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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## REFERENCES

1. Seamark D, Seamark C. GP researchers. *Br J Gen Pract* 2009; **58(554):** 691.
2. Mathers N, Howe A, Field S. Clinical research by GPs in their own practices. *Br J Gen Pract* 2009; **59(561):** 296–297.
3. Schon DA. *Educating the reflective practitioner*. San Francisco, CA: Jossey-Bass, 1987.
4. McWhinney IR. Assessing clinical discoveries. *Ann Fam Med* 2008; **6(1):** 3–5.
5. Gillies JCM, Mercer SW, Lyon A, *et al*. Distilling the essence of general practice: a learning journey in progress. *Br J Gen Pract* 2009; **59(562):** e167–176.
6. Heath I. That by which it is what it is. *Br J Gen Pract* 2009; **59(562):** e142–143.
7. Tudor Hart J. Clinical research by GPs in their own practices. *Br J Gen Pract* 2009; **59(560):** 214–215.

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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

that clinical setting; a commitment to the recognition of the huge efforts made by GPs and other primary care researchers; and a concern that excessive bureaucracy, underfunding, and lack of support by practice colleagues could damage the increasingly impressive profile of internationally successful GP research in the UK. Our main concern was to broaden awareness of how much the RCGP already does to support individual researchers, practice-based research, and the strategy and delivery of the national research agenda. Both the Seamarks and Tudor Hart acknowledge the need for GPs to group up to deliver: 'Multicentre studies on and with participating patients, conducted peripherally by primary care staff with personal knowledge of and responsibility for those patients, and coordinated centrally by groups including both fully trained researchers and experienced primary care staff, provide the only possible sites for research on patients as they actually are, where they actually live, which we must have for guidelines to become optimally effective aids to clinical decisions.'[1] The individual GP researcher is not extinct — they are just working with others across the UK, backed by the RCGP, and advocating for the highest quality research we can deliver at all levels.

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## REFERENCE

1. Tudor Hart J. Clinical research by GPs in their own practices. *Br J Gen Pract* 2009; **59(560):** 214–215.

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## Re: Practice-based research

*This correspondence is now closed — Ed.*

# Future of general practice

The marked contrast between the personal view 'A final g'day to English general practice'[1] and 'Practice, politics, and possibilities'[2] was striking.

Much of Adrian Elliot-Smith's observations about the changes in general practice may ring true, but his defeatist and world weary acceptance of the demise of urban general practice in this country is far from the mark and surely needs challenging.

Martin Marshall makes an excellent case for concentrating on the core values of general practice (commitment to excellent medical generalism, whole patient care, and the advocacy role of GPs on behalf of their patients and communities) and the need for social marketing to get the message across of the benefits of good local general practice.

We need to recognise that collectively and by working collaboratively we can influence the debate about the future of general practice. We need to get out of our silos. The government and society want autonomous and self-responsible clinicians.[3] The government can only set the direction, ensure minimum standards, and help to break barriers that prevent development of good services. As professionals we need to promote creativity and ambition, raise skills, be flexible, pursue excellence, promote excellent leadership and management, and set our own challenging standards of excellence. Our accountability to society will be strengthened by empowering patients and by demonstrating transparency of performance and our commitment to addressing health inequalities.

Perhaps we have being too long cultivating our own garden. It is time to look beyond its hedges and fences because the world will continue to intrude. Unfortunately, Voltaire never told us how to cultivate it successfully.

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By way of biography I work as lead GP for a community enterprise organisation. The practice has been established for a year in a deprived and previously under-doctored area.

## REFERENCES

1. Elliot-Smith A. A final g'day to English general practice. *Br J Gen Pract* 2009; **59(565):** 618–620.
2. Marshall M. Practice, politics, and possibilities. *Br J Gen Pract* 2009; **59(565):** 605–612.
3. Cabinet Office. *New professionalism.* Strategy Unit, Cabinet Office, 25th February 2009. http://www.cabinetoffice.gov.uk/strategy/publications/excellence_and_fairness/report/html/new_professionalism.aspx (accessed 11 Aug 2009).

10.3399/bjgp09X454188

# Politics and primary care

The August *BJGP* contained articles that run straight to the heart of 21st century UK health care and what must be done to secure the future for the patients. Kath Checkland, Adrian Elliot-Smith, and Martin Marshall are to be thanked for their contributions, that viewed together, frame the scene perfectly.

The commercialisation, atomisation, proletarianisation, managerialism, and contractualism that infests so much of contemporary national life and the health service in particular ought not to go unanswered. Together we can respond effectively, but who will join the fight?

In order to prevail we must be fully and directly engaged politically — that means we must get elected in some numbers. I have committed myself to standing as an Independent as far back as 2006[1] and retired prematurely from general practice in 2008 for that purpose. In the last couple of days Dr Wollaston from Totnes has become a candidate with substantial chances of success — arguably because she is not a typical party politician.

It is my view and I suspect the view of many, that primary health care is best delivered by multidisciplinary, autonomous, coherent teams dealing with defined populations — this is no golden-age idyll, merely the objective reality. Likewise, coherence and collaboration between all sections of the healthcare delivery system