

THE BEST OF TIMES ...

Thirty-odd years ago I was a partner in a six-man (literally) practice in Hampshire, where I had a personal list of over 2500 patients, responsibilities at the adjacent casualty department and cottage hospital, and was on a one-in-six weekdays and weekend on-call rota in a practice area of about 300 square miles. There was, unimaginably now, still time to get home at lunchtime and even do a bit of gardening or DIY before baby clinic and the evening surgery. There were no mobile phones and my wife triaged the calls that came in when I was on the road. I look back on those days as a golden age.

There was also time for research: defined around then by an American wag as 'an unnatural act, performed by faculty to achieve tenure'. That wasn't quite my motivation, but research in general practice in the early 1980s was certainly a minority activity, viewed with some suspicion by my partners. I remember one day when I had taken myself off to the tiny library in the cottage hospital to write up the results of a trial of single-dose antibiotic treatment of urinary tract infections when the practice manager came on the phone to say 'You're not doing anything, are you? Can you come over and see a patient ...?' And of course in many ways she was right: the GP contract, with its origins in the original NHS Act that launched the NHS, never did and still does not recognise remunerable time for GPs to do anything but see patients. Contrast this with the iterations of the NHS consultant contract and with local trust arrangements, which include paid research and other 'white time' sessions, often with little oversight or performance management. Doing research in general practice in those days and to some extent these days too, was an out-of-hours activity. Before the university departments of general practice and primary care really got going in the late 1980s and the 1990s, GP researchers met in clandestine organisations such as the national GP Research Club founded by John Fry, and the cringingly apologetically-named 'Small r group' in the south of England.

Things have, thank heavens, moved on and the UK's research output from general practice, primary care and the community-based sciences is probably the best in the world.

In this issue of the *BJGP* we are putting the spotlight on GP research, not research for its own sake but research that has its roots in general practice and feeds back in to the discipline to add to the evidence base for delivering clinically-effective, equitable, safe, accessible, and cost-effective care. However, Richard Hobbs, who directs the National School of Primary Care Research, and Clare Taylor warn us that the present situation is not necessarily stable and self-sustaining, and that continued investment is required. In my own editorial I have tried to make the point that nothing can be taken for granted about the links between research and practice, and getting clinicians and planners to change what they do in response to new evidence is a continuing struggle. The dissemination and implementation of research deserve the same attention as the research itself. As we pointed in last month's Journal, it is one thing to be able to estimate risk and quite another to be able to communicate it accurately and usefully.

Finally, and very seriously, this is decidedly not a golden age, and general practice in the UK does seem to be at risk, as really good practices struggle to cope with the rising tide of patients' needs and demands, and recruitment, even to idyllic locations, is becoming increasingly problematic. In the Thatcher era the government ran away with the notion that general practice care meant cheap care, and invented nonsensical and hollow slogans like the 'primary care led NHS'. We now are grappling with the results of that misunderstanding, as more and more clinical work is transferred to general practice without a parallel transfer of resources. Barbara Starfield's observations on the positive effect of primary care on overall health system costs and outcomes only apply when primary care is strong: a weakened, underfunded system of general practice in the UK is likely to have exactly the opposite impact on national health and wealth.

Roger Jones
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DOI: 10.3399/bjgp14X679525

© British Journal of General Practice 2014; 64: 209-264.

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2012 impact factor: 2.034

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PUBLISHED BY

The Royal College of General Practitioners
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ISSN 0960-1643 (Print) ISSN 1478-5242 (Online)

PRINTED IN GREAT BRITAIN BY

HPM Limited, Prime House,
Park 2000, Heighington Lane Business Park,
Newton Aycliffe,
Co. Durham, DL5 6AR.

Printed on
Carbon Balanced
paper



www.carbonbalancedpaper.com
CBP000480504111835