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Research quality in higher education and the NHS

Differing values

VARYING approaches to research can come into conflict under the growing pressure to collaborate across organisational boundaries and to achieve high quality standards, making it necessary for researchers to adapt. There can be a tendency to become 'tribal' about research, resulting in some of the pressures identified in this article. In turn, maladaptive coping strategies may be employed (e.g. 'black and white' thinking). The purpose here is to illustrate these pressures by means of a fictitious case-study approach (inspired by Jones, 2000). The article also indicates some potentially helpful ways of adapting to the pressure.

The case

The Professor was a five-star researcher who had recently extended his undoubted talents as a solo researcher by becoming head of a new research centre. However, the centre required the Professor to collaborate closely with colleagues in the applied end of his field, a new and stressful challenge.

Low esteem The first sign of trouble for the previously confident and energetic Professor was an uncharacteristically indecisive spell, following the time that the chief executive of one of the local NHS trusts that part-funded the centre had publicly questioned his rigorous research style and 'selfish' publication objectives. Appeals from the Professor to the requirements of the Research Assessment

Exercise, particularly the need to publish in high-quality journals, had provoked a stunning attack. In particular, the Professor was somewhat baffled by the alien criteria that the NHS used to judge the quality of his research (e.g. emphasis on benefits for the service), not to mention feeling misunderstood and devalued. On reflection, he could pinpoint the cause of his distress to these seemingly irreconcilable objectives. Previously, when working within the university, he had always had confidence about his goals and achievements. Now he began to doubt himself and decided to seek help.

Acceptance Therapy was not an easy option for the Professor, who had thrived in the university's pervasive culture of rugged individualism. But from the outset his somewhat dismissive notions about therapy were challenged. First he found that his preconceptions about therapists gave too little credit to their research orientation, in the form of generating and testing hypotheses by drawing on published research (the therapist had adopted acceptance and commitment therapy (ACT) as a result of her appraisal of the relevant literature: for a brief overview see Hayes & Toarmino, 1999).

A second challenge to the Professor's preconceptions was how the first stage of ACT, like a good theory, helped him to understand his distress. In place of the appeals to 'willpower' and personal resourcefulness that were customary within the university, the Professor was

encouraged to accept that his current approach placed him in a hopeless situation. Detailed discussion had clarified that he had developed a self-blaming attachment to some faulty beliefs (e.g. that he should be able to solve his problems by working harder). Indeed, since this extra effort was focused on producing even higher-quality research towards the Research Assessment Exercise (RAE), the problem of conflicting research criteria was exacerbated.

Far from deriding the Professor, the therapist made use of metaphors, quotes and detailed questioning to destabilise his current misunderstanding and to highlight the unworkability of his present efforts. One quote stood out: 'If you always do what you always did, you'll always get what you always got' (cited in Hayes *et al.*, 1999). Gradually the Professor came to see how the demands of the RAE and the National Health Service's R&D initiative had created a tension that was hard for anybody to reconcile. He also became better able to accept his own reactions, the first goal of ACT.

Commitment Following a number of therapy sessions in which his unsuccessful efforts to overcome his low self-esteem were clarified and his self-defeating thinking was highlighted, the Professor was willing to commit himself to a fresh start. Following the ACT approach, the therapist gave him a series of behavioural assignments, to move him away from his usual thought patterns.

The first task set was to search the social psychology literature for alternative wisdom on how to work with other organisations. In order to make the research centre a successful partner for the NHS and to raise his self-esteem, it was clear that he required a fresh perspective. The literature on innovation was a revelation. Book after book spoke directly to his experience and he was increasingly able to smile at the naivety of his past efforts. He had, he now realised,

TABLE 1 The Professor's homework, listing some perspectives on quality

Quality as excellence	Quality is synonymous with the exceptional – i.e. only attainable by an elite few
Quality as perfection	Flawless performance or outcomes are taken to indicate quality ('quality control')
Quality as fitness for purpose	Meeting customer or service demands fully
Quality as value for money	Return on investment/effort/resources
Quality as transformation	Changing a user/service from one state to another, more valued, one

been what one of these books termed a 'hero-innovator', doomed to fail (Georgiades & Phillimore, 1975).

