

# Letters

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## Meeting the challenge of medical student placement capacity in primary care by rewiring later-career GPs

Thornton *et al*<sup>1</sup> have missed a potentially significant way to increase medical student placement capacity in primary care and simultaneously help with GP retention. The Later Career and Retired Members group (LCARM) of the Royal College of General Practitioners (RCGP) has, for a long time, been encouraging the development of 'portfolio careers' for older GPs.<sup>2</sup> Diversifying the role of later-career GPs can enable them to remain clinically engaged while also developing and using other skills.

A promising way forward for maximising GP engagement with teaching would be for teams of teachers to be organised at Primary Care Network (PCN) level, with outreach to GPs considering reducing their clinical sessions. Often GPs have difficulty negotiating reduced hours with their practice, but the provision of funding to replace their clinical time will help. 'Jobshare' roles shared between later-career and younger GPs incorporating teaching can also be developed. The GPs within the teaching teams could be spread around all the practices within a PCN, working to consistently high standards and acting as ambassadors for teaching.

Rather than even thinking of adding mandatory teaching to the workforce that is already recognised as pressured and overstretched, medical schools could develop a previously untapped resource.

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DOI: <https://doi.org/10.3399/bjgp24X736173>

## Registered Reports: benefits and challenges of implementing in medicine

Registered Reports (RRs) are a publication format that is submitted in two stages.<sup>1</sup> At Stage 1, the introduction and proposed methods are peer reviewed prior to commencing the study, and can be granted in-principle acceptance. At Stage 2, the full study is peer reviewed to ensure that the protocol has been adhered to, with minor deviations documented and justified. To date, over 350 offer publication through RRs.<sup>2</sup> The format has been slower to be adopted across medical and health journals, with approximately 1% of journals indexed in MEDLINE offering RRs.<sup>3</sup> The *British Journal of General Practice* (BJGP) is one such medical journal offering RR submissions, having introduced the format in 2020. However, uptake is low. Since its introduction in 2020, the BJGP has to date only published two.<sup>4,5</sup>

There are several benefits to adopting RRs for the medical research community. RRs are granted in-principle acceptance based on the study protocol, which means the subsequent findings do not influence the decision to publish. Therefore, the format can improve research quality by reducing the incentive for researchers to use 'questionable research practices' to increase the chance of publication, such

as HARKing (Hypothesising After Results are Known),<sup>6</sup> *p*-hacking (re-running statistical analyses to generate a significant result), and selective outcome reporting.<sup>7</sup> Stage 1 RRs also enable peer review to be received at a crucial stage where changes can be implemented. Early evidence suggests RRs are indeed leading to significant improvements in methodological design and analysis.<sup>8</sup>

There are also useful benefits to researchers adopting the format, as RRs alleviate the pressure to report statistically significant results to increase the chance of publication. RRs can therefore minimise the 'file-drawer effect' where many studies with non-significant findings are never published. In April 2023, one of us (Kelly Lloyd) published an RR in the BJGP.<sup>4</sup> While initially concerned that an RR would delay publication, the format likely resulted in a quicker publication than following the traditional route as non-significant findings were observed for the main hypothesis. Indeed, research has found that studies published through the traditional route report a much higher rate of positive findings than RRs (96% in traditional literature versus 44% in RRs).<sup>9</sup>

Despite the benefits of RRs, there are also challenges.<sup>1</sup> For one, the format was originally developed quite narrowly for hypothesis-driven research; however, RRs are continuously being adapted for other study designs, such as qualitative research.<sup>10</sup> The time taken to review Stage 1 RRs will also inevitably delay study commencement,<sup>1</sup> which can be challenging when there are contract and funding end dates. New initiatives are being developed to streamline this process. The 'Peer Community in Registered Reports' (PCIR) aims to provide a central platform for receiving and reviewing RRs across multiple disciplinary journals,<sup>11</sup> and also offers a scheduled review track to accelerate Stage 1 evaluation. Following acceptance of Stage 2, authors have the option

to publish in a PCI RR-friendly journal without further peer review, which can expedite the publication process. To date, there are 33 PCI RR-friendly journals, most of which are oriented towards psychology or neuroscience, and there is a clear need for medical journals, such as the *BJGP*, to join such an initiative.

Overall, there are a multitude of benefits for the medical research community to adopt RRs, including reducing publication bias and outcome reporting bias. While there are challenges, many are being addressed with new initiatives, such as PCI RR. We call on more researchers to consider adopting the format, and medical journals to increasingly support RRs and their adjacent initiatives.

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#### Funding

Kelly E Lloyd acknowledges funding from an Economic and Social Research Council Postdoctoral Fellowship (reference: ES/Y00759X/1).

#### Competing interests

Kelly E Lloyd has previously advocated for adopting practices to improve health and medical research, including the implementation of RRs (<https://www.improvehealthresearch.com>). Christopher D Chambers is a co-founder of RRs and PCI RR, and was part of the team that introduced RRs at *Cortex*. He currently serves as the RR editor at the journals *Imaging Neuroscience*, *PLOS Biology*, and *Royal Society Open Science*.

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DOI: <https://doi.org/10.3399/BJGP.2024X736185>

## Post-attack asthma reviews

I read Dr Edwards' letter in response to the article by Punyadasa *et al.*<sup>1</sup> Unfortunately the outcome of this study was whether any post-admission intervention occurred, and these ranged quite widely, without considering readmission, further attacks, or deaths. The National Review of Asthma Deaths (NRAD)<sup>2</sup> and subsequent inquests provided considerable evidence of poor care for people who died from asthma attacks. Most asthma attacks, hospital admissions, and deaths can be prevented by ensuring that appropriate preventer medication is prescribed, collected, and correctly taken.<sup>3</sup> That's the reason why a post-attack review was recommended many years ago in the UK asthma guidelines<sup>3</sup> and subsequently included in the requirements for Quality and Outcomes Framework (QOF) payment. So the need for a post-attack or post-admission review following an asthma attack is really based on common sense. Furthermore, as asthma is a chronic condition it is illogical to simply treat attacks without trying to identify any modifiable risk factors and adjust management to deal with these. The British Thoracic Society annual audits<sup>4</sup> continue to show fairly high numbers of people readmitted following asthma admissions. We did a detailed audit<sup>5</sup>

of children and young people (CYP) in 34 practices where modifiable risk factors<sup>6</sup> (see Box 2-2) were identified, with clear guidance provided for the practices on suggested actions in these CYP. As a result, admissions in CYP reduced by 16% the following year. While this was a relatively small study, it demonstrated that detailed post-attack reviews can identify and deal with modifiable risk factors with reduction in unscheduled care.

Further to Dr Edwards' point about evidence, this could so easily be provided dynamically if access to GP records was made available to bodies such as the NHS.

It's now 10 years after the NRAD was published<sup>2</sup> and we are still seeing very high numbers of preventable asthma deaths and admissions in the UK. Simply changing attitudes and managing asthma as a chronic (not an acute disease) would improve patient outcomes and reduce GP and hospital workload from unscheduled care.

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