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.

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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.

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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.

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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

the doctor would be comforted by the reassuring sight of an open door.

The marked seasonal variation, with 81% of patients opting for an open consultation during the summer months (compared with 60% in the winter) is as likely to reflect the need for air-conditioning in the consulting rooms as it is the desire for confidentiality.

While this was an interesting study, it appears to have posed more questions than it has answered. It would have been more useful had an attempt been made to determine what factors had led to the decision to leave the door open or closed.

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Accessibility of GPs: a patients' liaison group survey

Sir,

The North-West England Faculty of the Royal College of General Practitioners has formed a patients' liaison group mirroring locally the national patients' liaison group, composed of members of the College and representatives from local community health councils and one patient participation group in the region. We considered how we could best contribute to the evaluation and subsequent improvement of general practitioner care in the north-west of England. One of the topics the group has chosen to study is patients' perceptions of the accessibility of general practitioners.

In November 1985 the group commissioned a pilot study with random samples of 200 adults, 100 in each of two constituent districts. Structured interviews were carried out in respondents' homes by trained professional interviewers using questionnaires. The samples contained more women and older people than expected. The questionnaire invited comment about a range of topics, including travel to the surgery, contact arrangements with the practice and perceived attitudes of receptionists and general practitioners.

Important general findings from this pilot study were: first, many respondents wished to be able to talk directly to their general practitioner by telephone; second, the number of patients preferring an appointment system was not much greater than the number preferring an 'open system'; third, there was a large minority of patients expressing dissatisfaction with various aspects of the service.

Almost two-thirds of the respondents said they always made an appointment to see the doctor. Nearly three-quarters of those using practices with appointment systems said they could consult any of the doctors. Some patients preferred a particular practitioner and of these a third said they had to wait until the next day and one in five had to wait two days. However, nearly a quarter waited three days or more. Twenty per cent of patients found this wait unsatisfactory.

Over a third of patients who had made appointments said they waited less than 15 minutes in the waiting room. A similar number had to wait 15 to 30 minutes, but a quarter had to wait longer. One in five patients were dissatisfied with this.

Nearly a third of the respondents who needed to make an appointment had tried to see the doctor urgently. Of these, the majority were seen quickly, although a handful had to wait until the second day. Eighty-five per cent were satisfied with the response to requests for urgent consultations. Just over a third of patients (36%) could go to their doctor without having to make an appointment. A quarter of them were dissatisfied with the general level of accessibility.

General preferences for contact arrangements were almost equally split between being able 'to go along and wait' and booking to make an appointment to see the doctor. Only a few preferred a mixed system. Most people found existing surgery hours convenient. Almost 20% wanted additional hours, the most popular being on Saturday morning.

Four out of five respondents had a telephone in their house but only 25% had ever tried to telephone the general practitioner to discuss a problem. Of these, most found they could talk directly to the doctor without difficulty. The majority (67%) said they would like to be able to telephone and talk directly to the doctor.

Almost half the respondents had asked for a home visit in the last year and nearly all had had no difficulty in getting one. About one-fifth had tried to contact their doctor out-of-hours in the last year and most of them said the doctor arrived within an hour. Eight respondents waited longer than two hours. Forty-five per cent said the service was quick but 15% thought the delay seemed too long and 40% that it seemed very long.

When respondents were asked in an open question if anything would make it easier for them to see the doctor 72% could think of nothing. Asked about particular items 47% of respondents requested shorter waits in the surgery, 45% wanted the facility to talk to the doctor on the telephone, 35% shorter waits for appointment slots, 27% quicker response to emergency calls, 22% longer surgery hours, 16% a better telephone system and 12% 'better receptionists'.

In many respects the results from this pilot study are similar to the larger national studies carried out by Cartwright and Anderson[1] and Ritchie and colleagues.[2] There are, however, differences in some aspects which justify further study of inter-district variations and strengthen the case for more locally focussed studies. The patients' liaison group proposes to extend the survey to most districts in the North-West Region and is currently seeking support for this. The group would welcome comments from others who may have carried out similar work.

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References

1. Cartwright A, Anderson R. *General practice revisited: a second study of patients and their doctors.* London: Tavistock, 1981.
2. Ritchie J, Jacoby A, Bone M. *Access to primary care.* London: HMSO, 1981.

Exercise and sport

Sir,

Over recent years there has been a general increase in public interest in exercise and sport. At the end of 1985 I attempted a survey of how many patients presented to their general practitioners in the Dumfries and Galloway Health Board area with problems related to exercise and sport (during the month of November). As only 26 of the 120 practitioners in the area replied, firm conclusions are not possible.

I write to mention points which seem of particular interest:

1. Six of the 52 cases presented were considered by the reporting practitioner to be preventable.
2. Eleven of the 52 cases were injuries to the head and face, with three concussions.
3. Five of 10 cases in females were injuries to the hand and wrist.