

**A future in primary care research: a view from the middle**

Sudeh Cheraghi-Sohi PhD<sup>1</sup>, Marieke Perry MD PhD<sup>2</sup>, Emma Wallace PhD<sup>3</sup>, Jenni Burt PhD<sup>4</sup>,  
Katharine A Wallis MBChB PhD MBHL<sup>5</sup>, Adam W A Geraghty PhD<sup>6\*</sup>, Karlijn J Joling  
PhD<sup>7</sup>, Fiona L Hamilton MBBS PhD<sup>8</sup>, Albine Moser PhD<sup>9</sup>, Andrew D Pinto MD<sup>10</sup>.

<sup>1</sup> NIHR Greater Manchester Primary Care Patient Safety Translational Research Centre, University of Manchester, Manchester, UK. <sup>2</sup> Department of Primary and Community Care, Radboud University Medical Center Nijmegen, The Netherlands. <sup>3</sup> HRB Centre for Primary Care Research, Royal College of Surgeons in Ireland (RCSI), Dublin, Ireland. <sup>4</sup> THIS Institute (The Healthcare Improvement Studies Institute), University of Cambridge, Cambridge, United Kingdom <sup>5</sup> Department of General Practice & Primary Health Care, Faculty of Medical and Health Sciences, The University of Auckland, Auckland, New Zealand. <sup>6</sup> Primary Care and Population Sciences Division, University of Southampton, Southampton, UK. <sup>7</sup> Department of General Practice and Elderly Care Medicine, Amsterdam Public Health research institute, VU University Medical Center, Amsterdam, The Netherlands. <sup>8</sup> eHealth Unit, Department of Primary Care & Population Health, University College London, London, UK. <sup>9</sup> Department of Family Medicine, Faculty of Health, Medicine and Life Sciences, Maastricht University, Maastricht, The Netherlands. <sup>10</sup> Department of Family and Community Medicine, Faculty of Medicine, University of Toronto.

**Support:** Sudeh Cheraghi-Sohi is funded by the National Institute of Health Research Greater Manchester Primary Care Patient Safety Translational Research Centre, Emma

Wallace is funded by the Health Research Board of Ireland reference HRC-2014-1. Jenni

Burt is funded by the National Institute of Health Research School for Primary Care

Research. Andrew D. Pinto is funded by the Department of Family and Community Medicine at St. Michael's Hospital, the Li Ka Shing Knowledge Institute and the Department of Family and Community Medicine, Faculty of Medicine at the University of Toronto.

The future of primary care research (PCR) has recently undergone critical analyses from major thought leaders in the field, resulting in a mixed view of its prospects.<sup>1-3</sup> In response, as members of the Oxford International Primary Care Research Leadership programme's 2016-2018 cohort (<http://www.oxfordleadershipprogramme.co.uk/>), we provide our mid-career analysis of the future of the field, as well as making some recommendations for supporting a positive outlook.<sup>4</sup>

### *Our vision*

We are committed to the tenet that primary care is the foundation of efficient and high quality health systems around the world. High quality primary care is underpinned by high quality research. We need research to evaluate policy, practice, service design, the role of health technology in care delivery, and innovative solutions to ever-pressing workforce issues. A strong pipeline of primary care researchers (PCRs) is required to deliver this agenda. In this piece, we briefly reflect on where we feel the key blockage in the pipeline is, the 'mid-career primary care researcher', and make recommendations on how we might 'unblock' it.

