## Problems of audit and research

Sir,

I find Dr Patterson's assertion (May *Journal,* p.196) that audit and research are different to be unconvincing. He states that the difference lies in the relevance of the findings to other situations, the parochialism of audit compared with research and differing levels of scientific rigour. I believe that all audit is research and much research, directly or indirectly, is audit. The experiences of two of our trainees are relevant.

Last year our then trainee did an audit into the use and outcome of contrast studies in our practice. One interesting and unexpected finding was that it is almost always a waste of time to do a barium meal if the patient is a non-smoker. This work did not test a specific hypothesis but was a case-finding and a case-scrutiny study, which is justifiable when the subject is ill-explored and ill-defined. The study duly generated a hypothesis for further testing. This sequence of facts leading to a hypothesis which in turn is tested against facts is the very stuff of science (the hypothetico-deductive method). Our present trainee contemplated doing a study to test the hypothesis that at-risk patients who suffered a stroke had identifiable defects of pre-stroke management compared with at-risk patients who did not suffer a stroke. He abandoned this study because of the formidable difficulties of identifying meaningful controls. He is now investigating inter-partner differences in interpreting pathological eardrums and the significance of this for the management of glue ear. These projects are most certainly valuable audits; they are also research.

All research is parochial since any given study must be done on a defined population rather than a universal one. The outcome of Doll and Hill's study on British doctors and smoking can, taken in isolation, only be applied to British doctors. It cannot be applied to British dentists, Japanese fishermen or Balinese dancers. But if the outcome of many studies done on different populations all show the same trend, then extrapolation of the results to a universal population is justified. Parochialism, therefore, is not a discriminant between audit and research, it characterizes both.

I recently talked to a group of trainees. I suggested to them that the responsibility for case reports and research did not belong to an anonymous group of academics and eccentrics somewhere 'out there', but that each one of them should, throughout their professional life, try to add to the corpus of knowledge which he or she had inherited. Some were sympathetic, but others clearly felt threatened, perhaps because research endeavour in general practice is so recent. There must obviously be limitations and constraints on a trainee's project, but there is no place for flawed methodology. The time to start establishing a research tradition is here and now. The expectation should be that only high standards will suffice and that high standards are expected.

A.M.W. PORTER

37 Upper Gordon Road
Camberley
Surrey GU15 2HJ

Sir,

I am delighted that my comments on audit and research have stimulated discussion — that is after all their purpose.

Dr Porter suggests that audit and research are synonymous. If they do not represent separate concepts why are they given different names? He also suggests that the hypothetico-deductive method is common to 'both'. I cannot quarrel with this, since it is the relevance of the results which differ according to the rigour of the exercise. He points out that parochialism does not discriminate between research and audit. I used this word to indicate the limited nature of the relevance of the findings of audit as opposed to research, not the population on which they are undertaken. I think we are dealing with a spectrum of organized curiosity stretching from a descriptive study, merging into an audit exercise which generates further hypothesis and gives rise to prospective research projects.

I hope this debate will help to clarify what I feel sure is an area of confusion for many.

H.R. PATTERSON

Clinical Sciences Department
Glenfield General Hospital
Groby Road
Leicester LF3 9QP

## Part-time posts in general practice

Sir,

I refer to the letter from Dr Priddle about part-time posts for single women (May *Journal,* p.229).

On no occasion has Glasgow Local Medical Committee instructed that women without family commitments will not be considered for part-time posts as principals. It would not be within their power or their remit so to do. The situation is that the Medical Practices Committee, set up by the Secretary of State for Scotland, has laid down guidelines about the admission of principals to the medical list. These guidelines indicate a minimum notional list average of 1500, below which an additional partner will not be approved. The Medical Practices Committee, however, go on to state that exceptionally they will admit a doctor who for professional or domestic reasons is limited to residence and practising in the district concerned despite the notional list being reduced below 1500. If, as appears to be the case, Dr Priddle was applying to join a practice where the notional average list was below 1500, then her application would certainly not be approved; there is no question, however, of any discriminatory ruling by the local medical committee.

Dr Priddle apparently has no family or domestic ties and I am glad to say that she has now obtained a post in another part of Glasgow.

J. ALISTAIR RIDDELL

Glasgow Local Medical Committee
9 Lynedoch Crescent
Glasgow G3 6EA

## Professional confidentiality

Sir,

In his report on the patient's view of professional confidentiality (May *Journal,* p.227), Dr Savage Jones recognizes that 'many variables are involved in the decision by patients to leave the consulting room door open'. I would go further and suggest that this decision has such wide-ranging implications that it would be imprudent to regard it as an indicator of the desire for confidentiality. I note, for example, that 250 (85.0%) of the 294 female patients with respiratory tract infections opted for an open consultation in rooms where 'it was possible for the patient to see others waiting outside'. Presumably these females had learnt that a physical examination of their chests was extremely unlikely, or perhaps they were trying to dissuade the doctor from such an examination.

Is it not conceivable that a patient might be reluctant to close a door and risk antagonizing the doctor who had just left it open? It could be that those patients who felt ill at ease or even frightened by