

EDITORIAL:

THE ROLE OF DOCTORS AS COUNSELLORS

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The roles of a doctor include prevention, diagnosis and management of disease. With the ideal increased emphasis of the primary care physician or any one of numerous medical specialists as a member of a health care team, his role may include planning and provision of services for the physical, mental and social health. The concept of a team will include everyone who participates in the management of a patient. Behavioural sciences and physical sciences are components that contribute to the practice of medicine. A doctor cannot avoid noticing the ecological, industrial, occupational, familial and personal factors in the maintenance of health and contribution towards the etiology and progress of disease. In practice, most physicians today would advise a chronic heavy smoker with a recent myocardial infarct to stop smoking. But how many doctors will have the time to listen to a patient and take a history of stresses at work or at home when a patient presents with symptoms of vague aches and pains?

The word *doctor*, *doctorem* meaning teacher arises from the Latin word *docere*, meaning teach. This corresponds to the word *discere*, meaning learn. Thus, "doctor, teacher: highly proficient in a branch of learning or holding the highest university degree: especially doctor of medicine, hence medical practitioner".¹

Counselling is now generally a term used in most writings by and for primary care physicians or general practitioners.² Counselling involves psychological treatment of a person's problem by a trained therapist with the expressed purpose of relieving discomfort or illness. Among the behavioural

sciences, psychology, sociology and anthropology attempt to look at the arts of medical practice — doctor-patient relationship and aspects of counselling. Bernard Green,³ a psychiatrist and psychoanalyst agreed that psychological treatment will include therapy carried out by a variety of individuals with differing backgrounds and training. Professional counsellors and psychotherapists without medical training have to undergo training or supervision. Most psychiatrists have training in psychotherapy. Significant minority of general practitioners in Britain and America have organized their own training programmes or continuous medical education in counselling. Even though most doctors do not receive adequate training as counsellors, patients still expect their doctors to understand their illness and manage them.

FACTORS INFLUENCING COUNSELLING

All doctors interact with patients to a varying degree. The doctor's personality, thus his choice of speciality will influence the extent of his need for therapeutic use of the doctor-patient relationship, i.e., counselling. The general practitioner, the gynaecologist, paediatrician, surgeon and the psychiatrist may defer in their degree of interaction. But all of them have to gather relevant clinical history and information, and provide counselling sometimes. The time available, the fees charged and the patients' appreciation or request for counselling will determine the quality and quantity of counselling provided, assuming that the doctor is interested and skilled in counselling.

Time is a reality constraint in most medical practices. estimated as three minutes for some

outpatients in busy general hospitals in Malaysia to the proverbial six minutes consultation in the British National Health Scheme doctors. Patients' expectation of the roles of the doctors is the other reality. Even some of our educated patients consult their indigenous healers whom they share the same world's view of the supernatural and interpersonal causations of illness while seeking mechanical, physical investigation and treatment from the doctors. Thus, it is not surprising that patients' selective demand for service contributes towards the increased income of doctors who perform more instrumentation and surgery rather than those who prescribe.

Counselling involves an educational effort which takes into consideration the psychological interaction between a counsellor and a counselee. A doctor who is a counsellor may have the advantage of medical knowledge and the socially accepted role of the care-giving authority. But he has to be careful that for some patients, he does not encourage over-dependency on him. Initially, some patients need and contribute towards the projected role of the omnipotent doctors. But soon they may be disillusioned with their persistent aches and pain, or the persistence and progress of their illness. The perceived incompetent doctor may be the target of malpractice suit if there is poor doctor-patient relationship.

As a doctor, his relationship with the patients vary from parent/child interaction when he manages a hospitalized, seriously-ill patient; adult/adult relationship when he discusses with a patient about a need to either decrease the amount and type of food intake or increase the output of calories by involvement in regular exercises in a programme of weight reduction for a middle-aged patient with mild diabetes. A counsellor is more than a teacher. G.M. Carstairs remarked that counsellors, just as psychotherapists, soon learn that "advice can be given freely but without effect so long as the recipient is caught up in his own emotional problem. The unburdening of these problems to a trusted listener is a necessary preliminary to being able to receive help, and an important part of the skill of the counsellor, as of the therapist, lies in knowing how to facilitate that unburdening".⁴

Differences in cultural, social, religious and personal values may affect counselling. Reassurances and advice given too readily by a doctor without awareness of these values, needs and resources of the patient will contribute towards loss of trust in the doctor by the patient.

