HOW DO WE DO WHAT WE DO WITH PATIENTS AND HOW CAN WE DO IT BETTER?

North West London Hospitals NHS Trust

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INTRODUCTION

HEALTH ADVISING TODAY. CRISIS. WHAT CRISIS?

"Is Health Advising just a job or does it have the characteristics of a profession? Are Health Advisers merely ancillary workers for the medical profession carrying out a delegated range of tasks, or do they have a coherent way of conceptualising their role in a way that relates theory to practice, and which betokens a distinct professional identity and role"? (Leach 1998:1)

Health Advisers, who originated in Genito Urinary Medicine as contact tracers have evolved in the modern HIV/GUM Centre providing counselling on all aspects of sexual health to patients and partners.

The authors of the current study, three experienced Health Advisers believe we must take pride in our origins but that we are now at the evolutionary stage to emerge with self-confidence as a distinct profession with a clear identity within the modern NHS. To do so we must articulate our Health Adviser practice in a coherent and comprehensive way. This is extremely important at the present time when questions about our very existence are being asked. At a time also when it appears we are feeling marginalised and demoralised. In a review of twenty one London clinics

"There was a feeling amongst some (Health Advisers) especially in smaller clinics, the tasks no-one else wants to do fall to them" (Weatherburn et al 1998:14)

This vulnerability is being expressed at a time when (voluntary and statutory), specialist HIV support services are being reduced and professional groups are finding their very existence in question. In 1996 Nurse Practitioners and Clinical Psychologists 'absorbed' the role of the Health Advisers at St. Mary's. This does not imply that all the Health Adviser functions are being adequately met by the other professionals there. It is not known whether there has been an audit or comparative study to establish this. There has been a cross district reduction in the numbers of Health Advisers at Chelsea and Westminster in 1998, despite increasing numbers of patients and cut backs in HIV psychiatric liaison resources at a time when people with HIV are fortunately living longer and healthier lives; and therefore patient numbers doubling in under five years (THT 1998).

This study proposes we meet the challenge by choosing to value our interactions and as a whole profession begin to agree on and articulate an evidence based Health Adviser practice. We must stand up for ourselves and be counted. We do this by addressing the deficit of clinical audit, research and standard setting across our 'emergent' profession.

The authors propose we 'come out' as Health Advisers in Genito-Urinary-Medicine who counsel patients with sexually transmitted infections including HIV. The following data is presented as significant evidence for the development of a research based conceptual model of all aspects of the Health Adviser role inclusive of SHASTD's 'core areas' of Health Advising.

OBJECTIVES OF THE RESEARCH

The overall aim of the Research is to evaluate and conceptualise Health Adviser interactions with a specific patient group: HIV antibody positive gay men referred for psychological support; with a view towards developing and supporting an evidence based Health Adviser practice applicable to all patients referred. It is a baseline study.

From the responses to the patient questionnaire the authors considered three specific though inter-related questions:

i) What knowledge, skills and attitudes inform a Health Adviser interaction with a patient in a HIV/GUM centre?

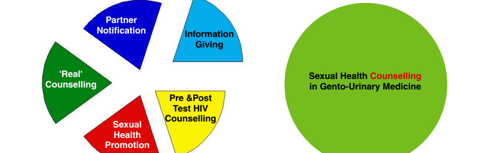
ii) How can we better define and characterise our patient interactions?

iii) What implication do these findings have for the professional development of Health Advising with particular reference to the core areas of Health Advising (SHASTD – Guidelines for Good Practice, 1999)

RESEARCH DESIGN

The project proposal was devised by the Practitioner Researcher in 1998. The qualitative data was gathered at St. Stephen's Centre, Chelsea & Westminster Hospital from March 1998 to April 1999. A final analysis of the data was subsequently completed with the assistance of two Health Adviser colleagues from North West London Hospitals NHS Trust.
The research received supervision from Dr. David Woodhead, Faculty of Health and Social Science, South Bank University.
Fifty-four Patient Questionnaires were given out by seven members of the Health Adviser team from the period 27th July 1998 to 1st April 1999. HIV antibody positive patients were asked to complete this on their own, at the end of the Health Adviser interaction by the Health Adviser they had just seen.
The project was approved by the Local Research Ethics Committee at Chelsea & Westminster NHS Trust in June 1999

The Fragmented Professional Model — The Proposed Integrative Model



ANALYSIS

The qualitative data has been collected by means of a patient questionnaire. The data has been collated in the form of a Data Management File. For the purposes of this analysis the sequential order of the questions on the questionnaire is followed. The text considers and reflects upon the patients written responses.

