exploration of many issues which are not scientifically definable, for example the critical incident technique which uses semi-structured interviews and the recording of recurrent themes.[19] Just as there is a balance between art and science, there is a need for a balance between qualitative and quantitative research. The two approaches to research should complement each other as part of their symbiotic relationship.

The dilemma and challenge for primary care research is the need to reconcile the accelerating advance of technological medical knowledge and skills, *scientia,* with a warm and caring relationship, *caritas.* Unfortunately, the general practice environment is constrained by intense competition for resource allocation and patients' rising expectations of medical care, thus impeding the growth of research.[15] Furthermore, the current move of secondary care into the community requires not only research into illnesses where no obvious cause can be identified but also those diseases requiring acute and chronic management.

The future improvement of health care lies in the continued proliferation of primary care research as noted by an important mentor at the turn of the century, James Mackenzie:

> 'As a result of my experience I take a very different view, and assert with confidence that medicine will take but halting progress, while whole fields essential to the progress of medicine will remain unexplored, until the general practitioner takes his place as an investigator.'[20]

In a letter to the *British Medical Journal* in 1942 it was suggested that cooperation between the general practitioner and research worker is required to 'throw some light on many problems at present obscure'.[21] It is important not only to encourage this cooperation but also to encourage general practitioners to be enquirers and researchers themselves. It is the increase in primary care research into all aspects of health which will strengthen general practice as an academic discipline for, as Denis Pereira Gray states, 'published research is the only way to turn a craft into a profession and a profession into a discipline'.[22]

RODGER CHARLTON
Senior lecturer, Department of Primary Health Care, Keele University

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Address for correspondence
Dr R Charlton, The Surgery, Fentham Hall, Marsh Lane, Hampton-in-Arden, Solihull, West Midlands B92 0AH.

General practitioners and public health doctors: sharing common goals?

FOR the patient the quality of the consultation has always been the key to good health care. But general practitioners are increasingly being asked to look beyond caring for individuals and to consider the way in which care is provided in the wider community. Reorganization of local health care has become the stuff of daily life. If general practitioners are to play an effective part in today's health service , they cannot afford to ignore this change in role or the way resources are rationed on ever more explicit criteria.

Public health doctors have been charged with advising health authorities on how to promote health and commission effective care,[1] a responsibility that will formally extend to primary care when family health services authorities and district health authorities merge in April 1996.[2] General practitioners are interested in the same issues, although from a different perspective. They deliver much of the health service's health promotion, stand at the gateway to secondary care and increasingly help to set priorities for local resource allocation, whether as fundholders or working through other commissioning mechanisms.[3-5]

Conventional wisdom decrees that the two disciplines of public health and general practice bring complementary but distinct skills to the commissioning process.[6] Yet, as both Hannay[6] and Bhopal[7] have observed, public health doctors and general practitioners often miss opportunities to collaborate. This is

partly a reflection of the way in which general practice and public health medicine have evolved as separate academic disciplines, each focusing on its own territory rather than developing a common ground. There are, however, more fundamental reasons for this lack of collaboration. The National Health Service reforms have given public health doctors a clear role in setting local priorities. But with this, there is a risk that they may lose their independence and be blamed when the health authorities they advise make unpopular decisions.

Some clinicians also perceive a conflict between the rational, evidence-based medicine that underpins public health medicine and the individualism of the doctor–patient relationship.[8] Similar concerns have been raised about the role of clinical guidelines, but providing they are seen as a way to structure clinical decision making, rather than as a set of rules which dictate individual care, most general practitioners welcome them.[9] These fears need to be understood, but general practitioners cannot ignore the case for offering more of those treatments which have been shown to be effective and fewer of those which have not.

Fundholding has added stresses to the relationship between general practitioners and public health doctors. Fundholding was established initially as an alternative to health authorities purchasing secondary care, and fundholding general practitioners were asked to prove they could do it better. Tensions were created when fundholders focused on their own patients' needs while public health doctors still had to consider those of the whole population. Further tensions arose when resources were allocated to fundholding practices on a different basis from that used for the rest of the population.[10] However, these problems appear to have been recognized and the Department of Health has made it clear that health authorities will in future adopt a more strategic role in commissioning services that general practitioners, whether fundholding or not, will purchase.[11,12] For this to work well, health authorities and public health doctors will need to learn how to influence, rather than control, the purchasing decisions of general practitioners.

How then can the two disciplines collaborate more effectively? First, as Murray and Graham[13] and others[14-16] have shown, public health doctors and general practitioners could share needs assessment and clinical audit work more creatively. Public health departments should consider offering general practitioners sessional contracts or the opportunity to lead work on specific projects such as cancer screening. They should also build closer links with academic departments of general practice and primary care. Such approaches will help dispel the false dichotomy between the 'bottom up' or 'felt need' approach of the general practitioner and the 'top down' epidemiological assessments of public health. There is clearly much to learn from both approaches.

Secondly, the annual report which directors of public health are required to produce offers an opportunity to address needs and set priorities for health services locally. General practitioners should be invited to contribute to this report and to discuss it at a practice level, at postgraduate meetings and in more formal consultative settings, for example at local medical committees. If general practitioners feel they have a stake in the report, they are more likely to act on its recommendations.

Thirdly, the training of general practitioners and public health doctors will need to adapt to the realities of the new NHS. Both the Royal College of General Practitioners[17] and the National Association of Health Authorities and Trusts[18] have proposed supplementing vocational training with a further two years of higher professional training, partly to prepare future general practitioners for their role as purchasers. The public health doctors of the future will also need a clear understanding of primary care. Changes must begin at the level of the undergraduate curriculum, continuing the trend to base more medical education in general practice and using the resources of general practice to make epidemiology more relevant to students. At a postgraduate level, doctors in training and experienced doctors in both disciplines should have more opportunities to work in each other's disciplines.

Fourthly, health authorities require good clinical advice about individuals' care. Public health doctors are often called on to give advice beyond their expertise when this would be more appropriately obtained from a family health services authority medical adviser, general practitioner or other member of the primary health care team.

Lastly, and perhaps most importantly, with the impending mergers of family health services authorities and district health authorities, public health doctors will be increasingly involved in commissioning primary care. This could have profound effects on the range and quality of general practice and these may or may not be beneficial. There is a risk that the newly merged health authorities and their public health advisers, many of whom will have a limited understanding of general practice, may take decisions that undermine the quality of primary care. Good links between general practitioners and public health doctors at a local level will be important to ensure this does not happen.

Ultimately, general practitioners will need to overcome their mistrust of the corporate role that public health doctors, in particular directors of public health, have in health authorities. Directors of public health can do much to dispel this concern by continuing to show their independent mettle — through their annual public health reports and by their advocacy for better health for the local population and a more just distribution of resources. If both general practitioners and public health doctors demonstrate an unswerving commitment to better health care for patients, they will have no difficulty in sharing common goals.

JONATHAN GRAFFY

RCGP research training fellow,
Academic Department of General Practice and Primary Care,
Medical College of St Bartholomew's and
the Royal London Hospitals, London

BOBBIE JACOBSON

Director of Public Health,
East London and the City Health Authority, London

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Address for correspondence

Dr J Graffy, Statham Grove Surgery, Statham Grove, London N16 9DP.