pregnancy continuing.²¹ The act makes no such provision, and the words "without the patient's consent" do not appear. Nor are the emergency provisions that are itemised in section 1, sub-section (4) directed to the question of consent: rather, they dispense with the requirement earlier in that section for the opinions of two medical practitioners to be obtained and the requirement that the termination take place in an NHS hospital. There is no reference to consent by the patient, since if there was it would undermine the whole body of case law enshrining the right of the individual to determine what is done to his or her body.

It is true that in certain cases doctors may in an emergency act without consent, but only under the rules of the common law, which require either valid consent or justification under the principle of necessity. Special provisions relate to children and people who are mentally ill. If there is doubt about the justification of dispensing with consent an application to the court is the only safe course for the practitioner unless intervention is needed immediately to save life; even then the practitioner is at risk if consent has been specifically withheld.

MARGARET PUXON
Queen's counsel

19 Clarence Gate Gardens,
London NW1 6AY

1 Dyer C. Gynaecologist acquitted in hysterectomy case. *BMJ* 1996;312:11-2. (6 January.)

Patients' views of priority setting

Details of qualitative studies are needed

EDITOR,—Does the *BMJ* have a method for reviewing the standard of qualitative research projects? If so, why was Andrew Dicker and David Armstrong's paper on patients' views of priority setting accepted for publication? There are uniform requirements for manuscripts submitted to biomedical journals²—yet Dicker and Armstrong fail to report who invited the patients to take part in the study, what selection criteria were used, and who conducted the interviews. If the general practitioner conducted the interviews this may explain why respondents were reluctant to reveal their personal opinions. Respondents will not necessarily behave as "interviewees" rather than "patients" because their general practitioner is wearing a different "hat." The interviews took place in the surgery—hardly conducive to an open and informal atmosphere. We are told that the interviews took 30-40 minutes to complete—hardly enough time to complete a detailed structured questionnaire, let alone rank nine hospital and community services and discuss resource allocation policies.

Semistructured interviews are explorative and allow participants to describe their own experiences and perspectives in their own time. It is not surprising to find that the respondents had difficulty "engaging in the task." Resource allocation, after all, is complicated and controversial. Additionally, qualitative analysis, like statistical analysis, should be detailed, so that a knowledgeable reader can assess the reliability of the results—but we are not told which qualitative method for analysis was used (grounded theory, discourse analysis, etc); what rules were used to transcribe the recordings; whether there were any checks for consistency in the coding of transcripts (interrater or intrarater reliability); and how excerpts were selected for presentation (presumably the excerpts are representative).

The authors conclude that local people are insufficiently qualified to take part in decision making processes on the basis that respondents were reluctant to give opinions based on self interest. This reluctance seems perfectly reasonable

to me. The shortcoming rests with the design of the study and not with the inability of lay people to grasp complex issues. A paper in the same issue of the *BMJ* shows that local people can make decisions on health service priorities.³

Guidelines and standards for qualitative research exist. Only this summer the *BMJ* published a series of seven papers on qualitative methods.⁴ Reference to such literature would enable a more systematic assessment of qualitative papers for publication.

SARAH PERRY
Research associate

Faculty of Medicine, University of Leicester,
Leicester LE1 6TP

- 1 Dicker A, Armstrong D. Patients' views of priority setting in health care: an interview survey in one practice. *BMJ* 1995; 311:1137-9. (28 October.)
- 2 International Committee of Medical Journal Editors. Uniform requirements for manuscripts submitted to biomedical journals. *BMJ* 1991;302:338-41.
- 3 Bowie C, Richardson A, Sykes W. Consulting the public about health service priorities. *BMJ* 1995;311:1155-8. (28 October.)
- 4 Pope C, Mays N. Researching the parts other methods cannot reach: an introduction to qualitative methods in health and health services research. *BMJ* 1995;311:42-5.

Authors' reply

EDITOR,—Sarah Perry takes issue with the *BMJ* for publishing a paper that in her view is inadequate in its description of the qualitative methodology used. In part, this is a matter for the *BMJ*'s referees and reviewing procedures, but the criticism does raise the question of standards in reporting qualitative research. This is a particular problem for qualitative research methods in that they have yet to be codified and formalised to the same extent as quantitative methods. For example, in a survey it is sufficient to say that a "representative" sample was selected without specifying exactly how this was achieved. Equally, it is usually unnecessary to provide the coding frame through which questionnaire responses are transposed into numbers for data analysis.