For the period 27th July 1999 to 1st April 1999 fifty four HIV antibody positive gay men referred for psychological support completed a questionnaire eliciting information on the interaction they had just experienced with a Health Adviser and at the discretion of that Health Adviser.

Have you seen a Health Adviser before?

Yes	No	Don't Know
37	17	None

If yes, when and why.

Thirty seven out of the fifty four patients had seen a Health Adviser before though there seems to have been little continuity of contact on which one patient commented *'continuity of contact is absolutely essential, I feel!'* More than half of the patients had remembered seeing a Health Adviser in the pre-test discussion or when they were first diagnosed. One patient puts this succinctly, *'HIV status before test and when receiving results'*. Other reasons for seeing a Health Adviser in the past included *'when I was going through a bad time'* and *'because I needed advice'*. Several times in the last twelve years for HIV related issues'.

Four patients only remembered seeing a Health Adviser in the role of 'Sexual' Health Adviser.
This low figure gestures towards the Health Adviser in sexually transmitted infections versus HIV Counsellor false dichotomy; and the, as yet, unresolved tensions and confusion with regard to Health Adviser identity which this study is specifically addressing. However that the majority of patients had remembered experiencing the Health Adviser in their role of HIV Counsellor is perhaps less surprising, considering the patients recruited are all HIV antibody positive gay men. The questionnaire was given out to five patients at the end of an interaction in which they had been informed of their HIV antibody positive status.

One patient juxtaposed two life defining turning points or crises through which he had experienced the support of a Health Adviser, though it is not clear whether the two events coincided: *'coming to terms with HIV and being gay'*. Such a comment is significant because it indicates that Health Advisers have developed the skills as health care professionals to engage in interactions where the deepest and most intimate concerns are worked through.

What did you expect to happen today?

When asked about their expectations of the interaction the overwhelming majority of patients expected an interactive meeting which included the provision of information, advice and emotional support. As one patient put it, *'someone that would listen, understand me question and give advice where needed'*.

Eight patients did not know nor were uncertain what to expect when they were referred to the Health Adviser.
One patient in the any other comments section of the patient questionnaire expressed an anxiety regarding an expectation they were being referred to what they feared would be:

"an invasive discussion about sexual practices, for in the past I have experienced quite a patronising attitude from Health Advisers, which has made me quite wary of visiting them".

This type of remark is perhaps not surprising from a patient who may have been referred routinely to a Health Adviser to discuss partner notification and treatment compliance when they had been diagnosed with Gonorrhoea, Chlamydia or Syphilis. However that HIV antibody positive gay men has expressed a wariness of the interaction because of what he perceived as an intrusive or negative past experience with a Health Adviser working in a different modality is an important concern. It is a reminder that Health Advisers have to negotiate a sometimes difficult task discharging their public health duty as well as meeting the needs of the presenting patients. The authors believe there can be strategies within professional sexual health counselling to achieve this aim and this matter will be further explored in Conclusions and Recommendations .

In conclusion to the analysis of this section of the questionnaire it is noted that twelve patients had the expectation of counselling and twenty-one used the words information and advice.

Please describe what happened when you saw the Health Adviser today?

When asked to describe the interaction of majority of patients described a friendly, informal and informative talk that was emotionally supportive or empathic and calming. The following comments are typical:

"I feel rather unwell and tired today and not really in a responsive mood. But feeling calmer having discussed some of my fears and anxieties and helped by my Health Adviser's comments."

"Talked about my status and the events leading up to my become HIV and other personal issues. I had a good chat and she was very helpful".

"Ran through my fears and questions booked an appointment for examination and blood tests".

"We talked about the viral load and CD4 count tests and described how I felt after receiving a positive result and what my next steps would be with regards to this".

It is also apparent from these comments that these interactions are grounded in information giving and the appropriate use of referrals. The majority of the comments describe the delivery of what might be called pragmatic, time limited, psychological support.

