



### Moving on

The *BJGP* is one of my favourite journals and you, gentle readers, have never given me any trouble. But this month, I bid you farewell. Here's why.

I recently became Dean for Research Impact in my medical school. Until recently, our universities used to get a block grant from the government just for being there. From 2014, when the results of the ongoing Research Excellence Framework become available, a proportion of their income will be awarded on the basis of the 'impact' of the research they do. It can be economic (for example, creating jobs or generating profits for industry) or sociocultural (contributing to civil society or improving public understanding of science), but in our medical specialties there is no impact like saving lives, relieving suffering, reducing inequalities, or preventing harm.

The new component of my job has involved scouting round the various research groups in the medical school (from basic scientists studying genes and cells to public health specialists studying population-level interventions) and helping them weave a plausible narrative that links a study they conducted 10 or 15 years ago with improved health outcomes today.

Impact is most readily demonstrated in rare examples of linear causation, such as: when a single, mega-trial produces a definitive finding; policy and guidelines change soon afterwards to reflect that finding; clinical practice follows suit and the benefits can be demonstrated unambiguously in a clear, patient-relevant metric of success. But in today's complex world, drawing a linear link between this piece of research and that subsequent improvement in health is something of a rhetorical challenge.

Take smoking, for example. How should the work of basic scientists (who develop drugs to support quitting) be judged against that of clinical trialists (who test those interventions) or anthropologists (who study why people from some minority ethnic groups may be less likely to engage with smoking-cessation services)? There are no self-evident answers to such questions, since one person's impact is another's surrogate outcome and nobody has yet worked out how to recognise the work

of researchers who take on important topics with complex chains of causation (such as domestic violence) for which impactful quick fixes are unlikely.

Another dimension of my new role is helping develop an infrastructure for supporting future research impact. Universities need to move beyond the linear model of 'doing research' followed by 'translating it into practice' and instead see the research lifecycle as organic and dependent on two-way dialogue between the people who do research and those who could potentially benefit from it.<sup>1</sup> The best way for your research to have impact on patients, for example, is to start by involving patients and carers in setting research priorities and designing studies. Another unanswered question is how to prevent the assessment of impact from being morally naïve. Profits from cigarette sales, for example, are 'economic impact' of a sort — and prolonging the lives of the very sick while extending their suffering is a questionable metric of 'health impact'.

All this means that before the science of research impact gets set in stone, I need to spend time challenging policymakers' assumptions and asking uncomfortable questions about whose voices are included in the debate. It means that I will — with some nostalgia but much anticipation for new challenges — be doing less clinical work and shifting the focus of my writing to topics (and audiences) more directly linked to what is grandly referred to as higher education's 'impact agenda'. My Twitter posts will continue on @trishgreenhalgh.

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#### REFERENCE

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