This ACT homework had been a great success; the next obstacle to tackle was the Professor's rather monolithic concept of 'quality' in research. In order to reconstrue this he was encouraged to contact the quality departments within the neighbouring NHS Trusts, the task this time being to define and write down as many

different aspects of quality as possible. He was somewhat surprised to discover that 'quality' as defined by the RAE was only one of several perspectives, and he was again pleased to present his homework (see Table 1, based on Harvey, 1995).

Careful questioning by his ACT therapist helped him to realise that there was an inherent validity to all these perspectives on quality. He could readily make the connection with his own beloved

research methods, in the sense that their validity also depended on such things as the particular purpose or question one was pursuing (e.g. RAE equated quality with 'excellence', whereas the NHS placed greater emphasis on 'fitness for purpose').

Integrating quality

So as to draw out the implications of this important reappraisal of quality, the Professor's therapist next asked him to tackle an apparent paradox, this time through a collaborative discussion of his research values. The paradox posed was that of integrating such seemingly discrete perspectives on quality. In concrete terms, how could he square the RAE version of quality with that of the NHS? To help him, the ACT therapist posed some imaginary situations. In this way, they generated together a flipchart sheet full of the Professor's research values, which are reproduced in Table 2 (from Milne, 1999). The different priorities of the NHS and the university sector are set out stereotypically, for emphasis.

On completing this task, the Professor realised with relief that one could both integrate the disparate aspects of quality by recognising their underlying commonalities and understand the pressure as arising from the different prioritisation of them across different organisations.

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TABLE 2 An integrative perspective on research quality

Dimensions of quality	Definitions, characteristics and differences of emphasis
<i>Sophistication</i>	The rigour and elegance of the methods used (e.g. peer review and grading of an elaborate research protocol in relation to funding decisions); the 'truth value' dimension. Includes high internal validity and objectivity (e.g. independent replication). Basic laboratory research in the RAE; randomised controlled trials in the NHS.
<i>Credibility</i>	The performance of the researcher (e.g. demeanour), the characteristics of the researcher (including qualifications and affiliation); and participants involved or problems tackled (ecological validity: simulations with university students versus people in the NHS experiencing socially important problems). High status in the university sector (e.g. 'professor') versus great experience and competence (e.g. 'track record') in the NHS.
<i>Timeliness</i>	Originality in the focus and methods of research; practical value of the findings in relation to a pressing practical problem (i.e. optimal timing of an intervention). Path-breaking versus urgent problem-solving research.
<i>Utility</i>	Practical value or relevance of research in facilitating understanding or problem solving (e.g. data serving as informational feedback): the 'action' dimension, including being sustainable and inexpensive. Minimised in the university context ('knowledge for its own sake') but crucial and hence salient in the NHS.
<i>Conformance to product</i>	Defining and meeting specifications for the technology or intervention (e.g. <i>standards</i> flexible and eclectic therapy in the NHS versus the 'fidelity check' on the therapist's adherence to a therapy protocol).
<i>Customer perceptions</i>	Vantage point of user on research findings taken into consideration skilfully and patiently. Quality is in the eyes of the user (satisfying demands or 'fitness for use'). For RAE purposes this is the impact factors of the journals in which the research is published. For the NHS, a well-regarded and widely-read outlet is preferred, even if it has no impact factor.
<i>Execution process</i>	A flowchart of tasks and checkpoints is detailed: checking quality while the research process is unfolding. Engaging persistently and actively in seeking disconfirmation of one's hypotheses. Getting it right first time and sticking to the plan. For example, collaboration with 'stakeholders' is paramount in the NHS, partly as it contributes to 'utility'; whereas 'replicability' may be more highly stressed in a university.
<i>Communication</i>	The tangible (e.g. audit of a report or publication) and intangible (e.g. interpersonal skills) aspects of information transmission, which are judged for objectivity, authenticity, completeness and influence. For example, the NHS investigator may be less concerned with the objectivity or dissemination of information than a university colleague.

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