psychotherapists. Often our patients come not wanting to understand but to be understood. It was Fairbairn[1] who pointed out that people are not motivated primarily towards tension relief as postulated by Freud, but rather towards self-expression in relationships with other human beings. Since Fairbairn, object-relations theory has developed increasing respectability[2] and there has been a resurgence of interest in the importance of empathic listening.[3] In view of the fact that patients' expectations of the doctor in terms of object relations are a primary personality drive, I am less than convinced that an explanation of what the doctor expects will have any effect on the patient as Drs Gau and Gau suggest. Indeed in their survey the patients already knew only too well the expectations of the doctor. My experience of analysing videotaped general practice consultations is that such educational exercises seem harmful to the doctor–patient relationship especially in terms of the patient's perception of the doctor's empathic rapport.

It seems probable that the experience of being empathically listened to will actually improve outcome as traditionally defined by doctors in terms of symptom relief, as well as increasing patient satisfaction; this needs further research. In a recent study in Gateshead we replicated the work of Goldberg and Blackwell[4] in estimating the prevalence of emotional disturbance in general practice. Our preliminary findings show emotional disturbance in more than 40% of consecutive consultations based on a survey of over 1000 patients. If these patients are to be listened to and taken seriously, then organizational changes will have to be made in practice, both in terms of the time taken with patients in the consultation and in terms of training the general practitioner in the listening skills necessary to achieve empathic consultation.

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General practitioners and hospitals in Nigeria

Sir,

In the UK we have become accustomed to a form of general practice which is largely excluded from hospitals, apart from access to certain diagnostic services. Dr Blair and colleagues have shown from their experience in Perthshire (August *Journal,* p.359) that there are still important exceptions to this and they make a good case on the grounds of cost-effectiveness and convenience for patients for 'extending the capacity of the surgical side of general practice hospitals, and their use as low-technology medical units.' In the same issue of the *Journal* Roger Jones commented (August *Journal,* p.346) on the variety of systems in operation around the world.

In Nigeria the specialty of general practice was accepted as a discipline before the separation of general practitioners from hospital work. Doctors are few, and the population large — 9000 doctors for 100 million people. The range of casualty and surgical services provided at Blairgowrie is not too dissimilar from that accepted as part of general practice in Nigeria where the 'low technology medical unit' with high cost-effectiveness is referred to as secondary care. The fully departmentalized high-technology hospital service, staffed by specialists, is regarded as tertiary care. Primary care in urban areas is provided by doctors in hospital casualty and outpatient departments, and private clinics, but in rural areas most primary care is provided in health centres and aid posts staffed by nurses, midwives and community health personnel, with only an occasional medical visit. The refinements of primary care which have so greatly improved general practice in the west, have yet to make much impact in Nigeria.

In Nigeria the low technology medical unit has been found ideal for the first two years of the four-year general practitioner training programme. The entire hospital is subject to inspection and accreditation, rather than just approved posts, as in the UK. Learning to manage a wide range of conditions with a limited range of drugs and a minimum of technology is a vital part of the training, and prepares doctors for medical work in isolated areas.

Could general practitioner hospitals be used in training in the UK, perhaps on an elective basis, as in other western countries? Certainly, doctors with the MRCGP and experience of such centres in the UK would have attitudes and skills of great value to training hospitals in Nigeria and other developing countries.

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Primary health care in Italy

Sir,

As an advisor in primary health care to the Tuscan Region and the Chianti Health District, I would like to refer to Dr Jefferson's letter (June *Journal,* p.291).

Most of us will join Dr Jefferson in his condemnation of unnecessary and even iatrogenic interventions offered to cancer patients in the private sector. However, this is unfortunately not confined to Italy. We frequently hear of families impoverished by fruitless visits to 'great specialists' in France, Switzerland, Germany, the UK and even the USA, against the advice of their general practitioners in the Italian national health service.

It is true that the Italian national health service, which is only six years old, has many problems still to solve, including severe shortages of personnel and funding. This may account for some of the nursing deficiencies suffered by Dr Jefferson's mother in a private ward in one of our local hospitals. However, every Italian citizen has the right to the services of a general practitioner of his or her choice and all necessary specialist and hospital care, as in the UK.

In our experience, the majority of doctors, nurses and other workers in the health service are battling against considerable difficulties to raise the standards of care. Recently in our own local hospital a seminar on terminal care was attended by consultants, hospital doctors, general practitioners, nurses and members of voluntary organizations, and we are as concerned with this difficult problem as our colleagues in the UK, though none of us would claim to have solved it.

Recently the Società Italiana della Medicina Generale was founded with considerable help and advice from the RCGP. An important minority of general practitioners is actively seeking to improve the quality of care in general practice in Italy. This is the theme of our International Conference in Florence from 27 to 30 November 1986, in which Dr Crombie and other leading members of the College hope to take part. Simultaneous translation will be available and we will be delighted to welcome other British colleagues to Florence, this year the cultural city of Europe, and I will gladly forward details to anyone interested.

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