Quis custodiet ipsos custodes?

WHEN Colin Waine, standing in the ranks of the ordinary council members, made his short statement explaining his resignation as chairman of council, it was probably the saddest and most poignant moment in the history of the Royal College of General Practitioners. To most council members it came as a total surprise and their shock was apparent in the stunned silence that greeted the statement. As president, I was of course aware of the agonizing decision that Dr Waine had had to make and had to make swiftly, since the letter from the secretary of state for health finding him in breach of the terms and conditions of service only reached him the day before the council meeting. The immediate response of council was overwhelming in the warmth of the sympathy and support extended to its resigning chairman. These feelings were articulated in a moving contribution from Clifford Kay.

The reaction to Dr Waine's resignation has been equally overwhelming from individual members, from faculties, and from a wide range of colleagues in other colleges and organizations who were unanimous in expressing their respect for the honourable decision Dr Waine has made, and sadness that this tragic event should have overtaken a man whose dedication to medicine and to the College has been so apparent to everyone.

We cannot dwell on the specific details of the complaint that led to the secretary of state's findings, but it is fair to indicate that the incident provoking the complaint was a self-limiting condition. The extent of the concern expressed to the College in relation to this episode does, however, demand a response. It is clear that there are aspects of the complaints procedure that are unsatisfactory, conflicting with natural justice, and leading to a loss of respect for the process.

Conflict with natural justice relates to the extended time between notification of the initial complaint and the report of the findings, should there be an appeal against a decision by a local service committee hearing. This may be between two and a half and three years, during which time the doctor against whom a complaint has been laid is under considerable stress, to the detriment of his professional and family life. The consequence of an appeal upheld against a practising doctor will in many cases be out of all proportion to the complaint itself. A process, not in itself a complicated one, that takes up to three years to produce a decision is clearly in breach of natural justice and demands urgent remedy.

The constitution of a service committee panel draws equal representation from members of the public and general practitioners, under the chairmanship and administration of officials of the family health services authority or health board, and is clearly democratic. The constitution of an appeal panel in England and Wales relies on the opinion of only two doctors, under a legal chairman. One of the doctors is appointed by the Department of Health and the other by the General Medical Services Committee. These two doctors therefore not only carry responsibility for opinions relating to the regulatory aspects of the terms and conditions of service, but increasingly express opinions in relation to clinical judgement without indicating the source of authority for these clinical opinions where these are at variance with the findings of a service committee. The notes of guidance to the England and Wales service committee and tribunal regulations 1990 state that, 'A general medical practitioner will not necessarily have acted improperly if his conduct could be viewed as appropriate by a responsible body of medical practitioners.' We need to ask, therefore, how the opinion of an appeal panel in matters of clinical judgement, is tested against the professional opinion of the doctors on a service committee or 'a responsible body of medical practitioners'.

A third point of concern regarding the appeal process is the absence of any requirement to indicate why the findings of a service committee have been overturned.

Morale among general practitioners is currently at a low ebb and attendance at trainee conferences suggests an increasing apprehension regarding future careers in general practice, with increasing litigation placed high in the list of these concerns. Patients' interests should have the highest priority, but unless the process by which judgements are reached in regard to the safeguarding of these interests is held in respect, then not only is the morale of the profession further diminished, but the interests of the patients themselves will be damaged by the excessive practice of defensive medicine, leading to rising costs of investigation and referral to hospital.

There appears to be a clear need to review the processes of dealing with complaints, not least in regard to time. From the point of view of an academic body concerned with clinical standards, it is important that standards should not be formed from an aggregate of opinions expressed by appeal panels unless these are soundly based and supported by an authoritative body of general practice opinion.

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Qualitative research and general practice

THE nature of general practice is such that a variety of research methods are needed to explore all its intricacies.[1] Qualitative methods have a great deal to offer: they can open up topics that are not amenable to investigation by quantitative methods. For example, the current emphasis on audit has led some doctors to measure patient satisfaction, a topic which is enhanced by the use of qualitative methods.

