

Addressing the credibility gap in general practice research: better theory; more feeling; less strategy

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SUMMARY

A substantial international network of general practice researchers has grown up over the past 30 years, and the literature of the discipline is now extensive and diverse. Nevertheless, there is considerable ambivalence within the profession about what research can offer, where its weight should be being put and how best the opportunities its insights create can be taken advantage of. The sometimes disappointingly low credibility of research and researchers needs to be addressed. The issues of the adequacy of underlying 'theory' and of ownership of research agendas may contain the basis of a way forward.

Keywords: research; theory; contextual issues.

The problem of identity

IT happens to be 30 years since I became a general practice principal and a researcher in the discipline, and inevitably, that legitimizes reflection and reminiscence. In 1966, John Fry's *Profiles of Disease*¹ and Keith Hodgkin's *Towards Earlier Diagnosis*² were the best known works in a relatively small literature of general practice, although the then *Journal of the College of General Practitioners* was quickly evolving from its earliest days as the *Research Newsletter*. One national morbidity study³ and a good review of workload data⁴ had anticipated other key outline morbidity and workload research, and Clifford Kay was about to start recruiting general practices for the Oral Contraception Study.⁵ Eimerl & Laidlaw had written their *Handbook for Research in General Practice*,⁶ but the writings of Balint,⁷ Browne and Freeling⁸ on the consultation and the *Future General Practitioner*⁹ were either not yet widely known or still in the future. In many ways, it was easier then than now to ask important and answerable research questions.

In 1996, there is now a substantial international network of general practice researchers whose individual and combined endeavours enhance clinical, operational and behavioural science research. The literature of the discipline is extensive and diverse, and despite the complexity of researching in the field, much of it is of admirable quality.

Yet paradoxes persist. During 1996, the UK academic constituency of some 27 university departments of general practice will offer over 1000 examples of research-centred written output to the Higher Education Funding Council's periodic review of research quality. Many of these will have been published in the *British Journal of General Practice*, but the persistent criticism of the *Journal's* readers about the accessibility, interest and relevance of its contents has created a real threat to the *Journal's* future as a journal of academic record. College Council is reported as being more on the side of the readers than the writers, and

that is a matter of concern to everyone and needs to be debated responsibly. Then again, it is noteworthy that when 'evidence-based medicine', and 'protocols' and 'guidelines' are so much 'in-thinking' in NHS circles, a not inconsiderable part of both the clinical and research communities worries that unsafe generalizations are being or will be made from population data to the care of individual patients. Of course, research should (and can now) shape our thinking about our work and working practices, but it is unlikely that the decisions which compose the blend of art and science of our discipline will ever be reducible to absolute statements of right and wrong.¹¹

As the need for appropriate general practice/primary care practice and thinking to help mediate between society and bio-medicine becomes more apparent, and as political opportunity creates real opportunities to move resources to support the academic infrastructure of the discipline of general practice, can we identify why there is so much ambivalence within the profession about what research can offer, where its weight should be being put and how best the opportunities its insights create can be taken advantage of?

The theory of the discipline

The different specialisms which comprise bio-medicine draw for their knowledge base on complex theories which describe the behaviour of cells and systems in normal and abnormal functioning, but bio-medicine as a whole has never seen a need to reflect on the theory or models which describe how clinical decisions are taken in practice. The historical absence of such thinking in part explains why it is proving so difficult to cope with the practical and ethical difficulties posed by the juxtaposition of increasing expectation and capability on the one hand, and of finite and insufficient resources on the other.

However, general practice has begun to think seriously about the basis for its practice. Kuhn's theory on the 'structure of scientific revolution'¹¹ has had a significant influence in shaping the philosophy of a 'paradigm shift' from the narrowly 'cell-based' vision of medical progress towards a more holistic 'patient-based' or 'behavioural' vision of practice,^{12,13} even though Kuhn explicitly stated that his theory on how scientific beliefs evolved when existing theories progressively failed to explain new observations or problems had not been tested in the domain of medicine. A number of social science theories could and do contribute to improving the understanding of the relationships between bio-science, society and politics. Glaser and Strauss'¹⁴ concept of 'grounded theory', which allows theory to be developed from observation/data rather than depend on prior definition of a uniting theory which data is then collected to test, fits well with the pragmatic culture of general practice, even though at present the hypothetico-deductive approach to research is often preferred to the inductive one, as it is in clinical decision-making.

