

Barriers between community pharmacists and GPs <i>C Seamark</i>	885	Author's response <i>J Kedward</i>	887
Authors' response <i>C Hughes and S McCann</i>	885	Early complications of circumcisions performed in the community <i>HJ Corbett and GME Humphrey</i>	887
Barriers to the use of statins <i>J Penston</i>	886	Save our soul <i>J Erskine</i>	888
<i>T Kemple</i>	886	<i>D Jeffries</i>	888

All letters are subject to editing and may be shortened. Letters should be sent to the BJGP office by e-mail in the first instance, addressed to [journal@rcgp.org.uk](mailto:journal@rcgp.org.uk) (please include your postal address). Alternatively, they may be sent by post (please use double spacing and, if possible, include a MS Word or plain text version on an IBM PC-formatted disk). We regret that we cannot notify authors regarding publication.

## Barriers between community pharmacists and GPs

It is encouraging to see more qualitative papers being published, especially those using interpretative phenomenological analysis (IPA). However, I found myself confused by the methodology of the paper by Hughes and McCann.<sup>1</sup> They state that they analysed the transcripts of the focus groups in their study using IPA. However, they then go on to say that 'the principles of grounded theory were used to develop explanatory theories for the emerging themes to further understand the interface between community pharmacy and general practice'.

Although many of the components of qualitative research, such as using taped and transcribed interviews and focus groups, and then using an iterative approach to identify emerging themes, are common to different qualitative data analyses,<sup>2</sup> there are also important distinctions.

IPA emerged in the 1990s within health psychology and is concerned with a person's experience and how they make sense of what is happening to them.<sup>3</sup> The process also involves the researcher's interpretation. When undertaking an IPA, a purposive sample of a homogeneous group of people experiencing the condition or situation under study would usually be chosen. In general, there would be small numbers of participants, often fewer than 10 and rarely more than 20. Most work has been done with semi-structured interviews, although other methods of data collection may be used. IPA arises from a general research question and not from a specific hypothesis that needs to be tested.<sup>4</sup>

Grounded theory was 'discovered' in the 1960s by Glaser and Strauss and is designed for generating and testing theories that relate to a particular situa-

tion.<sup>5</sup> The sample would often involve interviews with 20–30 theoretically selected informants. There are different viewpoints, with some thinking that significant issues and data are readily apparent from the data,<sup>6,7</sup> and others assuming an interaction between the researcher and the researched in the production of the data.<sup>8</sup>

However, although IPA and grounded theory may share a theoretical base, they are approaching the subject under study in two quite distinct ways. Grounded theory attempts to make claims for a larger population at a quicker rate using theoretical sampling to look for variation and try to achieve generalisability.<sup>8</sup> In IPA, the analysis emerges from the individual cases. It may be possible to move towards a 'tentative' grounded theory, but this is not the aim and usually the theoretical model leads to further research and elaboration not to the final statement on the subject.<sup>9</sup> I therefore find it difficult to understand why the authors have tried to incorporate two distinct qualitative methodologies for this study. It does make it difficult to know how the study should be interpreted.

CLARE SEAMARK

The Honiton Group Practice, Marl pits Lane, Honiton, Devon EX14 2NY

## References

- Hughes CM, McCann S. Perceived inter-professional barriers between community pharmacists and general practitioners: a qualitative assessment. *Br J Gen Pract* 2003; **53**: 600-606.
- Gantley M, Harding G, Kumar S, Tissier J. *An introduction to qualitative methods for health professionals*. London: RCGP, 1999.
- Smith JA, Jarman M, Osborn M. Doing interpretative phenomenological analysis. In: Murray M, Chamberlain K (eds). *Qualitative health psychology: theories and methods*. London: Sage Publications Ltd., 1999.
- Smith JA. Semi-structured interviewing and qualitative analysis. In: Smith JA, Harré R, Van Langenhove L (eds).

*Rethinking methods in psychology*.

London: Sage Publications Ltd., 1995.

