

Editorial

How to help clinically relevant research survive?

In the present issue of the *Acta Psychiatrica Scandinavica*, Munk-Jørgensen et al. (1) draw attention to an important challenge for our field: There is a considerable gap between available knowledge and its use in clinical psychiatry. They underline that updating clinical practice depends on the presence of research activity and that research knowledge should not only have to be implemented into clinical practice, but also be developed there. If we want clinical practice to be more up to date with clinical knowledge, we must focus on the individuals who carry out the difficult task of treating patients. They need to combine knowledge of the literature with a profound knowledge of local clinical practices. These individuals – physician scientists – must be allowed to build practical wisdom by making mistakes and earning experience. The authors therefore ask for more research relevant to patients. However, this is easier said than done, and the authors warn that the clinical investigator may be an endangered species. They give several examples of how promising projects faded out due to insurmountable barriers. A major stumbling block was the lack of research culture in the departments. There was no tradition for disciplined systematic collection of data by the staff treating the patients. The clinical management was highly occupied by daily clinical work and administrative obligations and did not give priority to projects. There were repetitive complaints about lack of resources, even when wards had been given generous grants for participating, and even seemingly simple problems proved to be impossible to solve. An example was that routine data could not be transferred from the electronic patient record system to the research database.

The problems sound depressively familiar for one who has been heavily involved in clinical research for decades. How can we change this sad state of affairs? A first step must be to better understand the dynamic behind the problems. Munk-Jørgensen et al. identify important factors. They state that too many department managers, low-level managers, psychiatrists, and staff do not support clinical research. They point to three main

reasons. The first is the heavy emphasis on ‘production’. The key performance indicator is seen as continuing patient flow through the departments. As a consequence, there is a focus on acute problem solving and rapid discharge. The lack of a long-term perspective limits the interest about how the patients are doing once they have left the ward.

The second is a lack of organizational support to use research-based information in clinical decision. The authors point to over-reliance on clinical guidelines as part of the problem. If such guidelines are perceived as mandatory to follow, they may stiffen clinical decision making and paralyze the clinicians’ curiosity. The British psychiatrist Tom Main warned against what he termed ‘hierarchical promotion of ideas’ where new promising procedures are transformed into unbreakable laws (2). Any deviation will easily create fear of sanctions while following the rules protects against criticism despite outcome. There are sad examples of poor outcomes where the management has dismissed the need to reevaluate practice because the reviewing board concluded that guidelines were followed appropriately. In contrast to such an attitude, Main advocated a ‘culture of enquiry’ (3). That implies an open-minded attitude which dares to face the risk of having to conclude that the unit’s standard treatment has limited effect and even may be antitherapeutic. Such an attitude can hardly develop in rule governed wards that are driven by ‘effectiveness’.

The third factor is also related to demands on effectiveness, but this time on part of the researchers. Munk-Jørgensen et al. point to a development where research has moved from the ward to the laboratory and the researcher loses contact with the ward and the clinicians. They state: ‘Researchers parachute into departments, grasp their sample, conduct their intervention and leave a huge work load for the clinicians’. In this way, the ward is reduced to a deliverer of raw material. Often data are sampled from more units, and the results may be of limited relevance for the single unit. In addition, there is a lack of communication of results from researchers to clinicians. Such

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research can give high impact and create many publications, but runs the risk of alienating the wards from research and depriving them of any benefit for their clinical work.

The authors point to some promising solutions: One project became a success due to a highly competent project leader working among and together with the staff. Engagement seemed to be the key facilitator for success. The other success story was involvement of medical students. They had a fresh and dedicated attitude of not being afraid of hard work, long hours, and especially not being reluctant to addressing new tasks. The authors' experiences are in line with my own. A crucial factor is that the units recruit persons with research competency and give them sufficient time to do research. It is of particular importance with sufficient time for meetings between clinicians and researchers, where they can learn to know the perspectives and thinking of the other. The researchers have to acknowledge the importance of the clinicians' contribution and create an atmosphere of reciprocal respect. It usually is an advantage if several professions are involved. This helps securing a broad-based feeling of project ownership in the ward. That will help to create room for curiosity and to develop capacity for tolerating uncertainty. Additionally, the researchers can provide resources, for example, for diagnostic evaluation. This will reduce the burden of the staff and give clinically useful feedback.

Such cooperation will make it easier to get the necessary backing from the management on all levels. Such a backing is vital to secure sufficient resources and predictability to carry out research, not only initially but over time. An advantage for the management is that researchers can help to document the value of the program. But such an evaluation requires some patience from the

management. They cannot change the program till the evaluation has been completed. Experience indicates that such a guarantee ought to be given before the evaluation starts. Ideally units with similar treatment programs should join their efforts to create a research network with common research instruments. That can enable evaluation of who the units are treating, what kind of treatment they give, how the outcome is, and what it costs. It is demanding to run such a network. It requires a firm commitment from all units, comprehensive training of raters, a central database, and rigorous quality assurance of data. A highly successful example is the Norwegian treatment research network for patients with personality disorders (4).

It is demanding to conduct clinically relevant research. But it is also highly rewarding and of crucial importance for the quality of the clinical work. To help this type of research develop, we need an alliance of managers, clinicians, consumers, and researchers. It is hoped that a new generation will take the challenge.

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