

## Mid-Career Entry to Academic Medicine



## Executive Summary

Medical academics contribute to the education of future generations of doctors and the advancement of medicine. Over the last 15 years, however, the number of medical academics has fallen in absolute terms and the academic/student ratio worsened from that at the turn of the 21st century.

Since 2006, there has been an established academic training pathway to promote the future generations of clinical academics. To meet the immediate requirements for senior and mid-career medical academics, however, we need to establish flexibility to move mid-career between classical clinical pathways and academia, whether that be towards the end of specialty training or early consultant years. The extensive experience of these mid-career entrants to academia would enable crucial contributions to both education and research. These doctors come with a wealth of “coal face” experience that benefits both trainees and research environments. Further, their practical experience facilitates clinically credible teaching and generates important translational research questions. As such they would add value to any research team both directly or indirectly in their roles of mentorship and role models.

There are potential impediments to the changeover from full-time clinician to clinical academic that need to be addressed in order to facilitate smooth transition in both directions. This includes a lack of transparency within the hierarchy of academic career structure leading to a perceived pay discrepancy between university and NHS employees. These discrepancies may be real in universities facing budget cuts, offering contracts that limit private work with discrepancies in pension rights compared to NHS contracts. Additionally, the possibility of the job security offered within the NHS being traded for the grant-dependant employment of universities may present potential risks that would discourage mobility between career pathways.

To address these concerns and promote the wealth of experience that these mid-career clinicians bring to an academic environment, the Medical Academic Staff Committee (MASC) details some recommendations that we believe would promote mobility between NHS career pathways and academia. These include raising the awareness of the benefits of academic careers to the individual, to the research community and to medical trainees. This can be promoted at all career stages, stimulating potential mid-career academics to consider an alternative career in academia. To make these career options attractive, however, we would need to work with funding bodies to ensure that they would value a sustainable and varied medical workforce and employers to consider the importance of medical academics. There should be recognition of the experience of mid-career entrant clinical academics that result in development of pay-scales, terms and conditions that do not disadvantage NHS clinicians wishing to explore the flexibility of university positions. Finally, this flexibility should be in both directions such that the NHS clinician should be secure in the knowledge that, should their period in academia be time-limited or even be unsuccessful, their time out of clinical medicine would not disadvantage their long-term prospects in the NHS.

## What do we mean by Academic Medicine?

Academic medicine involves active research in order to drive forward the study and practice of medicine and the conveying of current best practice through teaching, writing and presenting. It embraces all disciplines, including the scientist researching molecular mechanisms; medical innovators, engineers designing prosthetics and other devices; the epidemiologist looking at public health trends or the GP interested in health care utilisation. Medical academia also covers undertaking a range of research into basic pathological and other mechanisms, participating in commercial trials as chief investigators, designing trials and applying for funding, participating in a range of innovative developments in fields such as IT and delivering health economic research. Medical academics deliver education to student and trainee doctors at all stages of their careers, and are invaluable in facilitating translational medicine.

In our position paper *Every Doctor a Scientist and a Scholar*, we present compelling reasons why every practicing doctor should become familiar with research processes and conduct. Nonetheless, we remain convinced of the value of a cadre of academic doctors dedicated to research and teaching and to combining these activities with clinical practice. We, therefore, welcomed the establishment of the integrated academic training pathway following the Walport Report, as a means of replenishing this group of doctors. However, not every participant in the scheme will practice full-time academic medicine immediately post-CCT, with many wanting to consolidate their clinical practice first. In addition, not every doctor will realise that they would benefit from an academic component to their career from the start. We believe that doctors should be given the opportunity to enter or return to academic medicine throughout their career; not only because this ensures the best use of a precious resource, but also because mid-career entrants will bring valuable clinical experience and research questions derived from that experience into academia.

Not every mid-career entrant to academia will necessarily go on to have a life-long career in academic medicine. However, the experience and skills gained while in the academic environment will provide invaluable experience for future work in clinical practice. As MASC declared in its paper *Every Doctor a Scientist and a Scholar*, research training and teaching practice are useful for all doctors.

