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RESEARCH ARTICLE

Priorities in Medical Research: elite dynamics in a pivotal episode for British health research

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Abstract

Priorities in Medical Research (*PMR*) was published in 1988 by a select committee of the House of Lords. The report ushered in an era of NHS research and development (R & D) that lasted from 2001 to 2006. The inquiry's origins lay in concerns about academic medicine in the United Kingdom, yet *PMR* gave relatively little attention to this subject. Instead the report focused critically on the disconnect between the Department of Health and the NHS in R & D. This, the committee argued, had led to the neglect of research into health services and public health. To sidestep the report's unwelcome proposal for a National Health Research Agency, the department eventually grafted R & D management onto structures created as part of wider NHS reforms. The Medical Research Council successfully pursued a strategy of keeping the committee's attention away from sensitive aspects of its own programme. The final focus of *PMR* was shaped by an alignment between committee members with an industrial view of research and champions of health services research. The actions of the various actors involved are interpreted using elite models of the state, and the applicability of these models is critically examined.

In April 1988, the House of Lords Select Committee on Science and Technology published a report titled *Priorities in Medical Research* (*PMR*). The committee's terms of reference were to examine this subject 'with particular reference to the needs of the National Health Service'. This they did through an inquiry that took just over a year. Amongst the report's findings and recommendations, two presented significant difficulties for the government. The committee was highly critical of the health department's research and development (R & D) programme and of its remoteness from the National Health Service (NHS).[1] 'No research system', it observed, 'can function efficiently when the principal customer for research (the NHS) has so small an input into the initiation of research programmes'. The committee recommended that a National Health Research Authority (NHRA) be established, and that the NHS should thereby 'be brought into the mainstream of medical research'. This new body, they argued, should be part of the NHS, not of the Department of Health.[2] The government did not like this proposal, but could not deny

1 In April 1988, the government department concerned was the Department of Health and Social Security (DHSS). In July 1988, responsibility for health and social security was divided between two ministries, and the Department of Health (DH) was created. 'The Department of Health', or just 'the department', is used for either incarnation, except where quoting from a source.

2 House of Lords, *Priorities in Medical Research: 3rd Report of the House of Lords Select Committee on Science and Technology 1987–88 Session*, London: HMSO, 1988.

the existence of a disconnect in existing organizational arrangements. After a period of uncertainty, a solution that was acceptable to the committee and other stakeholders was eventually found, but without creating an NHRA.

The publication of *PMR* was a pivotal episode in the history of publicly funded health research in England and Wales.[3] The inquiry set in motion a process that ended with the creation of a new national leadership role and NHS regional infrastructure for R & D. A new strategy, *Research for Health*, set out a future in which 'R & D becomes an integral part of health care so that clinicians, managers and other staff find it natural to rely on research in their day-to-day decision making and longer-term strategic planning'. This strategy shaped departmental policy over the next fifteen years.[4] Led by the cadre of newly appointed regional R & D directors, the NHS became more research-engaged.[5] New research-commissioning programmes, oriented towards the knowledge needs of the NHS, were set up. Over time, these developed processes and structures for involving stakeholders in setting priorities, and began to demonstrate the impact of their growing portfolios of commissioned studies.[6] *PMR* clarified the distinction between the knowledge needs of ministers and other central policy makers, and those of the NHS. The department set up an in-house Policy Research Programme to serve the centre, whereas NHS commissioning programmes were managed through extramural coordinating centres. The first national director of R & D, Michael Peckham, emphasized the importance of research translating into improved services and health interventions.[7] His message was aligned with that of a wider international movement, known as 'evidence-based medicine' (EBM), which was growing in momentum during the 1990s. This called for the review, synthesis and application to clinical practice of research findings.[8] *PMR* shifted policy discourse in the UK, breaking down the concept of 'medical research' in a novel way and positioning public health and health services research as critical to NHS effectiveness and efficiency. *Research for Health* marked the start of an era that lasted until 2006, when the National Institute for Health Research (NIHR), a creature of the Department of Health, superseded NHS R & D. The research-commissioning programmes established in this era continued, and further evolved, within NIHR.

This article has two aims. First, it seeks to illuminate this pivotal episode in British health research policy, drawing on recently opened archival sources. Second, it is intended to serve as a case study of how health research policy was made in the British state during the 1980s. The article begins with a brief discussion of the elite-dominated nature of health research policy making in this period. The origins of the *PMR* inquiry are examined, placing this in the context of wider controversies in British science and technology policy between 1986 and 1988. The conduct of the inquiry and the principal recommendations of the report are summarized, and the aftermath is described. The actions of each of the principal actor institutions is then considered and interpreted through the lens of elite theory. A concluding discussion reflects on how

3 Scotland followed a separate path in health research policy.

4 Department of Health, *Research for Health: A Research and Development Strategy for the NHS*, London: HMSO, 1991.

5 Mark Baker and Simon Kirk (eds.), *Research and Development for the NHS*, Abingdon: Radcliffe Medical, 1998.

6 Andrew Stevens and Ruairidh Milne, 'Health technology assessment in England and Wales', *International Journal of Technology Assessment in Health Care* (2004) 1, pp. 11–24; Pauline Allen, Stephen Peckham, Stuart Anderson and Nick Goodwin, 'Commissioning research that is used: the experience of the NHS Service Delivery and Organisation Research and Development Programme', *Evidence and Policy* (2007) 3(1), pp. 119–34.

7 Richard Smith, 'Filling the lacuna between research and practice: an interview with Michael Peckham', *British Medical Journal* (27 November 1993) 307, pp. 1403–7.

8 Jeanne Daly, *Evidence-Based Medicine and the Search for a Science of Clinical Care*, Berkeley: University of California Press and Millbank Memorial Fund, 2005.

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elite dynamics shaped a process that started out as an inquiry into the woes of academic medicine, and ended with the untested solution of health research being grafted onto newly formed management structures for the NHS.

