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Research general practices

IN October 1994 the Royal College of General Practitioners appointed its first two research general practices following national advertisement. Drs Jim Cox of Cumbria and Andrew Farmer of Oxfordshire were successful and their practices became research general practices. Their appointments began immediately.

In February 1995 the Research and Development Directorate of the National Health Service Executive (South and West) was the first among the NHS research directorates to follow this up. Ten research general practices were appointed, also after advertisement, but limited this time to the geographical area contained by the South and West Regional Health Authority. The appointments started in April 1995. The RCGP congratulates Professor Stephen Frankel on being the first regional director to respond to this RCGP initiative.

Thus a new organizational animal has appeared in general practice. What are research general practices? Why are they necessary? And what is their significance?

Research in general practice has a long and honourable history dating back to Smellie in the early 18th century, Jenner in the late 18th century, through Budd¹ in the early 19th century, Mackenzie² in the late 19th century, and Pickles³ and Huygen⁴ in the 20th century.

Since the second world war Fry,⁵ Tudor Hart⁶ and Marsh⁷ have been outstanding as general practitioner researchers working from their own practices and publishing much original work in major peer-reviewed journals of international standing. They have shown that the single general practice is still appropriate as a place for research.

One of the first policies of the newly formed College of General Practitioners in 1952 was to start a campaign to get general practitioners into the universities⁸ and this has been increasingly successful — there are now departments of general practice in all medical schools in the United Kingdom, and chairs of general practice in all but two. Between the establishment of the first chair of general practice in the world in Edinburgh in 1963 and the end of the 1980s, emphasis has been placed primarily on the emerging university departments as they themselves and the RCGP have campaigned to build up departments of general practice and get them well established. Meanwhile, however, there were always individual practitioners with a research interest who developed their discipline from the base of ordinary NHS practice. Although many of these practitioners linked up with their university colleagues, some (notably John Fry) did not. Whatever the case, there was no facility to provide any infrastructure support for them.

Infrastructure in this context comprises extra staff, extra or

more powerful computers, additional telephone use, extra stationery and, above all, partners' time to reflect on and discuss research ideas. Such practices tend to attract many more visitors than usual, for example colleagues from all branches of medicine and NHS managers, and carry all the expenses themselves. Those who sometimes criticize the quantity or quality of clinical research in general practice often forget that the doctors concerned have been paying all the infrastructure costs out of their own pockets.

Such issues have never been comparable in specialist medicine. The university funding councils fund a large number of academics but in addition there has also been much infrastructure support provided through the NHS. Many chairs and academic posts in universities, both full and part time, are funded by regional health authorities or district health authorities, or by hospital and community trusts. The chairman of the conference of medical royal colleges and faculties on science and technology has recently estimated that some medical schools have as many as 40% of their staff funded by the NHS.⁹ By contrast family health services authorities/health boards have no equivalent funding to offer general practitioners.

There are also several NHS funds such as the 'service increment for teaching' in England (and equivalent funds in Scotland and Northern Ireland) of which the vast majority go to secondary rather than primary care. Other NHS funds, such as non-service increment for teaching funds, go virtually exclusively to hospitals.

The NHS research system has been hostile to general practice since 1948 and it has always been the RCGP's strategy to work progressively towards a more level playing field.¹⁰ The strategy is twofold: first, to build up in primary care the organizational equivalent of the teaching hospital; secondly, and simultaneously, to open a second NHS funding stream for general practice in addition to the university route through the national funding councils.

The idea of a research general practice first emerged in the peer-reviewed literature in 1991 in a piece summarizing the obstacles to general practice research.¹¹ This call for research general practices is an idea that the RCGP has been nurturing and developing ever since. The RCGP's research plan is to appoint and develop research general practices, while simultaneously seeking to persuade the NHS to develop and fund them, in the same way as training practices, throughout the UK.

Research general practices are defined as ordinary general practices offering at least one practice partner, preferably two, with a real interest in research and a current research capability. These appointments are not training fellowships and are not

designed to build up research skills. They are designed to reimburse the infrastructure costs to those who have already acquired research skills and are now actively undertaking research and are having their work published in the major peer-reviewed literature. Thus the criteria hinge critically on successful publication and a demonstrated competence in the research world with its special demands.

Of course, research practices must also have certain characteristics, such as good practice management, a sophisticated computer system and a wide range of applications of age-sex registers and diagnostic registers, so that they are easily able to examine the important day-to-day clinical issues facing doctors in 'the front line of a National Health Service'.¹² The criteria stipulated by both the RCGP and the South and West Regional Health Authority are very similar.

Among the 12 general practitioners currently appointed are several with higher university degrees, including one who was awarded the Raymond Horton Smith prize for the best MD thesis of his year at the University of Cambridge. In the South and West Regional Health Authority a small minority hold double memberships of the Royal College of Physicians and the RCGP. They have between them achieved a substantial range of publications, particularly in this *Journal* (previously the *Journal of the Royal College of General Practitioners*) and the *British Medical Journal*. Their interests range widely, from coronary heart disease and hypercholesterolaemia (in physical medicine) through maternity services, to psychosocial medicine (including social deprivation). These doctors are spread over a wide geographical area and include those practising in inner cities and those in remote rural areas. Many will choose to link with university departments of general practice; several have already done so and are being warmly welcomed. However, those who wish to undertake research alone will be free to do so.

The most appropriate level of payment is not yet known, as the true costs of infrastructure support for this kind of work have never been published. In the meantime, the south and west region is paying £12 500 a year to each of these practices for three years, subject to annual review. This will also be the rate for the RCGP research practices being advertised in 1995.

The 12 general practitioners already working in the research practices are being given this new resource to provide support and infrastructure, particularly in the pre-protocol phase of research application. It is now up to them to seek their own research funding from wherever they choose. In doing so they will of course be entitled to describe themselves as either RCGP research general practices or NHS research general practices of the South and West Regional Health Authority.

This exciting new development will give support and encouragement to a wide range of health care professionals, because all these doctors work with colleagues in primary health care teams.

The impact will therefore be magnified, in a form of academic gearing, particularly if the RCGP and south and west region continue their programme of appointments as is hoped over the next three years.

Already there are discussions about ways of grouping the research practices together into what may in effect become a new form of research network, which should enable them to share ideas, support each other and develop even further.

The real issue is whether or not other regional research directors in England will follow this interesting example and whether or not it will be followed by others in Scotland, Wales and Northern Ireland, where interest has already been expressed. It will be the RCGP's policy to encourage them vigorously to do so.

Research general practices are a new idea and mark a new policy shift of the NHS as it moves towards a 'primary care-led' NHS.¹³ Research general practices convert a great historical tradition into a new organizational entity, appropriate for the 21st century.

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Investigation in general practice of patients with suspected heart failure: how should the essential echocardiographic service be delivered?

HEART failure is a life threatening disorder that affects between 0.4% and 2% of the general population and up to 10% of elderly subjects in Europe and North America.¹⁻³ Annual mortality exceeds 60% in severe cases,⁴ and the five-year mortality approaches 50% in milder cases.⁵ These rates are as high as

for many forms of cancer. The morbidity caused by heart failure is reflected in the workloads of both the hospital service and general practice: there are 120 000 hospital admissions per year (5% of all admissions to adult medical and geriatric wards),⁶⁻⁹ and it is estimated that for each hospital admission 14 consulta-