

## Interview to Trisha Greenhalgh

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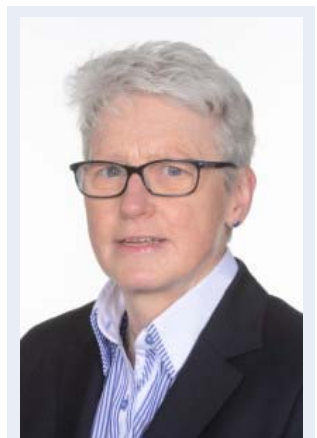
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Trisha Greenhalgh is Professor of Primary Care Health Sciences and Fellow of Green Templeton College at the University of Oxford. She studied Medical, Social and Political Sciences at Cambridge and Clinical Medicine at Oxford before training as an academic GP. She has previously worked at University College London (1986-2010) and Barts and the London School of Medicine and Dentistry (2010-2014).

Trish, as she is called by her friends, leads a programme of research at the interface between the social sciences and medicine. Her work seeks to celebrate and retain the traditional and the humanistic aspects of medicine and healthcare while also embracing the unparalleled opportunities of contemporary science and technology to improve health outcomes and relieve suffering. Three particular interests are the health needs and illness narratives of minority and disadvantaged groups; the introduction of technology-based innovations in healthcare; and the complex links (philosophical and empirical) between research, policy and practice. She is the author of 250 peer-reviewed publications and 8 textbooks. She was awarded the Order of the British Empire (OBE) for Services to Medicine by Her Majesty the Queen in 2001 and made a Fellow of the Academy of Medical Sciences in 2014.



Trisha Greenhalgh

♦ ***Dr. Greenhalgh, you are an accomplished clinician and researcher that has grasped the breadth of the challenge of properly understanding EBM (the "hard") while not losing sight either of the individuals (the "soft") and of the community (the "unhandled"). Do you feel that it's been an easy path or have you faced different hurdles in the way frequently healthcare is arranged in "silos" (of knowledge, of practice, of services)? And if so how have you faced does hurdles? In other words how you combine believing, practicing & teaching EBM, while believing, practicing & teaching realist, qualitative, narrative research?***

To rephrase your question, I am a member of many different epistemic communities. I am comfortable working in more than one paradigm. As the philosopher Thomas Kuhn said, it is not possible to fully engage with the work of one paradigm through the lens of a different paradigm. Many qualitative researchers are comfortable with the notion of multiple paradigms (or world views), and some even publish papers analysing a phenomenon through more than one disciplinary lens. However, conventional, positivistic science assumes a single, 'hard' reality and depicts the search for truth as the pursuit of this hard reality. Those who believe in a single reality (and that covers most EBM enthusiasts) will have problems engaging with different paradigms. But I think EBM is in a very interesting space right now. As Kuhn predicted, after 20 years of "normal science" in which the basic assumptions of EBM more or less held true, we are now at a stage in the development of the discipline where those early assumptions are being questioned because they don't explain the latest findings from research. This is Kuhn's 'post-paradigmatic phase' – and it may lead to breakaway group(s) seeking to go off and form a new discipline.

♦ ***What would you say to people leaning on "hard" evidence about narrative, qualitative approaches? What does the former misses and the latter may bring? (EBM conceptual cul-de-sacs, off-road alternatives routes; biases against patients and carers...)***

I'd say a 'hard' perspective on narrative is based on the assumption that there are some facts out there in the stories and the researcher's job is to find those facts. A 'soft' perspective on narrative considers the unique story, told in a particular way to a particular audience and asks "why did the narrator tell the story in this way to this person at this time and in this place – and why did he/she leave out of their story and why?".

♦ ***What would you recommend for people convinced in the value of qualitative and narrative approaches in order to be more successful in the goal to bring better health care for individuals and populations?***

First, don't get angry that some people don't value narrative approaches. It often takes some really good examples to show them. And you must SHOW, not TELL, what narrative adds. I recently wrote a monograph for the World Health Organisation on the value of narrative evidence. About half the monograph was taken up with three detailed examples. One example was mental health in refugees and asylum seekers. There are lots of quantitative statistics describing the scale of the problem and categorising people into 'depression', 'post-traumatic stress disorder', 'psychosis' and so on, but these very dry data do not convey the actual experience of mental health problems and other mental distress in displaced people. Fortunately, there has been some excellent work on this topic by some qualitative researchers, and I was able to cite this to illustrate what narrative research can add.

(To download the monograph: <http://www.euro.who.int/en/data-and-evidence/evidence-informed-policy-making/publications/2016/cultural-contexts-of-health->

♦ **Talking about personal stories and narratives, has any personal (family) experience with illness help you keep in track with medicine's and health care system's goals?**

Yes. I have lectured about my experience of major trauma two years ago (see youtube: [https://www.youtube.com/watch?v=qYvdhA697jl&list=PLPdZt8Yjl\\_fCdMQiFysZUAgGIFz2g2t-T&index=5](https://www.youtube.com/watch?v=qYvdhA697jl&list=PLPdZt8Yjl_fCdMQiFysZUAgGIFz2g2t-T&index=5)). I also had early breast cancer a year ago so I have experienced mastectomy, chemotherapy, molecular targeted therapy (Herceptin) and plastic surgery reconstruction – as well as septicaemia as a complication of chemotherapy. Indeed, I'd say I now qualify as an “expert patient” after so many operations and medications! Seriously, I owe my life to EBM and am lucky to be looking forward to the future after a disease that would have killed me 40 years ago. My own predicted prognosis is greater than 99% disease-free survival at ten years.