The elite nature of the health research policy arena

In his study of the politics of British science, published in 1986, Martin Ince, a science journalist, complains that policy making is 'the province of a small set of overlapping elites', and comments on the mismatch between the priorities of these elites and those of the public.[9] Such views were also voiced by other contemporary commentators, who looked hopefully for signs that science and technology policy was becoming more open and democratic.[10] These observations were certainly applicable to health research policy. Publicly funded medical research was, prior to 1948, the preserve of the Medical Research Council (MRC), an organization controlled by a scientific elite within the elite profession of medicine.[11] It was not until 1961 that the Department of Health set up its own R & D programme, commissioning a diverse and growing portfolio of operational, social, epidemiological and 'service-oriented' medical research. In the case of the MRC, the programme of making grants and of intramural research was managed by a secretariat that was representative of the organization and, under all but the most exceptional circumstances, fully aligned with the governing council. At the department, in contrast, the power of medically qualified civil servants was constrained by a parallel hierarchy of generalist civil servants, who led the commissioning of the social, operational, computing, supplies and buildings research that accounted for the bulk of the programme. The medical civil service was subject to ministerial direction, but enjoyed a measure of professional autonomy through its accountability to the chief medical officer.[12] The Rothschild reforms of the early 1970s tilted the balance towards medical dominance, by mandating the role of a chief scientist that was, in practice, reserved exclusively for the medically qualified, and the MRC used its influence to ensure that only sympathetic individuals were appointed to this post.[13] The extent to which a small medico-administrative elite, tied by shared values and networks, preferred to cooperate across organizational boundaries, rather than to compete, was demonstrated through the reversal of the Rothschild system for biomedical research.[14]

Elite theories of the state thus appear pertinent to the arena of health research, especially where this is publicly funded. 'Classical' elite theory has been elaborated over many decades, so that there is now a diversity of elite theories.[15] One insight from the empirical material that follows is that, in shaping and contesting *PMR*, different institutional and individual actors acted on the basis of different elite models of the state. This adoption

9 Martin Ince, *The Politics of British Science*, Brighton: Wheatsheaf Press, 1986, p. 186.

10 Roger Williams, 'UK science and technology: policy, controversy and advice', *Political Quarterly* (1988) 59(2), pp. 132–44; Ian Christie, 'Research and development policy: the great debate', *Policy Studies* (1988) 8(4), pp. 11–22.

11 Joan Austoker and Linda Bryder, *Historical Perspectives on the Role of the MRC*, Oxford: Oxford University Press, 1989.

12 Sally Sheard, 'Quacks and clerks: historical and contemporary perspectives on the structure and function of the British medical civil service', *Social Policy and Administration* (2010) 44(2), pp. 193–207.

13 Stephen M. Davies, 'Organisation and policy for research and development: the Health Department for England and Wales 1961 to 1986', PhD thesis, University of London, 2017, at https://researchonline.lshtm.ac.uk/id/eprint/4646130/.

14 Stephen M. Davies, 'Rothschild reversed: explaining the exceptionalism of biomedical research', *BJHS* (2019) 52(1), pp. 143–63.

15 Mark Evans, 'Elitism', in Colin Hay, Michael Lister and David Marsh (eds.), *The State: Theories and Issues*, Basingstoke: Macmillan International, 2006, pp. 39–58.

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of dissimilar models may have been more informed by values and traditions than by explicit rational calculation about how to capture power and resources. As a heuristic tool, this article adopts the framework of elite models of the state proposed by Dunleavy and O'Leary.[16] More specifically, it draws on three 'sub-types': democratic elitist, liberal corporatist and autonomous models. *A priori*, these models appear relevant, and so their applicability is tested through a critical examination of the behaviour of the three principal actor groups: the Select Committee on Science and Technology, the Department of Health, and the MRC.

The background to *Priorities in Medical Research*

Nick Black, a health services researcher writing in the mid-1990s, attributes the *PMR* inquiry to the convergence of three concerns. First was a supposed decline in British academic medicine. As evidence of this decline, critics pointed to a falling national share of publications and reducing numbers of medically qualified academic staff. Second was that the health research agenda was too science-driven, rather than being led by the needs of the clinicians and managers responsible for healthcare delivery. Third was that there was a widespread failure to systematically translate research findings into improved clinical practices. Black argues that these concerns were shared by several interest groups: politicians who were concerned about practice variations; health services managers seeking to contain costs and improve quality; public-health professionals and the general public, with 'their newfound pluralist power'.[17] Michael Peckham refers only to the first of Black's three concerns, the apparent decline in academic medicine in the UK, as prompting the inquiry. Specifically, he points to a debate on 'academic medicine and the NHS' held in the House of Lords in November 1986.[18] During this debate, a succession of peers called for an increase in University Grants Committee funding for medical schools; special arrangements for the funding of teaching hospitals; and new money for research into neglected and emerging fields of medicine, such as mental illness and clinical genetics.[19] Speakers also voiced concern about the terms of employment for clinical academic staff, the special circumstances of the medical schools in London, and the national 'brain drain' of talented medical researchers. Walter Holland, who was a special adviser to the *PMR* subcommittee, similarly points to 'a number of questions and debates in the Houses of Parliament' as prompting the inquiry.[20]

Medical discontent was but one aspect of a 'wave of criticism', sometimes more kindly described as a 'great debate', concerning national science and technology policy between 1986 and 1988.[21] The Save British Science campaign was launched at the start of 1986, attracting substantial support across a broad spectrum of scientists. The campaign claimed government indifference to science and collapsing morale and held up the spectre of declining national competitiveness.[22] Early in 1987, the House of Lords Select Committee on Science and Technology had published a report on civil R & D that

16 Patrick Dunleavy and Brendan O'Leary, *Theories of the State*, Basingstoke: Palgrave Macmillan, 1987, pp. 184–97.

17 Nick Black, 'A national strategy for research and development: lessons from England', *Annual Review of Public Health* (1997) 18, pp. 485–505.

18 Michael Peckham, *A Model for Health*, London: The Nuffield Trust, 2000, p. 6. 'Academic medicine' is a term used to describe the advancement of research and education in clinical settings.

19 House of Lords Debates (subsequently HL Deb.) vol. 482 (26 November 1986), cols. 591–621.

20 Walter H. Holland, *Improving Health Services*, Cheltenham: Edward Elgar, 2013, pp. 186–7.

21 Christie, op. cit. (10)

22 Tom Wilkie, *British Science and Politics since 1945*, Oxford: Basil Blackwell, 1991, pp. 96–122; Jon Agar, *Science Policy under Thatcher*, London: UCL Press, 2019.

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identified a general decline in British science over the preceding five years, 'turmoil and frustration' amongst scientists, and the prospect of a national 'brain drain'.[23] Equally gloomy diagnoses were produced by the Advisory Board for the Research Councils and the Office for Health Economics.[24] A rhetoric of crisis, collapsing morale and national decline was widely adopted.

