Editorial

Research and development in internal medicine in the United Kingdom

The Editor interviewed Professor Leslie Turnberg, President of the Royal College of Physicians, London on 21 May 1993. The following is an edited extract of that interview.

Research and training

Editor: It seems rather difficult for the individual physician in a district general hospital to do useful clinical research—not because of any person's ability, nor even because of the structure of the unit—but because of the requisite numbers of patients, the need for randomisation, and the way in which controlled trials become very elaborate. Do you think that this is in fact inhibiting for the average physician in thinking about research and development?

Professor Turnberg: I think it is inhibiting if the individual consultant expects to do it all himself or herself—the mountain that they see before them is far too big. The only way they can become involved is through a much larger coordinated exercise, perhaps regionally or supraregionally.

Does the College have a role in this type of activity?

Yes, although much of that sort of work goes on through the specialist societies and I think that is very much what Michael Peckham (Director of the NHS R&D programme) will be promoting. The College has tremendous resources in terms of its members and fellows but we do not have the resources to mount major multicentre trials.

We have been looking at the training appropriate for a consultant physician in a district general hospital, and the place of research in that training. I believe that it is of value for all future NHS consultants practising clinical medicine to have had some research background. Rather than trainees being pressed into doing laboratory research, what we think may be valuable for many doctors in training grades is R&D type research—perhaps a small project involving education in epidemiology and statistics, and training in research methodology that allows clinical trial research to be done well and assessed well. This would be invaluable for an NHS consultant and I hope that the R&D initiative might fund a number of periods of training of this sort for future NHS consultants. We would think in terms of six months or a year out of a total training programme, and we are beginning to ask whether the universities will be able to put on MSc courses for that sort of training.

Would that need separate funding or would this be part of the senior registrar programme? Laboratory research was often done as part of their job, I think.

Trainees often obtained support from locally organised research schemes and a variety of other charitable sources (usually local and non-competitively granted) and also from drug companies.

There seems to be an arguable case for saying that this should be part of their routine training with specified funding.

I agree. Of course the postgraduate deans would have to be convinced since they hold half the training budgets. The other possibility is to allow day-release in some way during the training years.

It has seemed in the past to be the exception rather than the rule that the average clinician really focused on any sort of long term outcome.

Do you think that is the case, and does it have to be the case?

I don't think it has to be the case at all, and I don't think it's true that physicians only look at outcomes in terms of getting people out of hospital. I think they do look to see patients getting better—by that I mean not simply better enough to get out of hospital. But there is a problem in measuring outcome and in being able to assess the relative merits of different treatments.

Health services

If we are looking at development of services rather than development of disease or patient-specific management, does not that require the involvement of more than hospital physicians?

Managers have to be involved in decisions about care because of their control of resources. But at the moment we do not have enough advice about purely clinical matters—that is where the gap is. At some point, as we get better at knowing what is the best clinical management of common important conditions, then we will have to move much more closely to the management side. I agree that when you think of the needs of patients—to keep them well and to treat their illnesses—you cannot simply think in terms of what happens in the hospital because that is a small element of their total illness load. So we are conscious of the need to look at all aspects of care as a package. The purchaser/provider divide could be counterproductive for continuing patient care; we must ensure that the care of patients can be seen to encompass the divide between general practitioner, community trust, and hospital trust. Patients with illnesses do not think in terms of being one sort of person on one side, and a different one on the other; they look to their health care as being seamless. In fact, one of the thrusts of the Conference of Colleges (monthly meeting of presidents of all medical royal colleges and their faculties) is to try to ensure that patients are treated in a continuum of care, not in divided competitive care.

Development and guidelines

What are the problems about the "development" side of R&D for internal medicine in the UK?

Sometimes it takes a very long time before physicians in practice take on innovations that may have been clearly shown

to be advantageous in one way or another. There is a difficulty in permeating the system with new data and new information, and in producing change.

What are the particular mechanisms which you try to use?

