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It's official: evaluative research must become part of routine care in the NHS

The recently published *NHS Plan* sets out some core principles upon which the National Health Service is to be based[1]. One states that the NHS 'will work continuously to improve quality services and to minimise error', and that 'healthcare organisations and professions will establish ways to identify procedures that should be modified or abandoned and new practices that will lead to improved patient care'. Another states that the NHS will 'provide open access to information about services, treatment and performance', and that it will 'continue to use information to improve the quality of services for all and to generate new knowledge about future medical benefits'. These are important and welcome statements of principle, both for those who agree with Archie Cochrane[2] that the results of rigorous evaluative research should inform policies and decisions in the NHS, and for those who have argued that secrecy about the effects of licensed drugs is incompatible with a professed commitment to promoting the health of the public[3].

The *NHS Plan* does not go into detail about how these principles will be translated into practice. The only direct reference to research (para 14.7) is to a new NHS Cancer Research Network, the initial aim of which is 'to double the total proportion of adult cancer patients entering trials within three years'[4]. This, too, is an encouraging sign. More than two decades ago, Helen Tate and her colleagues documented the very small proportion of cancer patients in the UK who were being treated within the context of controlled trials[5]. The *NHS Plan* makes clear that the Government rejects the widespread notion that such patients are guinea-pigs, being sacrificed for the benefit of future patients, and shows that it accepts the evidence that increasing the proportion of patients participating in controlled trials is a way of improving their current and future care, as well as helping to provide the information needed to improve the care of others.

Evaluative research should become an increasingly accepted element of routine care offered to all patients, irrespective of what has caused them to seek help from the NHS. Indeed, this will be necessary to facilitate the work of the National Institute for Clinical Excellence, which has stated that 'in some instances the Institute may indicate that technologies should only be used in the context of appropriately designed clinical trials'[6]. With Government support, the NHS Research and Development Programme should be able to organize a superb infrastructure within the NHS for addressing research questions that are really important to patients and to the service. In particular, it should be able to harness the talents that exist within the NHS outside the well-known research centres, in areas and institutions that Julian Tudor Hart has dubbed 'peripheries of excellence'[7].

What is needed to make progress towards this vision? First, we should make a more concerted effort to help the public understand how biases and the play of chance can lead to dangerously incorrect conclusions about the effects of healthcare interventions. So far, none of the organizations that currently profess an interest in educating the public about 'science' has made a sustained effort to confront public ignorance about the kind of studies that are necessary to distinguish useful from useless or harmful forms of care.

Second, health professionals and managers working in the service must be persuaded that research to address important unanswered questions is to be regarded as a part of routine care in the NHS, and a professional duty. As the surgeon Sir Miles Irving commented recently[8], 'the first thing to do is to stop ourselves thinking that service provision prevents us from conducting research'. He went on to point out to managers that 'if the NHS . . . is investing in an evaluation, then it is quite wrong for other [clinicians] to weaken that evaluation by using the new technology without incorporating it into evaluation studies'. Widespread acceptance of these principles should also help to ensure that the results of research are reflected in subsequent practice.

Third, we need to confront the continued promotion of a double standard on informed consent to treatment within and outside controlled trials—summarized by Richard Smithell's memorable comment, 'I need permission to give a drug to half of my patients, but not to give it to them all'[9]. In the light of the evidence that participants in controlled trials fare better, on average, than apparently comparable patients treated outside controlled trials[10], the emphasis in most current discussions about informed consent to treatment is the reverse of what it should be[11].

Fourth, we need to have more efficient systems for assessing what can already be known from existing research. High-quality syntheses of relevant existing evidence must be prepared, kept up to date, and disseminated effectively to those working in and using the NHS, and to those contemplating additional research. Although progress has been made, in large part thanks to the NHS Research and Development Programme, no-one (anywhere in the world) has yet managed to create a system providing valid and up-to-date evidence of this kind[12].

Fifth, steps must be taken to counter the current distortions of clinical and health services research. The agendas are at present driven too much by commercial and academic forces rather than the needs of those using the NHS. It is important to know, for example, whether magnesium sulphate can help women with severe pre-eclampsia, whether indomethacin can delay the progress of Alzheimer's disease, whether expensive hip-joint prostheses are better than less expensive versions, whether referrals from general practitioners to counsellors are cost-effective, and whether hospital inpatients with windows looking out on trees or who have ready access to a telephone are less anxious, recover faster and are more satisfied with their experience of the NHS than those without. Multicentre collaborative studies will often be needed to address questions such as these, which are of negligible interest to commercial sponsors and to many academics.

A reorientation of the research agenda on these lines is most likely to come about from greater public involvement in and scrutiny of research being done within the NHS, whether this be by helping to frame the research questions to be addressed, or by signalling the outcomes that patients rate as important[13]. Lay involvement has been an accepted principle within the NHS Research and Development Programme for several years now[14], although translating the principle into effective practice remains a substantial challenge. Perhaps a patient-led Good Controlled Trials Guide would be a move in the right direction[15].

In summary, the *NHS Plan* offers a real opportunity to promote the integration of applied research and clinical practice. To conclude with a rallying call from Miles Irving: we have got to learn to use the NHS as a test-bed, 'and with 60 million people in this country all using the NHS, the opportunities to answer questions quickly if everybody collaborates is unique'[8]. Those who use the NHS deserve nothing less.

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