LETTERS

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How useful is qualitative research?

Sir,

I enjoyed reading the paper by Cromarty (September *Journal*) concerning what patients think about during their consultations.[1] It is a pleasure to see qualitative research methods applied appropriately and rigorously to a research question that could not have been meaningfully addressed using quantitative methodology. The fact that the patient's perception of the consultation is relatively unexplored and complex, involving interpersonal interaction, makes this study ideal for naturalistic enquiry.[2]

It is, however, typical of many of the qualitative studies that are currently being published in the peer-reviewed medical journals, in that it is essentially *descriptive*. Of course, description must form the foundation of any naturalistic study,[3] but if that is as far as it goes, the reader is often left with a rather hollow, 'so what?' impression. The next stage in data analysis is *interpretation*[4], which can lead to the construction of theoretical models and can be aided by computer software programs such as ATLASTI (Thomas Muhr, Berlin, 1994). Model-building and the subsequent testing of these models against the available evidence is an intellectually demanding but fulfilling exercise. It is only by creating models that the study moves from being interesting to positively useful to health care professionals, teachers and patients. As Cromarty points out, there are plenty of models of the consultation, mostly from the doctors perspective. If his study had resulted in a model incorporating the patient's agenda, it would have formed a useful focus for academic debate.

The current enthusiasm for qualitative methods in health care research is most likely to be sustained if tangible outcomes of this expensive and time-consuming method of research are produced.

MARTIN MARSHALL

Institute of General Practice
Postgraduate Medical School
University of Exeter
Barrack Road
Exeter EX2 5DW

References

1. Cromarty I. What do patients think about during their consultations? a qualitative study. *Br J Gen Pract* 1996; **46:** 525-528.
2. Denzin NK, Lincoln YS (eds). *Handbook of Qualitative Research.* London: Sage Publications, 1994.
3. Hammersly M, Atkinson P. *Ethnography: Principles in practice.* Tavistock, 1983.
4. Miles MB, Huberman AM. *Qualitative data analysis.* 2nd edn. London: Sage Publications, 1994.

Evidence-based learning for general practice

Sir,

Leone Ridsdale's editorial (September *Journal*) fails to mention the possible contribution of local public health departments to evidence-based learning in general practice.

The MFPHM exam, like the MRCGP, requires the ability to critically appraise an article under examination conditions. In addition, most trainees in public health now undertake a taught MSc/MPH course and so receive formal training in research methodology (both qualitative and quantitative), epidemiology and statistics.

In their work within health authorities, public health physicians are frequently asked to appraise the quality of research and advise as to how the commissioning of services can be made more evidence-based.[1] Public health medicine trainees and consultants are thus an important potential training resource for the teaching of critical appraisal skills to GP registrars and GP principals. They also have the additional advantage of being based in health authorities, which are more numerous and more uniformly distributed geographically than university departments of general practice.

TIM STOKES

Leicestershire Heath
Gwendolen Road
Leicester LE5 4QF

References

1. Stocking B. Why research findings are not used by commissions — and what can be done about it. *J Public Health Med* 1995; **17:** 380-382.

Mental disorders in primary care

Sir,

Goldberg and Gater[1] (August *Journal*) should be commended for their excellent paper describing the findings of Ustim[2] and the WHO report on mental disorders seen in primary care settings.

The implications of these findings for general practice service delivery and training are far reaching. However, Goldberg's and Gater's suggestion that there is 'a need efficacy' presupposes that all general practitioners will be able to apply the 'interventions' to an equally high standard, and that all patients will respond equally well. This is very unlikely for the reasons laid out below.

In many parts of the country, the first two prerequisites — continuity of personal care, and the mutual trust which this encourages — are all too often not present.[3] As these preconditions are usually necessary for all successful psychotherapeutic interventions, busy general