has been a stone in Qantas's shoe ever since. Qantas is soon to be floated on the stock exchange and plainly will wish to avoid any negative publicity that besmirches its reputation as a passenger friendly international airline. The small Taiwanese company EVA Air has responded a full year in advance of

the International Civil Aviation Organisation's recommendation on non-smoking flights. Many would not be surprised to see Qantas bring forward its deadline for fully smoke free flights.

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Collings report on general practice in England in 1950: unrecognised, pioneering piece of British social research?

Roland Petchey

Collings's grim description of postwar general practice in England and his sombre analysis of its prospects created an immediate sensation. In addition to its value as a historical document, the report is also regarded as a turning point in the postwar history of British general practice. The study is also interesting for another reason, which has not been acknowledged: Collings merits recognition as a pioneer of ethnographic research at a time when it was largely unknown elsewhere in British social research.

J S Collings's survey of English general practice was published in the *Lancet* on 25 March 1950.¹ His grim description of postwar general practice and his sombre evaluation of its prospects (box) created an immediate sensation. His report, however, is of more than antiquarian interest. Within British general practice it has acquired semimythical status. It has been acclaimed a "classic report,"² "the most devastating attack on the image of the family doctor,"³ and "an Exocet fired right through the basis of general practice."⁴ More positively, it has been hailed as a turning point,⁵ the single most effective factor in mobilising opinion in favour of constructive change,⁶ and a seminal contribution to the formation of the Royal College of General Practitioners.⁷ I will argue that Collings also deserves to be recognised as a pioneer of ethnographic method in British social research.

Origins and publication of the report

The Collings report is unusual in several regards. Firstly, Collings seems an improbable choice as researcher. An Australian, he had previously worked in New Zealand as a general practitioner and in Canada as a medical officer of health. At the time of the report he was a research fellow at Harvard University School of Public Health. Despite this wide ranging experience, he had never visited Great Britain so was unfamiliar with the health system and conditions there.

Secondly, Collings was funded by the Nuffield Trust, which had hitherto been exclusively concerned with representing provincial voluntary hospitals in the national health policy debate.^{8,9} Collings's research was its first excursion into general practice. Apart from one later survey,¹⁰ the trust's interest in general practice at this time was confined to funding pilot health centre projects.

Thirdly, the report's status was ambiguous. Almost uniquely, Collings's study was not published by the trust. It did approve it—but only after it had been edited by Theodore Fox, editor of the *Lancet*. There are other indications that the trust failed to anticipate the report's impact. Although a later source refers to the sensation it created,¹¹ in contemporary official records it was completely unreported.¹² Indeed, elsewhere, it is described as an unofficial document.¹⁰

Collings's main findings and recommendations

Findings

"The overall state of general practice is bad and still deteriorating"

"The development of other medical services . . . has resulted . . . in wide departure from both the idea and the ideal of family doctoring"

"Some [working conditions] are bad enough to require condemnation in the public interest"

Inner city practice is "at best . . . very unsatisfactory and at worst a positive source of public danger"

Rural practice is "an anachronism" and suburban practice a "casualty-clearing" service

Recommendations

"An attempt should be made to define the function of general practice within . . . the NHS"

"Group practice units . . . should be formed"

Finally, the form of the published article is perplexing. In 1950 the *Lancet* did not consistently observe the modern conventions of scientific publishing.¹³ The format of articles therefore varied considerably. Even so, Collings's report stands out in several respects. That year the *Lancet* published 356 Original and Special Articles. Their median length was two pages (interquartile range 2-4). Only 21 articles (6%) exceeded six pages and, apart from the Collings report, the longest was 12 pages.¹⁴ Collings's article was 30 pages. It deviated stylistically in two further respects: it was the only article reporting original research that was not headed as either an Original or a Special Article and it alone was entirely unreferenced.

Methodological issues

What makes the report distinctive are two features of its method rather than the departures from publishing convention of its printed form. Collings's procedure for obtaining a sample of practices for study was the more controversial feature at the time. His method of data collection was not as controversial, but it is perhaps ultimately the more important.

SAMPLING METHOD

To obtain his sample, Collings initially identified three regions which he was advised "would present the general picture." No other selection criteria are given, other than that he had been warned to exclude London because of "its aggregation of teaching hospitals and many other complicating factors peculiar to a city of this size." In two regions he selected practices on the advice from regional officers of health, medical officers of health, and consultants, relying on their judgment of what were good, fair, and bad practices. Again, no

selection criteria are given. In the third region he relied on a single adviser and selected practices according to location rather than reputation. This, Collings claimed, made the selection process in this region "much more random." He gives no information on the refusal rate among practices identified for study, although he admits that the choice of practice sometimes depended on availability. It is also apparent that the level of cooperation he received varied, although again no details are given. Collings pronounced himself "well satisfied" that his final sample of 55 practices was "fair and representative."