PATIENT-CENTRED MEDICINE

Counselling relationship highlights the interpersonal aspects of the doctor-patient relationship. With a patient who may present with insomnia, palpitation or indigestion, the exclusive treatment of the symptom or underlying physical illness may not be the only things need to be done. The symptoms may be physical symptoms which are related to anxiety and depression over a current life change at work or at home or acute exacerbation of chronic stress. Unless encouraged by the doctors to talk about these social and personal areas, a patient may feel that it is inappropriate to give these information to the doctors. This particular patient may have considered a referral to a psychiatrist as a rejection by his doctor. Even if he agrees to see a psychiatrist, he may find the ideally half-an-hour to an hour's interview with a psychiatrist for a new patient as too threatening. On the other hand, a perceptive family practitioner with an awareness of the socio-cultural, economical and family background of a patient and actual contacts with some or all of the family members during their previous visits to the doctors may be able to have a meaningful, effective and therapeutic, 'flash' interview with a patient within five to six minutes. Both doctors and patients are able to mutually understand the reason for a consultation or the probable contributory factors to the present illness or symptoms. This is possible because of the 'pre-flash', psychosocial information available to the doctor who knows the patient.⁵

In their practice of patient-centred medicine, Balint and his fellow medical practitioners initially separated the patients seen into three different categories: organized diseases; unorganized diseases; and no illness.⁵ For each category, the doctor will plan his management with the following guidelines: the traditional diagnosis; the actual reasons for coming to the doctor on a particular day; and an overall diagnosis.

This overall diagnosis is a psychosocial overview of the patient and his family and the current emotional, social and financial status of the patient. With **organized diseases**, which include all those patients whose diseases are identifiable in the traditional diagnoses, the psychological aspects of the disease or concomitant psychological problems are also cared for. For those patients with **unorganized illness**, which include all the physical and psychological symptoms which cannot be attributed to any known disease entity, the overall diagnosis helps a doctor to understand the patient and proceed towards a management of the psychosocial stresses, and the psychological reactions. This will help towards rapid recovery from symptoms which ultimately may lead to either a well-recognized medical or psychiatric illness, i.e., an organised disease. For those with **no illness** situation, which include normal people who come for routine antenatal check-up or specific medical examination for employment, application to colleges or insurance coverage, etc., preventive psychiatry or counselling of likely conflicts in view of the current personal and interpersonal relationship may be undertaken.⁵

CONTINUOUS EDUCATION AND EVALUATION

Michael Balint and the general practitioners in Britain and United States who have participated in continuous education groups which studied the doctor-patient relationship are aware that in spite of the most sophisticated intellectual knowledge of the literature, the affectional perceptivity of a doctor can only improve with continuous participation in a learning-emotional experience which provides opportunities for the participants to present their own managements of their own patients.⁵ Paediatricians who have to counsel parents on the management of children also benefit from supervision provided by medical social workers.⁶ The end result of this form of education preferably during medical students' days, but

occasionally after beginning private practice, is to have patients and doctors involved in patient-centred medical practice rather than disease-oriented practice.

The art of medical practice is complex and time is fleeting. The following remarks by a research clinical psychologist, Dr Hans Strupp, about psychotherapy may assist all doctors to look at their role in counselling: "What sets psychotherapy apart from other forms of 'psychological healing' — and of course medicine — is the planful and systematic application of psychological principles, concerning whose character and effects we are committed to become explicit. As psychotherapists and researchers, we want to learn more about what we are doing; we want to be able to do it better; we strive to be objective; and we are willing to work hard towards this end. To me, these are the beginnings of science, if not its essence."⁷

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