Five of the patients had been recruited at the end of an interaction in which they had just been told they were HIV antibody positive. Such news can often be traumatic and it is the role of the Health Advisor to contain these feelings and guide the patient through the crisis of diagnosis - a time of danger and opportunity for the patient (Leach 1998); meeting both the emotional and information needs of the presenting patient.

Two patients responded in a self-conscious manner *"I talked incessantly gibberish perhaps at times and Much as I expected". "I talked may be too much".* However the opportunity for patients to talk about themselves in this kind of interaction is given overwhelming endorsement by the comments.

The following are typical:

"He made me feel very welcome and he just let me talk in my own time about a specific subject"

"I was asked if there was anything in particular I wanted to talk about and about how I felt when first diagnosed"

"We discussed the nature of my problems and a referral was made at the Victoria Clinic for me".

There is a sense from these comments that the patients feel empowered and heard in their descriptions of these patient centred interactions.

Did You Find This Helpful?

Yes 48	no 1	don't know 5

Over ninety percent of the sample found the interaction helpful. The Practitioner Researcher acknowledges bias in the context that a patient may express a more favourable response to an interaction the patient has just experienced than one they have had time to reflect upon. However such an endorsement is impressive. This is backed up by the fact that a similar percentage of patients indicated they would see a Health Adviser again.

These results the authors believe provide evidence that we have developed the knowledge, skills and attitudes to work in a professional and meaningful way with patients referred. In the last section of the questionnaire a patient stated the fear that an invasive discussion about sexual practices would occur based on previous experiences of Health Adviser interactions. The authors believe that such concerns need to be addressed in the emerging comprehensive, inclusive, ethical evidence based definition sexual health counselling which this study proposes.

If yes why

"Because this kind of approach made me feel really comfy".

The provision of advice, information in a manner which is reassuring, engaging and containing, appear to be the key elements to this feeling of helpfulness

"I feel in good hands. It helped me to understand more and has taken away a lot of fears".

It is important to reflect on the possible implications on the above comments. If as Health Advisers we have the skills to help lessen the fears of HIV antibody gay men, we are developing a practice which creates the conditions required for a meaningful and sex positive discussion can occur around sexual practices. (Summerside THT,1998)

The authors do not provide a definition of a 'sex positive' Health Adviser practice here but we believe this data provides important evidence to begin to describe this. (See Appendix I) The data repeatedly refers to the friendliness and informality of the interaction. They feel safe and secure. Two patients commented on the value of talking to a stranger. All these factors perhaps are the prerequisite for a professional Health Adviser practice which can facilitate disclosure regarding extremely intimate sexual matters.

One patient made an important point to bear in mind working in the context of a Centre for medical research. They would see a Health Adviser again

"If something else comes up that I wanted to talk about I feel I could call here any time. Makes me feel like a person and not just a number".

The patient clearly experienced a humane and affirming interaction. He felt he was listened to and heard. Egan conceptualises counselling interactions using this approach

"The helping model, through its stages and steps provides principles rather than formulae. These principles serve as guidelines for helper and client alike the right formula that is the most effective application of these principles must be found in the interaction with each client". (Egan 1990:vi)

This study has given the patient the opportunity to voice what they have liked (and disliked) about Health Adviser interactions. Health Advisers nationally have developed implicitly their practice of listening to patients; and this listening the authors believe should be a central principle in creating an evidence based practice.

Would you see a Health Adviser again?

Yes 49	no 2	Dn't know 3

The overwhelming majority of patients would see a Health Adviser again. The principle motivation to do so appears to be the value they attach to the paracletic or comforting and informative nature of the interaction they have just experienced.

If Yes Why

Here is a typical selection of the responses:

"To discuss my future progress and to help demystify a lot of the medical jargon".

"I find it helpful to talk to someone who I don't have close contact with about HIV"

"I would if I felt it would help me get things sorted out in my mind. Even if it is temporarily does ease some of the tension and fears and helps me view some things differently".

"Good to talk and put things into perspective".

"If I needed information on health issues etc. also if I needed someone to talk to".

"It helps to talk".

The patients would see the Health Adviser again because the skilled interaction makes a difference. The authors believe it is impossible to read these comments and deny the proposition that Health Advisers counsel patients.

CONCLUSIONS

What knowledge, skills and attitudes inform a Health Adviser interaction with a patient in a HIV/GUM centre?

