

AB/leb/Cooksey

30 May 2006

Sir David Cooksey  
Consultation Responses  
Cooksey Review Secretariat  
HM Treasurer  
1 Horse Guards Road  
LONDON  
SW1A 2HQ

Dear Sir David

I welcome the opportunity of commenting on the proposal to combine the Medical Research Council and NHS R&D research into a single programme, an exciting proposal that I think has the potential to combine the strengths of both. I am not competent to comment on all the questions raised in your invitation, but would like to concentrate on the central issue of how to combine basic and clinical research in the most fruitful way. For over 20 years I directed a MRC Unit in Cambridge that explicitly aimed to provide such a link. During that time I served on a range of MRC committees including chairing the Neuroscience Board, and was also involved in NHS R&D committees at the local and national level. I would like to discuss the strengths and weakness of the MRC and the NHS R&D in terms of two clinically important research areas with which my Unit was directly involved. The first of these concerns cognitive behavioural therapy for emotional disorders, and the second the development of neuropsychological rehabilitation for brain damaged patients.

There is no doubt that the development of cognitive approaches to the treatment of emotional disorders has been successful, and has relied heavily on research in the UK. The presence of a strong behavioural psychology tradition at the Institute of Psychiatry in the middle years of the last century, led to both the development of new treatment methods, and the training of clinical psychologists with an appreciation of these methods. This research theme was continued in Oxford, and subsequently at my own Unit in Cambridge, where it was related to new developments in mainstream cognitive psychology. This led to a number of developments including a new method for the treatment of depression which significantly reduces the likelihood of relapse (Teasdale et al, 2000)\*. I was pleased to note that DoH has now recommended that cognitive behavioural therapy be used as a preferred method for treating a range of emotional disorders.

I believe the success of this line of research was based on two factors. The first was the strong links between clinical issues and scientific research that typifies the training of clinicians at the

---

\* Teasdale, J. D., Segal, Z. V., Williams, J. M. G., Ridgeway, V. A., Soulsby, J. M., & Lau, M. A. (2000). Prevention of relapse/recurrence in major depression by mindfulness-based cognitive therapy. *Journal of Consulting and Clinical Psychology*, 68, 615-623.

Institute of Psychiatry. The second was the willingness of MRC to continue support over the many years that it takes to develop and validate new methods of treatment. In the case of my own Unit for example it took more than five years to establish that the link between cognitive and clinical psychology did indeed offer a valid and fruitful new approach. This was possible within an MRC Unit context, but it would have been difficult to obtain such sustained support in a university.

While the collaboration between MRC and NHS worked very well in the case of cognitive therapy, it worked less well in the area of neurorehabilitation. A major problem for the NHS is how to deal with patients suffering from traumatic brain injury. These often result from road traffic accidents typically to young men who will then have a normal life expectancy. My own interest stems from my research on memory disorders, a prominent feature of this condition. Typically the damage is diffuse, and the pattern of deficits varied, with the result that this group does not lend itself to the testing of theoretically-driven hypotheses. As such it tends to be difficult to convince academically orientated referees and boards to rate such projects very highly. Despite this, MRC has supported work over the years, initially funding the Jennett Committee to survey research in this area; they found there was very little. I myself became involved through a request for advice from clinical neuropsychologists who had formed an Anglo-Dutch group to further investigate the topic. MRC funded two posts in my Unit, and have continued to provide support, eventually resulting in the appointment at a professorial level of Dr Barbara Wilson, a leading figure in the area who had previously work exclusively within NHS, and who has maintained strong clinical links both here and abroad. She was able to build a group within my Unit, and subsequently set up a model rehabilitation centre funded jointly by NHS and MRC. This have proved extremely successful not only in developing new techniques, but also in training clinician-scientists to carry on the work elsewhere.

It has however, as mentioned previously, always been rather difficult to convince MRC boards of the scientific importance of such work, whereas this has been less the case with NHS, who have to my knowledge, funded two major research initiatives in this area.

One of these was to select the area of "Physical and Complex Disabilities" as one of the major areas to be funded as part of the R&D initiative launched a decade or so ago. I was asked to chair this particular committee, with a budget that grossly exceeded anything that had come into the field previously. We received a very large number of proposals, often based on good ideas, but very few backed by the scientific experience or competence to conduct the programme. The lack of earlier support meant that there was very little research infrastructure in the area. We were however able to set up a number of worthwhile studies that seemed likely to develop such an infrastructure, given continued funding. Unfortunately however, after the initial investment there seems to have been no follow up, other than a request for final reports. I attempted to resign as chair, but could find no one who appeared to know enough about the programme to be able to accept my resignation.

A second example concerned an invitation to tender for an NHS R&D funded trial of treatment for traumatic brain injury. Professor Wilson and myself were invited to join the programme because of our expertise in evaluation, and were somewhat puzzled by the research design. This involved inviting proposals for model treatment programmes, and selecting about a dozen such proposals for subsequent evaluation by to the Warwick Business School. When we asked about control groups, we were told that the recently developed statistical methods available at Warwick made this unnecessary. We were sceptical, but were assured that this was the case. In due course data were collected from the dozen or so centres, and fed into what proved to be a relatively standard multivariate statistical analysis, essentially correlational in nature. The main conclusion to emerge was that the more treatment the patients received, the more serious was their cognitive deficit. As we pointed out, correlation does not necessary imply causation,

otherwise one should abolish hospitals. They simply found that more impaired patients received more therapy.

I gather that the programme was run by someone whose background was in nursing, and who had the laudable though impractical aim of trying to combine research with providing more support for rehabilitation. This basic design error would not have happened in a programme overseen by the MRC.

In conclusion, I think it would be a major step forward, if the new structure could combine the scientific excellence of the MRC with the capacity to focus on questions that may be clinically important, even though not scientifically exciting. At the same time it is important that questions are chosen that are tractable, given the current state of knowledge. That again requires highly expert scientific and clinical involvement. Finally, while it is important that politicians and civil servants have the opportunity to realise the very laudable concern to “do something quickly” about important problems, it is also crucial that it is recognised that good science takes time.

So what should be done? First of all the two organizations should be brought closer together. It is clearly crucial that the MRC continues to do basic research at the international cutting edge. It is also important however that the scientific expertise should be made available to the more clinically oriented research that is currently the province of NHS R&D, perhaps by the creation of new Boards containing a blend of basic and clinical scientists. They should be free of immediate political pressure, and be given a sufficiently stable budget to allow them to develop the long-term research programmes that are essential for genuine clinical progress. Given these conditions the proposed programme has the potential to improve dramatically the quality of medical research in the UK.

Yours sincerely

A handwritten signature in cursive script that reads "Alan Baddeley".

Professor A D Baddeley CBE FRS  
Department of Psychology  
University of York