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research that has an immediate and direct impact on service improvement. This may apply to the quality improvement initiatives of Paxton *et al* but is unfortunately often unrealistic for rigorous scientific research. Studies that can actually contribute to the knowledge about how services can be improved often take several years and eventually only contribute a tiny amount to a worldwide growing body of evidence on a specific research issue. This evidence will then be reviewed and as a whole, one hopes, influence guidelines, clinical practice and decisions on service development. Thus, the connection between a given piece of research and practical improvements in services is more complex than those who are less familiar with research understandably tend to hope. If the processes described by Paxton *et al* are honest attempts to include stakeholders in decisions on research, they will have to compromise – sometimes on the smallest common denominator – on the research questions to address and the methods to use. High-quality research frequently requires independent thinking and unusual ideas. Compromises between many stakeholders are rarely the way forward in this.

Final comments

I wholeheartedly welcome the initiatives that Paxton *et al* propose. They can help to improve services directly – through the immediate results – as well as indirectly – through increasing commitment and enthusiasm of staff, patients and carers involved. Like any other provider of healthcare, the National Health Service should be encouraged to fund these initiatives. Yet, when Paxton *et al* call their approach 'research', they should at least acknowledge that this is not without difficulty and that there may be a tension between the interest of local stakeholders and those of the global research community. Also, if the terms 'quality improvement', 'reflective practice' and 'research' are not synonymous, their different connotations should be clarified for a useful debate on what 'research' in the real world should encompass.

Declaration of interest

None.

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Unity is strength. Commentary on . . . Research in the real world†

Our knowledge of the causes of and effective treatments for psychiatric disorders is still quite limited. There are substantial areas of clinical uncertainty. A frequent contributor to the stress and strain of psychiatric practice is our lack of knowledge and the subsequent difficulty of making decisions. Hence research into the causes and treatment of psychiatric disorder should be a priority for mental health professionals, service users and their informal carers. No one would countenance the notion that the acquisition of knowledge about psychiatric disorders should stop in 2006.

These arguments are frequently rehearsed and often met with nodding heads of approval. However, the experience of carrying out research in clinical settings is often quite different. Although there are many enthusiasts for research among clinicians, there is also a perception – at least from the perspective of my 'ivory tower' – that research is an irrelevant or an extra and tiresome task with low priority. Randomisation is at times felt to be an unnecessary complication and with dubious ethical justification. The academics themselves appear, often with justification, to be pursuing research for their own aggrandisement rather than in an effort to improve knowledge. The outputs of research in the *British Journal of Psychiatry* often seem technical and far removed from clinical practice. Frequently, clinicians in the National Health Service see recruitment of patients into a research project as providing help towards career enhancement for the university-based academic rather than a contribution to a collective effort to increase understanding.

There have always been divisions and some hostility between those in our profession who have chosen an academic career and those who pursue a more clinical vocation. Nevertheless, there appear to be other areas of medicine where the research effort is more of a partnership between the ivory towers and the clinics. In a discipline such as cardiology, almost all consultants have had a period of full-time research and have an MD. From the outside it would appear that academic and clinical cardiologists work more closely and share a common research agenda. Large trials such as The Second International Study of Infarct Survival (ISIS-2), in which many thousands of patients have been randomised, are a testament to this collaboration (ISIS-2, 1988).

Paxton *et al* describe a collaborative approach towards research designed to bridge the gap between academic and clinical practice. This is an innovative and interesting idea but can only be applied to research concerned with the implementation of policy. There is no doubt that we need more of a collaborative ethic towards building our knowledge base in psychiatry. We need to develop a much more comprehensive collaborative throughout the whole of mental health services in order to create a professional consensus around the important questions that need to be addressed. We must also accept that all kinds of research are needed from genetics and imaging through randomised controlled trials to more

†See pp. 43–45 and pp. 45–46, this issue.

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applied research. Psychiatry, possibly more than any other area of medicine, requires a broad range of investigative techniques from the biological to the sociological.

In 1848, Karl Marx and Friedrich Engels ended *The Communist Manifesto* with the timeless phrase: WORKING MEN OF ALL COUNTRIES UNITE! Although much of the content of this publication has been assigned to the remainder pile, this call for unity of purpose is still worth repeating for both men and women. A collective professional and international effort is needed to improve our knowledge of psychiatric disorders. We have nothing to lose but our chains.

Declaration of interest

None.

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Reference

SECOND INTERNATIONAL STUDY OF INFARCT SURVIVAL (ISIS-2) (1988) Randomised trial of intravenous streptokinase, oral aspirin, both or neither among 17,187 cases of suspected acute myocardial infarction. *Lancet*, *ii*, 349–360.

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