The Royal New Zealand College of General Practitioners
Te Whare Tohu Rata o Aotearoa

EDITORIAL

Rapid research for rapidly evolving healthcare needs

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My very first research paper was published in 1990[1] and over the following three decades I learned that it took at least a year of planning, a year of data collection, and a year of analysis and writing to complete any meaningful research project (all things being equal and other commitments allowing). Add at least another year if external funding was necessary to enable the project. My doctoral research in the 1990s related to health policy and it taught me that governments' policy decisions could seldom wait three years or more (the term of a government in New Zealand) for relevant research and that policy (not research) was king in decisions about health services implementation. Thus, we had a conundrum: the existing process produced research that failed to inform acute policy needs and much health policy was consequently created in a research vacuum. The end result was implementation of health services of unknown quality and effectiveness until robust research could be completed.

Times have changed. All around the world in 2020 the COVID-19 pandemic has forced governments to make rapid policy decisions and it is a relief to see that funding agencies supporting health research are mindful of the need to avoid long time lags in making funding available for research. In New Zealand the Health Research Council (HRC) released a call for 'actionable' (useful) research and required early completion and research reporting.[2] Rapid research is different from classical health research. It concentrates on novel questions so is largely unsupported by an existing literature, aims to understand evolving situations, uses tools and methods that are enabled by advancing technology, and it is expected to have an early impact on health services delivery. It complements, rather than replaces, traditional health research.

In the last issue of this Journal we published personal experiences and viewpoints related to the pandemic while we waited for fresh research to start becoming available for publication.[3–5] In this issue we publish our first two research reports with lessons for COVID-19 pandemic responses in this country and internationally.[6,7] One paper reports a response to the research call by the HRC in March, that collected data in April, completed an analysis and wrote a paper sent to us in July, in time for a rapid review process to be completed before publication in September.[6] Even so, the authors recognise that the April data they analysed will not reflect the September reality. It does however, provide a baseline for their later investigations into mask use in New Zealand.

We also have COVID-19-related papers from Sweden and Italy, two countries badly affected by the virus. The second COVID-19 research report comes from Sweden, where the New Zealand model of 'lock-down', we are told, is constitutionally prohibited.[7] Concerned about a possible increase in COVID-19 vulnerability in the coming winter months, the authors analysed data from weekly COVID-19 management sources in Stockholm to develop recommendations to refine future COVID-19 management. They conclude that this emergency offers valuable opportunities not only to build better systems for emergency management but also to improve routine care. Our Guest editorialist comments on this and the New Zealand COVID-19 research report.[8] Two young doctors from Italy anticipate that their professional futures will be defined by new emergencies and reflect that this has profound implications for both medical education and structural changes in health service delivery.[9]

The clinical research papers in this issue capture the broad scope of clinical primary care. General practice researchers measured the burden of care in different settings for patients diagnosed with cancer and enrolled in one large general practice, finding that most care for these cancer patients came from general practice and not hospitals.[10] Pharmacy researchers report the substances used in

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intentional self-poisoning among people presenting to emergency departments[11] and identify a gap in patient education as a result of perceived professional boundaries of pharmacists and general practitioners: each thought the other was filling this gap.[12] Physiotherapy researchers demonstrate associations between sleep apnoea and lack of exercise, among other things.[13] Nurse researchers highlight topics for discussion in consultations with patients with pain management needs and identify areas (such as sleep and exercise) where their work in general practice could provide better self-management support.[14] Teams of mixed primary care professional groups contributed to one article reviewing low back pain care[15] and another reporting research testing an electronic tool intended to help midwives screen their patients for mental health problems.[16]

The policy-related research in this issue addresses ageing in New Zealand and Australia[17] and health consciousness in Australia.[18] Higher health consciousness is associated with (among other things) greater self- and collective responsibility for health, which in turn has implications for management of the COVID-19 pandemic.[18]

A little while ago I lived for a short time in the Middle East, where pomegranates became my favourite fruit. I am delighted to learn of their health benefits in this issue's Potion or Poison column and hope readers will find this of interest too.[19]

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