trainer's consultations were primarily for gynaecological disorders and a surprising 29% of the trainee's. This high rate can be partly explained by the atypical practice age distribution and the even higher rate for the female trainee presumably reflects some women's preference for a woman doctor.[2]

Thus, as Pearson and Goss state, the trainee can expect to see a different workload from that of the trainer and it seems that it is dependent upon the type of training practice. This finding has important implications for education and training.

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Continuing medical education

Sir,

The Department of Health's new contract for general practitioners[1] will introduce a new postgraduate education allowance of around £1700 per annum which will replace the vocational and postgraduate training allowances. Wall and Houghton's editorial (August *Journal*, p.311) criticizes the effects of the new contract on continuing medical education but this criticism may be premature.

The vocational training allowance was paid regardless of whether the doctor ever picked up another journal or attended another lecture. The postgraduate training allowance went some way towards encouraging doctors to continue in their medical education but did not go far enough. The criteria for the postgraduate training allowance could be met by a one week course and the allowance could only be claimed once in five years and a maximum of twice before the doctor became eligible for the first seniority payment.

The new postgraduate education allowance may provide an incentive to all doctors, not only those who have some connection with vocational training. The criteria for the allowance do seem rather cumbersome and rigid but I am sure that those who make a genuine effort to continue their medical education will be rewarded and those who do not will not. A regional advisor who investigates and recommends more educationally worthwhile activities will be rewarded by a greater number and broader spectrum of doctors attending meetings.

While the new contract has not addressed vocational training I think that it will encourage more continuing education for everyone and will on balance be good for the profession.

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Patient satisfaction

Sir,

In their review of the measurement of patient satisfaction, Keeble and Keeble (July *Journal*, p.269) are right to draw attention to the difficulties involved. However, there are flaws in their argument that 'a more appropriate way of increasing consumer participation in the NHS might be to allow the public greater representation on family practitioner committees, district and regional health authorities and the boards of self governing hospitals'. How can such representatives of the public know the views of other patients without asking them? Should they rely on anecdotal reports or on the media, or should they use information collected in formal ways that have been tested for validity and reliability? In individual general practices where patient representation is still unusual, how are general practitioners to know if their patients are satisfied without asking them?

There are other good reasons why we should measure patient satisfaction. Patients have a right to expect that their views on all aspects of their care will be listened to and taken into account. This is essential within the consultation if a therapeutic doctor–patient relationship is to be established. It is also necessary in the wider context of health service planning if facilities are to be provided that patients are willing to use. Donabedian describes three reasons for measuring satisfaction: first that satisfaction is one objective of care, secondly that a satisfied patient is more likely to comply with advice, and thirdly, that satisfaction is a judgement by the patient on the care received.[1]

The measurement of satisfaction may not be straightforward, but, as Keeble and Keeble point out, these difficulties should not be used as an excuse for ignoring patients' views. Difficult does not mean impossible, and careful investigation may well allow many of the problems to be overcome. After all, the same shortcomings apply to virtually every other measurement in medicine. Perhaps the biggest obstacle to the measurement of patient satisfaction is that we are apprehensive about what our patients might think of us. In recent years, we have come to accept the value of the opinions of colleagues through peer review. I hope in the future we will come to accept the related principle of review by patients through the informed use of satisfaction surveys.

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Sir,

The editorial by Keeble and Keeble on patient satisfaction (July *Journal*, p.269) raises some perplexing questions and offers answers to none of them. The suggestion that consumer participation on family practitioner committees should be increased is undoubtedly one of the government's plans and certainly the medical profession's participation in family practitioner committees seems certain to be reduced. This must be regarded as a retrograde step as it will result in doctors practising defensive medicine, and an even greater gap in the understanding at committee level of what happens in the consultation. The government may consider the current system with a good medical input on various committees to be unsatisfactory but a committee composed of those that are medically ignorant is unlikely to be any better.

Having sent out a postal questionnaire to 77 patients who had been referred to outpatient departments I was pleasantly surprised to find that 90% of them were perfectly satisfied with the length of time they had to wait for an outpatient appointment to see a consultant, and approximately 96% were satisfied with the consultation they received with both the general practitioner and the consultant. However, having considered all the variables in Keeble and Keeble's editorial