Every branch of medicine needs doctors at every stage of their career who are familiar with research and the principles of research practice. They can then use their experience to fulfil the roles of principal investigator and act as academic mentors or teachers in their local NHS organisation. The Keogh report<sup>1</sup> showed that failing trusts are often both professionally and academically isolated. We believe that by raising the profile of academic medicine and inviting entrants into research at every stage in the medical career, there would be a measurable improvement in the quality of care provided by the NHS. These priorities are reflected in the current drive by the Department of Health in England to include a research dashboard of academic activities at every foundation trust, with every trust being compelled to display their research activity.

### What is Mid-Career?

In discussing this paper, MASC has taken a flexible view on the definition of mid-career. For MASC it does not just mean doctors who have obtained their CCT and started independent practice. It can also mean more senior doctors-in-training or graduate entrants from other disciplines who may be interested in academia or had a previous academic background. The impression given by the new integrated academic training programmes has made it seem to many medical students and trainees considering academic medicine that if you do not get on the pipeline at the start then academic careers are not an option. Flexibility in and out of academia must also be encouraged for them and the failure to do so is a huge missed

<sup>1</sup> Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report, Professor Sir Bruce Keogh KBE, 16 July 2013.

opportunity. We also need to consider the issue within context of lifestyle issues including maternity and parental leave and caring responsibilities. This also requires having different a perspective on the speed and intensity of academic activities from that which is currently the norm.

### Why mid-career entry to academia?

- The extensive clinical experience of mid-career entrants to academia with their greater understanding of patients' social as well as medical problems enables them to make crucial contributions to education and research.
- There is a greater need for doctors who are experienced in both research and clinical practice to take up positions as lead clinicians as well as engaging with or taking on local and national advisory positions in health care.
- Doctors who enter into academia later in their careers will come with a wealth of new experiences and views which can revitalise medical academia by introducing research questions and other new ideas which are informed by clinical practice and life experience. This may include how benefits to patients can be derived from the shared experiences between patients, practitioners and academics and how this eases the transition of ideas from academic theory to clinical practice.
- Mid-career entry allows flexibility for those who develop an interest in medical academia later in their careers.
- Mid-career entry allows potential academics to embed their clinical practice and skills after training before undertaking a PhD or further research. There is specific evidence of a desire for this from primary care and from the Walport Report.<sup>2</sup>
- Mid-career entry gives the chance to widen the range of opportunities available for doctors returning to work after career breaks, maternity leave or time spent caring for relatives, and also for UK doctors currently practising overseas, especially in academic medicine.

### Characteristics of mid-career entrants to medical academia

A mid-career entrant to medical academia is typically a doctor interested in research related to their field of experience. Their breadth of clinical experience may lead to a special interest in particular conditions or diseases or types of patient groups poorly served by current trials. They may pose research questions about personalised medicine or have an interest in research in health economics, particularly as many clinicians struggle to determine how best to deliver best practice care in an ever-tighter funding environment.

Mid-career entrants to medical academia may have obtained a Certificate of Completion of Training (CCT) and worked as a consultant or GP for several years. They may also be an Associate Specialist, a Specialty doctor or a trainee with experience in their field.

There has historically been no single route into medical academia, and it is important that this flexibility is maintained in recognition of the fact that doctors may develop an interest in research at any stage of their career. Traditionally, grant allocation and funding bodies have favoured early-career researchers, for a variety of reasons not least the desire to kick-start trainees' careers, but it is important that these bodies also recognise that a later entrant to academic medicine may come forward with new ideas based on their experience and background which would be worth pursuing and funding.

Some doctors, especially those in primary care, may aspire to enter medical academia only once they have completed training and spent a period of several years embedding their skills. Others prefer to embark upon an academic career immediately after completing their clinical training. Academic training 'from scratch' is important, but doctors must be able (and have the necessary skills) to switch into academia at any stage in their career, in order to ensure a balance between the skills and experience of medical academics.

<sup>2</sup> *Recommendations for medically and dentally-qualified staff: recommendations for training the researchers and educators of the future*, by the UK Clinical Research Collaboration and Modernising Medical Careers, March 2005.

The Walport Report also recognised that GPs are more likely than secondary care doctors to have completed their clinical training prior to moving into an academic career, and thus required an entry route into academia which reflected this. It recommended that mid-career GPs be encouraged to enter academia via a dedicated scheme consisting of a two-year 50% clinical 50% academic fellowship, with a well-defined academic content that could include a Master's degree. In light of the changes to the NHS structure following 1 April 2013, it is essential to identify a body which will fund the clinical elements of these posts, including local clinical excellence awards.