The inquiry and report

The chairman of the Lords Select Committee on Science and Technology, Lord Sherfield,[25] also chaired the subcommittee responsible for the civil R & D report and was the driving force behind the choice of medical research for investigation in the next session of Parliament.[26] The new inquiry was delegated to a subcommittee, chaired by Lord Nelson of Stafford.[27] The influence of the Lords debate on academic medicine is evident in the early activities of the committee, which met first in February 1987. The first of these was an informal discussion with Sir James Gowans, the secretary of the MRC.[28] This was followed by a visit to the MRC Clinical Research Centre at Northwick Park Hospital. In April, committee members visited University College and Middlesex Medical School, University College Hospital, and the Middlesex Hospital. The next month, the United Medical School of Guy's and St Thomas's Hospitals was visited. The issues presented to the visiting delegation on each occasion covered the same ground debated by peers five months earlier: funding, NHS support for research and clinical academic careers.[29]

The subcommittee appointed two specialist advisers, Professors Sir John Butterfield and Walter Holland. Butterfield (1920–2000) was Regius Professor of Physic at the University of Cambridge. Holland (1929–2018) was head of the Department of Clinical Epidemiology and Social Medicine at St Thomas's Hospital Medical School. Nearly a hundred organizations were invited to submit written evidence, including charities, universities and medical schools, regional health authorities, the pharmaceutical industry, trade associations, royal colleges, and professional societies.[30] Further requests for evidence followed as the inquiry progressed, and eventually the subcommittee considered around two hundred written submissions and heard oral evidence from forty-two individuals and institutions. In addition, representatives from the Medical Research Council, the Economic and Social Research Council and the Department of Health (including ministers) were interviewed. Four of the committee members accompanied Holland on a study trip to the USA, where they visited universities, research institutes and government departments. The study group was impressed by the more advanced state of epidemiological and health services research in the USA.[31] The rigour with which the inquiry was undertaken added weight, both figuratively and literally, to *PMR*.

The subcommittee met over twenty times before *Priorities in Medical Research* was published on 12 April 1988. The report rejected conventional distinctions between basic, strategic and applied research. Instead it adopted four categories: basic research,

23 House of Lords, *Civil Research and Development: 1st Report of the House of Lords Select Committee on Science and Technology 1986–87 Session*, London: HMSO, 1987.

24 Williams, op. cit. (10).

25 Roger Makins, 1st Baron Sherfield, 1904–96.

26 National Archives (subsequently NA), FD 7/2686, correspondence and file notes August to November 1986.

27 Henry George Nelson, 2nd Baron Nelson of Stafford, 1917–95.

28 House of Lords Archives (subsequently HLA) HL/CP/1481.

29 HLA HL/CP/1482, 1483, 1485, 1486.

30 HLA/HL/CP/1506 ST/87/M1 Appendix 1.

31 HLA/HP/CP/1491.

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clinical research, public-health research and operational research. All were described as having a common strategic objective: improved health and quality of life. The committee did not adopt the term 'health services research', despite its use by numerous consultees, because members wanted to make a distinction between studies primarily concerned with the health status and needs of populations, including demand for health services (public-health research), and those concerned with the organization, delivery and outcomes of health services (operational research).[32] Here the committee was not using the term 'operational research' in a narrow disciplinary sense but instead meant research into health services operations, which it recognized as a multidisciplinary endeavour. In broad terms, the committee assigned leadership for basic and clinical research to the MRC, while the Department of Health was to lead on operational and public-health research. The report acknowledged that this distinction was blurred in practice, with the MRC funding some HSR and the department some clinical research. In addition, a modest amount of research (mostly clinical) was commissioned through health authorities, who received a separate funding stream from the department for locally organized studies. Hospital charitable funds were also used to support locally commissioned research, especially in teaching hospitals, where such funds were concentrated.

Under its discussion of 'establishing priorities', *PMR* was forthright in its criticism of the Department of Health. Noting a collapse of morale among medical researchers, the report claimed that the 'over-riding cause … is the impression, right or wrong, that neither the NHS nor the DHSS demonstrates any awareness of the importance of research nor is it prepared to devote time, effort and resources to promote it, save only when an immediate saving of money is in prospect'.[33] The research leadership of the department was described as 'weak'. The committee was 'dismayed' by the department's statement that the primary purpose of its R & D programme was 'to provide guidance to Ministers on ways of improving the efficiency and effectiveness of the health and personal social services by promoting improvements in organisation, operation and administration'.[34] This revealed, in the committee's view, a failure to appreciate the distinction between the needs of ministers and the needs of the NHS. It is against this background that *PMR* observes, 'Ministers need a research programme, obviously. The NHS needs a research programme also, and it is likely to be different, both in scale and kind'. Having charged both NHS and department alike with neglect of R & D, *PMR* then acknowledged that the NHS was not altogether lacking in engagement at the local level. Some regions had been proactive in using their own resources to supplement those made available through the department for locally organized research.[35] However, this approach was described as leaving too much to chance 'in ensuring firstly that the NHS plays its part in formulating its research needs and supporting medical researchers in meeting those needs and secondly that the NHS is aware of what research is being done in the United Kingdom'. In the committee's opinion, 'the key lies not in the DHSS but in the NHS'.

PMR proposed a remedy to the disconnect between the department's R & D programme and the NHS. The committee recommended 'that the NHS should be brought into the mainstream of medical research … it should articulate its research needs … assist in meeting those needs … and ensure that the fruits of research are systematically transferred into service'. This would be achieved through a National Health Research Authority (NHRA), established as a special health authority, and funded by a transfer of funds

32 House of Lords, op. cit. (2), paras. 1.7–1.8.

33 House of Lords, op. cit. (2), Chapter 3

34 House of Lords, op. cit. (2), para. 3.24.

35 The submissions of South East Thames and Trent Regional Health Authorities make cogent arguments for an increase in locally initiated research, especially health services research. HLA/HL/CP/1506 ST/87/M24, M57.

