Primary care groups and research networks: opportunities for R&D in context

PRIMARY care groups (PCGs) raise a tricky but unavoidable agenda for research and development in primary care. Challenging questions about how to make the 'R' (research) and 'D' (development) relevant to the local situation are posed by initiatives such as clinical governance and evidence-based prescribing. Important opportunities to answer such questions may be realised by the present investment in primary care research.[1] This has resulted in over 30 primary care research networks in the country, some quite small and others involving hundreds of practitioners.

Medical research has valued the importance of statistically significant outcomes and generalisable truths from controlled trials. Primary care research networks can continue to do this but they must also grapple with the realities that many truths encountered by practitioners and PCGs depend upon local contexts. Research must, more than ever in a primary care-led National Health Service, have the power to understand these contexts. Here, PCGs collaborating with local primary care research networks may offer exciting prospects for patients. Research can potentially be readily linked to development by translating locally-owned and relevant findings into changes in practice or service delivery. In doing so, both the science of discovery *and* the science of implementation must be embraced and valued.[2] For example, while evidence-based guidelines for prescribing in primary care provide knowledge about *what* practitioners and PCGs might do, understanding *how* they can be facilitated to respond and change is equally important. If the former type of research prevails without the latter, there will be little impact upon practice,[3] and opportunities to improve the health care experience of patients will be lost.

Primary care research must remain, at least in part, faithful to the generalist discipline that it represents. The primary care practitioner has to juggle with multiple truths on a daily basis when assisting individuals and families to develop healthy and meaningful lives. What the science of discovery says may frequently conflict with what the person in front of them believes and with their prevailing culture and social constraints. Different types of truth can be of equal importance in the hurly-burly of the real world. The challenge is to explain how to undertake this complex juggling act and learn relevant and diverse insights for generalist practice and PCGs. As the Medical Research Council has noted, 'the theoretical bases of innovation and complex systems is an important area for research'.[2]

Some of these challenges can be helped by theory commonly used in other disciplines, such as theory concerning complexity[4] and organisational learning.[5] Understanding how diverse stakeholders — practitioners, patients, and researchers — can come together to construct something of use to all is helped by social theory, network theory,[6] and participatory action research.[7] We do not have to reinvent these things. What we must do is understand and value them. Examples involving PCGs are now becoming available.[8] We must engage with, and develop, new paradigms and appropriate methodologies that recognise this wealth of theory from other disciplines. Primary care research networks offer these opportunities; particularly where there is investment in bringing together individuals from different academic and professional disciplines.

However, we cannot expect too much from primary care research networks. The agenda is large and we start from inexperience. New organisations take time to develop their culture and systems. Models of how to simultaneously engage people from both 'top-down' and 'bottom-up' perspectives need to be devised if we are to develop a primary care infrastructure that promotes sustainable development. Too much top-down may stifle innovation (but will produce research publications quickly) and too much bottom-up may produce continuing reinvention of wheels (but can engage people in successful local action). Networks need time to develop pathways for people to participate and to promote a synergy of diverse interests for collaborative research and development. It will take time before the skills to provide effective learning environments are widely available and the learning skills of the participants are mature enough to use these learning opportunities well. Evaluation of networks must not revolve solely around production of peer-reviewed publications and securing research grant income, but must measure the extent to which they change cultures and engage people, practitioners, communities, and researchers in ways that are locally relevant and that create multidisciplinary coalitions.

Fortunately, many of those in primary care who are actively engaged in PCGs are also those now seeking answers to important questions and wishing to do so within primary care networks. There are exciting opportunities to ensure we realise research and development in primary care that combines discovery and implementation. Exploring and developing effective models will take several years, but there is an unavoidable message for today: primary care research networks and PCGs will succeed or fail depending on the extent to which they make theory, research, and practice all relevant to each other. None must come first; each must engage the other, accepting the validity of different types of truth and the value of different activities.

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A cautious welcome for the new guidelines on management of drug dependence

As drug misuse becomes more prevalent, general practitioners (GPs) are increasingly involved in providing both general medical services and specific interventions, including treatment of related illness, immunisations, and substitute prescribing. The newly revised *Drug Misuse and Dependence: Guidelines on Clinical Management* was launched in April 1999;[1] it updates the 1991[2] version in response to 'substantial changes in the extent and patterns of drug misuse and developments in treatment'.[1] Although it is aimed at all doctors, its distribution is targeted at GPs. The development team of 18 individuals included three practising GPs and eight psychiatrists working within the Department of Health's Guidelines Development Framework. While described as evidence-based, 'primarily…obtained from expert committee reports and the clinical experience of respected authorities',[1] the strength of evidence supporting recommendations is not quantified.