#### **Mid-career entrants to medical academia:**

- bring a different clinical perspective to teaching and research
- provide practical examples and clinical credibility in teaching situations
- generate research ideas directly related to or informed by their clinical practice
- bolster the promotion of the importance of research in medical training, as well as the value brought to it by experience in clinical practice
- put clinical experience to good use translating research into practice
- are valuable mentors and role models

The experience of mid-career entrants to academia complements that of their colleagues who have followed the established pathways into academic medicine. They are able to draw upon a greater range of practical examples, have a better understanding of the factors that influence health behaviours and provide solid clinical credibility in teaching and educational situations. Medical school staff comprising both doctors who have entered the area mid-career and those who have followed the academic path from medical school will provide a wide range of outlooks and role models for students.

Mid-career entrants are likely to generate research ideas which are directly related to or informed by clinical practice, having identified subject areas ideal for research during their clinical work. They may also identify applications for the outcomes of research using their previous clinical experience. For the full benefits of medical research to be realised, they need to be translated into clinical practice. Mid-career entrants to academia tend to be more clinically-focussed and as such are ideally positioned to push forward translational medicine.

Mid-career entrants can bring a different viewpoint to mentoring relationships compared with their academic colleagues. Many academic trainees feel that they need three different mentors to help them as they develop their clinical and academic roles and their relationship with their healthcare employer. A mid-career entrant could provide mentorship in all these areas. They are also well-suited to mentor other mid-career entrants, especially as they become more established in their academic role.

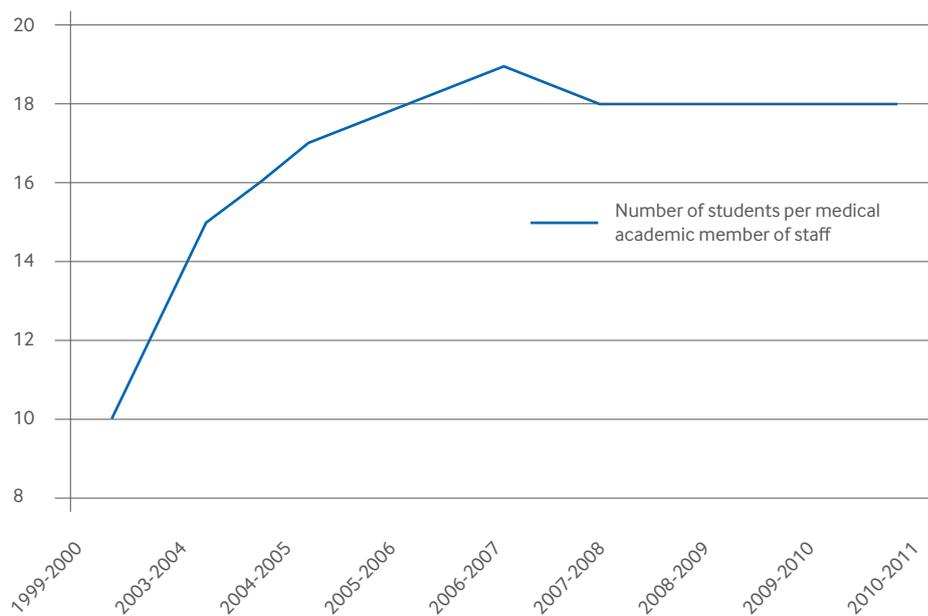
Mid-career entrants could also act as role models to their clinical colleagues who are considering a similar move into academia or who wish to undertake academic activity as part of their clinical job and to young doctors more generally. The move of mid-career entrants into academia can, in itself, highlight the possibility of such moves. The presence of mid-career entrants can also help academic doctors who decide that they would like to move into a fully clinical role. The Walport Report identified the importance of a route into full-time clinical work for academic doctors who did not feel that academia was the right place for them. The report noted that colleagues with more recent experience of the clinical environment could help provide advice and guidance on moving.

### Why do we need more mid-career entrants to medical academia?

- Low numbers of medical academics
- Increasing demand for research and translational medicine
- An ageing cohort of senior clinical academics on the verge of retirement

The number of medical academic consultants employed by English medical schools remained broadly the same in the years from 2000-2010. There were 2,091fte in 2000, and 2,145fte in 2010.<sup>3</sup> Over the same period, the number of medical students has increased from 48,195 to 66,840. The ratio of students to medical academic staff has thus significantly increased from 23:1 to 31:1.