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from the department and a levy on regional health authorities. The NHRA would lead on the commissioning of 'close-to-adoption' clinical research, public-health research and operational research, and it would support the development of capacity in these fields. It would act as a central point of contact between the NHS, the MRC, other research councils, the royal colleges and the medical research charities. It would also lead the dissemination of research outputs. The advancement of public-health and operational research would be especially important for the NHS and the report noted that these traditions had been inadequately supported in the UK. 'It is especially serious', the report noted, 'that so large an organization as the NHS devotes so small a part of a budget to seeking to improve its own operations'.[36]

The report argued that a 'science-led' approach should be dominant for biomedical research, whilst conceding that 'a wholly science-led approach cannot be effective' and that 'some setting of priorities and some emphasis on problem-led research is essential'. The inference is that basic research should be science-led, and public-health and operational research more problem-led, although this is not made explicit. The committee recommended that the NHRA should commission clinical research into interventions likely to be adopted into practice in the near future, whereas the MRC would retain the lead on clinical research 'arising out of the advances of science'. The council's commitment to clinical research had been called into question by some witnesses. However, the committee was persuaded that the MRC Clinical Research Centre at Northwick Park demonstrated the contrary and settled for a mild rebuke, saying that the MRC should 'take pains to strengthen the contribution of clinicians to its work'.

Discussion of the state of British academic medicine is surprisingly limited, given the report's origins. *PMR* argued for some rerouting of NHS money to medical schools (using a funding stream known as Service Increment for Teaching (SIFT)) to ensure that the needs of teaching and research were not compromised by service pressures. It also argued that SIFT should be increased to include the additional NHS service costs of hosting research. Their Lordships were not in favour of attempting to unpick the 'knock for knock' between medical schools and hospitals (an established understanding that avoided complex financial transfers between the two sectors in recognition that NHS staff provided teaching that benefited the universities, and university-employed clinical academics provided service inputs that benefited the NHS).[37] Finally, the committee made some brief and anodyne recommendations about the role of medical-research charities, and of the pharmaceuticals and medical-devices industries. In summary, the original stimulus – concern about the state of British academic medicine – had been eclipsed by other matters raised during the inquiry. Of these, the most prominent was the disconnect between the Department of Health and the National Health Service for R & D.

The debate and aftermath

The debate on *PMR*, held on 15 June 1988, was opened by the subcommittee chairman, Lord Nelson.[38] After commenting favourably on the workings of the MRC and the dual support system, Nelson turned to more challenging matters. The committee, he said, 'felt strongly the need to balance the Medical Research Council's science-led programme with a more dynamic, forceful and more clearly defined National Health Service need-led programme'. There was 'a crucial missing link' between the NHS and 'science-led academic research'. The committee was 'surprised' that the largest organization in the

36 House of Lords, op. cit. (2), Chapter 4.

37 House of Lords, op. cit. (2), paras. 4.26–4.32.

38 HL Deb. vol. 498, cols. 273–345.

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country, with over a million employees, had so little capability for public-health and operational research – fields that 'could make a major and important contribution to the efficiency and effectiveness of the service'. A National Health Research Authority would 'fill a gap in the administration of the National Health Service which clearly exists at the present time'. Other members of the subcommittee added to Nelson's arguments. Baroness Lockwood pointed out that the £18 million R & D budget of the Department of Health amounted to less than a tenth of 1 per cent of total annual expenditure on the NHS. 'If any industry', she said, 'were to consider spending such a small proportion of its turnover on research and development, it would be very seriously criticised by the Government'. Lord Kearton also drew attention to the R & D spending budget, describing it as 'a trivial figure' and further arguing the case for an NHRA. In all, nineteen peers spoke over the five hours of debate, voicing widespread support for the committee's recommendations. Responding for the government, the health minister in the Lords, Skelmersdale, argued that much of the research commissioned by the department was of direct and practical relevance to the NHS.[39] He gave several examples to support this point, and pointed out that the department commissioned such research through engagement with NHS clinician–researchers. This defence did not, however, address the committee's fundamental concern, which was with where control of research commissioning should be sited.

Immediately after the debate, Skelmersdale acknowledged in private that the government would need to give 'a carefully considered and solid response' to *PMR*, given the rigour of the committee's investigations and the strength of cross-party support.[40] After inter-departmental discussion, it was agreed that the Department of Health would lead the process, for which convention allowed a maximum of six months.[41] By September 1988, it had become apparent that the government would be unable to meet this deadline. The director of research management at the Department of Health, Dr Jeremy Metters, wrote to the committee clerk requesting an extension pending the outcome of a review of the NHS, launched by Prime Minister Margaret Thatcher at the start of the year.[42] By the summer of 1988, this review process had become bogged down in arguments about the future role of private health insurance and tax reliefs. The Department of Health and Social Security had also been split in two at this point, so that the context into which *PMR* was launched was altered.[43] In November 1988, Nelson submitted a written question about when a government response could be expected and was again told that this was dependent on the progress on the NHS review, the outcome of which was expected 'in the new year'.[44] The review White Paper was eventually published in January 1989, introducing plans for an 'internal market' in the NHS.[45] However, there was still no sign of a government response to *PMR*. Nelson wrote to the Secretary of State soon thereafter to express his concern that the White Paper included no proposals for strengthening the research capacity of the NHS. Whilst conceding that the specific organizational recommendations of *PMR* might no longer be appropriate, he argued that 'structural change is still needed to allow NHS managers at all levels to identify their research needs, to commission that research in centres of excellence, and implement the fruits of that research'. The appointment of a director of research, accountable to the

39 HL Deb. vol. 498, cols. 279–80

40 NA JA 367/190/2, Skelmersdale to Minister of Health, June 1988.

41 NA JA 367/190/1, Notes of a Meeting on 25 April 1988.

42 NA JA 367/191/3, Metters to Slater, 8 September 1988.

43 Brian Edwards and Margaret Fall, *The Executive Years of the NHS: The England Account 1985–2003*, Oxford: Radcliffe Publishing for the Nuffield Trust, 2005, pp. 64–71; Rudolph Klein, *The New Politics of the NHS*, Oxford: Radcliffe Publishing, 2006, pp. 140–52.