### *Primary care research strengths*

Primary care encompasses a distinct and complex model of health care, with core values of first contact, person-centred, comprehensive and ongoing care which underpins how we design, deliver and monitor ongoing care for most of our population here in the UK and in many other countries.<sup>4</sup> In order to respond to the increasingly complex needs of patients (e.g. ageing, multimorbidity), PCRs are challenged to pursue complex, innovative and wide-reaching research agendas.<sup>5-8</sup> The complexity of such concepts reflects the fact that a variety of researchers are typically engaged in these issues: clinicians, nurses, pharmacists,

psychologists, sociologists, anthropologists, statisticians, health economists and those who simply term themselves ‘health services researchers.’ Indeed, we see the diversity of researchers routinely involved in PCR as another core strength, with multidisciplinary research teams working together to provide fertile ground to design and evaluate complex interventions in the real world, and to create innovate methodologies. For example, ‘pragmatic trials’, whose results are readily applicable to day-to-day care, are on the rise, with primary care demonstrating world-leading expertise in the design and delivery of ‘real-world’ trials,<sup>9</sup> alongside qualitative research approaches, including ethnographic interactional approaches to uncover the complex processes at work within primary care practices.<sup>10</sup>

### *The challenges at mid-career*

However, there are many barriers to the achievement of sustained high quality PCR and a stable primary care research workforce. We have focused on our own mid-career stage as we see this as *the* key transition point in the PCR pipeline with issues arising at the macro, meso and micro level. Whilst some of these issues span disciplines, some are unique to or magnified in the field of PCR.

### *Macro: the academic system*

As mid-career researchers, we are typically forging our own research identities, which are recognised within our institutions and are expected to begin to have an impact on a national and international scale, while simultaneously gaining teaching, supervision, and administrative responsibilities. However, ‘middle grade’ posts are rarely tenured, placing enhanced pressures on us to secure not only our future salaries, but those of our nascent research teams. The two main system currencies of: 1) research grant income, and 2) ‘high impact’ publications have resulted in us increasingly being economically dependent on

securing high levels of both. This is even more pertinent for PCRs, who, from a clinical academic perspective, can be viewed as the intellectual and academic ‘Cinderella’ of the health research domain. This subsequently impacts on the streams of funding we can apply for, with some of the largest and most prestigious funders having fewer calls for PCR. Consequently, we can be left chasing a wide variety of potential and smaller funding sources, which makes developing a coherent research identity more challenging as opposed to specialty research. Furthermore, whilst trying to maintain and promote its distinct identity by having discipline-specific journals, conferences and the like, PCR may have inadvertently done itself a disservice by not targeting and having a sustained presence in the top medical journals and their editorial boards. This has a knock on effect for the rating of our work by our institutions, funders and national research assessment exercises which pit us against those medical researchers engaged in research more typically seen in the top scientific journals.

#### *Meso: skill development*

Mid-career is a time when researchers must develop and refine multiple skills, including converting ideas into fundable projects, and publishing high impact manuscripts. Concurrently, one needs to develop project and line management skills; build networks; learn how to supervise and mentor; and be willing to take on institutional roles. To build a vision and develop a research identity the mid-career researcher needs to learn an ever-expanding variety of core skills as well as now developing a savvy social media profile, hitting the ‘altmetrics’ in order to engage a wide variety of audiences including colleagues, funders, the public and policy makers.

### *Micro: work-life integration*

Mid-career is often also a time when many researchers from all disciplines find themselves at a unique nexus point juggling major competing professional and personal demands, including caring for young families/elders, managing dual-career households, and for clinicians, maintaining a clinical portfolio of work. Clinical PCRs encounter specific challenges: research institutes and clinical practices often have different and, at times, conflicting interests, in contrast with hospital settings where research is more integrated to everyday work. Both personal and clinical commitments may also limit flexibility in terms of attending research meetings and conferences essential to developing networks.

### *Supporting the middle*

Having briefly outlined some of the challenges encountered in mid-career academic primary care, we now want to focus on some potential solutions to support a stable primary care research workforce.

We endorse the recent Bratislava Declaration of Young Researchers' call to recognize the special role that young researchers play, and to better enable them: i) to realise their ideas to understand and improve the world; ii) to find sustainable and transparent career trajectories; iii) to work in a diverse, collaborative, inter-disciplinary, open and ethical research environment; and iv) to have a healthy integration of work with the rest of life.<sup>11</sup> However, we acknowledge that enacting change at that macro level, in a historic and hierarchical academic system, will take time and perseverance. The desirable outcome of change here must be the availability of a clear, structured and supportive career path to those who are willing and able to follow it.