#### Ratio of medical students to medical academic members of staff



The Medical Schools Council (MSC) report, *A Survey of Staffing Levels of Medical Clinical Academics in UK Medical Schools* from 2017, reported that the number of medical academics between the ages of 26-55 increased slightly between 2004 and 2016, but that there had been an approximate increase of 12% in those aged over 56. Furthermore, the MSC report noted that the age profile of clinical academics at Consultant level (Senior Lecturer and Professor) was slightly older than the wider NHS consultant population.

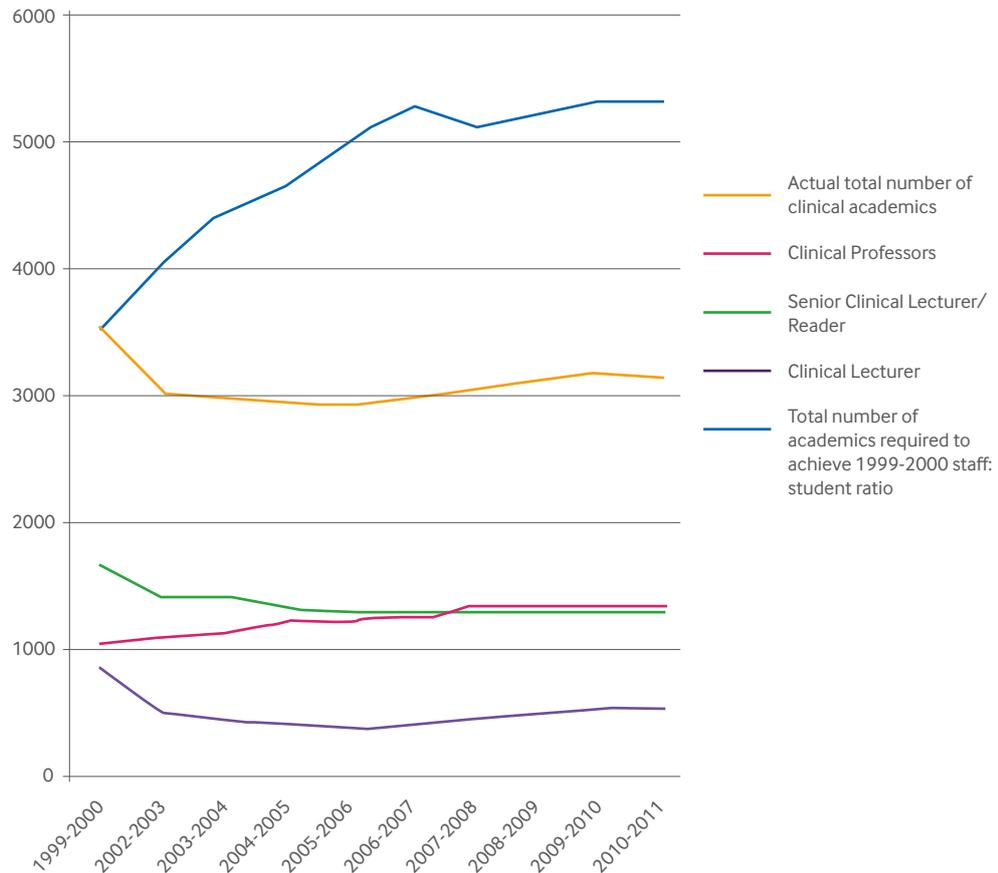
Senior medical academics in universities are not being replaced at a sustainable rate. The medical academic recruitment crisis of over a decade ago and the loss of doctors to medical academia during that period, have together resulted in a fall in the numbers of academic clinicians, notably in some of the smaller specialties. Fewer doctors are moving into medical academia from other careers, while a significant cohort of medical academics are verging on retirement. The loss of these senior academics will lead to the loss of role models for medical students, mentorship for and supervision of trainee academics, as well as a loss of leadership in many medical specialties.

