Coordinating academic training for physicians

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Preservation of the traditionally high level of academic achievement by UK consultant staff working within the NHS is in the public and national interest. A commitment to teaching and research (either directly, or through facilitation of both) is regarded by many as a duty for doctors, and the Royal College of Physician's annual surveys identify some 800 consultant-level physicians (around 10% of the total workforce) expressing a commitment to academic medicine.

The integrated academic training pathway (IATP) developed by the UK Clinical Research Collaboration, under the chairmanship of Professor Mark Walport, aimed to re-shape academic clinical training. The IATP proposed that academic clinical fellows (ACFs) would, over a three-year period, spend 25% of their time in research and 75% in clinical training. Following this experience, ACFs would either have developed sufficient ideas and preliminary data to apply successfully for a three-year clinical training fellowship leading to the award of a PhD, or would move back to a conventional specialist registrar appointment in clinical medicine. Those successfully completing a higher degree could compete for a clinical lectureship of some four years' duration, with time split equally between clinical and postdoctoral training. At the end of this period they would either move (having successfully obtained a certificate of completion of training, CCT) into a higher education funding council (HEFC) or other funded research appointment, or obtain an NHS consultancy. For many specialties it is likely that this structure represents the bedrock of future academic development, in that some 250 ACFs are to be appointed, together with around 200 clinical lectureships (half through NHS Research and Development and half via universities) every year for the indefinite future. On the basis of previous experience, about 50% of these are likely to be occupied by trainees from physician-based specialties.

The administration of the IATP is the joint responsibility of the (regional) deanery structure and the universities, although ACFs are also NHS employees. The IATP was introduced because of challenges to the future of academic medicine which have emerged in several arenas.

- Changes towards a consultant-delivered, contractually-based system have proved challenging for those with multiple (ie clinical and academic) roles.
- Some have asserted that academic leadership has been fragmented and disengaged, and that a concentration on educationalism rather than traditional research has been an undesirable consequence.
- Parallel changes in the scientific community involving greater specialisation, together with a possible tendency to disregard clinical, patient-oriented, academic endeavour as being of lesser importance than 'pure science' has brought separation between the clinical and biomedical communities.
- A perceived lack of flexibility, inadequate local support and local mentorship, and contradictory messages from the royal colleges may have contributed to an overall atmosphere of uncertainty.
- Although, when introduced, the Modernising Medical Careers (MMC) programme was designed to produce a structured training curriculum for junior clinical staff, the design of training programmes has been influenced heavily by the European Working Time Directive and has proved inflexible. Thus, the idea that individuals would acquire clinical competencies at differing rates, thereby providing flexibility and facilitating academic development has not been adopted. The idea that successful academics are always identified early on in their careers has been widespread, to the disadvantage of those trainees who decide later upon an academic career and encounter difficulty in leaving their clinical training programmes to gain research experience.
- Regional variations in access to, and the conduct of, academic training may be apparent. Centres such as Oxford, Cambridge, London and Manchester, which have relatively large numbers of academic training positions, may be better able to adapt and integrate these with clinical training programmes. In other centres in which overall numbers of academic appointments are lower, the provision of a support structure may be more difficult.
- The perception that research is a waste of time if the trainee does not seek an academic appointment has been widespread, and the distinction between the clinically qualified

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biomedical scientist, the university academic clinician scientist and the academically active practising doctor is insufficiently elucidated.

Significant alterations to the UK research funding structure have also emerged recently in *Best research for best health*, which introduced the concept of a National Institute for Health Research (NIHR), and the Cooksey Report, which was designed to ring-fence funding for the establishing of an Office of Scientific Strategy and Research and for the Medical Research Council.[1,2] Secondly, the Medical Training and Assessment Selection (MTAS) system which was the subject of much criticism in 2007, and the publication of *Aspiring to excellence*, the independent inquiry into MMC, chaired by Sir John Tooke, has led to a degree of uncertainty in the academic training environment.[3] This has been manifest in part through relatively low numbers of applicants for some of the specialised IATP posts identified above. However, the NIHR aims to work with the clinical academic careers panel (chaired by Professor Peter Kopelman) to develop a detailed plan to move from the present ACF schemes to future programmes as envisaged by the Tooke Report.

The Royal College of Physicians (RCP) is committed to supporting the vision of developing and protecting a group of world-class clinician scientists through the above initiatives, recognising that the IATP represents only one of a number of routes for trainees to acquire research training and enter an academic career. However, programme leadership is also needed, together with the establishing of a body of clinician academics translating basic scientific achievements into practice, and identifying and motivating NHS consultant physicians trained in research to lead and develop clinical projects. In summary, a body of educated clinicians facilitating and presenting clinical research is needed.

The Working Group on Coordinating Academic Training for Physicians was convened in December 2007 to assist in this process. It aimed to inform specialist medical societies of current best practices in the implementation of academic training initiatives; to identify and address any difficulties that might arise for trainees undertaking academic and clinical training; and to use the RCP as a focus for interchange between societies and to facilitate the take-up of academic training opportunities. The group chose four specific areas in which to make recommendations for the further development of academic training programmes, within and outside the RCP. These were:

- the development of optimal specialty and regional structures for the supervision of academic training
- reconciling the demands of simultaneous academic and clinical training
- how best to assess such trainees through an academic record of in-training assessment (RITA)
- perhaps, most importantly, the development of long-term employment opportunities.

Thus, it seems unlikely that the universities, research councils and NIHR will be able to absorb the large numbers of academics exiting the national programmes. Identifying opportunities for trusts to use NHS monies to employ these individuals to further their corporate research and development endeavours is of paramount importance if the current investment into translational medical research is to succeed, and the best trainees are to remain attracted to academic careers.

The report and recommendations of the working group were considered by Council at its meeting in May 2008 and adopted as RCP policy.[4] The RCP's Academic Medicine Committee was tasked with its implementation, and will involve relevant outside bodies including the Joint Royal Colleges of Physicians Training Board and Academy of Medical Sciences in this process. However, if the high level of academic achievement of UK clinical medicine is to be preserved and developed, it is incumbent upon the specialist societies, and the wider consultant and trainee body to become engaged as rapidly and fully as possible.

References

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