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Grooming for general practice

Sir,

Dr Styles defined many of my own misgivings about general practice training in his excellent William Pickles lecture 1990 (July *Journal,* p.270) and I agree with his proposed modifications to medical education.

I would, however, like to suggest a small alteration in terminology which I find helps me overcome a large psychological barrier to the overall aims of training for general practice and that is to the word 'training' itself. This finite term, meaning 'teaching a specified skill' implies that, once learnt, there is nothing more to learn. I prefer the word 'grooming', defined in the *Oxford dictionary* as 'preparing or training (a person) for a particular purpose or activity (was groomed for the top job)', as it enables me to broaden my attitude to teaching the trainee.

Nevertheless, I realize that we cannot rename trainers grooms, in case the trainees feel that they are being treated like horses.

RICHARD J GALLOW

Parkwood Drive Surgery
Hemel Hempstead
Herts HP1 2LD

Research for all in general practice

Sir,

Your editorial (September *Journal,* p.357) does not do justice to its title. If 'Research for all' is to mean what it says, research must become a routine activity for every practice. How can we plan our work to achieve future objectives if we do not know where we are starting from? Despite all its serious errors, the new contract does at least oblige us to set targets and measure their attainment, and this involves systematic, standardized recording of clinical events, related to an enumerated base population. The contract can and must be revised to bring it in line with the experience of those of us who have been doing work of this kind for 20 years or more, none of whom appear to have been consulted; but the positive features of the contract will remain, and will surely be extended to wider and more clinically interesting fields.

Spurred by the requirements of the contract, over half of all practices are already using computers to record clinical data, and within the next two years the remainder will probably join them. Competing computer systems will fall in number, and converge in format. Exasperation with futile processes undertaken merely because they are paid for will spur us to produce the evidence we need for a contract which measures outcomes, regardless of how they are attained. Many intermediate outcome measures are already available: blood pressure in hypertensive patients, glycosylated haemoglobin levels in diabetics, body mass index in the obese, number of fits in epileptics, hospital admissions in asthmatic children, and so on. The minister of health should be interested in ends and not in means. He should want to know the proportion of a population whose blood pressure, body mass index, peak expiratory flow rates and tobacco and alcohol intake had been recorded, not whether clinics are held which claim to be able to change these indices.

Training in sophisticated research methods, and a career structure for academic general practice, are real and important problems, worsened by the philistine times in which we live. They must be addressed and the Royal College of General Practitioners should help university departments to solve them, but that is not the most important task. Research is a systematic search for relevant truth, and testing of truth by active search for error; no more, no less. Without research of some kind, no practice can get itself beyond passive response to patient demand. Research in these simple terms is not an intellectual luxury, an option for enthusiasts, but a necessity for everyone in socially responsible practice.

All general practitioners are now undertaking research in their own practices; sharpening up the definition and age structure of their populations at risk, looking at population related rates for some clinical activities, and publishing what they find in an annual report. We ought to be helping them, not just in practical ways, but by assisting the birth of a new kind of clinical and social imagination, which no longer regards research as a minority option. Our great opportunity is not the recruitment of a few more professionals, but the accession of 30 000 absolute beginners.

JULIAN TUDOR HART

The Queens
Glyncorrwg
West Glamorgan SA13 3BL

Sir,

Your editorial clearly described the difficulties experienced in performing research work in general practice, particularly now that the bureaucracy of practice is diverting attention from clinical work.

Mention was made of the Syntex awards and the research units, and of James Mackenzie, but of no others. You ask why research is not yet an integral part of the culture of general practice, and I think the answer must be that the mind of a researcher is rare anywhere. You should also realize that it takes many years for a general practitioner to obtain 'respectability'. For example, I was one of the first to observe tremor reduction by beta blockade,[1] but my publication caused little stir initially because I was only a general practitioner.

Whereas James Mackenzie's research and that of William Pickles were limited to specifics, John Fry's studies have covered a remarkable range of common diseases, and have affected patient management more widely than any other research I can think of. Having met Pickles, and seen Fry's method, I must conclude that research depends upon an unusual combination of mental properties: tenacious curiosity, the ability to identify events requiring examination, wide and critical reading of the work of others, and the construction of a methodology for recording and analysing data. Some of these properties can be taught, but the devotion of time and effort outside the already demanding hours of consultation and administration require unusual energy, restriction of other interests, monastic seclusion, a legalistic balance of judgement concerning the results and literary skills in producing a paper.

It seems to me that one of the main areas for which general practitioners are perhaps uniquely suited is the longitudinal study of the ageing process. My own work[2] has shown that changes in the internal environment, which lead to the diseases of ageing, and which lie on a scale between apparent normality at one end and gross disturbance at the other are fundamental to our understanding of atherosclerosis, age-related obesity, essential hypertension, type II diabetes, cancer, and so on. We no longer live in a time when one has to decide whether one has a disease or not: instead, diseases are to be expected in later life when what matters is not so much their presence but the rate at which they progress.

M K THOMPSON

28 Steep Hill
Stanhope Road, Croyden CR0 5NS