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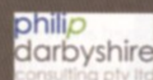

Reform, research and the clinical world

Philip Darbyshire shows how to 'Get a GRIP' on improving research culture

As we face another round of major reform to the health care system, staff across our organisations may be experiencing signs of the dreaded 'BOHICA Syndrome' or, 'Bend Over, Here It Comes Again'. For it seems that no force on earth can satiate the desire of politicians and policy makers (of whatever hue) to reorganise and reform. Health care provokes this desire like no other area of policy.

This time around let's hope that decisions are governed not by expediency and personal preference but by research and evidence. There is an absolute onus on those who move the levers of power to practice the kind of evidence-based and research informed thinking and decision making at policy level that they demand of clinicians and health professionals in their everyday practice.

The planets are certainly aligned for improving research within the current reform agenda. This is especially so for the kinds of practice focused research that engages practitioners and clinicians. Such research and inquiry should take a much more prominent and rightful place in health service planning and provision but has often been the poor relation of 'proper research'.

The NHHRC research reform impetus

The exemplary National Health and Hospitals Reform Commission (NHHRC) report, 'A Healthier Future For all Australians'[1], is a clarion call for practice research reform and it would be a waste verging on criminal if such a once-in-a-generation work were to become a paperweight rather than a catalyst. The danger is real though. As Florence Nightingale cautioned, "reports are not self executive."

The NHHRC urged us to create a health system where research is not a supposedly esoteric activity practised by a rare breed of geniuses, but instead "is visible and regarded as a normal part of providing health services" (NHHRC: 141). Their vision is that research thinking, practice and use will become as integral to a nurse's, physio's, manager's or doctor's everyday practice as is safety, care, compassion, skill, effectiveness and quality. Research thinking and engagement will be part of every health professional's 'core business' and an elemental aspect of any organisational understanding of 'productive hours'.

This is a bold but absolutely achievable vision. The Commission was unequivocal that "to promote research and uptake of research findings in clinical practice, we recommend that clinical and health services research be given higher priority" (NHHRC: 281).

Flattening the research hierarchy

The research world can be notoriously hierarchical and the place of such practice-focused 'clinical and health services research', inquiry and knowledge generation have historically been overlooked or relegated. Flagship research centres and institutes are lauded, large NHMRC project or program grants mean major kudos, large randomised control trials are deemed to be a 'gold standard' and comparing 'h-indexes' is now almost a contact sport among researchers.

These 'top table' research efforts and achievements are certainly admirable. For

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the majority of clinicians and practitioners in health care however, becoming involved in any research activity is simply not on the agenda, such as generating and exploring new clinical research questions arising from their practice, systematically evaluating care or services, or investigating how existing research could be translated and used to improve care.

Some hospitals and health services can legitimately boast of their "vibrant culture of innovation and research" (NHHRC: 133) but for many, there is more active culture in yoghurt.

Dismantling barriers

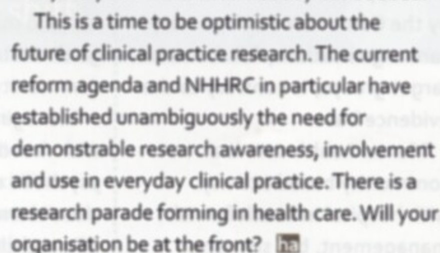
Health professionals who want research and inquiry to become a normal part of their service face genuine barriers. These impediments are not new. They are the unholy trinity of: No Time; No Money; No Clue. These are not imaginary concerns for clinicians. Ask any service director how easy it is to 'release staff' (and here the language itself is revelatory) for any kind of educational or 'non-clinical' activity. Ask clinicians or service managers if they have a dedicated budget for research. Ask them how comfortable they will be in commencing that double blind, twin tailed RCT or Husserlian phenomenological investigation that you had in mind and note their reactions.

These barriers may be real but they are not 'get out of jail free' excuses that clinicians and managers can keep using from now until the end of time. This much we know: there will never be a time in health services anywhere when there are no shortages of staff, endless funding for all needs and where health professionals will have all possible research skills and knowledge. If we decide to wait for the arrival of this Nirvana before we begin because 'it isn't a good time just now', we may as well be Waiting For Godot.

Get a GRIP (Getting Research Into Practice)

We cannot afford research inaction until all NHHRC recommendations or other reforms are implemented and so should start creating healthy organisational research cultures as if it were already standard practice. What can hospitals and health services do now to get their research culture 'reform fit'? Here are six strategies:

- Carry out a research reality check. If research is truly 'critical to the sustainability of your service' (NHHRC: 52), then it should be visible, viable, valued and vaunted in every aspect of your service, from planning through care delivery to evaluation. If there is only a stand-alone 'Research Unit' or solitary 'Research Nurse' post somewhere, this scarcely constitutes a culture of research.
- Expect more of health professionals. Don't patronise or underestimate them by sending overt or covert signals that research is only for the chosen few. Make it clear that research is something that all engage with in this organisation, from level 1 RN to CEO and if you want to be good enough to work in this organisation, research will be an explicit, supported and assessed expectation.
- Enable staff to engage with research at different levels and in different ways. Every health professional does not need to become a Chief Investigator on a $100,000 research study but everyone should be able to support, encourage, participate in, use, or conduct research.
- Australia is ranked among the worst countries for industry-higher education cooperation[2]. Clinical health research can buck this trend. Don't create insular change. Look outside of your organisation for new research culture stimuli, ideas, different thinking and fresh eyes. Collaborate and establish the linkages and partnerships (NHHRC: 138) that elevate 'synergies' from cliché to concrete.
- Process is important but keep a laser focus on outcomes. Missouri in the USA is known as the "Show Me" state. Use what I call the 'Missouri Maxim' to assess progress and achievement in research culture development. Don't settle for spin about how the organisation is 'fully committed' to developing a thriving research culture. Insist on "Show Me".
- Be vigilant lest clinical research is allowed to become 'nobody's baby'. The ubiquitous quality is universally deemed to be everybody's business, as are: safety, change, standards, and virtually every other issue in health care, yet a glance at any recent 'hospital scandal' report quickly disabuses us of this notion. One measure of how seriously an organisation takes clinical research is budget allocation with commensurate accountabilities. When it's everybody's business but nobody's budget then anybody can see that somebody has boobed.



This is a time to be optimistic about the future of clinical practice research. The current reform agenda and NHHRC in particular have established unambiguously the need for demonstrable research awareness, involvement and use in everyday clinical practice. There is a research parade forming in health care. Will your organisation be at the front? ha

1. *National Health and Hospitals Reform Commission (2009). A Healthier Future For All Australians – Final Report of the National Health and Hospitals Reform Commission – June 2009. Canberra.*

2. *Kane, P. (2009). "Working Together" Fast Thinking (Winter): 62-64.*