Feedback to subjects may be important in epidemiological studies. For example, in one study on general practitioner referrals of patients with rectal bleeding, 83% of patients indicated that they would like to see a copy of the report.[15] In a qualitative study on patients' consultation behaviour, 61% of participants requested information about the results.[16] This may indicate a wish for greater involvement and for more information by subjects, in some areas of research at least, although there are logistic difficulties in providing this information and also problems of interpretation when the information is presented as part of a formal research report, although an abbreviated or summary version of the research study report could be produced.

Consequences for participants also need to be considered. Collecting information about smoking or drinking habits, for example, may simply serve to stigmatize certain social groups and to reinforce inappropriate stereotypes. Re-interpretation of research data through the lay media may caricature not only the research findings but also the research subjects. Research that has implications for increasing the provision of services, requiring allocation of resources over which the researchers themselves have no control, may create inappropriate expectations and subsequent disappointments if suggestions for increased resources are not implemented. Researchers have to pay particular attention to the presentation and discussion of information in which criticism of the subjects of research, who may be colleagues or other medical professionals, is explicit or implicit, as well as considering the likely effect of such criticism on future research collaboration.

Conclusion

This paper has discussed some of the ethical problems facing primary care researchers, some of which are specific to research undertaken in the community and in general practice and often reflect dilemmas which apply generally to medical research. These issues have, we believe, implications not only for the assessment of the ethics of research proposals, and for ensuring that research ethics committees are appropriately constituted, but also for the designs of the research studies themselves. None of the ethical dilemmas presented here should be regarded as a barrier to research that sets out to answer questions likely to inform better clinical practice, but they should be considered by researchers when framing research questions, choosing study methods and presenting results. In grasping the rich research opportunities available to them, primary care researchers need to ensure that their concerns for the rights and well-being of the individual as a research subject are articulated at least as strongly as general practitioners' advocacy for the individual as a patient.

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Obstetric care by family physicians in Canada

THIS Canadian article describes intrapartum care given by family physicians in a hospital staffed by four obstetricians and 39 family physicians with 'hospital privileges'.

Of 925 women giving birth between January and June 1990, 74% were booked for local family physician care. Of these 683 women, 82 were transferred to obstetrician care before giving birth. The study focuses on the remaining 601 women, 44% of whom were primiparous. Eleven per cent of the primiparous women and 8% of the multiparous women had caesarian sections. These are considered examples of low intervention rates which might surprise readers in the United Kingdom but this is a north American study, and just over a third of women booked for care by the family physicians were described as 'high risk'. Unfortunately the risk factors are not described.

The proportion of low risk women having epidural anaesthesia was 7%, lower than other Canadian studies quoted. Induced births (14% of all women) and episiotomy (43% of all women) are described as low rates which again comes as a surprise.

Family practice plays a much more prominent role in intrapartum care in Canada than in the UK. The author talks about the lack of an effective voice for family practice in maternity care. I was envious of family physicians' level of commitment and wondered what lay behind the disparity between Canada and the UK. Canada has only just recognized midwives and, although I welcome the role of midwives, it will alter the role of family physicians at births. Canadian general practitioners can hardly learn from general practitioners in the UK as we have been unable to clarify effectively our role, let alone justify it.

Overall, this was an encouraging paper for those (like myself) who believe that general practitioners have a role at births. However, it was surprising (and wounding) to see how little the UK literature was quoted.

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Source: Radomsky NA. Family practice obstetrics in a community hospital. *Can Fam Physician* 1995; **41:** 617-624.

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