- Glaser BG, Strauss AL. *Discovery of grounded theory: strategies for qualitative research*. Chicago: Aldine de Gruyter, 1967.
- Strauss AL. *Qualitative analysis for social scientists*. Cambridge: Cambridge University Press, 1987.
- Glaser BG. *Doing grounded theory: issues and discussion*. California: Sociology Press, 1998.
- Charmaz K. Grounded Theory. In: Smith JA, Van Harré R, Langenhove L (eds). *Rethinking methods in psychology*. London: Sage Publications Ltd., 1995.
- Smith JA. Identity development during the transition to motherhood: an interpretative phenomenological analysis. *J Reprod Infant Psychol* 1999; **17**: 281-299.

## Authors' response

The area of qualitative analysis is often quite contentious and we welcome the opportunity to respond to Dr Seamark's letter. The data were analysed according to the guidelines for interpretative phenomenological analysis (IPA) outlined by Smith *et al*<sup>1</sup> and Smith and Osborn.<sup>2</sup> IPA was appropriate as we were interested in the groups' cognitions and they were interviewed in their professional groups. Furthermore, one of the reviewers of the paper stated that our approach was 'entirely appropriate'.

We did not set out to generate a theory using the research process of grounded theory. Indeed, it would not have been possible for us to undertake theoretical sampling per se as dictated by the grounded theory technique, because we had only two populations among the GPs and pharmacists: those with or without previous experience of working together. Hence, the sample of interest was quite unique and was predetermined by this characteristic. However, when our analysis was complete, it became apparent that a tentative theory had emerged. We used the term 'grounded theory' to indicate that our tentative theory was 'grounded' in the data and emerged through an

inductive process. We did not use the specific procedures of grounded theory methodology. However, by arriving at a tentative theory, we hope to have stimulated further work in the area.

CARMEL HUGHES

Senior Lecturer, School of Pharmacy,  
Queen's University Belfast, Northern  
Ireland. E-mail: c.hughes@qub.ac.uk

SIOBHAN MCCANN

Research Associate, School of  
Nursing, University of Ulster.

### References

1. Smith JA, Jarman M, Osborn M. Doing interpretive phenomenological analysis. In: Murray M, Chamberlain K (eds). *Qualitative health psychology: theories and methods*. London: Sage Publications Ltd., 1999.
2. Smith JA, Osborn M. Interpretive phenomenological analysis. In: Smith JA. *Qualitative psychology: a practical guide to research methods*. London: Sage Publications Ltd., 2003.

### Barriers to the use of statins

In the September edition of the *BJGP*, Kedward and Dakin reported certain barriers to the prescription of statins.<sup>1</sup> Unfortunately, a study comprising qualitative interviews with GPs is unsuitable for drawing any firm conclusions on which to base changes in practice. The absence of any numerical data concerning the proportion of participants citing each of the supposed barriers; for example, cost, effect on workload, compliance with medication, side effects and medicalisation, precludes any assessment of the importance of addressing these problems. Moreover, given that half of the GPs originally selected failed to participate in the study, it remains doubtful whether the conclusions genuinely represent the views of the majority.

A fundamental difficulty with the study is that Kedward and Dakin appear to assume that there are no problems with the underlying data supporting the widespread use of statins. This is not the case. Large-scale randomised trials in general, and those studies relating to treatment with statins in particular, are far from convincing.<sup>2</sup> The methodology is flawed and the conclusions derived from the

data are often biased. Any inquiry into the reasons behind the failure to use statins should take these criticisms into account. Similarly, given the scepticism concerning clinical guidelines,<sup>3</sup> GPs should be asked whether they actually accept the validity of their recommendations.

Large-scale trials yield, at best, only small treatment effects. Indeed, most studies report that statins are of benefit to less than 5% of patients receiving the drug over many years. This has important ethical implications.<sup>2</sup> A recent study has shown that if patients were fully informed of the small chance of benefit, they would be unwilling to accept treatment.<sup>4</sup> At present, though, very few patients are provided with sufficient data on which to make an informed decision.

Instead of being a source of angst, the reluctance of GPs to prescribe statins like confetti should be celebrated. Perhaps the failure to acquiesce to the guidelines is a reflection of the wise judgement of GPs concerning the inadequacy of the data supporting long-term therapy with statins, as well as an understanding of the views of their patients when faced with indefinite treatment of doubtful value.