This staffing crisis in clinical academia became acute following a sharp fall in clinical academic numbers between 1990 and 2000. As a result of concern being expressed by a number of bodies (including MASC), a working group led by Sir Mark Walport was established. The Walport Report recommended ways in which more doctors could be encouraged to

<sup>3</sup> *A Survey of Staffing Levels of Medical Clinical Academics in UK Medical Schools as at 31 July 2014*, A Report by the Medical Schools Council, July 2015

enter and remain in medical academia. A clear medical academic training pathway was introduced, which has been effective in increasing the number of medical academic trainees. The measure, however, essentially stabilised the number of medical academics at its, by then, low level and has not produced significant overall increases in medical academic numbers. This is despite the context of significant increases in the numbers in both NHS consultants and in medical students.

### The Clinical Academic Gap



The Walport Report also proposed that 'New Blood' Clinical Senior Lectureships be created and the Higher Education Funding Council for England (HEFCE) awarded 5-year Clinical Senior Lecturer post funding to various medical schools for five years from 2006. This has resulted in a small increase in medical academics in senior posts, some of whom have transferred from the NHS. However, the increasing pressure of grant capture and publication, which has resulted in a fragility of tenure in academia, has prevented many clinicians with an interest in an academic career from transferring to University employment from the NHS.

However, MASC believes that further effort is required to increase the number of mid-career medical academics, and to retain those currently working in this area.

## NIHR In-Practice Fellowships

In part in response to the need for mid-career entrants to academia, the NIHR has established an In-Practice Fellowship Scheme for general practitioners. The NIHR Trainees Co-Ordinating Centre website says the following about the scheme:

### **NIHR In-Practice Fellowships<sup>4</sup>**

*The NIHR In-Practice Fellowship (IPF) offers academic training to fully-qualified General Practitioners, General Dental Practitioners and Community Dentists who may have already spent some time in NHS practice and who have had little formal academic training at this point in their careers. Applicants must be able to demonstrate that they have outstanding potential for development as a clinical academic in research or research linked to medical education. Training will be flexible and trainee-centred with structured supervision to ensure the attainment of academic goals. Continued professional development will be expected of successful applicants.*

*The academic component of the training period may include completion of a Master's degree and the preparation of an application for a competitive peer-reviewed research training fellowship or educational research training programme leading to the award of a higher degree. Applicants who have completed a Master's or an MPhil, and who wish to use the Fellowship to support a bridging period to develop a proposal for a PhD fellowship for example, are also eligible to apply providing the additional research training is justified and appropriate. From 2013 onwards, Academic Clinical Fellows who will have completed their clinical training and wish to build on their previous academic training to develop funding opportunities such as NIHR DRF fellowships, whilst establishing themselves in clinical practice, will also be eligible to apply.*

The applicants to the scheme are assessed by a panel of senior clinical academics in primary care and associated disciplines from universities across England. In the last few years there have been between 7 and 11 successful applicants each year to the scheme. There is some concern, however, that the process favours applicants who have previously undertaken an ACF and that there have been fewer successful applicants from among established GPs. This would seem to be at some variance from the original purpose of the scheme. Concern has also been expressed at the extent to which such training could be undertaken part-time

<sup>4</sup> <https://www.nihr.ac.uk/funding-and-support/funding-for-training-and-career-development/training-programmes/integrated-academic-training-programme/in-practice-fellowships/>

## What prevents mid-career entry to academia?

Information	Research factors	Financial factors
Lack of transparent academic career structure	Insufficient research training	The perceived and actual differences in pay and conditions between university and NHS employers
Insufficient or no knowledge of how to transfer and no clear route of entry	The need to have a PhD (which will have to be at this stage mostly self-funded)	Concerns over stability of employment, with universities facing cuts in funding
Career structures that fail to reflect different clinical or academic workloads, or meet career development needs	Concerns over the Research Excellence Framework (REF) which encourages universities to hire established researchers over mid-career entrants to medical academia	Concerns about the loss of the right to an NHS Pension and/or loss of accrued maternity and other leave and pay, and redundancy
Insufficient awareness of the rewards offered by an academic career	Lack of funding streams for mid-career entrants and Funding Body preference for young researchers	The lack of private work opportunities both medical and non-medical

## Discussion: How to increase mid-career entry to academia

### Lack of information

#### No transparent academic career structure

A transparent career structure, with identified funding streams, may give potential mid-career entrants more confidence to pursue research. Similar initiatives to encourage qualified staff to undertake research in both Nursing and other AHPs have led to a rise in mid-career entrants to research within those professions, thereby raising standards, improving practice and increasing satisfaction and staff retention.

