

Reference

1. National Audit Office. *Repeat prescribing by general medical practitioners in England*. London: HMSO, 1993.

Research activity in general practice

Sir,
The Department of Health report *Research for health* states that 'the content and delivery of care in the National Health Service should be based on high quality research relevant to improving the health of the nation'.¹ General practice should be a logical place for such research to be carried out, since 90% of NHS health activity occurs exclusively within it.² However, little is known about the number of service general practitioners taking part in research. The Royal College of General Practitioners has suggested that both the quantity and quality of research in general practice should be improved³ and evidence from the numbers of publications by service practitioners suggests that their involvement is limited.⁴ Possible barriers to research have been identified as lack of time, patient cooperation and staff support.⁵ With the increasing employment of practice nurses by general practitioners could a solution be to involve nurses in research?

In March 1991, a questionnaire sent to all senior partners in 259 practices in Birmingham Family Health Services Authority explored the amount of research being undertaken in general practice by asking whether practices take part in personal research, national studies, clinical therapeutic trials or any other types of research. They were also asked if they employed a nurse, if the nurse was involved in research, and what their attitude was to a research role for the nurse.

After a single reminder 219 practices (84.6%) responded. Of these, 136 (62.1%) stated that their practice took part in some form of research. Of those practices taking part in research (57.4%) were involved in a single area of research (Table 1). The clinical therapeutic trial was the type of research reported most frequently by practices (32.4% of practices were only doing these trials and 69.9% of practices were carrying out trials among other research activities).

Involvement in research did not differ significantly with size of practice, but practices with four or more partners were more likely than those with three or fewer partners to carry out personal research (68.4% of 19 versus 34.9% of 109; $\chi^2 = 6.27, P < 0.05$).

Table 1. Type of research undertaken by practices.

Type of research	% of practices (n = 136)
CTT only	32.4
Personal/national/CTT	15.4
National surveys only	13.2
National/CTT	13.2
Personal research only	9.6
Personal/CTT	8.1
Personal/national	4.4
With other groups only	2.2
Personal/national/other	0.7
Personal/national/CTT/other	0.7

n = number of practices. CTT = clinical therapeutic trial.

The majority of the 219 responding practices (79.9%) employed at least one practice nurse and 79.5% of general practitioners thought that there was a research role for the nurse. For the 30 general practitioners who thought there was no role, the main reason given was that the nurse was already too busy. Although only 29.1% were already aided by the nurse in research, the more types of research undertaken by a practice the greater likelihood that the nurse was participating. In practices pursuing only one type of research 27% of 78 nurses assisted compared with 61% of 23 nurses in practices pursuing three or more types of research ($P < 0.01$). Nurse participation was most common in practices conducting personal research (53% of 53) followed by clinical therapeutic trials (46% of 95) and national surveys (34% of 65). Of the 51 practices where a nurse assisted, the nurse's most common research involvement was in patient care (49%), performing diagnostic tests (37%) and general administration (26%).

Research among service general practices in Birmingham appeared to be extensive. However, much of the research activity was in clinical therapeutic trials or national surveys, which involve an essentially passive role in servicing other peoples' protocols and ideas. Personal research involves identifying the problem area, initiating the protocol design, organizing the project, involving and motivating other members of the practice team, and analysing and reporting the results. Nevertheless, 53 of the 219 practices responding (24.2%) were engaged in personal research projects. These results suggest that the number of publications by general practitioner authors does not reflect the true extent of general practice research. The extent of research activity compared with the low rate of publication points to the need for greater investment in research training for doctors and nurses in general practice.

J E KENKRE
F D R HOBBS
S M GREENFIELD

Department of General Practice
University of Birmingham
Edgbaston
Birmingham B15 2TT

References

1. Department of Health. *Research for health. A research and development strategy for the NHS*. London: DoH, 1991.
2. Secretaries of State for Health, Wales, Northern Ireland and Scotland. *Working for patients (Cm 555)*. London: HMSO, 1989.
3. Royal College of General Practitioners. *A college plan — priorities for the future. Occasional paper 49*. London: RCGP, 1990.
4. Buckley EG. Research for all in general practice [editorial]. *Br J Gen Pract* 1990; **40**: 357-360.
5. Silagy CA, Carson NE. Factors affecting the level of interest and activity in primary care research among general practitioners. *Fam Pract* 1989; **6**: 173-176.

Telephone access in general practice

Sir,
Before we can assess the use and usefulness of the telephone in primary health care provision, the first issue to address is whether patients can make initial contact with the practice. If the telephone is often engaged, or the answering time unduly long, the public is likely to have a poor perception of the service, whatever the quality of health care subsequently provided. I was therefore pleased to see that Lesley Hallam made reference to this (*August Journal*, p.331) but surprised that a more objective method of assessing telephone access was not used.

A simple audit was devised to assess the telephone answering time for my practice of 8500 patients based in a health centre with three telephone lines. The advertised appointment number was called by someone with an unrecognizable voice three times each day at 08.30, 11.30 and 15.30 hours for a four week period. If the line was engaged, the number was redialled at five minute intervals until the ringing tone was obtained. The number of rings before the telephone was answered was recorded and the caller then asked a simple question which would not arouse suspicion among the reception staff. We were pleased to find that the line was answered within seven rings on 81% of occasions but were disappointed to discover that the line was engaged for 57% of first calls.