JAMES PENSTON

Consultant Physician, Scunthorpe  
General Hospital, Scunthorpe, North  
Lincolnshire DN15 7BH.  
E-mail: james.penston@nlg.nhs.uk

### References

1. Kedward J, Dakin L. A qualitative study of barriers to the use of statins and the implementation of coronary heart disease prevention in primary care. *Br J Gen Pract* 2003; **53**: 684-689.
2. Penston J. *Fiction and fantasy in medical research: the large-scale randomised trial*. London: The London Press, 2003.
3. Hampton JR. Guidelines — for the obedience of fools and the guidance of wise men? *Clin Med* 2003; **3**: 279-284.
4. Trewby PN, Reddy AV, Trewby CS, et al. Are preventive drugs preventive enough? A study of patients' expectation of benefit from preventive drugs. *Clin Med* 2002; **2**: 527-533.

Kedward and Dakin<sup>1</sup> sought to provide insights into the complexities and difficulties faced by GPs in prescribing statins and implementing coronary prevention guidelines. Themes like cost, workload, side effects, lifelong treatment, patient compliance, effects

on health, behaviour, and lifestyle, emerged as barriers to initiating statin therapy.

An observation from practice illustrates how this approach to understanding variation in performance might be incomplete. Our research practice hosts research and in a current project, doctors and practice nurses were asked to give a questionnaire to patients who had knee or shoulder problems, during their consultations. One hundred questionnaires were to be given out by 12 doctors and 5 practice nurses to a target group of roughly 350 patients in a practice with 13 500 patients. The questionnaire pack included a covering letter from the practice, information about the research project, the questionnaire, and a stamped envelope addressed to the researcher. My experience was that the questionnaire could be given to patients in less than a minute. My impression was that this did not reduce the quality of the consultation and that patients like to be involved in research that is relevant to their problem. Giving a simple questionnaire to willing patients seemed an easy task. None of the 'barriers' identified by Kedward and Dakin seemed relevant.

Surprisingly, it was difficult. Tracking the progress of the project allowed staff to be given feedback on their performance handing out questionnaires and to report back on any 'barriers'. These included the following: 'in a busy surgery I forget about it', 'I don't have a sense of ownership', 'too many time pressures', 'no benefit for either patients or doctor', 'I don't see any knee or shoulder problems', 'I must see different sorts of patients', 'the pack fell behind the desk', 'I don't really believe in it', 'you are more motivated than the rest of us'.

The electronic health records were checked and these confirmed that each doctor's personal list was comparable for the prevalence of knee and shoulder problems. Some doctors requested, and were given, prompts in the patients' electronic health records. Neither the feedback nor electronic prompts had dramatic effects on performance.

After 14 weeks, 88 questionnaires had been handed out and 44 received back to the researcher. The five practice nurses gave out three, two salaried

GPs gave out none, one ex-partner acting as a locum gave two, and the nine partners gave between two and 39 (2, 2, 2, 4, 5, 6, 9, 13 and 39). Two issues not reported by Kedward and Dakin seem relevant. First is the speed of implementation. Our experience with this and other changes, such as statin prescribing, is that provided there is regular feedback on performance the desired change does occur, but it may be slow. The second is that we have very little understanding about what is done in other doctors' consultations. Most doctors give different time for different priorities. Without the benefit of critical feedback they develop their own consultation styles and habits, and are reluctant to change them. In a changing world with changing priorities it is important to understand what the clinician is doing (and influence that), rather than just add an extra task.

Miller's pyramid for assessing clinical competence has stages where the practitioner knows, knows how, shows how, and does do the area of competency. This model fits with the barriers to progress in Kedward and Dakin's paper. To influence existing consultation styles and habits, we need a reverse process for assessing clinical performance in the consultation with stages where the practitioner identifies what was done, shows what they think they were doing, asks why they were doing it, and what needed to be done in the consultation. Perhaps it's time to open the 'black box' of the consultation.

TERRY KEMPLE

Horfield Health Centre, Lockleaze  
Road, Horfield, Bristol BS7 9RR.  
E-mail: TK@elpmek.demon.co.uk

## References

1. Kedward J, Dakin L. A qualitative study of barriers to the use of statins and the implementation of coronary heart disease prevention in primary care. *Br J Gen Pract* 2003; **53**: 684-689.

