The paper by Salmon et al. challenges many of the agreed international ‘norms’ for engaging practitioners in research projects. A group of UK researchers explore the reasons why only 67 out of 1934 family practitioners contacted agreed to take part in a study. We have all assumed that making time and resource available for practices, engaging practitioners in the design and prioritization of research projects and increasing their own research skills would increase the volume of research carried out in primary care. Indeed, much of the past 14 years’ initiatives in the UK, from primary care research networks, research capacity development programmes and now the UK Clinical Research Collaboration, have been founded on these principles. Salmon et al. find that it is not ‘time, money and lack of relevance’ that dissuade practitioners from taking part but a lack of prioritization based on perceived threats to professional autonomy and a lack of personal incentive.

In the UK, general practice is at a watershed between the traditional role of the independent practitioner, responsible only to his professional body and his patients, and the new world of managed care, quality and outcomes frameworks, and external accountability. This is not unique to the UK, similar moves are taking place in many countries as a culture of managerialism takes control of health services. It is my concern that primary care research risks being squeezed between a ‘rock and a hard place’ as we are valued neither by the old nor the new. It does not surprise me that whilst many of those interviewed were overtly willing to acknowledge the role of evidence-based medicine (EBM), yet at the same time espouse the ‘art’ of medicine and the role of the individual patient narrative as being more central to their professional practice than external interventions such as evidence-based guidelines. The individual therapeutic relationship between a patient and their family physician has long been both what patients value most and one of the key attractions of a career in family medicine. The challenge for those of us that teach EBM has always been to show how questions and their evidence-based answers are uniquely driven by the needs of clinical care. It has always astounded me that practitioners have not been rising up and demanding that more research takes place to inform their practice, are we ‘academics’ perverse and atypical in the way that we perceive our clinical practice? It seems that we may be, and if that is so we must do more to influence the norms and views of our peers.

Before academic family medicine became established in the 1970s, it would have been only a few brave pioneers (Hart, Fry, Withering) who could show that research in primary care had any value. The dominant epistemology was that of the ‘bench to bedside’ clinical specialist approach characterized by Sir William Osler. General practitioner’s work was of little value, and therefore of little importance for research. Academic family medicine is now represented in most medical schools around the world, and an ‘international’ journal such as Family Practice can receive excellent papers from the far side of the world. However, to many heads of academic institutions little has changed, and to quote one anonymously ‘Academic General Practice is not our core business’. The UK National Health Service at least has recognized that research that informs 90% of contacts in the health care system is its ‘core business’. Articles in this issue showing that many patients with ‘uncontrolled’ hypertension are in fact controlled when BP is measured appropriately, evaluating patient versus physician assessment of dyspeptic symptoms, and exploring the role of the electronic medical record in finding people at risk of diabetes are all directly relevant to clinical practice. That family medicine is central to the development of the UK Clinical Research Collaboration with the establishment of the Primary Care Research Network (PCRN) and the National...
School for Primary Care Research, investments both in using primary care as a resource for research, and in developing a programme of primary care-led research. In the USA, European Union and Canada there have also been investments in Practice-Based Research Networks and applied research programmes.

Like many researchers, I have personal experience of the difficulty of recruiting subjects through practices. In 2003 the UK Medical Research Council funded a randomized controlled trial of the cost-effectiveness of two alternative management strategies for patients consulting with dyspepsia, known as CUBE. Patients presenting to their general practitioner with dyspepsia were randomized to either a month of a proton pump inhibitor or ‘test and treat’ for Helicobacter pylori. It was not possible to enhance recruitment by screening for prevalent cases, as we relied on opportunistic recruitment by practices. Recruitment to CUBE proved to be more difficult than anticipated, with 699 subjects recruited to a target of 2000. Initial 1999 estimates of recruitment proved to be too low as in the ensuing 3 years many ‘early adopters’ had already incorporated ‘test and treat’ into their management of patients. Our response was to increase the number of practices from 79 to 140 by revising trial procedures to enable national support using a combination of the MRC General Practice Research Framework and remote support via an electronic system for training and online data entry (MidReC-en). Mid-trial recruitment of additional sites was severely hampered by the April 2004 introduction of new research approval procedures, and our need to apply to 64 separate responsible organizations (Primary Care Trusts). This had a catastrophic effect on the start-up of the new sites. Most sites were delayed until October/November, and 22 were still outstanding as of January 2006. Unfortunately the funders would not allow a study extension, even without additional funds to allow for this. It is hoped that revision of these procedures and national initiatives such as PCRN will prevent this happening in future.

Is the old giving way to a new world of engagement with research? I fear not. As Salmon et al. discover it is not just professional opinion that limits engagement but the role of practices as small organizations with their own needs and priorities. In the UK at least, these organizations are undergoing fundamental change as they are performance managed by Primary Care Trusts. Increasingly practices are looking to competition from the private sector for their core business as well as the demands of pay per performance. ‘Time is money’ but it is quite possible that practices will choose to prioritize demands of their clinical contracts above earning additional resource through research activities. Publicly funded research has never paid more than the marginal cost of this activity, and few practices would wish to take on the employment risk of additional staff. Some highly successful research consortia have developed where the capacity is pooled, but this takes both vision and effective leadership. Where healthcare is provided by third parties, they will be unwilling to take any responsibility for research unless this forms part of their core contract. Both nationally and internationally we need to forge a more effective partnership between researchers, health policy makers and the clinical professions. If health systems value an evidence-base they must prioritize research throughout their contracting, resourcing and training activities. If family medicine as a profession values research, national colleges must incorporate it into their definitions of professional competence and curricula. We must make research ‘core’ and directly relevant to both the management of health services and to the individual development of the non-academic clinician. Surely our patients deserve nothing less?

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