

LETTERS TO THE EDITOR

Public health medicine and primary care

Sir—Professor Bhopal's editorial on the relationship between public health and general practice¹ is important, and was a valuable review of the scene. It is not quite clear, however, that general practice necessarily wishes to be called primary health care and indeed in terms of the original WHO definition² this would include sanitation, clean water, the built environment, and some hospital secondary care departments such as accident and emergency and genito-urinary medicine.

He makes the important point that "ultimately, the professional goals of public health medicine and general practice are the same" and this certainly needs to be restated.

Professor Bhopal raises a difficult issue in writing that a public health doctor may find it "more practical to work with managers and administrators, and general practitioners' representatives rather than joining with general practices in solving their 'coal-face' problems". But these are the actual problems that patients face, and remaining distant from them runs the danger of diminishing the public health doctors' understanding and ability to be effective. In my recent Harben lecture,³ I tried to demonstrate some of the possibilities.

According to Professor Bhopal, "inequalities have been a major concern of public health doctors but not of the general practitioner . . .", and here I must strongly disagree. There is simply no substitute for understanding inequalities experienced by patients through direct face to face contact, both day and night, with those who suffer them. The best way of obtaining real understanding is by repeatedly visiting their homes and listening to them face to face. It is a long tradition of general practitioners to care first hand for the underprivileged. It is simply not true "that health inequalities have been a major concern of public health doctors but not of the general practitioner".

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- 1 Bhopal R. Public health medicine and primary health care: convergent, divergent, or parallel paths? Editorial. *Journal of Epidemiology and Community Health* 1995;49:113-16.
- 2 World Health Organisation and UNICEF. *Alma Ata Declaration*. Geneva, WHO and UNICEF 1978.
- 3 Pereira Gray D. Primary care and the public health. *Health and Hygiene* 1995;16:49-62.

Reply

Professor Denis Pereira-Gray's enthusiasm and interest in the common agenda facing public health and general practice/primary health care¹ is explicit in his recent article which focuses on the actual and potential contribution to the public health.² I agree with his view that general practice and the

British variant of primary health impacts strongly on public health care already and has yet more to give. This is a most welcome message.²

Like Professor Pereira-Gray I would like to see public health doctors working on the "coal face" issues affecting general practitioners. Similarly, general practitioners need to help with the "coal face" problems of public health doctors (an expectation which is seldom aired!). My point was a pragmatic, not theoretical one. If one full time public health doctor focused on general practice/public health issues in a district of 250 000 population (a situation which remains a luxury in many places), this person would relate to 125 general practitioners and their staff and perhaps 30-40 practices. Communications are not effective in these circumstances. Perhaps we need more general practitioners with public health skills and experience.

I endorse Professor Pereira-Gray's view that general practitioners see the consequences of underprivilege (and no doubt privilege). The combination of this profound experience, and of the epidemiological evidence, ought to be potent. The general practitioner is in a position to convey the human misery which underlies the stark inequalities demonstrated by the health statistics.

I have no doubt that my views and those of Professor Pereira-Gray are convergent!

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- 1 Bhopal RS. Public health medicine and primary health care: convergent, divergent and parallel paths. *J Epidemiol Community Health* 1995;49:113-116.
- 2 Pereira-Gray D. Primary care and the public health. *Health and Hygiene* 1995;16:49-62.

Getting to GRIP with a problem

Sir - We read your recent editorial on getting research into practice with interest.¹ We would like to share some of our experiences in a related field.

About three years ago, a chance remark by a new trainee in public health about doctors leaving medicine was related to the postgraduate board of medical and dental education. Other similar anecdotes came to light. The question, "Is there a problem and what effect might it have on medical care?" was asked. The trainee was encouraged to speak to the postgraduate dean and to seek funding for a small project. A research fellow was appointed and the study began. Further funding was obtained to study another group. Results came through suggesting that there was indeed a large problem. A feasibility study looking at the potential for providing a service was undertaken. Presentations were made at numerous conferences and seminars. A network of individuals with similar interests was created. A booklet dealing with the issue was distributed and later published.² Funding for the service was agreed just 18 months after the original remark, although it took another nine months to start it up. A follow up study was arranged, plus a considerably expanded version of the original study. The service began. A course requested by the respondents of the original survey was organised. Dissemination of the results of the first survey,

to anyone with an interest or contribution to make in the area began. The service started to receive referrals from other interested parties. A further piece of work was suggested with a view to expanding the service to accommodate the other parties. Finally, three years after that chance remark, a paper was published.³

This describes the history of a project looking at stress in doctors, the setting up of a counselling service to manage the problem, the production of a book to help individuals manage their stress better, a course to help medical students, a mountain of work, and finally "the gold standard", a peer reviewed paper. It may not be about creating a change in mainstream medical practice, but it is about doctors learning to admit that they may have a problem, and learning to do something about it. The outcomes? A ton of paper, sore feet, and a hoarse voice. The buying of hundreds of books, the training of medical students, the admission by doctors that they have a problem, the learning to seek help, and perhaps (and less easy to measure) better patient care and one less breakdown or suicide in the profession. Should GRIP not be about these things?

- Our lessons?
- Catch the crest of a wave - when a topic is of interest make use of it.
 - Have a champion - a figure head who believes in the work and will shout about it.
 - Have a driver or two - people who will do the work necessary to support the champion.
 - Demonstrate the importance of the topic with solid research.
 - Point out the benefits to the organisation and individual.
 - Talk to anyone - speak at conferences, share work with like minded people, network, and share lessons through the grapevine. Don't be afraid to write to people offering information. Most people welcome it.
 - Worry about getting the papers published later - do the change management first.
 - Think about your audience and publish in the appropriate place - and if it scores 0 on the university funding exercise, so be it.

Perhaps it is time to look at the marketing. After all, look at what Anne Diamond did for the *Back to sleep* campaign - if that isn't Getting Research into Practice, what is?

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- 1 Roland M. Getting research into practice. *J Epidemiol Community Health* 1995; 49: 225-6.
- 2 Grainger C. *Stress survival guide*. London BMJ Publishing 1995.
- 3 Grainger C, Harries E, Temple J, Griffiths R. Job satisfaction and health of house officers in the West Midlands. *Health Trends* 1995, 27 (1): 27-30.

Emotional reactions and colposcopy

Sir - In their recent paper¹ Gath *et al* observed that further investigation by colposcopy after an abnormal cervical smear is generally associated with low levels of anxiety and depression. This finding may be relevant to