It is clear from the analysis of the data that a high level of **medical knowledge** is expected from the Health Adviser. This has implications for induction and in service training. See Recommendations. In order to counsel patients in a professional manner in sexual infections in Genito Urinary Medicine the counsellor must have a good knowledge base to work from.

The skilled adviser is also an informed adviser who **listens** to the patient assessing and identifying information and emotional needs. The skilled helper especially in the context of giving HIV positive results has the responsibility of guiding the patient through unknown territory where facts and feelings may at times appear overwhelming and bewildering.

This guiding involves giving direction and may be misconstrued as a directive approach from those from a classical counselling theoretical background. Such advisers who may identify with a more rigid definition of so called 'pure' counselling theory sometimes express concern at what they perceive as a didactic element within the counselling interaction. However the authors contend that the best counsellors have always been teachers who do not tell others what to do. The skilled Health Adviser imparts knowledge to facilitate and empower the patient to make their own informed choices. This 'psychodidactic' element is central to counselling patients with sexually transmitted infections as the data in this study has shown.

Recent commentators have referred to the need to work in a **'sex positive'** manner with people who are HIV antibody positive (Summerside 1998 THT). The authors wholeheartedly endorse this approach and indeed we believe it is the basis on which we approach our interactions with all our patients diagnosed with sexually transmissible infections.

A friendly, relaxed, informal, engaging interaction are features which indicate perhaps a more **active use of the self**; and these attitudes and aptitudes are paradoxically normally associated with volunteers, paraprofessionals or amateurs! (as well as associated with features of crisis intervention and time limited counselling theory.) Well why can't we, as Health Advisers, choose to 'come out' so to speak, self consciously, as the first 'amateur' profession. In other words we strive as individual practitioners and as a profession, to become truly non-professionalised professionals i.e. both self reflexive and flexible not fossilised in our attitudes to our professional practice. The image of the 'barefoot professional' comes to mind and this image is perhaps an appropriate one for Health Advisers for whom a central aim of the interaction is to facilitate patient disclosure in a sex positive manner. See appendix I for a list of the features and characteristics of the Health Adviser interaction. as described in these findings.

How can we better define and characterise our interactions with patients?

The authors believe that the data from the questionnaire provides solid evidence that Health Advisers practice provides an opportunity for patients to live in a more satisfying and resourceful way. Health Advising as described by patients is concerned with developing medical and other knowledge and personal insight, coping with crisis improving relationships and resolving specific problems in a safe and supportive manner which respects the patients values and capacity for self determination.

The above is precisely how the BAC defines counselling (BAC 1989). Thus Health Advising has the evidence to support George Leach's contention that Health Advising may perhaps be thought of as a specialised form (or a number of specialised forms) of counselling. (Leach 1998:4)

The authors believe that we can better characterise and define our interactions with patients if we agree to describe them as **counselling interactions and we continue to develop an evidence based, ethical, Health Advising practice, namely sexual health counselling within Genito-Urinary-Medicine.** The aims of Sexual Health Counselling remain as yet only broadly defined in the clinical setting. Sexual Health Counselling certainly has the implicit goals of sexual health promotion and patient disclosure (a term used only in its broadest sense in this study.)

Currently these aims are being examined by a team of Health Adviser Researchers who are asking all the members of SHASTD how we characterise and define our practice with patients. The authors propose that a strategy be pursued that can link the important findings of this study centred on the patient responses from the Patient Questionnaire with the development of a model of Health Advising from data gathered from Health Advisers.

What implications do these findings have for the professional development of Health Advising with particular reference to the 'core areas' of Health Advising, SHASTD Guidelines for Good Practice 1999.

The authors believe that the overwhelming endorsement of the Health Adviser interactions in the findings of the Patient Questionnaire provides clear evidence to back the Health Adviser claim to legitimate ownership of our counselling interactions. While we commend SHASTD for the first edition of Guidelines for Good Practice 1999, we believe these findings form the basis of some constructive criticism. The core areas unfortunately lack a clear statement and an inclusive definition that Health Advisers counsel patients but instead list a number of loosely linked tasks or skills.

It is the view of the authors, (whose combined experience covers several London clinics over two decades); that the skilled practitioner does not do partner notification with patients; or sexual health promotion; or pre test counselling or 'real' counselling (of which there are several hundred models); or just information giving with counselling skills.(see the piechart).

