating disorders and post-traumatic stress which is becoming increasingly recognized as a source of morbidity.[9]

The number of hours counsellors work in practices varies widely. Some are able to provide only two or three hours a week while others, working as members of a counselling team in a fundholding practice, may run a comprehensive service, fully meeting the counselling needs of the practice so that waiting lists for their service are short or non-existent.

However small the input, the presence of a counsellor seems to be greatly appreciated by patients and their doctors.[10-14] It seems likely that counselling is here to stay. But does it work? Evaluation of the effectiveness of practice counselling remains a problem. We now have a considerable number of studies with the balance of evidence tentatively upholding the benefits of counselling. The paper by King and colleagues, published in this issue of the *Journal* provides a thoughtful examination of some of the difficulties.[14] Most studies have looked at the same group of end points which include reduction in consultations, referrals and prescriptions, as well as more subjective measures.[14] Most have suffered from the absence of controls[14] and, given the limited amount of research funding and the ethical and practical problems, this is probably insurmountable. Researchers also have to contend with many confounding variables such as variations in counsellor competence and experience, different referral patterns by general practitioners and the different number of hours provided by counsellors (which also affect referral patterns). Some of these difficulties are inherent in all research in psychotherapy and counselling.[15] Evaluation must go on and methods will inevitably become more sophisticated. However, the demand for counselling and the appreciation of its presence by the consumer is such that patients and practices are not content to wait for a definitive answer as to whether it works. The growth of counselling will continue and the aim should be to provide as professional a service as possible, meeting accurately and effectively the needs of general practice and its patients.

Three major areas of concern in counsellor provision are currently being addressed. The first is that of competency. The current yardsticks are the completion of a recognized period of training, adequate supervision and, perhaps, personal therapy for the counsellor. Unfortunately, some counsellors working in primary care do not fulfil even the basic requirements. However, family health services authorities are now better informed, following the publication of guidelines[16] and leaflets.[17] Family health services authorities are now tightening their criteria for approving partial reimbursement of counsellors' salaries.[18] Training opportunities are also improving: from January 1995, a master's level diploma in primary care counselling, developed by the Counselling in Primary Care Trust, will be offered by five universities and colleges.[19] Supervision is essential if the standard of work of counsellors is to improve and is also necessary to protect them and their clients. In recognition of its importance family health services authorities are increasingly including a reserved element of salary to pay for supervision.[18] A counsellor working one to one for 20 hours a week will need at least three hours of supervision weekly, and a trainee substantially more.[16]

The second problem is the lack of mutual understanding of each other's roles on the part of general practitioner and counsellor. Different ethical values, different models of illness, and conflicts over diagnosis and confidentiality are all obstacles to effective collaboration. Any practice wishing to start a counselling service will need to find ways around these obstacles if the service is to succeed. For instance, counsellors need to be included in practice meetings and given plenty of time for joint consultations so that they can be fully integrated into the practice team. Some family health services authorities are putting on joint workshops for counsellors and general practitioners to facilitate this process (Knight K, personal communication).

The third area of difficulty is the development of a working relationship between primary care and secondary mental health services.[20] Counsellors who identify difficult problems may find that their clients are referred to practitioners such as community psychiatric nurses whose level of counselling or psychotherapeutic competence is lower than their own. Hospital psychiatric outpatient departments can offer referral to a psychologist or psychotherapist in theory, but the overloading of their resources and the length of their waiting lists may prevent help being provided at the time when it is needed. Some community mental health trusts are planning to provide a vertically integrated service, developing a comprehensive counselling service employing and providing supervision for counsellors whose services can be acquired by fundholding practices and other purchasers.[21]

Despite the problems still to be solved, the future for counselling in general practice looks bright. The general public wants

more talking (or perhaps listening) treatment and less drug therapy for emotional problems and disorders.[22] Practices up and down the country are increasingly providing these services. General practitioners and family health services authorities are becoming better informed about how to ensure a high standard of counselling. Counselling training organizers are beginning to meet the real needs of primary care counsellors through both training and continuing education. Michael Balint would surely have approved of these developments.

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Practice policies for responding to patients with chest pain

A WORKING group, convened by the British Heart Foundation, has recently produced guidelines for the early management of patients with myocardial infarction.[1] The stimulus for updating previous recommendations[2] was new evidence that thrombolytic treatments produce greater benefits if given as soon as possible after onset of symptoms,[3,4] and continuing concern that much could be done to improve the care of heart attack victims.

In order to reduce the mortality and morbidity of myocardial infarction, there is a need to reduce the interval between onset of symptoms and provision of resuscitation skills, adequate analgesia, assessment and accurate diagnosis and, where appropriate, early thrombolytic therapy.[1] The working group makes the specific recommendation that patients with obvious acute myocardial infarction and no recognized contraindications should receive thrombolytic therapy within 60–90 minutes of summoning assistance.

Achieving these aims will require the development of a variety of options depending on local circumstances. General practitioners have an important part to play in determining the appropriate approach for their area. In many areas, patients with chest pain tend to contact their general practitioner before any other services.[5] The attending general practitioner makes a valuable contribution to the patient's care by providing essential diagnostic skills and the range of treatments needed for the management of myocardial infarction, including an intravenous opiate, an antiemetic drug, aspirin, atropine, lignocaine and possibly a thrombolytic agent. Although sometimes overlooked, the provision of pain relief is an easy and important way of providing patient comfort. The general practitioner's previous knowledge of the patient and his or her social circumstances, is often helpful when deciding on the appropriate management.

On the other hand, general practitioners may lack the equipment or skills to resuscitate patients who have had a cardiac arrest. These facilities, however, can be provided by frontline ambulances. It is for this reason that many practices may wish to adopt the policy of a joint response, whereby both ambulance and general practitioner respond to a call for help. A 'scoop and run' policy which involves ambulance staff bypassing the general practitioner and transporting heart attack victims to hospital as quickly as possible is, arguably, a less satisfactory option, although justified if there is likely to be a delay in the general practitioner attending.

Should general practitioners use thrombolytic therapy? For many the answer must be yes, if the target times for receiving such therapy are to be met. Geographical distance from hospital should no longer be regarded as the determining factor — many doctors in urban areas know that their patients reach hospital quickly, only to wait hours before receiving thrombolytic treatment. Each practice needs to know the likely delays in transporting their patients to hospital and the average time before receiving thrombolytic surgery after arrival. In the absence of any audit figures from the local hospital, the median times from arrival to