

## BUILDING RESEARCH CAPACITY

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## BUILDING RESEARCH CAPACITY

### WHY BOTHER?

- Improve prevention, diagnosis, care
- Exciting opportunity:
  - epidemiology
  - molecular, cell and tissue biology
  - clinical trials
  - public health
  - policy (quantitative)
- Enriches teaching – “today’s research is tomorrow’s practice”
- Money and brownie points

# BUILDING RESEARCH CAPACITY

## TO WHAT END?

Focus on three types of clinician (medic, nurse AHP...)

- Research aware – everyone
- Research active – e.g. UK NHS consultant
- Research led – e.g. (modern) UK NHS clinical academic

# BUILDING RESEARCH CAPACITY

## IS THERE A “MODEL” RESEARCH-LED CLINICIAN?

- Clinically active
  - 50%? 20%?
  - medics ✓ nurses x
  - pro's
  - con's
- Research-led
  - able to compete for funds as independent PI
  - must have PhD AND Post-doc training
- Participates in teaching

## SCOTLAND on SUNDAY

Sunday 31 August 2003

### Academic shortage hits doctors training hopes

PLANS to train hundreds more doctors to bail out Scotland's beleaguered NHS have been thrown into jeopardy by a shortage of academics at medical schools across the country.

Dozens of university teaching posts are vacant in Scotland because many doctors are no longer willing to juggle academic careers and their growing health service commitments.

## THE CLINICAL ACADEMIC PARADOX

Strong interest in *circa* 150 research training fellowships every year

vs

Extreme difficulty in appointing clinical academics  
(e.g. 1999; 74/401 clinical chairs vacant - 36 for over one year)

**Conclusion:** Something goes wrong along the career pathway

**Contributory Factors:**

- attractions of SpR grade
- restrictions of SpR grade
- RAE and pressure on clinical lecturer grade  
(10.2% posts disestablished in 2 years to 1997/98)

# The Academy of Medical Sciences

Working Party on Career Structure and Prospects for Clinical Scientists in the UK

## DISINCENTIVES

### (A) 3 KEY DISINCENTIVES APPLY IN ALL DISCIPLINES

1. Lack of clear career structure
2. Insufficient flexibility in combining clinical and research training
3. The prolonged insecurity of clinical academic training vs SpR training

### (B) ADDITIONAL DISINCENTIVES OPERATE IN SOME DISCIPLINES

4. Pressure to commence research training at the end of G.P.T.
5. Lack of research training opportunities and environments in some disciplines
6. Problems with remuneration in some disciplines

## CASE 1 : ARS LONGA, VITA ...

- 3 year Cambridge Hons
- 3 years London 15 prizes
- Pre-registration year
- 2 years SHO
- 2 years Registrar
- 3 years MRC Training Fellow
- 3 years Clinical Lecturer - CCST
- 3 years Wellcome Advanced Fellow (USA)
  
- **Age 37 years : 3 children : No job**

## PROPOSED SOLUTIONS TO THE DISINCENTIVES

1. Early experience of clinical research
2. Two stage academic career structure after general professional training
3. Key proposal: The Tenure Track Clinician Scientist
4. Clinical Lectureships must be retained
5. Addressing Specialty - Specific Disincentives
6. Gathering Career Track Data

# PROPOSED SOLUTIONS TO THE DISINCENTIVES (1)

## 1. Early Experience of Clinical Research

BSc/BMedSci                      MB/PhD

## 2. Two stage Academic Career Structure after General Professional Training

First 'doctoral' phase : Ideally from SpR base-allows smooth return  
**Research Training Fellowship**-ideally 3 yrs

Second 'post-doctoral' phase : Could be second Fellowship from SpR base or Clinical Lectureship but  
? Flexibility

# PROPOSED SOLUTIONS TO THE DISINCENTIVES (2)

## 3. Key Proposal : The Tenure Track Clinician Scientist

- National co-ordination of clinical and academic training
- Dedicated clinician scientist NTN for those in hospital specialties
- Tenure track status

## 4. Clinical Lectureships must be retained

## GENERAL INTERNAL MEDICINE

*One year of the research fellowship counts towards the specialty training requirements*

|                            |                                   |   |                    |                            |
|----------------------------|-----------------------------------|---|--------------------|----------------------------|
| PRHO                       | SHO                               | SHO                                       | SHO<br><i>MRCP</i> | Research Fellowship        |
| Research Fellowship        | Research Fellowship<br><i>PhD</i> | SpR                                       | SpR                | Specialty Training/<br>CSS |
| Specialty Training/<br>CSS | Specialty Training/<br>CSS        | Specialty Training/<br>CSS<br><i>CCST</i> | CSS                |                            |

## PROPOSED SOLUTIONS TO THE DISINCENTIVES (3)

### 5. Addressing Specialty - Specific Disincentives

*Dealing with pressure to commence research training "too early"*  
- SHO research training access scheme

*Promoting research training in some disciplines*  
- Limited earmarking of fellowships;  
- Links with strong centres;  
- SHO and Training Academic Access Scheme

*Addressing problems with remuneration*

*Enhancing flexibility in some disciplines*  
- Disciplines requiring persistent patient contact  
- Trainees with domestic commitments  
- Changing clinical activity after entry to the specialist register

### 6. Gathering Career Track Data

## CONCLUSION: ESSENTIAL FEATURES OF TRAINING

- *Clear structure*
- *Funded to promote flexibility*
- *Designed to maximise security*
  - excellent mentoring, especially at decision points
  - tenure track arrangements
  - “escape clause”: back to full-time practice
- *Outstanding research training*
  - interdisciplinary centres