At the meso-level, we feel that skills assessment, training, and coaching is essential. This is increasingly offered in leadership programmes. However, we have no idea what the outcomes

of these programmes are. We must ask whether they are working (what are we really trying to achieve?) and if not, why not? In addition to providing opportunities to build links and learn about leadership, we have benefited from the residential ‘time-out’ provided by our scheme. Time-out from everyday work provides us with opportunity to reflect, and time to develop new ideas, collaborations and future partnerships. Space for such inspiration and reflection is rare, and we feel a particular issue for mid-career PCRs. Short, institute supported sabbaticals with specific foci (e.g. grant writing) as well as more seed corn schemes aimed specifically at PCR ought to be prioritised, supported and instituted to nurture high-quality and innovative research. However, we also need current academic leaders to serve as mentors, showing us how to implement leadership skills in our daily work and be collaborative in spite of the competing and competitive demands (driven by the current system) of the PCR setting. We need our current leaders to help us develop our research ideas, research identity and methodological expertise. We stress the importance of both formal and informal mentoring relationships, with current leaders within departments actively seeking and partnering with promising mid-career PCRs. In short, we encourage a vision of a supportive meritocracy, with varied schemes at departments and institutions, endorsed by professional bodies to facilitate a smooth transition from mid-career to tenured senior posts.

Finally, and most importantly, what do we need from ourselves? We must be strategic with our time and actions, focusing on the key currencies of the current system in order to survive, as well as develop and show the resilience to work within the current system and change it from within in order to thrive. We must make our research matter; working with funders, policy makers and most importantly patients; co-producing our research priorities is one way of doing this. We believe that PCR priorities should be *the* priorities for any efficient, high performing health system. Investing in the future of PCR by supporting those of us who seek

to drive it forwards is one way of building both a strong PCR environment and a stronger health system.

## References

1. MacAuley D. Thinking the unthinkable: general practice research. *CMAJ Blogs* 2016; 29 Jan: <https://cmajblogs.com/thinking-theunthinkable-about-general-practice-research/> (accessed 25 Jul 2018).
2. Horton R. Offline: how to save primary care research. *Lancet* 2014; 384(9948): 1082.
3. Campbell J, Hobbs FDR, Irish B, et al. UK academic general practice and primary care. *BMJ* 2015; 351: h4164.
4. NHS England, Care Quality Commission, Public Health England, Health Education England, Monitor, Trust Development Authority. *NHS five year forward view*. London: NHS England, 2014.
5. Wallace E, Salisbury C, Guthrie B, et al. Managing patients with multimorbidity in primary care. *BMJ* 2015; 350: h176.
6. Barnett K, Mercer SW, Norbury M, et al. Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. *Lancet* 2012; 380(9836): 37–43.
7. Patterson SM, Cadogan CA, Kerse N, et al. Interventions to improve the appropriate use of polypharmacy for older people. *Cochrane Database Syst Rev* 2014; 10: CD008165.
8. Smith SM, Wallace E, O’Dowd T, Fortin M. Interventions for improving outcomes in patients with multimorbidity in primary care and community settings. *Cochrane Database Syst Rev* 2016; 3: CD006560.
9. Bower P, Kennedy A, Reeves D, et al. A cluster randomised controlled trial of the clinical and cost-effectiveness of a ‘whole systems’ model of self-management support for the management of long-term conditions in primary care: trial protocol. *Implement Sci* 2012; 7: 7.
10. Grant S, Checkland K, Bowie P, Guthrie B. The role of informal dimensions of safety in high-volume organisational routines: an ethnographic study of test results handling in UK general practice. *Implement Sci* 2017; 12(1): 56.
11. Bratislava Declaration of Young Researchers. 1 Aug 2017. <http://declaration.mimuw.edu.pl/> (accessed 25 Jul 2018).