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Editorial

Primary care R&D – contemporary threats and opportunities

There are plenty of threats to primary care R&D at the moment. But what are the opportunities? The proliferation of research networks that focus on diseases and randomized controlled trials, and the increasingly dominant role of pharmaceutical companies suggest a lurch back to the 1980s when a medical, disease-oriented understanding of primary health care dominated. This perception is reinforced by implementation in the UK of practice based commissioning and other models world-wide concerned primarily with medical things, based on the American style health maintenance organization that includes rigidly monitored care pathways for diseases, and largely ignores the need for cross-organization collaboration for health promotion (Meads, 2006). This over-emphasis on medical aspects of health means that we are far away from the ideal of 'community based research that is a catalyst for transforming primary health care rhetoric into practice' (Hills and Mullett, 2005).

Over-emphasis on medical treatment of diseases threatens primary health care because it is concerned with all aspects of health. Disease management is only a part. Treating diseases and promoting community health require very different approaches. I recently published a book about my 20 years experience of combining the two (Thomas, 2006). The nub of the challenge as I see it is to understand 'R&D'.

I, like many, inherited from medical school the idea that research examines what works, and development 'rolls out' the findings. But this does not work in complex situations, including primary health care, because adaptations between multiple factors cause unpredictable results (as has been proven by Complexity Theory). This false understanding of the relationship between research and development is old and pervasive. Weick quotes Kierkegaard about this:

> Most organizational theorists, as well as most philosophers, mistake the certainty of structures seen in hindsight for the emergent order that frames living forward. Neither group of scholars has come to grips with the fact that their conceptual understandings trail life and are of a different character than is living forward. (Weick, 1999)

I discovered Kierkegaard's truth for development when I set up the Liverpool Primary Care Facilitation Project in 1989. I was told that change was caused by carrots and sticks, and the only carrot that worked for GPs was money. I found it was not true. Instead I found that within an appreciative environment all GPs wanted to improve services. When this did not happen there were usually very understandable explanations. By getting the primary health care team to stand back within multidisciplinary teams and reflect on the obstacles to improvements, and helping them to make small successful changes, they became motivated to undertake more and more ambitious projects for which there was no financial gain. Smiles replaced frowns. Colour appeared on their walls as though by magic. I reasoned that this empowerment was the result of their creative activity – they had found how to be part of the solution rather than part of the problem. I then recognized how arrogant is the linear 'carrot and stick' metaphor, designed to move donkeys a short distance. Any self-respecting donkey would demand a map, compass, and full belly when undertaking a long and difficult journey. In search of insight into longer-term journeys I explored theories that purposefully sought to surface the things that lie hidden beneath superficial motivations. I found useful leads in theories about complexity (Capra, 1997; Kernick, 2004), learning organizations (Senge, 1993; Argyris and

Schon, 1996), learning communities (Wenger, 2000) and whole systems (Pratt *et al*., 2005).

This led me to devise my own metaphor of development – dance. Each dancer brings their own rhythms, that contain their cultural roots. Through patient and mutual explorations the dancers come to understand the unfamiliar rhythms of others. Through shared testing of new steps they co-create new rhythms.

I also discovered Kierkegaard's truth for research. I had been told that the gold standard for research is a randomized controlled trial. Qualitative research apparently is done before or after this to ease the process, and participatory research is a lesser form of qualitative research that no academic should be bothered with. But I found that these different approaches to inquiry revealed different kinds of thing – they shine different lights that reveal different aspects of a world that is itself more complex and evolving than any discrete research insight can ever reveal. I have described the assumptions about truth made by these three approaches (Thomas, 2006). Quantitative research counts discrete things that are already known; it uses a positivist notion of truth (nuggets of truth are dug out of the melting pot of life). But when my young son beams a huge smile in the company of some friends but not others, I know that the smile is not a stand-alone truth. It is a manifestation of the relationships he enjoys with certain people in certain contexts – this is a feature not of the nugget, but of the melting pot itself. Inter-connected things cannot be researched through a positivist lens. It requires critical theory that sees beyond superficial phenomena to see interconnected and hidden things that matter at a more fundamental level. And when I banter with a stranger in the street, or experience a 'penny dropping moment' in a conversation, something else again is going on – we are co-creating knowledge, using each others' abilities to go beyond the insights of any of us and make leaps of imagination. This is constructivism, a theory of knowledge that expects truth to be generated through dynamic interactions – this is the mechanism of transformation, and sustainable development.

If any of this resonates with you, you are probably as worried as I am about the way international health care is going, and in particular primary health care R&D. The principles of Alma Ata seem to be getting left further and further behind. The same misunderstandings about R&D I encountered in 1989 are alive and kicking in 2007.

So how can we create opportunities?

- It is no longer contentious that for research to lead to sustainable development there needs to be ongoing participation of people from throughout the system of concern (Thomas *et al*., 2005). We can justifiably claim for primary health care an integrated R&D approach that does this, by embedding combined quantitative and qualitative research within a learning community that is closely connected with commissioning. We can provide training for leaders to use this approach.
- We can transfer work that was formerly done (in the UK) by primary care research networks into the heart of the new NHS. Alliances between primary care trusts and universities can support integrated development and research, and make sure that top down research projects genuinely fuel bottom up motivation and facilitate whole system development. 'R&D Practices' can provide local leadership. New community foundation trusts in partnership with these practices might challenge the notion that academic health sciences centres can only be located in hospital foundation trusts
- We can persuade pharmaceutical companies, trialists, and clinicians/managers who have strong controlling tendencies that they do have valuable roles. But without balance they are part of the problem. They can be part of the solution if they embrace health promotion as well as disease cure, qualitative, and participatory approaches to inquiry as well as quantitative, and empowerment as well as control. With such a combined approach we could create a new R&D dance and move forward to a health rather than disease driven primary health care system.

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Reference

Argyris C. and **Schon, D.A.** 1996: *Organizational learning 2 – Theory, method and practice*. USA: Addison Wesley.

Hills, M. and **Mullett, J.** 2005: Community-based research: a catalyst for transforming primary care rhetoric into practice. *Primary Health Care Research and Development* 6, 279–90.

Meads, G. 2006: Primary health care models: learning across continents. *Primary Health Care Research and Development* 7, 281–83.

Pratt, J., Gordon, P. and **Plamping, D.** 2005: Working whole systems: putting theory into practice in organisations. Second edition. Oxford: Radcliffe Publishing.

Senge, P. 1993: The fifth discipline. London: Century Hutchinson.

Thomas, P. 2006a: Integrating primary health care – leading, managing, facilitating. Oxford: Radcliffe Publishing.

Thomas, P. 2006b: General medical practitioners need to be aware of the theories on which our work depends. *Annals of Family Medicine* 4, 450–54.

Thomas, P., McDonnell J., McCulloch, J., While, A., Bosanquet, N., and **Ferlie, E.** 2005: Increasing capacity for innovation in large bureaucratic primary care organizations – a whole system participatory action research project. *Annals of Family Medicine* 3, 312–17.

Weick, K.E. 1999: That's moving: theories that matter. *Journal of Management Inquiry* 8, 134–42.

Wenger, E. 2000: Communities of practice and social learning systems. *Organization* 7, 225–46.

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