Qualitative research encompasses a variety of methods such as semi-structured interviewing, observation studies, group discussions, and the analysis of written documents. What distinguishes qualitative from quantitative methodology is its concern with understanding respondents' rather than researchers' meanings, and its use of open ended research questions. Focus is on the individual rather than the population, and on the way in which individuals construct their world. This means that, to a certain extent, the direction of qualitative research is guided by respondents. In the context of in-depth interviewing, the interviewer will seek to explore the respondents' cues, rather than introduce her or his own concepts, and will try to use the respondents' own language in following up such cues. The interviewer will not assume the meaning of common terms but will seek to explore the respondents' understanding of these terms. As a result, ideas

taken for granted by the profession may be challenged. The focus of the interviews may change as the research proceeds, in response to emerging ideas and themes.

Qualitative methods are used extensively by anthropologists, sociologists and educationalists. They provide a deeper understanding of poorly understood or sensitive topics, and insights into processes as opposed to outcomes. They can identify the range of attitudes or beliefs on a subject, and provide explanations for behaviour and attitudes. What qualitative research cannot do is measure the importance of an attitude or belief in terms of its distribution in the population, nor provide prevalence figures. In other words, the types of research question amenable to qualitative methods are different from those amenable to quantitative research. The end product of qualitative research may be elucidation of a new concept, construction of a new typology, mapping of the range of phenomena within a subject area, generation of new ideas or hypotheses, development of an explanatory framework, or the basis for an intervention strategy.

Those used to quantitative research can feel that something vital is missing if a qualitative study reports no numerical data. However, numbers are often inappropriate as they imply statistical representativeness and can create a misleading emphasis. It is inappropriate to force complex responses into simple categories in order to count them.

The weaknesses of qualitative research concern bias and generalization. The close relationships that qualitative researchers develop with their subjects open up the possibility of bias. There is some truth in the quip that quantitative methods are reliable but not valid and that qualitative methods are valid but not reliable. Readers therefore need to know about the methodology employed in qualitative research. This information would comprise the interviewing techniques used, how systematically the analysis was carried out, how themes or concepts were selected from the data, and whether any themes (especially counter themes) have been excluded from the analysis. Many qualitative researchers have not described their methods of analysis in detail, with a few notable exceptions.[2]

The issue of generalizability arises because sample sizes in qualitative research are smaller than those in quantitative research, and samples are not chosen to be representative. The guiding principle for sampling is to maximize diversity in order to describe the range of phenomena. Hence, there may be deliberate attempts to include members of minority groups who might be expected to differ on the attributes being studied. Thus, generalizations may be made, not on the basis of statistical representativeness, but on the basis of the range and diversity of experiences and the formulation of a coherent structure of evidence to explain this diversity.

Qualitative studies are complementary to quantitative studies. A multitude of quantitative studies have examined the mortality and morbidity associated with hypertension and its treatment. Qualitative work can examine patients' health beliefs: what meaning does high blood pressure hold for them and how does this relate to health workers' private beliefs and behaviour? There is burgeoning work on referrals: the quantitative side examines rates and destinations, while the qualitative side can explore the reasons general practitioners give for behaving in the way they do. Quantitative studies examine survival rates following different treatments for breast cancer; qualitative work can explore cancer patients' reactions, emotions and coping strategies in dealing with their disease, and the emotions of their families. Although different from the techniques used by sociologists, Balint's work used qualitative material to produce startling insights that have affected clinical work ever since.[3]

Qualitative methods involve listening to people and becoming involved in their world: an exciting process that is already a motivating force for many general practitioners in their work. It is tempting to think that interviewing skills are similar to those needed for clinical history taking and that data analysis requires little time and critical or analytical sophistication. However, there are many pitfalls and without appropriate training inexperienced researchers run the risk of producing poor research, although they would learn much about the complexity of the method.

General practitioners and social scientists need to undertake more qualitative work in general practice, and training in these methods needs to become more widely available. Those wishing to learn more can do so by reading[2,4–6] or by attending courses. A useful strategy would be for general practitioners and social scientists to collaborate on research projects of mutual interest: such pooling of expertise would be rewarding for both parties. General practitioners looking for such collaboration might approach social scientists in an academic department of general practice, public health medicine, sociology, anthropology or psychology. Qualitative researchers need to make their methodologies more explicit so that they are open to scrutiny and so that others may learn what these techniques involve.

Ideally, these apparently opposing methods of qualitative and quantitative research should be seen as complementary techniques which, taken together, can provide a rich methodological resource for general practice research.

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