Health Advisers counsel patients in sexually transmitted infections including HIV. This counselling involves a skilled and meaningful conversation which promotes sexual health and patient disclosure. This Health Adviser interaction is an integral part, indeed the 'sine qua non' of the good clinical management of patients in Genito Urinary Medicine within the modern NHS.

All skilled clinicians counsel patients however, self evidently, counselling is not the primary role of the doctor or nurse; it is the primary role of the Health Adviser and therefore it is essential that we characterise and define our counselling interactions in a comprehensive, coherent and professional manner.

RECOMMENDATIONS

1. SHASTD formally characterises and defines Health Adviser interactions with patients in Genito-Urinary-Medicine as counselling interactions; and links these important patient findings with those of a study of patient responses gathering data from Health Advisers in developing a model for Health Advising.

2 SHASTD co-ordinates a strategy for the production of an ethical, evidence based definition of sexual health counselling in Genito-Urinary-Medicine which will form the basis of the second edition of Guidelines for Good Practice.; and adopts the proposed integrative professional model for Health Advising in the new millennium. See piechart.

3. Health Advisers continue researching and evaluating their practice with a view to addressing the current invisibility of the profession. The authors propose the model of Practitioner-Researcher for Health Advisor Research and Professional Development .

4. SHASTD includes in 'Guidelines for Good Practice' See Section Professional Development; that Health Advisers who undertake training in related counselling fields are expected to bring this expertise back into Health Advising to strengthen the emergent skills base of the profession.

5 SHASTD includes a relevant section on the medical in service and induction training for all Health Advisers in Good Practice Guidelines.

Postscript

Choices for Health Advisers in the New Millennium

In this study the term Health Advising interaction is synonymous with counselling interaction in the context of Genito Urinary Medicine. However the authors want to make a sharp distinction it is not synonymous with counselling 'per se'.

The argument of this study is that Health Advising is not just a job comprised of a range of specific delegated tasks. The authors have identified our professional core skill we counsel patients in sexual infections; and we believe as Health Advisers, we are beginning to conceptualise our counselling practice appropriately. When committed and experienced Health Advisers meet and we discuss our work; we instinctively recognise each other as fellow professionals; though we may have come from many different backgrounds and theoretical trainings.

However we believe is important since we are still emerging professionals and therefore vulnerable to vested interest groups that we make a clear decision in terms of the path we follow for the development of the profession.

Do we want to identify Health Advising with counselling as therapy: a kind of personal growth hobby and thus with the world of relatively unregulated, recreational therapeutics. **Or do we want Health Advising to continue to develop as an evidence based, healthcare profession within the modern NHS which responds to urgent sexual health problems? .** (Feltham 1995).

The former identification the authors believe, poses grave risks for the profession; if its motivation derives in the main from Health Advisers who want to be seen primarily as professional counsellors doing the so called 'deeper' more higher status work; and who often want a change in their professional title to accommodate this eg. HIV Counsellor, or at its most extreme, psychotherapist. On one level this is clearly a desire to escape from Health Advising (Leach, 1998:8) and its core functions and is thus devaluing of our work and profession.

The latter identification offers a pragmatic and serious way forward for the development of the profession. The authors firmly believe that this change makes for a stronger, more self-confident, 'come of age' 'Health Adviser identity which embraces an evolving model of practice.

We believe if we emerge as a robust profession in this way then Health Advisers have the potential perhaps, to even change the structure itself, of the 'helping' or Health Care Professions.

It's our choice.

APPENDIX I

FEATURES OF HEALTH ADVISING (COUNSELLING) INTERACTIONS

- one off interaction (very) time limited
- interaction grounded in good up-to-date medical information regarding the transmission, diagnosis, prognosis and treatment of STIs including HIV
- information giving/advice giving skills
- informal, self-reflexive
- appropriate self disclosure
- crisis containment, assessment and referral
- open access: without the protection of some of the boundaries of contract counselling situation
- multidisciplinary style of working
- flexibility: repertoire of counselling modalitiesincluding contract counselling
- regular supervision.

Comments on the poster are welcome. Comments to James Monteith or Jo Greenaway at Patrick Clements Clinic, Central Middlesex Hospital, Acton Lane, London, NW10 7NS

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