Following discussion with the staff, a number of changes were made, such as limiting the use of the telephone for outgoing calls at busy times of the day and training receptionists to deal with calls

more quickly. Six months later, the second cycle of the audit has been completed and we have not managed to improve on the results. We are now committed to considering the costly option of replacing our antiquated telephone system before investigating the full potential of the telephone in service provision.

MARTIN N MARSHALL

Mount Pleasant Health Centre
Mount Pleasant Road
Exeter EX4 7BW

Pen torch test in patients with unilateral red eye

Sir,

Chong and Murray describe a simple test which could help distinguish mild from serious non-traumatic eye conditions (letter, June *Journal*, p.259). As they say, a similar study in a general practice setting is needed before extrapolating their results.

However, in practice it is difficult always to identify which cases are non-traumatic prior to examination. It is not uncommon for patients to present with a corneal foreign body, the possibility of which has not been considered by them. Undoubtedly, they would have a positive pen torch test, and this would confound the results. It was surprising not to see evidence of such patients in Chong and Murray's study. Before a similar trial is carried out in general practice this methodological point needs to be clarified.

MICHAEL R LEWIS

The Medical Centre
Salop Road
Welshpool
Powys SY21 7ER

Continuing education for general practice

Sir,

I was interested in the premise put forward in the discussion papers by Stanley, Al-Shehri and Thomas that the postgraduate education allowance arrangements in the United Kingdom may encourage irrelevant or harmful education activity.^{1,2} I have been practising in the United States of America for over 14 years and during that time have been obliged to accrue 50 hours per year of approved medical education. With most American practices it is now the rare physician who does not have to achieve these hours as part of state relicensure or professional organization certification. However, it is also the rare

physician who is unable to achieve these hours. Millions of dollars are spent by these doctors supporting a continuing medical education industry which aims to help physicians satisfy these requirements. Whether this educational activity has made any difference to patient outcome is unknown in the majority of cases. Indeed, even having a goal of reaching 50 hours per year is contrary to the principles of continuous quality improvement part of the total quality management philosophy currently espoused on both sides of the Atlantic by health care management.

The medical staff of Group Health are funded by a capitation agreement with the cooperative, and as well as providing an annual education allowance of dollars and days, it also pays for an educational department staffed by five administrative assistants and four part time general practitioners. They work both collectively and separately within Group Health's three regional divisions. Of our medical staff of 1100, about 600 are primary care physicians and it is at this group that most educational activities are aimed. Since the educational department is well aware that it is owned by the medical staff, it is responsive to their requests and suggestions, and provides a wide range of educational programmes from encouraging activities at the clinic level to organizing activities involving the whole cooperative. Ownership and responsiveness at a local level and the provision of a wide range of activities catering for individual preferences and learning styles, with the encouragement of informal inter-specialty communications (such as arranging consultant visits and presentations at general practice surgeries), provide a good basis for medical education programmes. Our medical education department is also involved in educational projects arising from our quality assurance and audit activity.

We are successful because our departments have credibility among our medical staff, there is general practitioner involvement in organizing these activities, and we provide good quality continuing medical education without hours or profit being the primary motive.

ALAN J SEARLE

Group Health Cooperative
South Region Medical Education
Tacoma Avenue Primary
124 Tacoma Avenue South
Tacoma, Washington 98402
USA

References

1. Stanley I, Al-Shehri A, Thomas P. Continuing education for general practice. 1. Experience, competence and the media of self-directed learning for established general practitioners. *Br J Gen Pract* 1993; 43: 210-214.

2. Al-Shehri A, Stanley I, Thomas P. Continuing education for general practice. 2. Systematic learning from experience. *Br J Gen Pract* 1993; 43: 249-253.

Qualitative research

Sir,

In their wide ranging observations on qualitative research Britten and Fisher do a disservice to a form of research that has produced so much valuable information (editorial, July *Journal*, p.270).

The weaknesses of qualitative research are identified as bias and lack of generalizability. In our experience one interview cannot truly lead to a close relationship. The skill in qualitative research is to remain open to what is being said and not to draw conclusions too early. The interviewer does better to wait for the complete wealth of information to be available. A recognition that interviewing known participants might inhibit their responses may encourage the researcher to cast the net a little wider. It is surely up to the researcher to identify potential pitfalls and work to eliminate them.

Generalization may be perceived as problematic if the boundaries exerted by quantitative research cannot be shaken off. With good interviewing techniques, wise choice of participant, an open mind and appropriate analysis, interviewing even 10 subjects can reveal so much information that, while there might be a slight hesitation in making global generalizations, it is certainly possible to draw interesting conclusions. Validation is usually quoted as of greater concern. The use of 'experts', such as colleagues involved in similar studies, to validate the findings can greatly eliminate such concerns.

To suggest that qualitative researchers are not making their methodologies explicit is a little unfair when standard texts exist and are often referred to in published papers.¹⁻³

We feel that qualitative methodology is being damned with faint praise, which is a pity. Until we can rid ourselves of the concept so dear to medical scientists of 'what can we measure?' we will fail to appreciate the significance of this form of study. All research is as good as the researcher and the insights produced by qualitative methods are so valuable for the professional that they should be encouraged with more vigour and conviction.

RODERICK D MACLEOD
MARY PENNELL

Dorothy House Foundation
164 Bloomfield Road
Bath BA2 2AT