♦ **That's is a challenging experience. All our sympathies for the future. Along this first-person experience. Has being an “expert patient” strengthen your commitment or shift in any way your “business as usual” to a rearrangement of priorities as health care professional / researcher?**

I gained a lot from being part of an online community of other cancer patients. The doctors and nurses who prescribe and administer chemotherapy can't tell you how to cope with it – but other patients can. As I say in my forthcoming book, these support communities are an important element of evidence-based healthcare, since support from other patients increases adherence to life-saving medication and reduces side effects.

In terms of my personal priorities, I was told that after cancer, I may decide to reduce my working hours – for example, work part time – but this hasn't happened. I love my job and am back working 12-hour days. I have no desire to retire or “take it easy”. The research evidence suggests that after breast cancer treatment, there is a danger of developing chronic fatigue syndrome, but I didn't get it. I think this was for three reasons: first, I have a great marriage and my husband was wonderfully supportive, so I didn't get depressed or melancholic. Second, I did take my doctor's advice for the first six months and finished work at 4 pm. Sometimes I went home and slept for a few hours before supper! So although I was working a full “normal day” I didn't add on the extra academic hours for many months after finishing treatment. And third, because I'm in a senior position at Oxford, I have a lot of control over my workload and the things I do. If I'm having a bad week, I can just defer or delegate things.

♦ **Changing gears to our focus on work in the community that we feel is too frequently underperformed even in Primary Care. What would you recommend from your experience to bump it up?**

Primary health care is a complex practice, since it involves not only clinical care but also surveillance, public health, patient education, preventive care and support for families. I think it would be an insult to the practitioners who deliver primary care for me to offer a two-sentence suggestion for “bumping it up”. There are no easy answers to the challenges we face!

♦ **Fair enough! No magic-pill, no short-cut for real life efforts. But then, let's turn to engaging the community in health issues. What do you think about community engagement? How do we make engagement more effective?**

The best way to have impact from research is to involve communities in undertaking that research. This is about being humble and not assuming that you know better than those communities what the key research questions are. We did a systematic review of community based participatory research here: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3460206/pdf/milq0090-0311.pdf>.

♦ **More food for thought, precisely with a realist review methodology, an example of your capacity of combining methodologies. With the same approach, a few years ago you talked about “modernising” a health service and you revisited the topic again with a “mixed-method organizational case study design”... (see <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3479382/pdf/milq0090-0516.pdf>).**

In that paper, we didn't use realist evaluation. I think we could have done – but the story had changed so much that we decided to produce an over-arching narrative of what had changed and why. The questions we had asked at the beginning were less relevant than new ones that had arisen in the interim. We used narrative to explain how the questions had changed, and what had unfolded in the complex project over time.

♦ **No doubt, fascinating initiatives; like following the development of RAMESES standards for the realist reviews cited, participatory research or co-creation. But let's move on to another topic of your interest. You take seriously IT, eHealth, and “big data”. How would you suggest these tools can improve health care services for the community?**

Not easily. I have recently begun a new collaboration looking at how people get meaning from big data. Much of the time there is a lot of data but its meaning is opaque. For many years we've produced aggregated data that show us trends over time – either in a single patient or across a population. But when the denominator is hundreds or thousands of people, it's often hard to work out what the data mean. We need to get better at asking hypothesis-driven questions of big data instead of just admiring its bigness!

♦ **Are you familiar with Spanish National Health System? With your NHS and European experience, could you share with us some thoughts or paths to undertake in order to achieve a better system in Spain (and if you wish –or dare- in Europe)?**

Sorry, I know almost nothing about the Spanish system but I could suggest another person for you to ask this question to in a different issue of your journal!

♦ **We'll try to meet this challenge. Finally, if we may, you were strongly advocating for Breain and against Brexit, how do you feel things will turn out and what challenges are you facing on the road ahead as a NHS?**

I was certainly a Remainer. The UK hasn't left the EU yet and I hope it never will. There are some interesting legal challenges going on in the UK right now!

*“The reason why Cochrane reviews are boring—and sometimes unimplementable in practice—is that the technical process of stripping away all but the bare bones of a focused experimental question removes what practitioners and policymakers most need to engage with: the messy context in which people get ill, seek health care (or not), receive and take treatment (or not), and change their behaviour (or not).”*

Greenhalgh T. Outside the box: Why are Cochrane reviews so boring? Br J Gen Pract. 2012 Jul;62(600):371.

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Interview to Trisha Greenhalgh  
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## COMENTARIOS

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