KNOWLEDGE BROKER

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Can you introduce your background and experience leading up to your role at the National Health and Medical Research Council (NHMRC)?

My background is primarily in clinical trials, systematic reviews and evidence-informed decision making. I joined NHMRC as Senior Principal Research Scientist in 2011 after five years as Team Leader with the Research Policy and Cooperation Department of the World Health Organization in Geneva, Switzerland. Before this I led the Systematic Review and Health Care Assessment team at the NHMRC Clinical Trials Centre at the University of Sydney.

As Senior Principal Research Scientist, what duties do you hold? What motivated you to engage in the field of research translation?

At NHMRC I provide advice and support to the CEO, and across the agency on various matters associated with creating and translating research evidence. I firmly believe that those engaged in the process of health and medical research have a moral responsibility to conduct their investigations in accordance with sound scientific principles, and to report the results of that work completely, honestly and transparently. Only then can it form part of our knowledge and help us make informed decisions about our health and healthcare.

As a national agency with a legislated remit to provide advice to the Australian community and governments on health, and to fund health and medical research, NHMRC is uniquely positioned to facilitate bridging the gap between research, policy and practice; it has an established governance mechanism and enormous potential. Personally, it is an opportunity to make a real difference and improve the health of Australians through doing what I can to facilitate functioning working relationships between researchers and decision makers.

In your view, what are Australia’s key competencies and competitive advantages in medical research?

Australia has strong research governance and regulatory systems in place to ensure the integrity of researchers and trustworthiness of the research they produce. While some may see these as barriers for those who invest financially or morally, it means that research is produced in accordance with sound ethical and legal principles. Not all countries are fortunate enough to have such systems in place.

We are spoiled for choice in this country when it comes to the variety, quality and competitiveness of its academic health and medical research sector. We know this from the ever-increasing number of outstanding applications for funding received by NHMRC each year.

Recently you presented a talk at the 3rd Annual NHMRC Symposium on Research Translation entitled ‘Increasing value and reducing waste by addressing accessibility’. Can you provide an overview of the presentation?

Every day around the globe, ordinary humans consent to doing an extraordinary thing – they agree to participate in clinical research. These studies are conducted because the researchers and clinicians doing them do not know the answers to important questions such as whether or not certain treatments work. The people who consent to take part do so understanding that they may not benefit personally from participating, but expecting that their participation will contribute to our knowledge about their healthcare condition.

Despite this expectation, we know that not all research is published. If it is published, it is often done so selectively – reporting the positive results but not the negative, such as potential harms – and it may take many years to appear. If research results are not made public, then it is impossible for that data to contribute to knowledge. This behaviour is not just wasteful, it is also unethical, and is why an increasing number of agencies are adopting policies that require registration of planned research on publicly accessible databases, such as clinical trial registries, and open access requirements to facilitate the dissemination of findings.

What were the key outcomes of the Symposium? Are there any changes you would like to see occurring as a result?

The phrase ‘research translation’ means different things to certain people. When we held the first Symposium in 2012, our aim was to establish a forum for NHMRC’s researchers to share their experiences in translating their own research: the barriers they have encountered; the successes and
the failures. This is achieved formally through submitted presentations, and informally through more social conversations held during breaks in the programme.

The Symposium is unique in that it does not focus on a particular healthcare condition, or on a particular type of research, but on encouraging researchers to think about how they might take their research results beyond simple publication in a peer reviewed journal. There are very few meetings like it held internationally.

I would like to see Australia’s health and medical research community talking more about research translation, whatever meaning that term holds for them. I would also like to see Australians who consume – and pay for – healthcare being more ‘research literate’ so they can make more informed decisions. At the end of the Symposium I believe those who attended had started having these conversations.

One of NHMRC’s primary responsibilities is supporting the effective and rapid translation of research into healthcare policy and practice. Can you provide an insight into how the Council is fulfilling this responsibility?

The need to accelerate research translation is a priority in the agency’s current strategic plan. Although NHMRC is not directly responsible for translating research results into policy and practice, it supports the process in a number of ways. It has various grant schemes with a focus on research translation, such as Centres of Research Excellence and Partnership Centres and Projects. It has also recently launched a new scheme for Advanced Health Research and Translation Centres. NHMRC has an important role in issuing health advice through publication of guidelines and other forms of information. It also has the ability to influence the situation and allow NHMRC to more effectively deliver on its remit to produce advice and guidance.

