

Review of UK Health Research.

I write to raise concerns about the current problems engendered by over-complex regulation for observational research within populations, and about the consequences of NHS organisational change for clinical research. I do so as a clinical academic, previously Dean of Medicine and Dentistry in Birmingham, and as one who was, until recently an NHS Trust chairman.

Frequent changes to trust structures have become the norm. Whether these are generally necessary, desirable and logically well-founded is not a matter for consideration here. However:-

(i) It seems clear that those involved practically in such restructuring have to concentrate on basic issues of budgetary control and the meeting of a proliferation of targets eg over waiting lists, and initiatives.

The consequences of large scale changes in patterns of care tend to be under-researched. Thus, in the ambulance service about half of all patients dialling 999 are now not conveyed to hospital [but given definitive treatment at home] by some ambulance trusts whereas all are conveyed by others. No scrutiny has yet been undertaken of the value of this large scale change, indeed it will be difficult to do because record systems of ambulance and other, notably hospital, services do not link effectively. Thus, early treatment of septicaemia is believed to save lives, ambulance service personnel can prescribe antibiotics, but do they do so appropriately and are patients at risk of septicaemia left at home or taken to hospital?

(ii) There is little consideration of the consequences of reorganisation for innovation in health care, and there is a lack of a culture supportive of research. A simple statement that research is to be expected, and is to be encouraged for its potential to improve health care should be placed in every trust's key principles. Those examining trust performance should also be mandated to ask about research undertaken and its value.

Research of mine examining the health of psychiatric patients was made extremely difficult because reorganisation of care [a move to Care in the Community] frequently made records inaccessible through placement in off-site store rooms without decent indices.

(iii) Frequent changes in personnel working within public health systems inevitably mean that those in post may have little knowledge and understanding of the needs of research workers. This is coupled with a tendency to procrastinate over requests for help because of fear of being pilloried for some infringement of the prevailing rules which govern data and tissue access.

Six years ago I obtained a grant from the Wellcome Trust to examine whether medicines which tended to impair electrical conduction pathways in the heart raised the risk of sudden death in the community, which seemed quite an important question. The work required comparison of practice records of drugs which had been prescribed for patients who later died suddenly with those taken by patients who did not die. It took three years to be able to start, with an amendment necessary to the Health and Social Care Act to allow record scrutiny. It was also notable that

cooperation in setting up the research was usually difficult to obtain for, I suspect, the reasons given above.

(iv). Concern for the meeting of numerical targets and new initiatives in patient care to which new organisational patterns are often linked, tends to reduce time available for considering the clinical value of what is done, and ways of improving it. My strong impression is that clinical academic involvement in NHS management has been eroded, and that the reduction in the influence of this voice may have tended to impede clinical development.

(v). Individual disciplines can be steadily eroded, because no strategy exists to ensure maintenance.

One of the national jewels in innovation is the pharmaceutical industry. Success in innovation is paralleled by high cost of developing new medicines. The industry, being commercial [nationalised drug industries have never succeeded] therefore will tend to accent the value of what it does. Steady erosion of clinical pharmacology as an academic research discipline is removing a partner, and objective counterweight to industry, as well as removing a clinical research to NHS link.*

The difficulty which seems to exist in preserving the clinical base for enquiry against a background of NHS organisational change and initiative makes me wary of restructuring the funding of research to a more integrated pattern, but cross links there certainly must be.

25/7/06
MD,FRCP,FMedSci.

Michael Langman

*Maxwell SRJ, Webb DJ. Clinical pharmacology-too young to die. Lancet 367,799,2006.