Theory can be defined in various ways ranging from 'abstract knowledge or reasoning' to 'a system of rules, procedures and assumptions used to produce a result'. In practical terms, a theory should explain the relationship of phenomena known to exist, and predict the relationship between present knowledge and that

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still to be discovered. A model is a way of representing the theory to allow it to be tested or to help its application.

Is it possible that the utility and direction of research in general practice could be advanced by defining one — or perhaps a few — better theories/models to underpin thinking about and enquiry into some of its core activities?

The core activity of general practice is the consultation between doctor and patient. A simple theory of the consultation (defendable by existing literature) might place four concepts in position as shown:

$$\text{content} + \text{values} + \text{context} \rightarrow \text{outcomes}$$

In the well-known Stott & Davis¹⁵ model, we have an admirable encapsulation of the potential content of consultations. A small adaptation to put 'psycho-social problems' in the top right-hand box perhaps improves the fit between the Stott-Davis' model and the argument I am developing. No one will argue that all consultations — or even most — will enter more than one box at one visit, but most will probably agree that consulting styles which are predominantly 'one box only' are an unacceptable interpretation of modern general practice.

It is equally arguable that general practice as a 'patient centred' discipline, contrasts with, but is continuous or overlaps with, the more 'disease centred' focus of specialist medicine. General practitioners vary in the degree of their patient-centredness, and this is reflected (although it is not necessarily the only variable at work) in terms of the priority they give to different

aspects of content at consultations, in the consulting skills they develop and use, and in the management strategies they adopt.¹⁶⁻²⁰ The aggregate of these skills and attitudes represents the values element of my model. It is the intellectually important part, and the part that is particularly resistant to quantification.

The third part of the model, context, has never been of greater importance in the setting of UK practice (and apparently elsewhere world-wide too). Again, it is the perceived wisdom of all who work in and negotiate on behalf of the discipline that external pressures are adversely constraining the relationship between the 'content' and 'values' parts of my model, and that 'outcomes' for both patients and doctors are being affected.

Figure 1 encapsulates some of the principal issues of context that are presently impinging on outcomes, and hints at how changes in these could affect quality, both in favourable as well as in an unfavourable direction. The model is schematically summated in Figure 2.

The 'theory' of the influences on consultations is that 'content', 'values' and 'context' are additively linked and combine to determine 'outcome'. Figure 3 clusters some of the kinds of outcome which are accessible to research. Effectiveness, efficiency and equity are about the management of illnesses, the distribution of resources and priorities; satisfaction and enablement are different but overlapping ways of measuring patients' feelings about consultations; stress and morale are doctor perceptions. The 'theory' implies that when 'content', 'values' and 'context' are summated, 'outcomes' will be predictable. There is both research and experience which confirm the 'explanatory' and 'predictive' power of the theory in relation to 'patient' and 'doctor' outcomes. More work is needed on the 'illness' or health status outcomes and on how to aggregate the outcomes as a complete set.

Scale and strategies

The other problem facing the general practice research community is that of agenda-setting. Once again, there is a real problem of conflicting interests. Bodies which have a responsibility for ensuring adequate coverage, and for ensuring value for investment, need to have strategies. The National Health Service now has its Research and Development Division with its central strategy; regions (or their successors) have their strategies, as do the Medical Research Council, Trusts and Charities, and even universities and departments of general practice themselves. However, the individual researcher often sees things differently. Most researchers research to satisfy innate curiosity, and whether explicitly or not, have their own personal hypotheses — as well as their more sanitized formal 'aims and objectives' — to drive them forward. For such people, a strategy is a straightjacket, and conforming to one is first restrictive and later demotivating. At

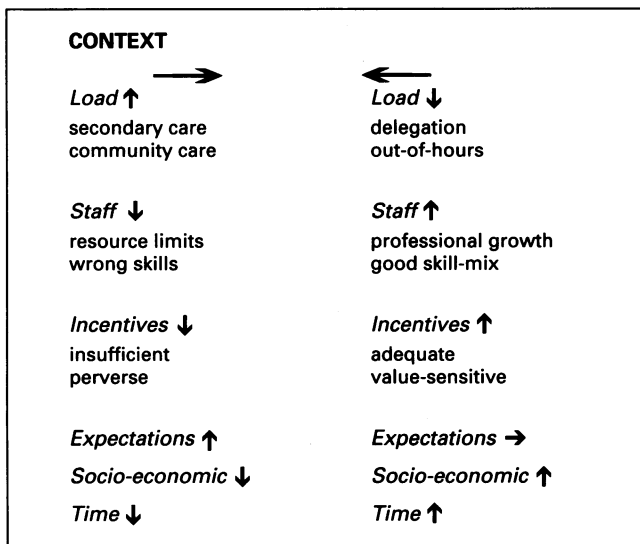


Figure 1. Examples of contextual issues which influence the nature of care.