Others, led by the *BMJ*, were more sceptical. It concluded that Collings's sampling was so suspect that any generalisation beyond the practices actually studied was "both unscientific and unjustifiable."¹⁵

DATA COLLECTION

Contemporary debate focused largely on the representativeness of Collings's sample, but the chief point of methodological interest is the method of data collection. The *BMJ* correctly described Collings as a "field anthropologist" who had come to study "the natives and their curious habits."¹⁵ He rejected the use of quantitative data partly because they were not available but mainly because he believed that the problems of general practice were not soluble in terms of statistics. Instead, he relied on qualitative data collected by sitting in on each practice for a period of between one and four or five days.

The purpose of sitting in was not simply observation, but also participation. He claimed that "as a rule" he achieved "nearly complete identification with the doctor's work and behaviour... I was able to join in examinations, to interrogate patients, and to discuss points at issue without embarrassment to any of the parties concerned."

Even on home visits he claimed that he "usually" enjoyed "complete and uninhibited participation in the consultation and examination," although occasionally

he was left downstairs to be entertained by relatives (or even outside in the doctor's car). The importance he attached to participation is reinforced by his discussion of "the few cases" in which he was not a participant and he was reduced to "sitting quietly in a corner trying to efface myself, while the doctor in an embarrassed and artificial way attempted to conduct his consultations." In such instances he "endeavoured to make allowances or write off the evidence obtained." How often these cases occurred and whether they were included in the final sample are not clear.

Although Collings insisted on taking part in the consultation, his data are derived from observation and conversation rather than from participation. None of his findings originate from his subjective experience as participant attempting to grasp the consultation subjectively through the eyes and language of the social actors taking part in it. He remained essentially a detached observer of the situation. This criticism is not meant to disparage Collings's skill as an observer. On the contrary, he shows himself to be extremely perceptive and resourceful. Take, for instance, his conclusion that English general practitioners underutilised what rudimentary equipment was available to them. He based it partly on directly observed non-use during consultations in which he was present. He corroborated it by indirect evidence: "I noticed on some occasions that a perfectly serviceable [examination] couch was piled with boxes and bottles; the adherence of these articles to the leather cover showed that they had occupied this position for some time."

Report's place in ethnographic research

In the context of contemporary English medical research Collings's ethnographic method was unique. No other article published in the *Lancet* between 1946 and 1955 used qualitative methods. In the context of wider social research it was also novel. Although an ethnographic tradition had been established in the United States in the 1920s,¹⁶ it remained undeveloped in Britain (with the exception of mass observation¹⁷) until the 1950s. Collings's fieldwork was contemporary with (if not earlier than) the studies of Stacey,¹⁸ Williams,¹⁹ and Frankenberg,²⁰ who are conventionally credited with pioneering ethnographic techniques in modern British social research.²¹

Collings's study was arguably also the first "work-place ethnography" in Great Britain (although in the United States the Hawthorne studies had inspired several such studies²²). It predated the innovative studies of Lupton and of Cunnison of workshops in Manchester.^{23,24} The studies described were all of manual workers, so Collings's study was the first systematic application of ethnographic techniques to a profession. Given the comparative underdevelopment of ethnography in Britain,²⁵ Collings's innovativeness is remarkable. Unfortunately, his failure to provide references makes it impossible to place him more precisely in the ethnographic tradition.

Reasons for report's impact

Why, given the weaknesses of his method, was Collings so successful in mobilising general practitioners? Largely, no doubt, it was because his analysis of general practice's plight (marginalisation, exclusion from hospitals, declining status) corresponded precisely with general practitioners' experience after the war.²⁶ Possibly also his richly descriptive method enabled his account to reflect the lives of ordinary general practitioners. The correspondence pages of the *Lancet* and *BMJ* show, however, that his audience, though receptive to his message, remained generally sceptical about his method. Although qualitative

Some living conditions, like working conditions, were "bad enough to require condemnation in the public interest"

POPPERFOTO/REUTER

research and family practice may be a marriage made in heaven.²⁷ Collings failed to establish the legitimacy of ethnography as a form of scientific inquiry. Within general practice Collings is remembered not for his contribution to research methods but for the revival of the specialty. At the same time (doubtless because it was published in a medical journal) his study has been neglected by historians of social research. As a result, Collings has failed to attract the consideration he deserves as a pioneer of British ethnography.

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- 1 Collings JS. General practice in England today: a reconnaissance. *Lancet* 1950;ii:555-85.
- 2 Hart JT. *A new kind of doctor*. London: Merlin, 1988.
- 3 Loudon I. The concept of the family doctor. *Bulletin of the History of Medicine* 1984;58:347-62.
- 4 Gray DP. *Forty years on: the story of the first forty years of the Royal College of General Practitioners*. London: Atalink, 1992.
- 5 Hunt JH. The scope and development of general practice in relation to other branches of medicine: a constructive review. *Lancet* 1955;ii:681-6.
- 6 Webster C. *The health services since the war*. Vol 1. *Problems of health care: the National Health Service before 1957*. London: HMSO, 1988.
- 7 Hunt JH. The foundation of a College: the conception, birth, and early days of the College of General Practitioners. *Journal of the Royal College of General Practitioners* 1973;23:5-20.