44 HLA HL/CP/2720, written question and response, 1 November 1988.

45 Department of Health, *Working for Patients: The Health Service Caring for the 1990s*, London: HMSO, 1989.

chief executive officer of the NHS Management Executive, would provide an alternative organizational solution.[46]

Nelson's abandonment of the NHRA proposal was pragmatic, as it was becoming evident that the department was firmly set against such a body and that *PMR* was at risk of being overtaken by wider events. As well as introducing quasi-market mechanisms, the White Paper was a pivotal moment in the rise of managerialism in the health service. This development had been set in train by the publication in 1983 of the NHS Management Inquiry, led by Sir Roy Griffiths, an adviser with a retail management background. The 'Griffiths report' was caustic about the established orthodoxy of 'consensus management' in the NHS and called for greater individual accountability and the recruitment of a new cadre of 'general managers'. Griffiths also called for a greater separation between the policy role of the Department of Health and its operational role as 'head office' of the NHS in England and Wales. He thought that the department could not, and should not attempt to, discharge the latter role, and recommended the establishment of an NHS management board with this remit.[47] The new general managers would be accountable to the new management board, which would be accountable to a supervisory board responsible for policy, resource allocation and general oversight. Ministers had initially attempted to maintain a high level of political control over the management board but by 1989 the government, convinced of the merits of market forces and better management, was yielding more control to NHS managers. The NHS management board became the NHS Management Executive (NHSME) and the Supervisory Board became the Policy Board, semantic shifts that signalled a greater distancing of ministers from the running of the NHS.[48]

Kenneth Clarke, elevated from minister of health to Secretary of State when Health and Social Security were separated the previous summer, was not initially persuaded by Nelson's alternative organizational solution. It was four months before he responded, saying that the composition of the NHSME board was settled and no further change was envisaged.[49] Nelson was not so easily deflected and wrote back pointing out that despite recent statements by Clarke that he wished to see the links between research and NHS management strengthened, no action had yet been taken towards this goal. Nelson was also concerned at the suggestion that research might be bolted onto the portfolio of another director. He wrote, 'we do not see that any of those, admirable though they may be in their own field, have the necessary experience for this role'. What was needed, he argued, was someone who could 'command respect within the medical profession and among academics.' He added that he was in touch with Lord Jellicoe, chairman of the MRC, in view of the concerns of the latter organization.[50] Jellicoe had also written to the Secretary of State earlier in the year, arguing that a director of research should be appointed to the NHSME board. Clarke had been moderately encouraging of the idea, whilst passing responsibility for the final decision to the new chief executive of the NHSME. Nelson and Jellicoe were moved to concerted action by the mismatch between ministerial blandishments and the new management structures implemented.[51]

46 HLA HL/CP/2720, Nelson to Clarke, 2 February 1989.
47 Roy Griffiths, *NHS Management Inquiry: Report to the Secretary of State for Social Services*, DHSS: London, 1983.
48 Klein, op. cit. (43), pp. 117–23.
49 HLA HL/CP/2720, Clarke to Nelson, 6 June 1989.
50 HLA HL/CP/2720, Nelson to Clarke, 16 June 1989.
51 HLA HL/CP/2720, Jellicoe to Clarke, 8 March 1989, reply 19 April.

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The government response

In December 1989, some twenty months after *PMR*'s publication, the government finally made its formal response. As anticipated, this flatly rejected the proposed NHRA, on the ground that 'this could cut across the responsibilities of the Management Executive, separating research from service delivery'. The government, the Command Paper explained, 'is particularly concerned that NHS research should stay within the mainstream of NHS management'.[52] The means for achieving this would be the establishment of a new post, the chief of research and development (CRD). The CRD would report directly to the chief executive of the NHSME or the permanent secretary, 'as appropriate', with an advisory role to both. However, the postholder would not be a member of the NHSME board. He or she would be supported by the existing Research Management Division (RMD) of the department and by a 'reconstituted Department Research Committee with a wider focus to embrace research strategies for the NHS as well as the Department'. The response also included a commitment to reform SIFT, which was to be uplifted to include the indirect costs of hosting research. Beyond this, the response on academic medicine was confined to statements that the NHS was committed to research, and exhortations to health authorities to be supportive of research. Other sections dealt, at a very high level, with the coordination of research and the importance of the pharmaceutical and medical-devices industry to the UK – themes that would later become more prominent in national policies for 'health and wealth'.

The proposals for research leadership were, in significant measure, a continuation of the very same structures that the *PMR* inquiry had previously found wanting. The CRD was to be little more than a re-badged chief scientist, with an advisory link to the chief executive of the NHS Management Executive bolted on. The value of such a mechanism was untested, as there was no experience of engagement with research by the new cadre of general managers, and no evidence that this was an occupational group inclined to embrace research. Control of research commissioning would remain with the RMD, with its established connections to policy leads within the department. Influential commentators, including a former chief scientist at the department, aired their concerns about these proposals in public.[53] Behind the scenes, Nelson and Jellicoe, with the support of his council, kept up the pressure on the Secretary of State to make the CRD a full member of the NHSME board.[54] In April 1990, Clarke changed tack and agreed to this course of action. A press release candidly admitted that 'the Secretary of State has given way to pressure from the Select Committee to integrate research into the management of the NHS'. The director of research and development (as the CRD post had now become) would be a full member of the management executive of the NHS.[55] Michael Peckham, a cancer doctor, was appointed the first director of research and development early in 1991. A Research and Development Directorate was established at the same time, replacing the RMU. Under Peckham, the first R & D strategy for the NHS was published, accompanied by guidance for regions.[56] This marked the start of an era of NHS R & D that lasted until 2006, when the National Institute for Health Research was established.[57] We now

52 Cm. 902, para. 2.10.

53 Alan Maynard, 'Peanuts and a job for God', *Health Service Journal*, 25 February 1990, p. 443; Douglas Black, 'Rothschild revived?', *Times Higher Education Supplement*, January 1990, p. 4.

54 NA FD9/2687, MRC comments, 26 February 1990.

55 HLA HL/CP/2720, press release, Department of Health, 16 May 1990.

56 Department of Health, op. cit. (4); NHS Management Executive, *Research and Development Strategy: Guidance for Regions*, September 1991.

57 Paul Atkinson, Sally Sheard and Tom Walley, 'All the stars were aligned? The origins of England's National Institute for Health Research', *Health Research Policy and Systems* (2019) 17, article no. 95.

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consider these events from the perspective of the three principal actor institutions: the select committee, the Department of Health and the MRC.

