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Encouraging additional research capacity as an intellectual enterprise: Extending Ernst's engagement

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Summary In volume 11, issue 3, Ernst wrote an opinion piece on the funding of centres of excellence. Whilst I agree with his argument, this response outlines a necessary, fundamental and complementary approach to building research capacity.

Introduction

I read Ernst's recent commentary published in volume 11, issue 3 with great interest, and agreed with his focused economic argument that, in comparison sponsoring research fellowships, funding for centers of excellence might be a more productive and efficient approach to create research capacity in CAM.[1] Indeed, through the presentation of some descriptive statistics, Ernst clearly showed that places such as his Unit in Exeter UK have helped produce expert CAM scholars, individuals who identify themselves primarily as CAM researchers, and who go on to contribute to the CAM literature. This acknowledged however, by introducing the issue of research capacity, Ernst has unintentionally highlighted the need for a more fundamental and detailed consideration of the range of approaches, that are and could be used, to increasing research capacity in CAM. The issue of research capacity has always been high on the CAM research community's agenda, largely due to the relative infancy of our research and the urgent need to provide an evidence-base for an ever-growing volume of practice. Nevertheless, whilst research capacity has undoubtedly increased—beyond calls for specific types of evidence—it continues in a rather ad hoc and unreflective manner, lacking sustained disciplinary debate or analysis of tactics and approaches. Moreover, such a debate is not only necessary, it resonates beyond CAM. Indeed, because of its unique position and potential to take different directions, CAM research makes a unique case study in capacity building potential in wider academia. The outcomes of the directions CAM researchers take, or choose not to take, provide lessons beyond our empirical

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field—broad though it is—to many other fields of medical, health and other inquiry. I certainly do not have the space here to review all the possible approaches to increasing research capacity. However, I can provide a very brief overview of my own beliefs and a sub-disciplinary approach to encouraging—as opposed to creating—research capacity.

An intellectual project: what does it look like?

How we define research capacity naturally has consequences with respect to how we attempt to increase it. Certainly, the word capacity suggests something that can be measured. In terms of what it might or might not be, we could define capacity as various resources, such as people, equipment or even financially. These are things that have a productive capacity, essentially states of potential. In Ernst's paper, capacity is taken to be researchers (labourforce). Capacity however, has other qualities, for example, it might also be consumable, meaning that it can be depleted but externally replenished. Alternatively, capacity might be resilient, meaning that it can be temporarily depleted but can attain its original level (independent from external replenishment). Of course, it is the latter form of self-replicating capacity that is most desirable in many situations, including CAM research (i.e. researchers training other researchers). Nevertheless, on its own, any form of capacity does not help society achieve it aims, the assumption being that it can be activated and used to achieve results. In the case of CAM research then, these results come in the form the generation of new system 'inputs' such as research grants, and 'outputs' such as journal articles, research reports, books and book chapters that provide the research evidence-for-practice and associated methodological and theoretical discussion. I do not think that my reading of capacity as being people, or their eventual output, is any different from Ernst's though I have my own ideas on who a new generation of CAM researchers might be, and how to obtain them.

The approach I advocate for is certainly not as highly structured, institutionally based or as immediately measurable as Ernst's, and notably its form of capacity building does not require financial pump priming. Whilst reading Ernst's paper, my thoughts immediately turned to disciplinary matters, specifically to increasing research capacity by provoking interests in 'other' disciplinary and sub-disciplinary communities who do not currently have a substantial interest or record in CAM research. Locating these is not difficult, because most of us already belong to them outside of our CAM endeavors. They are wide-ranging and include intellectual communities based on social science sub-disciplinary perspectives (for example, health economics, medical sociology, health geography, health psychology, health policy); intellectual communities based on health sciences and professions research (for example, nursing research, public healthcare, occupational therapy) and intellectual communities based on multi-disciplinary clinically focused research (for example, pediatric care, gerontology, oncology, mental health). On an individual level, these are central to our academic identities. On a collective level, these communities might be geographically dispersed yet intellectually close. Even if internal methodological or theoretical divides exist within them, they are bound by a common identity, often associated with a common perspective or purpose, and of course assisted by intra- and extra-institutional structures such as university departments, professional associations, academic journals and meeting points such as conferences. Moreover, for many of us they are simply where we work. In this sense then, the market for expansion in CAM research is literally at our doorsteps, staring us in the face.

To illustrate this point, I can use my own academic circumstances as an example, though readers will certainly be able to draw comparisons to their own. In terms of my academic perspective, I am a health geographer. My sub-discpline health geography is a relatively small strand of human geography (a slither of a discipline as one of my colleagues once half-joked) but nevertheless, in my opinion anyway, a rather productive slither that has made wide-ranging contributions to health debates for well over 3 decades. Moreover, and importantly it is 'my' sub-discipline, part of my academic identity and about which I care, particularly in terms of its progress and directions. It is important to note that like many other academics, I have other coexisting disciplinary identities and I also consider myself to be a nurse researcher (where I work and a good slice of my research and teaching interests), a social gerontologist and, of course, a CAM researcher. These are professional and subject disciplines that themselves differ greatly in terms of their basis, history, size, approach, methods and theories, the amount to which I am immersed in them, and that are, of course, variously interconnected (by myself and others). In a sense then, you could say that, like many other researchers, I am a part-time scholar of all of these disciplines. However, due to some considerable overlap, in