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.

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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.

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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.

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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.

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Personal medical attendant reports

Sir,

In his letter (September *Journal*, p.395) David Haslam questions my conclusion that the ethical issues for general practitioners in completing insurance reports are now largely resolved (letters, April *Journal*, p. 172. He confuses the separate issues for general practitioners and for their patients. My study clearly demonstrated that general practitioners feel entitled to pass information to insurance companies, because of the safeguards given to their patients by the access to medical reports act 1988. The issue for the patient is more complex. Do we have anything other than anecdotal evidence to suggest patients do not consult their general practitioner for fear of jeopardizing future insurance? Even if we accept this evidence, it cannot be ethically correct for a patient who perceives himself or herself to be at high risk of disease to deny this on the proposal form and expect to be corroborated by the general practitioner's report? This would, of course, invalidate the insurance policy too.

Secondly, the 57% of patients in Lorge's study who expected their general practitioner to withhold sensitive information have not been ignored.[1] This figure related to lifestyle questions, which have since been considerably changed by insurance companies. This group of patients would also be comforted by the underpublicized fact that the norm in insurance is to offer standard rates to about 90% of proposers.[2]

Finally, may I recommend that we general practitioners telephone the patient directly after completion of all reports. Almost no delay is caused by a request to see a report. The access to medical reports act 1988 has encouraged general practitioners to be accurate in their reports, and they are being so. In this they do their patients a service, not a disservice.

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Sir,

Following the letters from William Hamilton (April *Journal*, p.172) and David Haslam (September *Journal*, p.395), I think readers should be made aware that it is now RCGP policy that should information be divulged in a personal medical attendant's report which in the opinion of the general practitioner would be prejudicial to the patient then the patient should be involved either by being sent the report with a covering letter or by being informed of the detrimental nature of the information and of the implications of divulging it (*RCGP Connection* 1993; October: 3).

This by no means solves all the ethical problems these reports create but it is a significant improvement in current practice. I would suggest that all such reports are sent to the patient for their perusal before being forwarded to the insurance company.

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Making London better?

Sir,

In her wide ranging editorial Iona Heath covers many of the problems facing general practice in the London area (August *Journal*, p.314). Problems lie in the organizational structure of the National Health Service, the mode of delivery of care to vulnerable groups and the resourcing of primary care in the city.

Several solutions to the underlying problem of supply and demand regarding health provision in the city are suggested. Reorganization, re-financing and reappraisal of the methods of delivery of health care are but some of the possibilities. However, Iona Heath does not address the issue of the health seeking behaviour of the clients of the primary care team. It is assumed in the editorial that the demands of the patient are appropriate, when practical experience teaches that many of the demands of patients are inappropriate in their timing or direction.

The greatest strain on the health service both in terms of individuals and finances is the ever growing demands placed on it by the client group. In a climate of financial restraint these wants cannot be equated with needs. Unless the profession addresses the issue of educating people to have realistic expectations of what can be provided by their family doctor we will be swamped by their demands. We should take the lead in educating our patients in what is an appropriate use of the service and not allow their expectations to be shaped by the short term political expediency of those in power.

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Measuring alcohol consumption

Sir,

The use of units of alcohol as a standard by which to assess an individual's drinking habits is widespread and greatly simplifies the collection of data for health promotion purposes. How standard is the unit?

A visit to my local supermarket revealed beers and lagers which varied in strength from 2.3% to 5.6% alcohol by volume. Cider varied even more, from 3.5% to 8.4%. These were not barley wines or speciality drinks, although some were labelled 'extra strong'. Wines were mostly 12.0% alcohol but varied between 9.5% and 13.0%. The consequence of this variation in alcohol content is that a half a pint or one unit of a strong beer might contain more alcohol than two units of a weak one.

If we assume a standard strength for wine of 12.0% and that a standard 750 ml bottle provides six glasses, then a unit of wine contains 15 ml of alcohol. In order for a half pint of beer (284 ml) to contain the same amount of alcohol it would have to have a strength of 5.3%, which is near the top of the range of strengths quoted above. The sort of beer sold in large plastic bottles by supermarkets is often 3.0% alcohol by volume, so that a pint would only contain slightly more alcohol than the glass of wine.

While accepting the value of having a rule of thumb by which to compare different types of drinks, it is clear that there could be problems in using units of alcohol for quantitative research.

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