The select committee

The select-committee system in Parliament had been rationalized in 1979. The focus was on the House of Commons, where systematic institutional reform was attempted. In contrast, committees of the Lords were established on an ad hoc basis. The Science and Technology Committee was created in 1980 to fill a gap left by the disbanding of the equivalent Commons committee (later reinstated). The new committee was sessional, with its continued existence and membership decided each year in advance of each session of Parliament. It was, by design, an expert committee, with members chosen for their expertise by a committee of selection.[58] The fourteen members of the *PMR* subcommittee were drawn from a range of professional backgrounds and brought with them diverse views on R & D and its application. Nelson and Kierton were retired industrialists. The former had been chairman and chief executive of English Electric, one of the largest British engineering and aviation companies until it merged into GEC in 1968. Kierton had been chairman of Courtaulds, a textile company, and held other posts in bodies concerned with energy research. Sherfield, although originally a diplomat, also had experience of applied research from a spell as chairman of the United Kingdom Atomic Energy Authority. Walter Holland described these individuals as 'hard-nosed industrialists', concerned with the application of knowledge to practical problems.[59]

According to Holland, five members of the subcommittee were most actively engaged in the inquiry, including Nelson and Kierton. Two further 'active' members, Lord Rea and Baroness McFarlane, were healthcare professionals. Rea was a general practitioner with strong interests in public health. He also lectured in social medicine at St Thomas's Hospital. McFarlane was a nurse by profession and was appointed to the first chair in nursing in a British university. The fifth active member, Lord Flowers, had wide-ranging experience in public and university administration, including six years as chairman of the Science Research Council. He was most interested in the reform of SIFT, which had the potential to divert NHS funding to the universities.

Holland played the more active role of the two special advisers. Butterfield had less time available for the inquiry because of his commitments in Cambridge as head of both the medical school and a college. As the first holder of a chair in experimental medicine at Guy's Medical School, his research into diabetes had involved large-scale population studies.[60] Consequently he was sympathetic to public-health research, and content to let Holland take the lead. Holland was a member of a newer elite, being one of the directors of a dozen or so research units supported through rolling grants from the department since about 1970. His department at St Thomas's was the most successful of these units in terms of funding and publications.[61] He was a vigorous champion of HSR and, as such, perhaps not the most obvious choice for an enquiry into medical research. He claimed not to know exactly how he came to be appointed, and that he believed himself to have been second choice to a more mainstream candidate, who declined. Whatever the exact

58 T.StJ. Bates, 'Select committees in the House of Lords', in Gavin Drewry (ed.), *The New Select Committees*, Oxford: Clarendon Press, 1985, pp. 37–53.

59 Interview with Walter Holland, London School of Economics, March 2013.

60 Robert Mahler, 'William John Hughes Butterfield, Baron Butterfield of Stechford in the county of West Midland', *Monk's Roll* (2000) 11, p. 83.

61 Gordon McLachlan (ed.), *Portfolio for Health: The Role and Programme of the NHS in Health Services Research*, London: Oxford University Press for the Nuffield Provincial Hospitals Trust, 1971; Christopher Cook, 'Oral history: Walter Holland', *Journal of Public Health* (2004) 26(2), pp. 121–9.

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circumstances, Holland recognized that his appointment presented an exceptional opportunity to advance HSR.

According to Holland, the industrialists were 'scathing' about the department's stewardship of R & D and dismayed by how little was spent on R & D as a proportion of the NHS budget, drawing very unfavourable comparisons with industry. They were neither much interested in basic research nor inclined to dig deeply into the MRC and its programmes. The industrialists and those supportive of health services and public-health research, ably supported by Holland, made common cause, seeking reform to a system that privileged biomedical research and was insufficiently informed by NHS needs. For reasons that will be discussed later, other members, whom Holland described as 'more MRC', were content to sit back and see this unfold.

The Department of Health

Even before the publication of *PMR*, the 1980s had been a challenging decade for the department's R & D programme. The reversal of the Rothschild reforms for biomedical research in 1981 had been followed by declining real-terms funding for the remainder of the programme, reflecting wider public-spending constraints. This left little scope to redirect resources towards new priorities.[62] In 1986, the Office of the Chief Scientist was reorganized, becoming the Research Management Division (RMD), and the position of chief scientist was downgraded to a part-time role. The last chief scientist, Professor Francis O'Grady, operated in a semi-detached manner in comparison to his predecessors, being absent from most key meetings and contributing little in writing. The director of the RMD, Metters, ran research management on a day-to-day basis.[63] He was also tasked with coordinating the government response to *PMR*.

Against this background, *PMR* was an unwelcome development and there was little appetite at the department for any further change. The NHRA proposal was resisted from the outset. Realizing that the case for closer involvement of the NHS in research could not be dismissed outright, efforts were focused on finding some alternative means to achieve the same end. Jeremy Metters began to construct the case against an NHRA as soon as the pre-publication version of *PMR* was made available. He argued that the recommendation was 'not thought through' and that the committee 'appears to have been unclear about the distinction it makes between research needed by the NHS and that needed by Ministers'. Furthermore, 'it offers nothing, apart from the clear involvement of the NHS itself, which could not be done under the Department's existing arrangements if resources were substantially increased'. More tellingly, perhaps, 'ministerial control over research policy would be substantially reduced'. The new body would require more staff than the department currently employed in research management, yet the department would still need a policy research programme to advise ministers.[64]

As an alternative to an NHRA, Metters proposed a National Health Research Advisory Committee (NHRAC). This forum would 'identify for the DHSS the NHS's needs for research and encourage action based on research results.' He envisaged the NHRAC as a purely advisory body. Its role would be limited to influencing the commissioning decisions of existing committees at both the department and the MRC.[65] Metters's proposal went down badly within the department. One senior colleague warned, 'we are in danger

62 Davies, op. cit. (13), pp. 244–66.

63 NA BN 82/227, role of the chief scientist, 30 September 1986.

64 NA JA 367/190/1, briefing report, 6 April 1988. Appendix B.

65 NA JA 367/191/1, notes of a meeting, 9 June 1988.

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of creating a monster that will need to be fed with information and which will try to fulfil a role that goes beyond that which we had envisaged.'[66] Another, with past responsibilities for research management, was equally forthright, referring back to difficulties experienced in the 1970s when over-elaborate committee structures were combined with a lack of executive authority in research management.[67] Published research showed how problematic such arrangements had proved.[68] Faced with this reception, Metters sought more time to find an acceptable solution.[69] He set out three options: defending the present system, strengthening the present system, and adopting a modified version of the Lords' proposals. The second was preferred. More specifically, this meant linking NHS-relevant research into the NHS Management Board (NHSMB). This would maintain ministerial control, as the board was chaired by the Secretary of State.[70] Metters opened discussions with the chief executive of the NHSMB about implementation of this option. This took a further two years to achieve, such was the state of organizational flux. Between late 1988 and the appointment of Peckham, the NHSMB became the NHS Management Executive under a new chief executive; the government published its White Paper, *Working for Patients*; the post of CRD was redefined; and a new director of the RMD succeeded Metters, who was promoted to deputy chief medical officer in 1989.