## Author's response

Penston appear to lack an understanding of the use, nature and methodology of qualitative research, which seeks not to 'measure' numbers, but to interpret actions and behaviours.<sup>1</sup> His criticism of the study

methodology is unfair and he has misinterpreted the perspective of the researchers and the conclusions drawn. He incorrectly states that half of GPs selected failed to participate, when in fact 26 out of 37 (70%) doctors, who were still in practice, agreed to be interviewed, which is a high rate for interview studies of GPs. The use of maximum variety purposive sampling is a well recognised sampling method.<sup>2</sup> The validity of the results was tested by the sampled GPs who largely felt that their range of views were contained within a result summary.

Although not reported in this paper, the GPs in this study were asked about their interpretation of trial results and of statin prescribing guidelines. They almost universally accepted the benefits of statin use, and many were able to quote absolute and relative risk reduction from trials. Many of the GPs varied in their agreement with prescribing guidelines, in most cases feeling these were too conservative.

Penston is sceptical about the benefits of long-term statin treatment, and has presented his own view on how information on risk reduction should be presented to patients. The communication of risk is an interesting and complex area with a diversity of views on what trial results mean for the individual and how this should be communicated to the patient in the consultation.<sup>3</sup> It is likely to become an increasing issue within GPs consulting rooms in future years.

I agree with Kemple that the issues we identified may not be complete. Many interviewed GPs mentioned feedback from audit as a useful reminder, but only two or three mentioned the level of personal priority they placed on statins as influencing how they prescribed. I believe that the key to better understanding of these issues is also to understand the patient's perspective on statin use, and, as Kemple mentions, to have a clearer understanding of what actually happens between doctor and patient when discussing treatment options for heart disease prevention.

JOHN KEDWARD

GP Researcher, South Bedfordshire  
Practitioners' Group, Luton.

## References

1. Pope C, Mays N. *Qualitative research in health care*. 2nd ed. London: BMJ Books, 2000.
2. Murphy E, Dingwall R, Greatbatch D, et al. The methods of qualitative research. In: Murphy E, Dingwall R, Greatbatch D, et al. *Qualitative research methods in health technology assessment: a review of the literature. Health Technol Assessment* 1998; **2**(16): 89-112.
3. Edwards A. Communicating risks. *BMJ* 2003; **327**: 691-692.

## Early complications of circumcisions performed in the community

Many circumcisions of male children are performed 'in the community' by a variety of people, including some general practitioners.<sup>1</sup> The complication rate for 'community circumcisions' is reported to be higher than that for those performed in hospital.<sup>1</sup> This is supported by an increase in the rate of complications related to circumcision when hospital circumcision rates reduce.<sup>2,3</sup> The most frequent complication of circumcision in any setting is bleeding.<sup>4</sup>

Between August 2001 and April 2003 we saw 31 children with complications because of community performed circumcision. Their age range was from 4 weeks to 9 years (median 3 months). Nineteen boys had been circumcised with a Plastibell® ring. Twenty-five children presented with bleeding from 4 hours to 6 days post-circumcision. Haemoglobin (recorded in 21 patients) ranged from 6.2-15.2 g/dl. Five patients received a blood transfusion. Ten children needed surgical intervention under general anaesthesia to secure haemostasis. Four children presented from 8-30 days post-circumcision with the Plastibell® ring still *in situ*. Each had marked swelling of the glans and skin-mucosal dehiscence requiring re-circumcision. A neonate presented 12 hours following Plastibell® circumcision with a completely displaced ring; bleeding was minimal and so management was conservative. One child presented 5 days post-circumcision with a purulent infection that settled with oral antibiotics.

Over 21 months, at least 31 children presented with complications of 'community circumcision'. Most children

with bleeding were managed with compressive dressing alone, but a significant number required surgical haemostasis. Some of the infants had life-threatening blood loss requiring blood transfusion, which is not in itself without risk. The Plastibell® ring, made by Hollister Incorporated, is used with good results.<sup>1</sup> One source of bleeding was due to failure to tie the string tightly enough.<sup>1</sup> This problem was the cause of bleeding in one infant that we saw and was probably to blame in the case where the ring fell off prematurely. Vigilance when tying the string may prevent such complications.<sup>1</sup>

Our report highlights some of the complications of circumcision in children, which all GPs should be aware of. Such complications are not unique to circumcisions performed in the community and some were reported by Shah *et al* from their pioneering circumcision service in Bradford Hospitals NHS Trust.<sup>1</sup> What is crucial is that the practitioner should be suitably experienced, give suitable analgesia, counsel the parents, and provide appropriate aftercare.<sup>1,6</sup> We recommend that parents should be advised to seek medical attention if bleeding post-circumcision has filled the nappy or continues for more than 1 hour.