In reporting a qualitative study it is less clear what can be assumed and so the amount of detail to include remains a matter of judgment rather than convention: too much and the methods section becomes another text for doing qualitative research, too little and the purist can claim inadequacy. Moreover, in the context of a strict word limit, a dense methods section necessarily detracts from the detail that can be given in the results section. This too must be a matter of judgment, and we believe that in offering descriptions of sample selection, invitation and interview procedures, and the method of analysis, together with a coherent results section, we did achieve the necessary balance.

The rest of Perry's criticisms focus on the validity of results arising from interviews conducted by a general practitioner. No doubt a general practitioner interviewer might pose particular problems, but it seems severe to dismiss the research on such grounds: which researcher is wholly disinterested? As for the findings themselves, we did not, as Perry seems to believe, ask our interviewees to rank services: it is known from other studies that people are quite able to do this by ticking the appropriate box. We set out to explore the meaning and weight that might be given this process and concluded that such structured methods are probably not providing the views of health service priorities that researchers often presume. This conclusion might be unacceptable to Perry, but at least it is based on empirical study.

ANDREW DICKER
General practitioner

London SW1V 4PY

DAVID ARMSTRONG
Reader in sociology as applied to medicine

Department of Public Health Medicine,
United Medical and Dental School of Guy's and
St Thomas's Hospitals,
London SE1 9RT

BUPA's discretionary recognition of treatment

Psychosexual medicine is no longer recognised for benefit purposes

EDITOR,—Several years ago I started to work part time in the private sector while holding a sessional consultant post in psychosexual medicine in the then community health service. I applied to BUPA (British United Provident Association), an independent health care company and health insurer, for recognition as a specialist, and after careful scrutiny I was accepted for discretionary recognition on an outpatient basis only. Patients had to be referred from a general practitioner or a consultant and had to have psychosexual problems.

Recently, however, the claim forms for several patients were returned to me and I was told that this condition was not eligible for reimbursement. On further inquiry I was told that not only was my specialty no longer to be recognised but the company had never recognised it for benefit purposes. This was obviously nonsense as the group medical adviser had specifically written granting my acceptance: I have his letter. After I pointed this out I received further notification confirming that I, together with some of my colleagues who worked in psychosexual medicine, had indeed been recognised for benefit purposes but that this recognition had now been withdrawn. The company pointed out that it still accepted me as a consultant, even though it did not recognise my work for reimbursement purposes.

Most of the patients I see have psychosexual problems arising from medical conditions such as diabetes, hypertension, myocardial infarction, multiple sclerosis, and rheumatic disease. Some are physically disabled or have had radical surgery for bowel cancer or trauma. These patients are particularly vulnerable, and the return of their sexual function can be immensely important to their wellbeing and self esteem.

I am sorry that, at a time when we are urged to consider the sexual health of the community, BUPA, which is the largest of the insurance companies, should wish to save money by excluding such a vulnerable population from benefit. Most patients can be dealt with in relatively few consultations, so that the fees concerned are minimal. Is this the future ethics of business at the expense of patients? I and my colleagues who practise in this difficult area of medicine, and the patients, deserve better from BUPA.

RAYMOND E GOODMAN
Consultant in psychosexual medicine

Hope Hospital,
Salford M6 8HD

BUPA's reply

EDITOR,—Raymond E Goodman is correct in stating that he was, and continues to be, recognised by BUPA as a specialist for benefit purposes. It is unfortunate that he has experienced difficulties with reimbursement, and BUPA accepts responsibility for any confusion, which was caused by a change in the company's rules in 1992. Before this the treatment of psychosexual disorders was covered under the terms of membership and accounts were settled. The review of the rules in 1992 removed eligibility, but, unfortunately, our systems were not immediately altered to take account of this change.

Our systems have now been aligned with the current rules as published to our members, which specifically exclude sexual dysfunction, including impotence; thus these claims are now consistently rejected. BUPA regrets the confusion that has occurred.

A J VALLANCE-OWEN
Medical director

BUPA,
London WC2R 3AU