Primary care research in the postmodern world

Brendan Delaney


A new editor’s first editorial is a place to thank, take stock and define some objectives. First, I would like to thank Roger Jones for his kind comments in the last issue. I am very aware that I succeed two highly distinguished academics in the discipline of primary care, Roger Jones and John Howie, in editing this journal. They have created a journal that is now well established as the only overtly international primary care journal, and steadily improved the journal’s profile and impact. Having devoted 14 years to *Family Practice*, I know that Roger will watch my efforts with keen interest, and I am sure that I will be relying on his advice in the coming years. I bring experience as an author, reviewer and active researcher. I have served on the Editorial Boards of *Medical Decision Making* and the Cochrane Upper GI and Pancreatic Disease Group, and as an editorial advisor at the *British Medical Journal*. As an editor, I should be concerned about ‘impact factor’. In fact, all the primary care specialist journals have much lower impact factors than equivalent journals in other specialties. This is a problem for our whole discipline, and I would like to see the impact factor of all primary care journals improve. I hope that by providing a journal where authors will want to see their work published, the impact factor will naturally follow. Being a ‘modern’ editor, I have resisted the urge to change the cover (for now), but have re-written the mission statement.

“*Family Practice* is an international journal for those active in research, teaching and practice in the fields of Primary Care, Family Medicine and General Practice. We welcome contributions from disciplines outside medicine, including nursing and social science. Priority will be given to high-quality original research that advances knowledge in clinical care, organization or methodology and is generalizable to other settings and countries. We would particularly like to encourage the reporting of randomized controlled trials from primary care.”

My intention is to edit a ‘good’ journal. What is a ‘good’ journal? It starts with attracting ‘good’ papers from experienced and knowledgeable authors that readers will want to read. First and foremost we will be judged by the standards of our service to authors, prompt fair peer review and providing a place where authors will be happy to see their work published. With this in mind, we will be introducing a few changes to the way the journal handles papers. By the time you read this, we hope to have adopted an electronic submission, review and manuscript handling system. We will be developing the reviewer database and aim to provide a ‘slick’ service in the editorial office. There have also been a number of changes to the instructions for authors to bring them into line with best practice in ethical approval, disclosure of competing interests and reporting.

I am delighted to have the opportunity to welcome a new Editorial Board. First, we now have three Associate Editors. I am pleased to say that Tom Fahey from Dundee will be supporting me in dealing with manuscripts. This will provide continuity for absence, and a fair means of dealing with papers where I might have a conflict of interest. Lorne Becker from New York State is currently the chair of the Cochrane Colloquium Primary Care Field, and will be soliciting review articles that will enhance our skills in research methods. Martin Dawes, formerly director of the Centre for Evidence-based Medicine (CEBM) in Oxford, now head of Family Medicine at McGill (Montreal), will be editing a ‘back page’ with news and issues from the academic primary care community worldwide. (See the journal website for how to contribute to this.) For the Editorial Board, I have tried to create a balance regionally around the world and by discipline. Cindy Lam and Doris Young represent South East Asia and the Pacific regions, Niek de Wit, Europe, and David Mant and Tony Kendrick the UK. Elaine McColl is an experienced social scientist with interests in questionnaire design and the measurement of quality of life. Mark Sculpher is a respected health economist, and Martin Marshall knows health policy issues in both Europe and North America. Claire Harries has a psychology background and a research interest in the theory and application of medical decision making. Paul Glasziou is an academic GP from Australia, now director of the CEBM in Oxford, and has published widely in diagnostic test evaluation and modelling. Sandra Eldridge from Queen Mary and Westfield College, London, is our statistical advisor.
An editor should have some ‘vision’ as to where he should lead the journal in the coming years. Another journal with an international readership recently attacked primary care research after reporting an outbreak of intra-disciplinary navel gazing at the WONCA meeting in Canada last year, and tried to define what we should be studying.\(^1\) Whilst I agree with many of the views expressed, particularly that primary care is not ‘uniquely complex’, I think a focus on the ‘family’ as a particular focus for primary care research is too limiting. The concept of ‘the family’ as the focus of primary care reflects a framework developed in the 1970s and based on social theories at that time. The 1980s and 1990s saw the rise of the individual and the impact of postmodernism on both society and the relationships between individuals, society and the medical profession. My vision for the journal is to see it create a multidisciplinary ‘virtual community’ of researchers interested in sharing ideas about working with patients in first-contact settings.

The conceptual framework within which primary care research takes place is indeed a complex one, but one which links the individual as a consumer of health care with the need for evidence-based and cost-effective care. It is not the complexity of primary care research that is unique, but its blend of both quantitative and qualitative approaches, often bringing the perspective of the social sciences to more traditional methods such as randomized controlled trials (RCTs). Departments of Primary Care have a unique place in medical schools as places where individual and population perspectives on disease can co-exist within a practical clinical discipline. In the UK, primary care research has flourished in the past decade, with a large rise in the number of non-clinical researchers and four ‘internationally’ (five-star) rated departments in the 2001 research assessment exercise. My particular area of interest is in the management of dyspepsia, including health economic models, RCTs and meta-analysis. It is quite typical of ‘postmodern’ primary care research, using complex methodologies to explore how best to approach a common condition by studying the effects of treatment on individuals. What primary care does not bring is lucrative industry funds, based on the potential to develop patentable therapies. Perhaps the discipline’s relative weakness and the cause of the navel gazing is based not in any lack of relevance or rigour, but in University finance offices, looking to support their cash-strapped institutions at a time of crisis.

I welcome the \textit{Lancet}’s call for research that makes a difference to patients, and the best primary care research will have direct impacts on patient care. The challenges that the academic primary care community face are ones of cohesion and communication. We need to be able to define ourselves and our inventory of interests and methods, rather than be defined by others, and we need to be able to communicate our findings and beliefs not only to those outside primary care, but also to find relevance with practitioners who do not immediately see the value in ‘academic’ work. In part, this is because, relative to academic specialism, academic generalism is up to 100 times less represented as a proportion of practitioners, but also because the nature of generalism leads us to seek evidence in almost any area of clinical practice. Most successful clinical primary care academics will have alliances with a particular specialty and also methodologists. It is all too easy to lose sight of the fact that whilst we may chalk up our ‘greatest successes’ by being the face of primary care in Gastroenterology, Cardiology, Mental Health, Diabetes or Heath Economics, we are still primary care researchers. It is organizations such as the Society for Academic Primary Care in the UK, The North American Primary Care Research Group, WONCA and journals such as \textit{Family Practice} that provide the counterbalance, cohesion and a platform for communication. I am honoured to take over as editor of this journal, and ask all of those involved in primary care research to use the journal to communicate and build a more cohesive platform for our discipline internationally. I would ask all of you to think of \textit{Family Practice} as a natural home for your work, and to participate in the life of the journal as an author, reader or reviewer.

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Reference
\(^1\) Is primary-care research a lost cause? \textit{Lancet} 2003; 361: 977.