The Research Translation Faculty was established as a forum where investigators funded by NHMRC could share their experiences. It was also established so those researchers could work with NHMRC to identify gaps in the evidence and between knowledge and practice, and to suggest ideas about action that could be taken to bridge these gaps. This is being achieved through the development of ‘cases for action’ by a number of Steering Groups; one for each of the major health issues identified in NHMRC’s Strategic Plan. The members of each are drawn from the Faculty, and the health areas being addressed include mental health, cancer, diabetes and obesity.

The NHMRC also facilitates research translation through the Cochrane Collaboration. Can you describe this Collaboration and your involvement?

The Cochrane Collaboration is an international organisation that brings together groups of people, most of whom volunteer, to identify, synthesise and interpret the body of evidence pertaining to specific healthcare questions. Such an activity is important if we are to make healthcare decisions that are informed by all of the best available evidence, not just selective pieces of information.

NHMRC contributes to the Cochrane Collaboration by funding a number of groups based in Australia, including the Australasian Cochrane Centre. Our intention is to put the wealth of information produced by the Collaboration, including the systematic reviews they publish, to better use. We are, for example, exploring ways in which we can put good quality Cochrane reviews into an Australian context so they can be utilised in informing health policy and practice in this country. Another practical thing NHMRC does is pay for the national licence to the Cochrane Library so all Australians can access high quality, evidence-based healthcare information at no cost to themselves.

Are there specific measures that could be taken to improve NHMRC’s clinical and public health guidelines to address the gap between research evidence and implementation?

As NHMRC does not have an intramural research programme, its ability to deliver clinical practice and public health guidelines is limited. Most of the guidelines we produce in-house are the result of specific requests with accompanying funds. A more strategic approach to the identification of priorities would, I believe, improve this situation and allow NHMRC to more effectively deliver on its remit to produce advice and guidance.

We also need to make guidelines more accessible. The target audience should be able to find the guidelines when they need them, and be able to source information within the
NHMRC guidelines quickly and easily. More recently, for example, there has been an increase in the use of shorter guidelines, focused on clinical questions. We have to stop producing 300+ page text books that quickly become out of date, and take greater advantage of modern technology. In the case of clinical practice guidelines we need to better understand the environment in which clinicians practice and the information tools they use, and provide them with reliable information that is accessible using these tools.

NHMRC is also able to endorse guidelines produced by third parties, as long as those guidelines meet the NHMRC’s standards. The aim of these standards is to provide a benchmark for quality that will result in recommendations that Australians can trust. Unfortunately very few guidelines produced by third party agencies seek NHMRC endorsement or comply with the standards. Earlier this year, NHMRC reported on the 1,046 guidelines published in Australia between 2005 and 2013. The report revealed that only one in five made any reference to the evidence underpinning the recommendations made, and only one in 10 were informed by systematic reviews of the evidence. Most did not describe the processes used to develop the guidelines and, disturbingly, lacked transparency around who authored them, if and how their interests were declared and how conflicts of interest were managed.

The poor quality of most guidelines produced in Australia outside NHMRC processes is of enormous concern and a major challenge for NHMRC. Poor quality guidance leads to poor quality decisions. We need to engage more effectively with the groups that are producing these recommendations and the agencies that are funding them, and work together to do something about it.

What challenges does the effective translation of research in Australia still face? In your opinion, how can these issues be ameliorated?

We are a long way from solving any of the problems that are preventing us from achieving effective research translation! Communication is key, but knowing who to communicate with and how is difficult, and requires all of the players to at least share the same space occasionally. There needs to be a two-way dialogue rather than a unidirectional push of information at the intended recipient. Effective working relationships between the end-users of research, including clinicians, policy makers and those who do the research, do not happen naturally. A third party may be necessary to broker these relationships and make them intentional rather than opportunistic. Strategic, evidence-informed, active ‘knowledge brokering’ is something I would like to see happening more frequently in Australia.

COCHRANE COLLABORATION

- Established in 1993, the Cochrane Collaboration is formed of 31,000 international contributors from more than 120 countries
- 10 per cent of Cochrane’s reviewers are Australian and together they contribute to around 20 per cent of the reviews
- Reviews undertaken by the Cochrane Collaboration are published in the Cochrane Library
- The Australian Government has dedicated AUD $4.7 million to support 11 Cochrane entities within Australia
- This funding will go towards research in specialist fields such as public health, consumers and communication, breast cancer, and acute respiratory infections