Research in general practice: who is calling the tune?

IN 1979 in his book, *Research in general practice*, Howie stated '25 000 general practitioners and their aggregate of unanswered questions and untested impressions remain one of the most significant sources of research potential available to contemporary medicine'.[1] Although this statement was inspirational at the time, it now seems wistful, as the main question on the minds of general practitioners in the National Health Service seems to be how early they can retire from practice.[2] For general practice to be an academic discipline it must have an active area of research,[3] although it is widely recognized that research is a minority activity, for a few interested general practitioners and for those working in university departments of general practice.

Registrars (trainees) in general practice have received repeated exhortations to engage in projects during the year of training;[4] this is, of course, expecting too much of the registrar in the training year with its culture shock, clinical challenges and brevity. There is the additional difficulty in that trainers and course organizers have well developed teaching skills but may have little or no experience or training in research. Small wonder then that trainers do not encourage research enquiry in their registrars. If research projects are to succeed there has to be a climate of enquiry with competent supervision and time to carry out the research.

In an examination of the academic base for general practice, Allen and colleagues point to the lack of a research culture in general practice.[5] This may surprise many general practitioners who will have witnessed a growth in academic research over the last two decades. University departments of general practice now exist in many medical schools in Europe. However, despite the opportunities for research by general practitioners much of the research is done by people outside the discipline.[6,7] Indeed this is the rub. For general practice to grow and develop, research questions must arise from within general practice. However, general practitioners may not have the skills or support facilities to answer these research questions, just as they may not have the skills to answer complex clinical problems, and enquiry-led research is becoming endangered with the growth in the commissioning of research.

It is now the norm for research funding bodies in the United Kingdom and Europe to decide on areas of medicine and health that need further exploration. This is both a powerful and controlling approach as such bodies have a perspective on science and medicine that may be different from the perspective of active researchers or service providers. Often in health services research the questions are asked and answered by people outside general practice but using general practitioners as respondents or data gatherers.[6,7] There is usually no involvement of the general practitioners in the analysis or discussion of the project, although their time is acknowledged. Surely this is a modern form of colonization at intellectual and professional levels. Further, an academic base is not always needed for such research. It is, however, unlikely that answering questions that arise outside the discipline will enhance the academic reputation of general practice or indeed define its academic role.

If government departments are commissioning research they presumably have a say in what can be published. For example, the original Black report on inequalities in health was released as 260 photocopies over an August bank holiday in 1980;[8] those who were 'calling the tune' did not like its contents and thus tried to achieve minimal impact. Perhaps instead of declaring their sources of funding, authors should be obliged to state the origin of the research question they are attempting to answer. That way everyone will know who is calling the tune.

Bidding for funding for research is a complex and time consuming exercise in which researchers form alliances with other groups in other cities or even in other countries. Many general practitioners will be surprised to learn that their colleagues in university departments are caught in a spiral of fund seeking that is encouraged by university funding mechanisms. Considerable amounts of the time and energy of the relatively few academic general practitioners in medical schools are spent in pursuing funds in competition with colleagues from sister institutions. It is unlikely that general practice can develop as an academic discipline while its key players are distracted by the pressure to attract short-term funding for research.

A survey of violence against general practitioners published in 1991 demonstrated the extent of the problem of such violence but the author was unable to obtain funding for the study.[9] Yet the findings are of great interest to general practitioners and have implications for current practice and for the future of the discipline. The *Journal* recently published a study on the somatic presentation of psychiatric morbidity in a general practice which showed that 25% of general practice attenders were somatic presenters.[10] Both the somatic presenter and the general practitioner had frequent difficulty in distinguishing between the psyche and the soma. This finding has important educational and clinical implications for general practice and for the specialists to whom general practitioners refer these patients. The study does not acknowledge any funding and indeed none may have been necessary. It is, however, a useful contribution to the clinical domain of general practice which needs scientific research if good quality care is to be delivered.[11]

If good quality clinical research is produced will general practitioners take notice of it? Marshall Marinker may have been right when he declared that, for the most part, general practice research provided predictable answers to banal questions.[12] In this issue of the *Journal*, Penny Owen is critical of the way in which research is presented and highlights the need for intelligible information on the predictive value of symptoms and signs in clinical practice.[13] There is often a wide gulf in understanding between researchers and clinicians in specialist medicine; this need not exist in general practice. Research in general practice is seen as a good thing for patients and for medicine but it is not usually the subject of debate. It is likely that the lasting and robust research contributions of general practitioners to medicine will be those based on enquiry from within general practice rather than those commissioned by funding bodies.