HJ CORBETT

Specialist Registrar in Paediatric Surgery

GME HUMPHREY

Consultant Paediatric Surgeon  
Royal Manchester Children's Hospital,  
Hospital Road, Pendelbury,  
Manchester M27 4HA.

E-mail: gill.humphrey@cmmc.nhs.uk

## References

1. Shah T, Raistrick J, Taylor I, *et al*. A circumcision service for religious reasons. *BJU Int* 1999; **83**: 807-809.
2. Madden P, Boddy SAM. Should religious circumcisions be performed on the NHS? [Letter] *BMJ* 1991; **302**: 47.
3. Ahmed A, Mbibi NH, Dawam D, Kalayi GD. Complications of traditional male circumcision. *Ann Trop Paediatr* 1999; **19**: 113-117.
4. Williams N, Kapila L. Complications of circumcision. *Br J Surg* 1993; **80**: 1231-1236
5. Poland RL. The question of routine neonatal circumcision. *N Engl J Med* 1990; **322**: 1312-1315
6. The General Medical Council. *Guidance for doctors who are asked to circumcise male children*. London: The General Medical Council, 1997.

## Save our soul

David Carvel's letter about the absence of letters in the August issue of *BJGP* and the editorial response prompts an obvious question: is the in-house magazine of the RCGP really needed?

A journal of such bulk with such a massive mailing list should be provoking response all the time. If it is not, then perhaps it is time to offer college members an option of a free subscription to *The Lancet* or *BMJ* or another generalist magazine that does.

If this is too radical for some of the College to consider, then perhaps it is time to do a readership survey to see what RCGP members actually do want. A journal that fails to provoke response from its target audience seems to be one journal too many and is probably a costly white elephant.

I hope this letter does provoke a response! If not QED.

JAMES ERSKINE

Missionary doctor, The Gambia.

## References

1. Carvel D. Save our soul [Letter]. *Br J Gen Pract* 2003; **53**: 730.

You ask why you aren't flooded with angry letters month after month,<sup>1</sup> and David Carvel laments the absence of witty asides and healthy debate in the letters pages.<sup>1</sup> It seems to me that many of your readers may have been put off by the general tenor of the Journal. Its editorials tend to be uncontroversial, its research articles largely irrelevant to non-academic general practitioners (with too many articles dealing at one or two levels removed from daily practice), its letters dull and too long, and its back pages dominated by alarmingly erudite individuals who claim to understand post-modernism, or who write such witty and clever columns that the rest of us aren't try to compete.

Still, I'd like to have a go at sounding irascible, and I'm happy to try to engender some healthy debate. The question that has preoccupied my thoughts for several months now is why there has been so little protest about the quality framework in the new contract? Are we so delighted by

the prospect of shedding 24-hour responsibility and enhancing our already generous pensions that we can overlook the advent of an unprecedented system of central control and external surveillance? Are we happy to relinquish the principles of personal doctoring and continuity of care while being willing to focus the bulk of our efforts on filling-in spaces on the burgeoning clinical templates on our computer screens? Can we seriously accept that recording the Read code for 'cancer diagnosis discussed' has any validity whatsoever as a marker of high-quality terminal care? Do we have no misgivings about the quantum leap in the medicalisation of daily existence that this framework implies? Shame on us.

The irony of the outgoing president of the BMA lambasting the government in his retirement speech on its obsession with targets, while his own negotiators have agreed on enough targets to satisfy George Bush Jnr in his most trigger-happy mood, seems to have passed the commentators by.

I believe that this new contract will do more harm to the profession of general practice than the 1990 reforms. Please tell me why I'm wrong.

DOUGAL JEFFRIES

St Mary's Health Centre, Isles of Scilly.

## References

1. Carvel D. Save our soul [Letter]. *Br J Gen Pract* 2003; **53**: 730.