The Medical Research Council

The MRC was also resistant to change, but on less obvious grounds. The council had shown two main concerns when engaging with the select-committee inquiry into civil R & D. The first was to close down any reopening of discussion of the customer–contractor principle as applied to biomedical research. The Rothschild reforms introduced this principle for all government departments that commissioned, or ought to commission, applied R & D. Yet, by 1981, the Rothschild system had been reversed for biomedical research. In successfully lobbying for this special treatment, the MRC had argued that biomedical research was of an exceptional nature, and thus required exceptional treatment.[71] Against this background, the council was alarmed when the committee included questions on the working of the customer–contractor system in its call for evidence.[72] A further threat came from suggestions that research council boundaries should be redrawn, or even that a single research council might be established. The Agricultural and Food Research Council had floated the idea of establishing a Biological Resources Research Council covering agriculture, fisheries, forestry, conservation, the biological aspects of biotechnology and non-medical biological sciences. The MRC had a long-standing and substantial commitment to research into underlying biological mechanisms, but the development of molecular biology was making it increasingly evident that these mechanisms were not unique to human health.[73] The secretary of the MRC, Sir James Gowans, who had been pivotal in securing the return of funds from the department to the council in 1981, met these threats head-on in his submission to the civil R & D inquiry. Gowans argued that there was nothing wrong with the existing system that couldn't be fixed with more money; that any proposal to combine research councils was misguided; that

66 NA JA 367/191/2, Merrifield to Woolley, 2 August 1988.

67 NA JA 367/191/2, Rayner to Woolley, 28 July 1988.

68 Maurice Kogan and Mary Henkel, *Government and Research: The Rothschild Experiment in a Government Department*, London: Heinmann Educational, 1983.

69 NA JA 367/191/2, Metters to Slater, 12 August 1988.

70 NA JA 367/191/3 HPSS (88)30, August 1988, extract from minutes of meeting, 8 September 1988.

71 Davies, op. cit. (14), p. 147.

72 NA FD 7/2684, Subcommittee 1 call for evidence.

73 NA FD 7/2684, briefing note Harrison to Gowans, 19 March 1986. *Research Council Overlap*, 19 May 1986.

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state support was needed for medical research, but that the MRC should remain independent of government; and that the MRC should continue to be responsible for the 'full spectrum' of research from underpinning biological mechanisms through to clinical research.[74] In the event, there was little in the civil R & D report to trouble the MRC. Any change to research council boundaries was rejected in favour of 'evolution in the existing system'. The retention of the customer–contractor principle was endorsed, glossing over the reality that this was no longer being applied to biomedical research.[75] Although this was a satisfactory outcome for the MRC, the spotlight was nevertheless turned on to medical research the following year.

Some members of the *PMR* subcommittee were MRC loyalists. In the case of one, Baron Hunter of Newington, a physician, this included behind-the-scenes activity. Hunter wrote to Gowans on a 'personal and confidential' basis, alerting him to Sherfield's proposals to follow on from the civil R & D inquiry with an examination of priorities in medical research. The two then met in September 1986 to discuss this unwelcome development. Gowans suggested that the committee's interests might be diverted towards less potentially contentious territory, such as international collaboration in research. Two months later, Hunter met with Gowans again to tell him that the inquiry was definitely proceeding, assuring him that he would 'do all he could to steer the inquiry towards the DHSS, the pharmaceutical industry and the charities' – in other words, away from the MRC. The committee clerk, Douglas Slater, met with Gowans soon thereafter to explain the scope of the inquiry and inform him of the appointment of Holland and Butterfield. Gowans 'told Mr Slater frankly of his concern about the proposed examination of priorities in medical research and … the adequacy of the expert advisers'. He 'outlined particularly important potential problems including: re-opening of the Rothschild debate, the one research council concept, political interference in the scientific judgements of the MRC and the load which the inquiry might make on the MRC Headquarters office'. He also tried, without success, to persuade Slater to appoint advisers more to the MRC's liking.[76] Other members of the committee, notably Lords Adrian and Perry, were also, according to Holland, 'more MRC', but less active. Both had backgrounds in medical science. As the inquiry came to focus on the department, there was little need for peers of this persuasion to become involved in support of the MRC.

Another area where the MRC might have come under criticism, but did not, was its stewardship of HSR. As part of a revised 'concordat' of 1980, under which funds for commissioning biomedical research were to be returned by the department, the MRC had made a commitment to strengthen HSR. This was discharged as slowly and as cautiously as was possible. An HSR panel was established in 1981, but its members soon became frustrated with its purely advisory role and began lobbying the council for a more effective forum. A dedicated HSR committee eventually replaced the panel in 1986, but still with only limited grant-making powers and for an experimental period of three years.[77] There was little reason to draw attention to this heel-dragging in *PMR*, as the active members of the subcommittee wanted HSR to be taken forward by an NHRA, rather than by the MRC.[78] After *PMR*, the MRC maintained a narrow, medical view of HSR and distanced itself from the NHS, claiming that the council had no expertise or interest in operational research and would only be able to support research relevant to the NHS if resources

74 NA FD7/2684, written evidence from Gowans, 2 May 1986.
75 House of Lords, op. cit. (23), paras. 46, 48.
76 NA FD 7/2686, file notes and correspondence, August 1986–January 1987.
77 Davies, op. cit. (13), pp. 255–60.
78 House of Lords, op. cit. (2), 3.17.

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allowed.[79] This same anxiety had lain behind the council's half-hearted engagement with HSR since 1981.

Concluding discussion: elite dynamics in health research policy

How might the events and behaviours set out in this article be interpreted? To begin with the MRC, this is perhaps the organization that most comfortably conforms to one type of elite theory, that of liberal corporatism. This is the system in which the state delegates responsibility for a particular field to 'peak associations', which are granted exclusive rights in return for observing certain conventions around leadership and behaviour.[80] The British state adopted a liberal corporatist approach to medical research in the reconstruction period immediately after the First World War, assigning the field entirely to a medical scientific elite. This elite, aided by political allies, lobbied successfully for the new Medical Research Council not to be accountable to the Ministry of Health.[81] Over its first forty-five years, the council enjoyed public funding under scientific self-governance, with a fig leaf of accountability to Parliament through the Lord President. The Science and Technology Act of 1965 tightened accountability in formal terms, bringing the MRC within the remit of a new Department of Education and Science (DES). In practice, the council continued to enjoy considerable autonomy even after this cautious reform.[82] Although the DES was involved in discussions about the government response to *PMR*, its representatives never challenged any aspect of the MRC's position, nor added much of any consequence.[83] The strategy of the MRC was to avoid any further limitations to its autonomy and head off any close examination of potentially sensitive subjects. In this, they were supported by their friends on the select committee, who could afford to remain relatively inactive once the spotlight was turned on the department.