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Research general practices

IN October 1994 the Royal College of General Practitioners appointed its first two research general practices following national advertisement. Drs Jim Cox of Cumbria and Andrew Farmer of Oxfordshire were successful and their practices became research general practices. Their appointments began immediately.

In February 1995 the Research and Development Directorate of the National Health Service Executive (South and West) was the first among the NHS research directorates to follow this up. Ten research general practices were appointed, also after advertisement, but limited this time to the geographical area contained by the South and West Regional Health Authority. The appointments started in April 1995. The RCGP congratulates Professor Stephen Frankel on being the first regional director to respond to this RCGP initiative.

Thus a new organizational animal has appeared in general practice. What are research general practices? Why are they necessary? And what is their significance?

Research in general practice has a long and honourable history dating back to Smellie in the early 18th century, Jenner in the late 18th century, through Budd[1] in the early 19th century, Mackenzie[2] in the late 19th century, and Pickles[3] and Huygen[4] in the 20th century.

Since the second world war Fry,[5] Tudor Hart[6] and Marsh[7] have been outstanding as general practitioner researchers working from their own practices and publishing much original work in major peer-reviewed journals of international standing. They have shown that the single general practice is still appropriate as a place for research.

One of the first policies of the newly formed College of General Practitioners in 1952 was to start a campaign to get general practitioners into the universities[8] and this has been increasingly successful — there are now departments of general practice in all medical schools in the United Kingdom, and chairs of general practice in all but two. Between the establishment of the first chair of general practice in the world in Edinburgh in 1963 and the end of the 1980s, emphasis has been placed primarily on the emerging university departments as they themselves and the RCGP have campaigned to build up departments of general practice and get them well established. Meanwhile, however, there were always individual practitioners with a research interest who developed their discipline from the base of ordinary NHS practice. Although many of these practitioners linked up with their university colleagues, some (notably John Fry) did not. Whatever the case, there was no facility to provide any infrastructure support for them.

Infrastructure in this context comprises extra staff, extra or more powerful computers, additional telephone use, extra stationery and, above all, partners' time to reflect on and discuss research ideas. Such practices tend to attract many more visitors than usual, for example colleagues from all branches of medicine and NHS managers, and carry all the expenses themselves. Those who sometimes criticize the quantity or quality of clinical research in general practice often forget that the doctors concerned have been paying all the infrastructure costs out of their own pockets.

Such issues have never been comparable in specialist medicine. The university funding councils fund a large number of academics but in addition there has also been much infrastructure support provided through the NHS. Many chairs and academic posts in universities, both full and part time, are funded by regional health authorities or district health authorities, or by hospital and community trusts. The chairman of the conference of medical royal colleges and faculties on science and technology has recently estimated that some medical schools have as many as 40% of their staff funded by the NHS.[9] By contrast family health services authorities/health boards have no equivalent funding to offer general practitioners.

There are also several NHS funds such as the 'service increment for teaching' in England (and equivalent funds in Scotland and Northern Ireland) of which the vast majority go to secondary rather than primary care. Other NHS funds, such as non-service increment for teaching funds, go virtually exclusively to hospitals.

The NHS research system has been hostile to general practice since 1948 and it has always been the RCGP's strategy to work progressively towards a more level playing field.[10] The strategy is twofold: first, to build up in primary care the organizational equivalent of the teaching hospital; secondly, and simultaneously, to open a second NHS funding stream for general practice in addition to the university route through the national funding councils.

The idea of a research general practice first emerged in the peer-reviewed literature in 1991 in a piece summarizing the obstacles to general practice research.[11] This call for research general practices is an idea that the RCGP has been nurturing and developing ever since. The RCGP's research plan is to appoint and develop research general practices, while simultaneously seeking to persuade the NHS to develop and fund them, in the same way as training practices, throughout the UK.

Research general practices are defined as ordinary general practices offering at least one practice partner, preferably two, with a real interest in research and a current research capability. These appointments are not training fellowships and are not