Editorials

THE PATIENT'S POINT OF VIEW

O wad some power the giftie gie us
To see oursels as others see us!
It wad frae monie a blunder free us,
An' foolish notion.

IN the last two decades the trickle of research into general practice has swollen to a great flood, and although all good work in this matter ultimately affects the patient, comparatively little has been learnt of his point of view. In this, perhaps, we have erred, taking a too agoraphobic and introspective view of our own methods and motivations, and ignoring or perhaps even fearing the immortal Rabbie's somewhat foolhardy plea.

In this issue we publish three papers which examine this subject, and which read in conjunction with each other demonstrate the difficulties and complexities which surround the seeker after truth when he wanders into these largely uncharted deserts.

One of the Eternal Verities to be faced is that no doctor can ever think exactly like a patient, and *vice-versa.* Therefore it is possible that the doctor is unlikely ever to be the best man to research such a delicate and unquantifiable thing as an attitude of mind—especially when applied to himself. Some misinterpretation is probably inevitable. Add to this the average patient's innate politeness and desire to please when faced by questions from medical or paramedical enquirers, and the difficulties begin to grow.

Who is this 'patient', anyway? How do we tie the fellow down and anatomise him? He is a slippery customer, for the one common factor he shares with all his fellows is that he differs entirely from all his fellows. We all know that he has (at least) three guises: to our receptionists he can be the man-eating Bengal tiger, who on desperate reference to us at once becomes the sucking dove, cooing with the best: while, late at night in the bar parlour he—or more likely his mate, may assume the aspect of the viper, speaking with forked tongue and much acerbity of our failings and deficiencies. Add to this the second Eternal Verity, that "all doctors are rogues and fools except *my* doctor", and the search for truth becomes forbidding indeed.

We are from time to time assisted, not always with our enthusiastic consent, by various Patient-Associations, but these tend to be middle-class, intellectual, over-articulate and somewhat aggressive organisations—by no means patient associations—and occasionally defeat their own ends by antagonising those they wish to admonish and improve. They represent a highly self-selected minority.

From the few hard facts which emerge from the papers published in this issue—as usual in this field bewildering and hard to assess—one firm conclusion emerges. Just as supply leads to demand, so a certain type of supply can lead to acceptance *of that type of supply*. In short, our patients can be, and are being conditioned. This is a serious thing—good or bad—which must always be considered when any interpretation is made of patients' requested opinions.

Does the general public really share our enthusiasm for health centres, group practices, appointment schemes and the like? Is the single-handed practitioner really the doom-touched man that so many think? These and many other such questions are completely unanswered. We just don't know, but it is good that we are trying to find out. Even in a seller's market—in which doctors all over the world now find themselves—customer-research is never unproductive, but we must be ready to accept willingly much research and advice from other disciplines if we desire the whole truth, and wish to fructify the last two lines of our quotation.

CHOOSING A PRACTICE

HOW do general practitioners—especially young doctors—choose a practice? Little is known about the selection process and much of what exists comes from established principals. The views of the younger generation will eventually affect practices everywhere, especially when "for the first time in history young doctors are entering general practice having completed a three-year training programme designed to prepare them for their future work."[1]

The balance of power is swinging to the young because the relative shortage of general practitioners has weakened the position of existing principals. Also today's young doctors are more highly selected than ever before,[2] and most vocational training schemes specifically prepare them for their eventual choice of practice.

Principals, once appointed, move less than hospital colleagues so their choice is of great significance. The conflict of interest expressed and resolved in the eventual appointment represents for both sides a clash between idealism and reality. Gilmour and Drinkwater both comment today on the disproportionately high number of young doctors who, despite their professional preparation, seek "a small, group practice in an attractive market town not too far from the sea."

It has been thought in the past that doctors settle near their medical schools, and so it has even been suggested that the schools be moved to under-doctored areas. It is obvious from the practice advertisements in this *Journal* that doctors are thought to favour practices with services such as attached local-authority staff and open access. Barley today challenges this and certainly his tiny group were more concerned with the site of the practice and other relatively unalterable features.

Four principles

Place, pay, personalities and group size with practice philosophy, these are the main factors now guiding young doctors.

Place

Where the practice is placed is fundamental and unalterable. Young doctors must decide early whether urban or rural practice, or openings in large or small cities are desired. It is not yet known how well the vocational training schemes are helping them to balance the pros and cons of these very different forms of practice.

Pay

Graham stated openly the parity he was offering[3], and in this age of frank communication it is strange that none of today's papers comments on pay: in negotiation applicants are