Letters

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Practice-based research

We have followed with interest the thread of correspondence initiated by Murdoch[1] and culminating with the rather baffling and patronising article by Mathers *et al*.[2] Now we have had time to calm down we would like to put forward the case for practice-based primary care research, drawing on our experiences and those of our colleagues over the last 20 years.

The RCGP was very much at the forefront of establishing funding and support for GP researchers, and The Honiton Practice was one of the first RCGP Research Practices in the country being appointed in 1995. This gave the practice a sum of money to establish some research infrastructure with a view to starting research in the practice. Added to this Clare Seamark was awarded a RCGP Research Fellowship to undertake and complete a masters degree that was based solely in primary care.

Practice-based research has been a strong theme in the South West, particularly in Exeter and East Devon. There have been a number of research practices supported under NHS Research Funding schemes, such as Culyer. These schemes created a critical mass of GP researchers and associated research staff for remarkably little investment.

To our knowledge there have been at least five doctorates awarded to local GP researchers and many masters degrees.

Within the practice we know most about (Honiton), David Seamark already had a biochemical PhD before becoming a GP and starting in pragmatic practice-based research. Since then among the partners of the practice there have been two masters degrees and one doctorate (and one masters is ongoing). There have been 61 peer reviewed papers published in 22 journals ranging from the *BMJ* to *Soc Sci Med* and 15 of these papers have been in the *BJGP*.

We have been researching in fields as widely divergent as teenage sexual health to anticoagulant monitoring. We have had presentations at local, national, and international meetings. Many of our practice-initiated studies have led to significant changes in the way we and our PCT work. Work undertaken showing that anticoagulant monitoring and management by practice nurses was safe and reliable led to the roll-out of this service to the other practices in our PCT. Work on the benefits of pulmonary rehabilitation offered in community hospitals again led to the extension of this service to the rest of the PCT.

We published one of the first papers jointly authored by a patient, (*BMJ*) that attracted a lot of attention. We have also tried to encourage further patient involvement and have one study that was actually initiated by a patient from his own observations and a desire to know more and help doctors understand further people with chronic pain. He also became a member of the research team, undertook research training, and was an equal partner in the publications and presentations.

Our research experience and practical day-to-day knowledge of general practice has led to numerous collaborations (still ongoing) with academic departments in the UK, US, Australia, and India.

We have to move with the times and although our practice still continues to attract some research funding, as outlined in the correspondence, a lot of it is now linked to participating in larger studies and helping researchers access patients registered with the practice. We also try to move with these new ventures while still trying to hold onto what started us in research in the first place: the patients and clinical situations we meet each day and that stimulate more questions.

David Seamark is currently Research Champion for the local PCRN and we are both clinical leads for the new Academic Clinical Fellows in Primary Care based at the Peninsula School of Medicine and Dentistry.

The strength of general practice-based research is the generation of pertinent research questions, the piloting of ideas in preparation for substantive studies, and the translation of such research into evidence based practice.

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Author's response

The letter by Seamark and Seamark[1] is typical of the response from practice-based researchers on this subject. Privately, I have received several letters with the same themes — pride in the quality and publication of practice-based research, and disappointment and frustration that these efforts have not

been adequately recognised. The Honiton Practice has an academic record that would be the envy of many Departments of General Practice, but Mathers *et al*[2] seems to have made them uncomfortable as to what their future role might be. The fact that it has taken 6 months for such a prestigious group of general practice researchers to 'calm down' indicates the level of offence that their statements have aroused.

The statements that Mathers *et al* made about practice-based research were short if not sweet. The message seemed to be that research is too important to leave to 'gentleman amateurs' and should be done by professionals working through university departments, Schools of Primary Care, MRC networks, NIHR, and the like. The reason for this was that single practitioner research 'rarely results in a major contribution to the sum of our clinical knowledge,' although they conceded that 'such research has considerable benefits for the practitioner, the practice, and the patients.' It was interesting that no attempt was made to apply the benchmark of 'the best possible contribution to the knowledge-base of our discipline' to the new professionalised approach, although it is 'outstanding' and 'world class.' The questions I would ask are, in whose opinion and in which world?

There is no doubt that this move towards the professionalisation of general practice research has largely come through our involvement with universities. When I became a senior lecturer in general practice in 1977, I joined a very small group of people who believed that being involved in teaching and research in that academic community would enhance the status and value of general practice. Most of us had worked for many years in 'ordinary' practice and had real passion for the discipline, but we joined universities that had a philosophical basis quite different from general practice. A long time has passed, and as was pointed out in my original letter, the nature of general practice research and its publication has changed. The subsequent debate has revealed a change in philosophy in academic and College circles that, I believe, we have to examine carefully.

The fundamental question is 'What does the individual GP and their patients contribute to our body of knowledge?'

The source of the problem is that universities, research funding organisations, and presumably now the RCGP, are driven by a philosophy that Schon[3] has called technical rationality. This he defined as: 'an epistemology of practice derived from positivist philosophy, built into the very foundations of the modern research university, that holds that practitioners are instrumental problem solvers who select technical means best suited to particular purposes.' In this model the individual GP's role becomes that of the mouse, the subject of the experiment rather than the investigator, or that of the 'pimp for patients,' attracting a fee for each patient recruited to a study. Schon described the desired product of this philosophy as: 'rigorous professional practitioners who solve well-formed instrumental problems by applying theory and technique derived from systematic, preferably scientific knowledge.'

The main problem with this approach, according to Schon, is that: 'the problems of real world practice do not present themselves to practitioners as well formed structures. Indeed they tend not to present themselves as problems at all but as messy indeterminate situations.' If this is true, will these issues be picked up by large scale research networks driven by academics who do not know the real world? McWhinney[4] describes the essence of our discipline as 'an unconditional commitment to patients who have put their trust in us.' He also deplores the fact that: 'information is arrived at without knowing anything about those who are represented in the data. The investigator knows nothing about the most important work the physician has done listening to the patient.' In contrast the advice by Mathers *et al* seems to be, that the future of general practice research lies in such a removed and abstracted method. It is interesting that an important paper on the essence of general practice[5] identified 'tension between a focus on interpersonal relationships and the increasing use and potentially dehumanising effects of information technology' as a common theme throughout the project. If we are to research 'that by which it is what it is'[6] how else can that be done other than with our own patients?

In my view the clarification of the essence issue through research will require that at least a proportion of general practice researchers should be allied to the practice world and not to the alien academic world. In the words of Tudor Hart,[7] why should this valid activity still be 'regarded as a sort of personal hobby for unusual people which, like stamp collecting, should normally be unpaid'? What would be so wrong about funding real world practitioners to do research in their own practices? Who else but our own College should seek the funds for this to be done?

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Authors' response

It is wonderful to be reminded of another example of great general practice research leadership with so many outputs. Four key things unite all this correspondence — a passion for general practice; a thirst for relevant new knowledge starting within