physical characteristics of training practices, of which Irvine's (1972) *Training Practices* is a classic example. This phase of vocational training can be compared with the phase of general practice in the 1950s and 1960s when the emphasis was on practice organization, and attention focussed on premises, equipment and workload.

As time went on in general practice, interest moved to the doctor–patient relationship when books such as Balint's *Doctor, his Patient and the Illness* (1968) and Browne and Freeling's (1976) *The Doctor–Patient Relationship* led general practitioners into the theoretical study of the human aspects of their work, a theme which has continued in the study of the consultation and non-verbal communication.

Now a parallel is emerging in vocational training. In 1977 Pereira Gray suggested the analogy between the doctor–patient and trainer–trainee relationships and followed this recently (1982) with some models. Now Occasional Paper 21 underlines the central fact that the trainer–trainee relationship is probably the most important single variable affecting a trainee's progress, and that trainers whose trainees learn the most do have a number of identifiable and measurable characteristics. This is an encouraging finding. It means that trainers are not just born but can be made, and that many of the characteristics of effective trainers such as good libraries, broad reading, membership of the College, medical records and perhaps personal lists can be acquired by those determined to do so.

The Influence of Trainers on Trainees in General Practice is an important contribution to the evolving study of vocational training in general practice and can be warmly commended to all trainers and trainees.

The Influence of Trainers on Trainees in General Practice, Occasional Paper 21, can be obtained, price £3.25 including postage, from the Publications Sales Department, Royal College of General Practitioners, 14 Princes Gate, Hyde Park, London, SW7 1PU. Payment should be made with order.

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Patients' views of general practice

PATIENTS' views of the health care provided for them have been studied extensively in many Western countries. The results of these studies are remarkably similar: patients report surprisingly high levels of satisfaction, almost irrespective of other indicators of quality of care, such as evaluation by other doctors or comparisons of so-called objective criteria of care. Does this mean, therefore, that all is well? The answer must be no, for several reasons.

Firstly, patients are biased towards positive evaluations. Since all patients are concerned that their doctor should be able to heal them, they are more likely to build up a positive image. They want their doctor to be as effective as possible, so they try to picture him or her that way. Patients also get used to their doctor's usual way of working. This does not mean that they prefer this way of working, merely that they adjust to it.

Patients usually see only a limited range of doctors' styles. Most patients change their doctors infrequently, and therefore do not have the chance of making broad comparisons, and although they may see other partners within a practice, practice policies, and the natural tendency for like-minded doctors to work together, may limit the breadth of these comparisons.

Patients may feel that criticism they offer may get back to their own doctor, who may become less motivated to help. Furthermore, there is a study which has shown that patients and doctors agree in defining the 'good' patient as one who is deferential and who does not question the doctor's decision. This study was conducted in Australia by Boreham and Gibson in 1978, but there are many UK researchers (for instance Cartwright and Anderson, 1981) whose findings tend to support this view. It was also pointed out by Pratt and colleagues (1957) that whereas patients tend to wait for doctors to take the initiative in explanations, doctors perceive patients' lack of inquiry as indicating uninterest or inability to understand.

Lastly, patient satisfaction may be brought about by factors which are ultimately detrimental to the patient's health. It may be very comforting, for example, if the doctors were to encourage patients to regard them as virtually infallible, but to do so would not be conducive to patients being autonomous and self-reliant.

All these considerations mean that we should be concerned not with the overall level of satisfaction expressed, but rather with those aspects of general practice which come in for particular praise or criticism; we should then consider whether these are in the patients' best interests.

Patients are particularly critical of doctors who are relatively inaccessible. The most recent evidence for this view came from an Oxford Region survey of community health councils in England and Wales. There is also criticism of doctors who do not communicate adequately with their patients, either because they do not listen or because they do not volunteer enough. Cartwright and Anderson demonstrated that patients are more critical—especially for its paucity—of the information they receive from doctors than of any other aspect of health care. We should also remember that doctors who attempt to communicate more fully with their patients still do not produce higher levels of satisfaction than before they made the attempt (Houghton, 1968). The conclusion would seem to be, therefore, that doctors need training in how to give adequate information to patients at a level and in sufficient quantity for them to be able to understand it, and for them to develop from the information given a better picture of what is happening to them. This communication deficiency is not easily remedied. Tuckett (1981) has demonstrated that adequate explanations are rare in general practice consultations.

Doctors who come in for particular praise include, firstly, those who discover and deal with patients' concerns and expectations about their problems, secondly, those whose manner communicates warmth, interest and concern about the patient, and lastly those who volunteer a lot of information and explain matters to the patient in terms that are understood.

Recently, in a small but carefully controlled interview study, Pendleton (1981) was able to form the following views of general practice from a sample of people who use general practitioners' services, selected so that all age, sex and social class groupings were represented. This study demonstrated that patients from all groups were keen to be involved in making decisions about their health and treatment. This is not to say that some patients do not want an authoritarian doctor who tells them what to do, but the study revealed that these were in the minority. This study also showed that patients were broadly positive and supportive when questioned about their reactions to their general practitioner and to the services provided. This level of support has been confirmed by two large sample studies conducted earlier in 1982 by *Woman's Own* and by National Opinion Polls.

In the second part of Pendleton's study, a questionnaire was completed by nearly 300 patients in the Oxford Region. The following sources of satisfaction were discovered: the first, and by far the most important, was relief brought about by the thoroughness of the doctor's investigation of the problem presented. This relief included a large degree of satisfaction which was created when the patient was thoroughly examined. The second source of satisfaction was found to be patient involvement in the decision-making about their problems. What is more, when the doctor involved the patient, the doctor was seen as more competent by the patient. The third source was the satisfying effects of being treated empathically by the doctor.

In a third and very complicated study of 84 consultations in general practice, Pendleton demonstrated that patients were less satisfied overall if they were suffering from a chronic condition, partly because they were much less likely to be involved in making decisions about their problems.

There may be one additional reaction to general practice which is a much broader reaction than anything stated so far. Kleinman argued in 1980 that doctors frequently failed to heal patients' illnesses, and he contrasted this with a desire to heal their diseases. This distinction means simply that patients' concerns and discomfort about their problems are often not addressed in consultations, and he suggested that the evidence for this would be found not in the more conventional ways of measuring patients' views of health care, but in patient non-compliance, subsequent use of alternative health care services and, in the United States, in medical legal suits. If there is significant evidence and there is, at an anecdotal level, of patients increasingly turning to alternative medical systems, such as acupuncture, osteopathy and herbalism, then this may be an indicator of dissatisfaction with ordinary medical services. We already know that non-compliance is a major problem in general practice everywhere, and this is a further indicator of dissatisfaction with care.

We should examine ways in which patient involvement services provided by other professions and peer review can help doctors to learn appropriate skills. Each of these three major causes for concern could be influenced either by general practitioners becoming better administrators of their practices, or more skilled communicators with their patients.

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