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.

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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.

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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

practitioners (with ever shortening consulting times and working in practices with pooled lists where patients are seen on a 'first come first served' basis) are less likely to be able to apply an 'intervention' that is likely to produce the desired change.

No training package, public campaign or even ministerial exhortation is likely to overcome these difficulties, unless general practice itself is ready for the fundamental step of re-introducing a personal service which offers continuity of care and more time for the individual patient. In 1979[4] Pereira Gray described the effects in just one practice of changing from pooled lists of patients to personal ones, which demonstrated increased patient satisfaction, gains in service efficiency, and improved effectiveness. He did not comment on the effect on practice costs, but it is obvious that the effects noted were likely to have brought considerable cost benefits.

A further problem left unanswered by Goldberg and Gater (and by Ustim and Sartorius) is that general practitioners are obliged to care for patients with mental health problems (often associated with physical health problems) that are seemingly incurable. Unlike their psychiatric colleagues, who sometimes discharge patients labelled 'personality disordered' to the care of general practice because they have no effective treatments to offer them, general practitioners are obliged to continue to care for these patients.

Counsellors now working in many general practices are beginning to support the care of these patients and other groups of patients who would benefit from an 'intervention of proven efficacy' through their psychotherapeutic skills. These enable them to build up trust and to offer care and nurture in ways likely to expedite the interventions used.

I believe that, while the present situation continues in general practice in the United Kingdom, we need to concentrate on the development of counselling services, on better training for individual counsellors, and on their deployment as part of an efficient and acceptable service that is accessible to all patients who would benefit.

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Accessibility and availability of GPs

Sir,

The issue of the accessibility of general practitioners is important amidst a climate of increasing workload and stress in primary care. In his editorial (August *Journal*), Dr Davis suggest some strategies for increasing the provision of good accessibility for our patients.[1] Such ideas seem useful; many have been suggested before, but they fail to take into account the idiosyncrasies of our patients' behaviour.

Six months ago I became a part-time general practitioner when I took up an academic appointment. As expected, my surgeries are usually booked up a week in advance. Many patients make an appointment without having any particular medical problem that needs managing because 'it is so hard to get to see you these days, doctor'. This inefficient but it is hard not to view it as the result of creating a successful doctor–patient relationship.

Another difficulty is the variation in the definition of the word 'urgent'. Patients' perceptions of the urgency of their medical condition are drawn from a wide range of sources: the media, friends, prior experiences. Lack of education and lack of social support make it difficult for some families to 'wait and see' when their child has a rash. Well-trained staff may be able to deflect some urgent requests for appointments, but how much information should we expect a patient to offer a receptionist or nurse before a same-day slot is offered? A lengthy enquiry about the patient's condition reduces accessibility and may be seen as reducing confidentiality.

We all recognize the phenomenon of patient lists expanding to fill all available spaces. Practice nurses are also booked up in advance. An extra partner soon ceases to make a difference. Dropping outside work may create new surgery time but this would soon be engulfed at the expense of the partner's outside interests.

Research continues on frequent attenders, another source of pressure in practice,[2] but there is also a need to look at ways of helping patients distinguish between 'urgent' meaning acute, and 'urgent' meaning it will wait another twenty-four hours.

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Sir,

The pressure for same-day 'urgent' appointments has always caused stress for patients, receptionists and doctors. The Royal College of General Practitioners' information services have found only two reported studies of this, the most recent being 10 years ago.[1] This says that in four mainly suburban practices with 37 400 patients, out of 2424 consulting in one week in January 1986, 574 (22.7%) considered it essential to be seen on the day of request. Comparable figures are not easily derived from the recent West Lothian study.[2] If about 20% of daily consultations are 'urgent', the reasons for this, their context and content, and whether patients might be helped to become more self-reliant, merit further research.

Your editorial[3] (August *Journal*) suggests ways to meet demand, including the provision of sufficient 'urgent' appointment time and the delegation of more work to nurses. Since 1990 nurses have been employed more widely in general practice.[4] Does the work they do allow them to achieve their full potential? Many nurses, and certainly the primary care nurse practitioners now being trained at the Royal College of Nursing and elsewhere, would be able, if patients get the choice, to share 'urgent' appointments.[5]

The Yorkshire report[1] comments, 'perhaps it is an indictment of our education of patients that the upper respiratory tract infection, particularly, is still considered an emergency.' Nurses are good at listening, explaining and understanding.[6] Perhaps they would also be more able to help patients find their own solution to 'urgent' problems, now marked 'medical', by consultation with a doctor. Many nurse–doctor pairs do this in Ontario.[7] This may happen in Britain too. Where are the reports?