Why not give all trainees a taste of research?

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"THE drive to do research must come from within, there must first be a question to answer", is a frequently voiced reason for not ensuring that trainees have practical research experience. The statement is true, but it is not a valid excuse for ignorance of research methods. Unanswered questions are legion in daily general practice, but how many of us have the knowledge and training to find the answers? How many even know where to seek advice on research methods?

At the 1980 RCGP Annual General Meeting Symposium 'Grass Roots Research', Dr Peter Stott (1980) presented his award-winning study. He concluded with a brief account of the difficulties he had encountered due to his (and his trainer's) ignorance of research, and added a plea for more research training for trainees.

The individual trainee project is very difficult to complete within a year, particularly as it may be several months before a question appeals to the trainee, and, as with general practitioners, it will be a minority of trainees who wish to do individual research. Making such projects compulsory would produce the same tendency—"publish to progress"—that we see and abhor in traditional academic medicine, not the organized curiosity we wish to stimulate. As an alternative, I propose the day release course as an appropriate base for a continuing research project, lasting many years, into which trainees could slot for a year to gain experience of research methods. An initial pilot study in an enthusiastic centre may be needed, but organization could be on a regional basis, serviced with statistical and technical help from local universities or departments of community medicine. Existing techniques, such as the selective recording system and methods of practice activity analysis of the Birmingham Research Unit, could be employed. Each trainee would see the project run for a year at first hand and if a progress report were produced annually, each group would gain experience of producing a paper. Ex-trainees would be able to follow the progress of the project and may be stimulated to start further studies. If publication in existing medical journals were difficult, the trainees could start their own journal of trainee research. Project protocols would need to allow for inconsistencies in data collection as trainees change, and the design should proceed in steps so that each group could experience research design and not be involved just in boring data collection.

Trainees working throughout the country (with more time and objectivity than their practice principals) are a vast untapped research source, whose activity in a project such as I have described could have the following additional benefits: training practices would be required to have basic research tools to supply data for the project; trainees would teach the trainers how to use these tools, and perhaps stimulate the trainer and his partners to undertake research of their own; both would learn to look critically at what they do and see if they can do it better (audit); a co-ordinated national grid of day release courses would supply a continuous national morbidity survey; and the project would make full use of a micro-computer and analyse morbidity data for all training practices. Such analyses would improve practice efficiency and be helpful to practices which may not wish to have a computer on site. Trainees would gain first-hand experience of computer applications in primary care. Programs for use on cheap and reliable micro-computers are already available (Meldrum, 1981).

Curiosity is an essential ingredient of research. However, young general practitioners are not fully equipped for their future role if they are unfamiliar with the techniques needed to satisfy that curiosity.

References

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