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Research for all in general practice

THE imposition and implementation of the new contract for general practitioners in the National Health Service in the United Kingdom does not appear to make 1990 a propitious time to encourage general practitioners to incorporate research into their normal range of activities. The new contract has created new bureaucratic procedures which add to the already busy schedule of most general practitioners. The priority for many practices is simply coping and they have no time to devote to research. However, it has been possible for these changes to be implemented by the government because of the paucity of research evidence about the effectiveness and acceptability of much of our clinical work. Policy has been determined by dogma rather than by evidence. This is therefore an appropriate time to consider how research in general practice can be strengthened.

The Royal College of General Practitioners is developing a new strategy for fostering research in general practice. Previous research initiatives by the RCGP, notably the research units, have been useful but have not matched the College's achievements in education. Vocational training for general practice has been a conspicuous success and the RCGP can claim credit for providing many of the ideas and academic bases for the rapid creation of vocational training schemes throughout the UK. In contrast, research in general practice cannot yet claim to have taken firm root. However, there are signs of vitality and enthusiasm. The *Journal* now receives more than four times the number of research papers that it can publish, and of the published papers nearly half of their authors work in a university and one third in 'ordinary' general practice. On the face of it, this is a healthy state of affairs, but it has to be recognized that research remains a minority interest in general practice. The Mackenzie report¹ reveals how small and vulnerable the academic base is for what is the largest of the medical disciplines. Another report,² commissioned by the Chief Scientist of the Scottish Home and Health Department, confirms that research is not yet an integral part of the culture of general practice. Why is this?

Possible answers to this question lie in the origins and nature of general practice. As primary care physicians we can trace our ancestry back into antiquity, but the name 'general practitioner' is of remarkably recent origin.³ It was first used in the UK in the early 19th century and then rapidly came into common usage as a convenient term to describe doctors who undertook the same type of work as the surgeon/apothecaries and male midwives of the previous century. It distinguished these doctors from the physicians and surgeons who were members of their respective royal colleges. The type of work undertaken by physicians, surgeons and general practitioners in the early 19th century was very similar, but the status of these doctors was very different. Loudon has described the medical and political battles which thwarted the foundation of a college of general practitioners in the early 19th century.³ Academically, general practice was given and largely accepted a second class status. This early rejection by the academic establishment, who monopolized the teaching hospitals, fashioned the discipline for over a century. With notable exceptions, such as James Mackenzie, general practice attracted energetic pragmatists. Even in the 1950s influential medical leaders such as Lord Moran perceived general

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practice as being suitable for the less able medical graduates who were unable to climb the ladder of a hospital specialty.

The nature of general practice also presents difficulties for research. In all countries general practice tends to be an activity characterized by rapid decision making about problems which are ill-defined. Defining general practice itself has proved problematic. The Leeuwenhorst definition⁴ has gained most widespread acceptance but describes what general practitioners do, not what general practice is. We owe to Aristotle the academic tradition of seeking to define that which we wish to study. This can be unhelpful for a discipline such as general practice which has no boundaries and which has wide variation as a major characteristic. Traditional reductionist scientific methods have only limited application in general practice, and the almost exclusive emphasis on this type of research in medical education may be another reason for alienating general practitioners from taking an academic approach to their work. In their short existence, university departments of general practice have made a major contribution to research and teaching in spite of their meagre resources. Their position is weakened by their exclusion from postgraduate education. This exaggerates the differences between academic and service practices and undermines the unity of general practice.

Is a strong research culture in general practice necessary? Research is subversive in that it attacks conventional wisdom, but it is also liberating and creative. During the 1960s general practice in the UK survived more intact than in many other countries because of its protected if limited position within the National Health Service. Although general practice was initially protected by political action, recent events have shown how easy it would be for further political action to destroy it. We largely retain the goodwill of our patients but in a society which is increasingly well informed and critical of monopolies, we need to prove our value. Making research an integral part of general practice is the only way in which this can be done.

How can this be achieved? The task is not easy. A major cultural shift needs to take place and long term strategies are therefore required. Introducing appreciation and experience of research into vocational training for general practice is one feasible approach. The membership examination for the College now includes a critical reading paper in which candidates are required to assess a research paper. This is a useful start. Many will feel that the trainee year is already crowded and in the 1990 William

Pickles lecture Styles drew attention to the dangers of 'curriculumology' in which medical education becomes overburdened with content. However, the critical questioning required in research is a necessary counterbalance to the present emphasis on acquiring more knowledge. The Syntex awards⁵ have been a useful stimulus for trainees wishing to do a research project but have involved only a minority of trainees. If all trainees are to participate in research, trainers and course organizers will need to be enthusiastic about this aspect of training. We should not seek to replicate the research treadmill experienced by middle grade hospital doctors. A literature review may provide more original insights than data collection. In a discipline such as ours in which uncertainty is the norm, the humanities as well as the sciences provide useful methods of analysis.

Introducing research appreciation into vocational training is just one element. If research is to take root in general practice, then academic departments of general practice need to be strengthened, the division between undergraduate and postgraduate education overcome and protected time created for research by principals in general practice. However, just as the best form of continuing education for an experienced general practitioner is to have a trainee, an expansion in research activity by trainees will affect the whole of general practice.

E G BUCKLEY

Editor of the Journal

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Compliance with medical advice

It has been estimated that about 40% of patients do not comply with doctors' advice on treatment.^{1,2} At a national level the costs of non-compliance in health and economic terms are considerable. This situation has inspired investigation into the circumstances under which patients are most likely to cooperate with medical advice and several reviews of this research have been published.¹⁻⁴ The bulk of this work has been conducted over the past 20 years⁵ but concern with the problem of non-compliance has a lengthy history. In 200 BC Hippocrates advised physicians to consider non-compliance as a possible explanation for a patient's failure to recover when a typically effective treatment had been used.⁶ The implications of the research findings for clinical practice are presented here as a series of guidelines for improving patient compliance.

Develop an appointment system which ensures minimum patient waiting time. Patients who are seen promptly have been found to comply better with treatment regimens than those who are

kept waiting for long periods. If patients cannot be seen promptly, they should be given reasons for the delay and told how long it is likely to be before they are seen. Geersten and colleagues⁷ found that 67% of patients who had waited 30 minutes or less to see the doctor at an arthritis clinic were compliant compared with only 48% of those who waited 31-59 minutes and 31% of those who had to wait an hour or more.

Adopt a friendly and informal conversational style which encourages patients to provide information. Patients are more likely to give a spontaneous account of their complaints and their beliefs about these if the doctor seems friendly. Korsch⁸ and colleagues in a study of 800 consultations at a paediatric clinic noted that patient satisfaction was associated with five aspects of doctors' behaviour, chief among which was the doctor being friendly rather than businesslike. The other four factors were: the doctor being seen as understanding of the patient's concern; the patient's expectations about treatment being met;