The application of elite theory to the department is more problematic. On one level, the behaviour of the Research Management Division conformed with 'autonomous' models of the state, in which officials act on their own preferences with little regard for wider inputs. The director of the RMD, Metters, was described by one informant as 'the guardian' of the existing system, and his resistance to the NHRA proposal appears typical of budget-maximizing (or, in this case, budget-defending) behaviour by bureaucrats, as postulated by public-choice theorists.[84] Metters was not a member of the same networks as MRC leaders, having risen through the ranks of the medical civil service and being without a research background. His notional superior, Chief Scientist O'Grady, a medically qualified microbiologist, would have been better equipped by rank and background to operate in these circles, yet he largely absented himself from the discussions around *PMR*. Furthermore, Metters succeeded in deeply antagonizing his opposite numbers at the MRC.[85] There was thus no cross-organizational, collegial relationship that could be used to smooth relationships, and the department was left to flail about in search of a solution. Yet the MRC knew, from experience, that an effective research leader at the department was important for their own interests. A new MRC secretary, David 'Dai' Rees, who took over from Gowans in 1987, took an active interest in the discussions around this matter, as did the council chairman, Jellicoe. This all added to the discomfort

79 NA FD 7/2687, file note by Dodd, 1 August 1988.

80 P. Schmitter, 'Still the century of corporatism?', *Review of Politics* (1974) 36, pp. 85–131.

81 Arthur Landsburgh Thomson, *Half a Century of Medical Research*, vol. 1, *Origins and Policy of the Medical Research Council*, London: HMSO, 1973.

82 Hilary Rose and Steven Rose, *Science and Society*, Harmondsworth: Pelican, 1970, pp. 111–14.

83 NA JA 367/191/1.

84 Interview with former civil servant, Kent, October 2019.

85 NA FD 7/2687, file note, 1 August 1988.

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felt by the department. In this fraught situation, the decision to bolt new arrangements for R & D management onto untested NHS management structures, which had emerged through separate processes, provided an exit route for the department. From this perspective, *PMR* appears more of a case study of limitations on elite bureaucratic behaviour which, where seriously constrained, is still capable of blocking more radical change.

Finally, turning to the select committee itself, during the 'great debate' on science and technology policy between 1986 and 1988, some had looked for signs that policy making was becoming more democratic.[86] Against this background, an intervention into the arena of health research by a committee of Parliament might be viewed as a step towards greater democratic input. Black suggests that *PMR* saw increased pluralism in health research policy, including 'newfound' public power.[87] However, there is nothing in the evidence that supports this contention. At best, from the perspective of a search for wider inputs, the *PMR* case study might be 'democratic elitism' in action. Democratic elitist theory accepts the argument that, for both practical and normative reasons, elite groups are the key actors in liberal democracies. Its proponents argue that this does not mean that elite behaviour is unconstrained because of the prospect of periodic re-election in a liberal democracy. They also point out that although elite institutions may be closed to formal participation by outsiders, this does not mean that elite opinion is insulated from wider societal influences.[88] However, the Lords Select Committee on Science and Technology was a conspicuously closed institution. Its members were chosen from the unelected chamber by a committee of selection.[89] The *PMR* subcommittee included several hereditary peers, among them Sherfield, Nelson and Rea. Topics for investigation were chosen by the chairman. Committees had no formal powers, and their reports could be ignored where expedient.[90] Against this background, any argument that the intervention of the select committee amounted to a move towards greater democratic input seems tenuous, and democratic elitism unconvincing as a theoretical basis for interpretation of the *PMR* episode.

It has been demonstrated that the subcommittee was not a monolithic body, but rather one within which there were different subgroups and levels of participation. The alignment of those active members who subscribed to an industrial view of applied research with supporters of health services and public-health research, including the special advisers, shaped the committee's report. Viewed in this light, the committee appears ephemeral as a structure of the state, becoming little more than an elite forum within which different groups competed to advance their ideas about research governance. The subtypes of institutional theory discussed hitherto all fall within the tradition of modernist empiricism. More recent, 'decentred', interpretations reject this tradition, accusing its proponents of a reified view of structure. In this view, the state becomes no more than a 'cultural practice', shaped by the actions of individuals engaged in diverse 'practices of rule'. Decentred theory suggests the importance of paying more attention to the background against which elites construct their world views.[91] This is perhaps a more promising way to interpret the dynamics within the select committee. However, decentred

86 Ince, op. cit. (9), p. 204; Williams, op. cit. (10).

87 Black, op. cit. (17), p. 488.

88 Joseph Schumpeter, *Capitalism, Socialism and Democracy*, New York: Harper and Row, 1942; Carl J. Friedrich, *Man and His Government: An Empirical Theory of Politics*, Oxford: Oxford University Press, 1963; Heinrich Best and John Higley, 'Introduction: democratic elitism reappraised', in Best and Higley (eds.), *Democratic Elitism: New Theoretical and Comparative Perspectives*, Leiden: Brill, 2010, pp. 1–22.

89 Bates, op. cit. (58).

90 Philip Giddings, 'Select committees and parliamentary scrutiny: plus ça change', *Parliamentary Affairs* (1994) 47(4), pp. 669–86.

91 Mark Bevir and R.A.W. Rhodes, *The State as Cultural Practice*, Oxford: Oxford University Press, 2010.

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theory still begs questions of how cultural practice shapes institutional structures, the influencing of which was the goal of those committee members who were hoping that a new institution, the NHRA, would tilt the health research economy away from dominance by biomedical research and towards other health research traditions. Instead they had to settle for a compromise that led to HSR being tied to an emergent occupational group, NHS general managers. How this played out is a part of the history of the NHS R & D era which has yet to be written.

In summary, it is evident that no single variant of elite theory is satisfactory in explaining the complex elite dynamics that played out through and following the *PMR* inquiry. If there had been one single model of elite theory to which all the institutional actors subscribed, whether explicitly or tacitly, then working out a response would probably have been simpler for all involved. As it was, elite dynamics engendered a tortuous route from the starting point, an examination of the problems facing academic medicine, to a somewhat distant end point, novel management arrangements for NHS R & D.

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