The introduction summarises current challenges and evidence supporting treatment benefits. Subsequent sections focus on assessment, treatment, prescribing, and relapse prevention, plus extensive appendices. Statements observing that 'it is the responsibility of all doctors to provide care for both general health needs and drug-related problems, whether or not the patient is ready to withdraw from drugs', and that Health Authorities should support GPs in this regard, are particularly noteworthy.[1]

Large variations in prescribing practice persist. Whereas many GPs are skilled and enthusiastic, others still refuse to involve themselves at all in drug misuse treatment.[3,4] The guidelines divide non-specialists into 'generalists' and 'specialist-generalists', thereby acknowledging that GPs with a particular interest will probably remain a minority. The 'nihilist' stance that the responsibility of care for drug misusers should not be part of general practice is rejected. Instead, the recommendation is that GPs who remain disengaged should now receive adequate training, support, and encouragement, so that all are equipped to provide basic services, including 'the assessment of drug misusers, and, where appropriate, the prescribing of substitute medication'.[1] Those without specialised skills should work within a shared care scheme, which, if not locally provided, purchasers should support either by contracts with external providers or by enabling local practitioners to develop into 'specialist-generalists'. The guidelines strongly endorse the principle that straightforward drug problems should be managed in primary care. Specialist services will then have sufficient capacity to manage complex patients. All this is very welcome, as are new sections on combined drug and alcohol misuse, relapse prevention, young people, and training for clinicians.

The influential Advisory Council on Drug Misuse reports on *AIDS and Drug Misuse*[5,6] promoted needle exchange programmes, harm minimisation approaches, and easy access to methadone treatment programmes. Consequently, methadone is now widely prescribed on a long-term basis. There is evidence that these efforts are responsible for the 'stupendous public health achievement' of limiting the spread of HIV among drug misusers in the United Kingdom.[7] The previous guidelines were tentative in their endorsement of methadone maintenance treatment, describing it as 'specialised' and a 'helpful approach' for a 'small proportion of patients'.[2] This new edition acknowledges that randomised controlled studies 'have found that on a number of measures methadone maintenance was vastly superior to control conditions', and that 'it should form an important part of drug misuse services'.

This liberal attitude towards prescribing and service accessibility seems tempered by a desire for stricter control. Doctors are warned that, if they do not follow the guidelines, they may be disciplined by the General Medical Council, the Clinical Governance system, or even the Commission for Health Improvement. There are hints of a new Home Office licensing system, extending beyond cocaine, diamorphine, and dipipanone prescriptions. The recommendation that 'it is good practice for all new prescriptions to be taken initially under daily supervision for a minimum of three months'[1] was not even mentioned in the 1991 guidelines. It is not a response to new research evidence (indeed little research has been conducted in this area), but to fears concerning diverted methadone and its possible connection to rising drug-related deaths. This advice may have a profound effect on the cost and style of services.[8] It is acknowledged that implementation 'may need to be phased in over a time period'. Mortality among untreated heroin addicts is so high[9] that any measure that discourages participation in treatment may increase mortality, particularly as it is the most chaotic users who will falter with stricter regimes. The recent Effectiveness Review recommendation that 'where they have concerns about compliance' GPs should have access to supervised consumption facilities was more modest.[10] More research is needed in comparing uniform and targeted supervision and its effect on retention and service users' profiles.

Another fresh recommendation is methadone dose titration for newly presenting patients. Although sensible, it will put additional pressure on current resources. Indeed, it is unlikely that primary care drug services could implement these recommendations within current resources. We already have anecdotal evidence of these recommendations deterring GPs who are currently promoting shared-care services. Enthusiasm may also be cooled by the suggestion that primary care teams should participate in three days of training in a six-month period to provide them with the necessary skills and knowledge to act at even the most basic

level. This conflicts with concepts of individual training plans and perhaps primary care group priorities. Committed doctors will acquire the necessary skills without much extra training, whereas others will cite training time constraints as an extra reason for remaining disengaged. Appropriate knowledge is readily obtainable,[11-13] and specialists can provide skills training. Challenging the attitudes of uncommitted or hostile professionals will be more difficult. Although financial incentives are offered in some districts, the most effective incentive remains the desire to deliver good health care to an often neglected group of patients. However, workload shifts should be reflected in resource redistribution.

The guidelines seem unclear regarding whether services should be targeted at the population or aimed at individual clinical improvement. Good clinical results can be achieved using a United States model of well-resourced, closely supervised programmes that exclude poor compliers; however, these may have restricted impacts on public health.[11] Over the past decade, the UK favoured a rapid expansion of methadone treatment on a limited budget. Retention in treatment has generally been valued over achieving strict compliance. In spite of their many faults, the Effectiveness Review concluded that UK methadone maintenance programmes, as assessed by a commissioned research programme (NTORS), 'provide effective treatment and deliver significant benefits for the individual and society'.[10] Nonetheless, it is right that defects in treatment should be addressed by a targeted increase of resources linked to an improvement in clinical standards.

From a primary care perspective, these guidelines seem a mixed bag. They appear at odds with recent recommendations about style, brevity, flexibility to enable local adaptation, evidence grading, and development,[14,15] and may be difficult to implement in practice. Many GPs will identify an overemphasis on pharmacological treatment at the expense of holistic approaches and counselling support. Some will object to being asked to carry the burden for what is primarily a social problem, and policy must also emphasise prevention if we are to reverse rising trends in drug misuse. The threat of GMC involvement is intimidating, although GPs should not be at risk if they follow local guidance on best practice. It would be a shame if guideline recommendations were to work against recent successes in setting up shared-care services.[16] The guidelines' impact must be evaluated and undesirable impacts rectified in subsequent editions. Let us hope that we will not have to wait another eight years for that to happen.

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