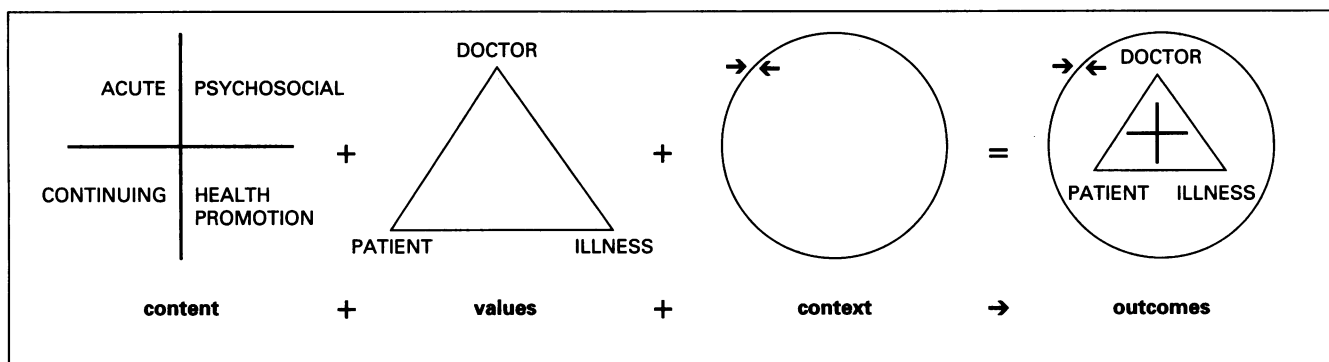


Figure 2. Schematic summation of Figure 1 (contextual issues).

OUTCOMES
effectiveness
efficiency
equity
satisfaction
enablement
stress
morale

Figure 3. Examples of outcomes which may be influenced by interactions between 'content', 'values' and 'context'.

the level of a department of general practice with perhaps between five and ten active researchers, it is relatively easy to create a strategy which combines a rationalization of current interests with a relatively short-term formal agenda of priorities. For individual researchers, smallness of scale becomes an isolating factor when it comes to competing for resources or having access to the necessary opportunities to break genuinely new ground. For larger research groups, too much time debating strategy risk both loss of time for fieldwork and downward intellectual compromise to enable an agreed agenda to be set.

The current trend towards inviting national bids for specific areas of work, with very short time scales for applicants to prepare, may be in the immediate interests of the research purchaser, but it seriously disadvantages the small researcher and the creative individual or group with an agenda that does not fit. All serious commentators on the future of health services research and development have spoken of the need to ensure that commissioned research is not allowed to compromise support for curiosity-driven research and for innovative researchers. However, it is increasingly difficult to see how this important commitment of faith can be put into practice in the current market-driven culture of both health services and higher education.

Moving forward

Whatever the cause, the persisting problem of the sometimes disappointingly low credibility of research and researchers needs to be addressed. Some components of it are avoidable. General practitioners have become wearied by incessant questionnaires whose simplistic designs predict an inevitable additional burden of the 'should do' syndrome.²¹ Research too often seems to be pursuing a managerial rather than a clinicians' agenda, and certainly not a patients' agenda.

The two issues of the adequacy of underlying 'theory' and of ownership of research agendas may contain the basis of a way forward. A more explicit and more perceptive theory of consultation (or of any other activity being studied) increases the probability that interesting questions will be asked, important principles explored, and appropriate populations identified and methods used. In the setting of 'the theory' outlined above, much more emphasis in research needs to be given to 'values' and to 'context' than seems generally the case in much of the purely descriptive research into the processes of care which seems to predominate in our current general practice research and development culture. A greater determination to pursue projects and

programmes of enquiry that unite researcher and researched will sooner or later force planners and managers of both research and of development to question whether the pursuit of agendas which increasingly diverge from those of patients and clinicians is the right way forward for anyone.

Originally, I chose for my title 'General practice research: the spaghetti junction feeling', because I saw a parallel between a well-meaning research community and the dilemma of a driver who knows he has taken the wrong exit from the motorway and can't see from ground level how to get back on course. In the end, I dropped it because its 'keywords' wouldn't have been indexed. That sums it up... 'strategy' taking over from 'feeling', and not enough good 'theory' to provide a bridge.

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