From the College point of view we are very interested in this whole area of informing both purchasers and providers (the providers being mainly our fellows and members) about the best forms of therapy, based on measurements of quality and of outcome. The whole *raison d'être* of our College Research Unit headed by Anthony Hopkins lies in this field of developing and improving measures of quality and outcome in a range of medical specialities. He is supported by the Department of Health, the Wolfson Foundation, and other organisations and has a large programme.

Do you think that the focus of R&D could be too narrow if it is largely tied to the five areas of the Health of the Nation¹ agenda? (Accidents, coronary heart disease and stroke, cancer, mental illness, and HIV, AIDS and sexual health).

The *Health of the Nation* agenda is a very reasonable one that we would strongly support. One can hardly argue with the major areas that have been chosen, but one should not be limited by them. Through its specialty committees the College has sought major areas of perceived difficulty in which there is a need to set out guidelines. We don't like the word protocol because of the difficulty that one might find oneself in with an unorthodox case—fitting in with a protocol may not be ideal, particularly with medical diseases where there is a tremendous variation in manifestation. Different patients with the same diagnosis may require different management and have very variable outcomes. Anthony Hopkins has asked the specialist committees to suggest reasonably common diseases in which there is some uncertainty about management. For example, the dermatologists came up with treatment guidelines for psoriasis; the rheumatologists are looking at osteoarthritis and rheumatoid arthritis. Another large problem is asthma, for which a range of interesting guidelines has developed for both short term and longer term management. This is an important disease which creates a lot of distress and is potentially fatal. I don't feel that the Department of Health is restricting support on the basis of the *Health of the Nation* document, although, of course, our interests do coincide in many ways.

Would you think it is fair to say that these treatment guidelines are really an important, if basic, step in the direction of "development"—trying to take "research" that has been done and coordinate a forward push with implementation?

Certainly, but I don't think it is restricted to that. We are keen to examine ways in which we can disseminate information about good practice based on currently available evidence. There is a particular need to examine how we can ensure that such information is put into practice. The efforts of our Research Unit focus on this development and applications

side. On the other hand I do not think that the College can get involved in basic biomedical research—we are much more at the development end.

What about costs?

The Government have been very concerned that guidelines and recommendations should include information about cost-benefit ratios. But it is clear that we would not always be recommending the cheapest treatment—sometimes the most appropriate treatments might be more expensive. On the other hand I do think that there are some expensive treatments which are probably not warranted and which good research evidence might help us remove. So, although on balance there might not be very much difference in total costs, some expensive treatments might go and others might come in. The College would tend to promote nationally agreed developments rather than parochial or regional groups which might have their own angle.

The problem is that costs are dominating discussions and we do need to get the benefit into the cost-benefit ratio to bring it into some sort of balance. We cannot ignore costs, but neither can we ignore benefits!

Royal College of Physicians and quality issues

Can you let our readers have a little more information about the College Research Unit and your publications?

Many of the publications that we have produced from this College focus on "quality of care" issues and measurement of quality and outcome. Many of those reports are derived from mixed groups of professionals which include not just hospital physicians. We are conscious of the fact that our publications do not reach all the people we would like to receive them.

Recent relevant publications from the Royal College of Physicians in London include:

- Accidents and emergencies in childhood*
- Allergy: conventional and alternative concepts*
- Appropriate investigation and treatment in clinical practice*
- Clinical genetic services in 1990 and beyond*
- Current themes in diabetes care*
- Health services for adults with physical disability*
- Health systems and public health medicine in the EC*
- Measurement of patients' satisfaction with their care*
- Measures of the quality of life*
- Measuring the outcomes of medical care*
- Paediatric specialty practice for the 1990s*
- Palliative care*
- The CARE scheme: clinical audit of long-term care of elderly people*

A price list and copies are available from the College.

¹ Secretary of State for Health. *Health of the nation: a consultative document for health in England*. London: HMSO, 1991. (Cmnd 1523).