Their lordships on medical research

Too backward looking

See p 1555

Historically research policy swings between two poles. One pole is research driven by researchers pursuing what makes them curious and the opposite pole is research directed by politicians and managers to solve the problems that most concern them. The 1988 House of Lords report on medical research (produced with advice from Walter Holland, a professor with a particular interest in health services research) identified the fact that most medical research in Britain bore little relation to the needs of the NHS.[1] From that House of Lords report grew the NHS research and development programme. But this week their lordships (advised this time by Keith Peters, regius professor of physics in Cambridge and a biomedical researcher to his fingertips) have produced a report in which they are worried that things have gone to far (p 1555).[2,3] Now they are concerned that hospital based clinical research is losing out to health services research and research in primary care and nursing. Their fears may be exaggerated.

Most *BMJ* readers are probably bewildered by the proliferation of reports on research, so I will summarise the story so far. The first House of Lords report was born into the ferment of the debate that preceded the NHS changes, and the government responded in December 1989 by saying that it would appoint a chief of research and development for the NHS and the Department of Health. Professor Mike Peckham started in that post in January 1991. In April 1991, the month the NHS changes were implemented, he announced a strategy for research and development. It aimed to produce a knowledge based service with a culture of evaluation, and it was "problem led" rather than "investigator led." The strategy included plans for being clear about what was already known, disseminating the results of research, and getting research into practice. It focused on interdisciplinary research.

The House of Lords found that its many witnesses approved of the NHS research and development programme, but while the programme was bedding down and the NHS changes beginning to bite worries were expressed about the effects on clinical research. Research was being harmed, doctors and others feared, by purchasers trying to reduce costs, the growth in general practice fundholding, the shift from secondary to primary care, proposals to reduce junior doctors' hours, and the Calman proposals on shorter speciality training for doctors.

The government's response was to set up yet another committee—chaired by health economist Tony Culyer. Its main proposal, published in September 1994, was to impose a levy on all health care purchasers to produce a "single, explicit funding stream" that would meet the costs of NHS research, the excess costs of non-commercial research conducted in the NHS, and the costs of maintaining research facilities.[4] The government broadly accepted these proposals, and the accountants are now busy unscrambling NHS research funding to allow it to happen. The new system should be fully implemented by 1997-8. The House of Lords report thus follows hard on the heels of the Culyer report, and much of this new new report is devoted to evaluating Culyer's report—all a little incestuous.

The most important contribution of the new report is to highlight the problem of careers in academic medicine. Recruits to some parts of academic medicine—particularly surgery, anaesthesia, paediatrics, geriatrics, obstetrics, orthopaedics, and pathology—are few and sometimes of poor quality. Senior posts are often unfilled. The two main causes, their lordships believe, is the disparity of reward between academic and non-academic medicine and the uncertainty engendered by the NHS changes, particularly the rationalisation of big city hospitals. But the career problems of academic medicine are longstanding, and neither disparity of reward nor uncertainty are new.[5] Their lordships conclude that "the disincentives to a clinical academic career are now so great as to warrant an immediate enquiry in their own right." This is a good proposal, but a deeper diagnosis is needed. I believe the problem has something to do with a medical culture that enthuses about research in the abstract but lays obstacles in the way of would be researchers.

Too much of the rest of this report sounds like the hankering after a world gone by when every professor of medicine was safe in his castle, most research was conducted in big hospitals, patients travelled dozens of miles to be entered into large trials, and general practitioners and nurses knew their place—which was helping hospital based academics conduct their research. Thus their lordships want all major university hospitals and clinical teaching centres to be guaranteed core funding for research. They argue against using the same kind of selectivity as the Higher Education Funding Councils on the grounds that "medical schools are few in number; . . . the calibre of their students and staff is high; and all undergraduate medical students proceed after graduation to a period of postgraduate training including some involvement in or at least exposure to research." But health research is not done only in medical schools and hospitals by doctors, the calibre of many non-medical students is high, and one of the problems of medical training is the pressure on so many young doctors to do research whether they want to or not. It is time for this amateur tradition to end. Research should be conducted by people well trained in research methods with important questions to answer. More selectivity might in fact result in better centres that could offer more stimulation, training, and better career prospects.

Nor can it make sense to refer patients to big centres simply for reasons of organising research. Patients will be in hospital less and less, and medical educators have already recognised that teaching needs to take place in the community. So does research. The biggest problems with conducting research in the new NHS (and it's worse in the United States) is the pressure on purchasers to cut costs, making them unwilling to accept the overheads incurred through research. One response to this is to create a culture in which purchasers understand the value of research, but another answer is the levy suggested by Professor Culyer. Nevertheless, that money needs to be used selectively: otherwise, it will be frittered away on the poor quality research that has been only too common in the past two decades.[6]

RICHARD SMITH
Editor

BMJ
London WC1H 9JR

1 House of Lords Select Committee on Science and Technology. *Priorities in medical research.* London: HMSO, 1988.
2 House of Lords Select Committee on Science and Technology. *Medical research and the NHS reforms.* London: HMSO, 1995.
3 Warden J. Peers define best and worst of NHS research. *BMJ* 1995;**310**:1555.
4 Research and Development Task Force. *Supporting research and development in the NHS.* London: HMSO, 1994.
5 Smith R. Medical researchers: training and straining. *BMJ* 1988;**296**:920-4.
6 Altman D. The scandal of poor medical research. *BMJ* 1994;**308**:283-4.