- 8 Nuffield Provincial Hospitals Trust. *The hospital surveys—the Domesday Book of the hospital services*. Oxford: Oxford University Press, 1945.
- 9 Honigsbaum F. *Health, happiness and security: the creation of the National Health Service*. London: Routledge, 1989.
- 10 Taylor S. *Good general practice*. Oxford: Oxford University Press, 1954.
- 11 McLachlan G. *A history of the Nuffield Provincial Hospitals Trust, 1940-1990*. London: Nuffield Provincial Hospitals Trust, 1992.
- 12 Nuffield Provincial Hospitals Trust. *Second report*. Oxford: Oxford University Press, 1951.
- 13 Bazerman C. *Shaping written knowledge*. Madison: University of Wisconsin Press, 1988.
- 14 Smith HV, Vollum RH. Effects of intrathecal tuberculin and streptomycin in tuberculous meningitis. *Lancet* 1950;iii:275-86.
- 15 Anonymous. The GP at the crossroads [editorial]. *BMJ* 1950;ii:709-13.
- 16 Hannerz U. *Exploring the city: inquiries towards an urban anthropology*. New York: Columbia University Press, 1980.
- 17 Harrison T. The future of sociology. *Pilot Papers* 1947;2:10-25.
- 18 Stacey M. *Tradition and change: a study of Banbury*. Oxford: Oxford University Press, 1960.
- 19 Williams WM. *The sociology of an English village: Gosforth*. London: Routledge and Kegan Paul, 1956.
- 20 Frankenberg R. *Village on the border*. London: Cohen and West, 1957.
- 21 Payne G, Dingwall R, Payne J, Carter M. *Sociology and social research*. London: Routledge and Kegan Paul, 1981.
- 22 Roethlisberger FJ, Dickson WJ. *Management and the worker*. Cambridge, MA: Harvard University Press, 1939.
- 23 Lupton T. *On the shop floor*. London: Pergamon, 1963.
- 24 Gunnison S. *Wages and work allocation*. London: Tavistock, 1966.
- 25 Dingwall R. Research note: thirty years on. *Sociology of Health and Illness* 1979;3:348-51.
- 26 Honigsbaum F. *The division in British medicine*. London: Kogan Page, 1979.
- 27 Murphy EA, Mattson B. Qualitative research and family practice: a marriage made in heaven? *Fam Pract* 1992;9:85-91.

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Qualitative Research

Reaching the parts other methods cannot reach: an introduction to qualitative methods in health and health services research

Catherine Pope, Nick Mays

This is the first of seven articles describing non-quantitative techniques and showing their value in health research

Qualitative research methods have a long history in the social sciences and deserve to be an essential component in health and health services research. Qualitative and quantitative approaches to research tend to be portrayed as antithetical; the aim of this series of papers is to show the value of a range of qualitative techniques and how they can complement quantitative research.

Aims of this series

Medical advances, increasing specialisation, rising patient expectations, and the sheer size and diversity of health service provision mean that today's health professionals work in an increasingly complex arena. The wide range of research questions generated by this complexity has encouraged the search for new ways of conducting research. The rapid expansion of research on and about health and health services, and the relatively recent demarcation of a distinct field of "health services research" depend heavily on doctors and other health professionals being investigators, participants, and peer reviewers. Yet some of the most important questions in health services concern the organisation and culture of those who provide health care, such as why the findings of randomised controlled trials are often difficult to apply in day to day clinical practice. The social science methods appropriate to studying such phenomena are very different from the methods familiar to many health professionals.

Although the more qualitative approaches found in certain of the social sciences may seem alien alongside the experimental, quantitative methods used in clinical and biomedical research, they should be an essential component of health services research—not just

because they enable us to access areas not amenable to quantitative research, such as lay and professional health beliefs, but also because qualitative description is a prerequisite of good quantitative research, particularly in areas that have received little previous investigation. A good example of this is the study of the social consequences of the application of new genetic techniques to screening for genetic disease.¹ New genetic technologies place individuals, couples, and families in novel circumstances facing unprecedented decisions about such things as reproduction, transmission of genetic defects, and the response to information about predisposition to particular diseases. The starting point for social research in this field is therefore an attempt to understand how and why people conceptualise genetic risks and why they behave as they do when faced with them.

The aim of this series is to introduce some of the main qualitative research methods currently used in health care research and to indicate how they can be appropriately and fruitfully employed. The papers review observation, in depth interviews, focus groups, consensus methods, and case studies, all of which doctors and other health professionals are increasingly coming into contact with. We hope that by making clear what these methods entail, how they are used, and how they can be evaluated, they will seem less strange and be viewed as valuable tools in the methodological tool box of health and health services research. The papers on specific qualitative methods are preceded by a paper on validity and reliability in qualitative research. Box 1 provides short definitions of some of the terms used in qualitative research which appear in the papers in the rest of the series.

Although relatively uncommon in health services research, qualitative methods have long been used in

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