#### No knowledge of how to transfer and no clear route of entry

Many mid-career entrants to academic medicine enter by chance or because of an interest in a specific disease or patient group. Entry can be mostly ad-hoc, whereas a more structured transfer system might succeed in attracting the most suitable applicants at an appropriate time to carry out research and teaching informed by their prior clinical experience.

Easily accessible information on how to move from clinical to academic employment should be made available to doctors, perhaps via their Royal Colleges or Faculties.

Mid-career entrants to medical academia on medical school staff in student-facing roles would provide role models for students and illustrate the wide variety of routes into academia.

### **Career structures that fail to reflect different clinical/academic workloads or meet career development needs**

For GPs, the Walport Report recommended the creation of a competitive one-year funding scheme to provide salary support for GPs who have completed a doctorate and wish to apply for a postdoctoral fellowship. Some of these posts have been established, particularly in Wales, and have proved to be popular and thus successful in attracting new trainees to such posts. These schemes appear to have increased the attractiveness for a career in primary care where they have been established. An expansion of this type of scheme would appear to be desirable.

As noted above, the Higher Education Funding Council for England (HEFCE) New Blood Clinical Senior Lecturer Awards has already facilitated the creation of posts for mid-career entrants from secondary care backgrounds. This also appears to have been a successful scheme, though a final analysis of it has not yet been published..

We do recognise, however, that problems can arise where these processes do not fit into existing career structures and how these have developed for individuals. Structural and organisational issues, such as getting pay protection and ongoing pay parity on moving to a new position in academia, or how such positions would fit with family or social commitments due to workload implications, can possibly lead to failure to meet the individual's career aspirations. There is also a greater need for academia to support doctors who wish to work part-time including through the facilitation of job-sharing.

### **Insufficient awareness of the rewards offered by an academic career**

Medical academic careers can be immensely satisfying. The opportunity to have the time and space to explore one's curiosity, to devote ample time to trial participants; the intellectual satisfaction in seeing a project through from idea to application; the opportunity to network and converse with other like-minded researchers away from the pressures and targets of today's NHS are all aspects that make the academic career attractive. Opportunities to teach, mentor and supervise are also reasons mid-career entrants searching for a new challenge should consider a switch.

## **Research factors**

### **Insufficient research training**

With the drive to condense medical education and training and the rise in tuition fees, the intercalated BSc, once the only possible route to an academic medical career, is at risk, potentially reducing the number of graduates willing and able to enter Academic Foundation Programme. There have been reports from a number of universities that some students appear to be choosing to opt out of this extra year for financial reasons and because of increasing concerns about medical employment. Further work is still required on collecting data about the impact of tuition fees and other changes to student financial support on the take-up of intercalated degrees. In contrast, an increasing number of senior doctors are now taking MScs in their areas of interest, such as education, management and leadership. Some of these doctors may be motivated to take their studies further to PhD level.

There is also a need to expand the number of SAS doctors undertaking higher degrees in order to develop the aspirations of doctors in these grades. In the context of improving research, education and management training more should be done, first to identify the specific training needs of this group doctors, and, second, to meet those needs and do so in ways that are appropriate to the learning background and specialty of each doctor. We would suggest that the medical Royal Colleges have a key role in meeting these needs along with improved co-operation between NHS organisations and the higher education sector locally.

### **The need to have a PhD**

The Medical Schools Council report on clinical academic staffing levels and other surveys demonstrate that the majority of university appointments at Lecturer and above require a higher degree (doctorate) and an established research track record. Limited postdoctoral experience can prevent individuals from developing sufficient expertise to compete for prestigious externally funded Intermediate Fellowships or Clinician Scientist Fellowships.

This is an issue that needs to be addressed urgently, especially if the Walport Report's recommendations are to be fully realised.

As PhDs are, therefore, effectively a pre-requisite for academic posts, doctors who have followed a clinical path for the early part of their career will have to fund this part of their academic training if they wish to meet the requirements for taking up a role in academia. This financial burden is a disincentive to clinicians who wish to move into the academic sphere, especially if they have started a family.

One possible solution to this might be the extension of distance learning packages with taught components which may take place over an extended time, such as the University of Lancaster Public Health related PhDs. Greater use of PhD programmes that recognise previous publications should also be considered. There is also, therefore, a need to create academic posts suitable for mid-career entrants to medical academia. A range of new academic positions for mid-career entrants also need to be developed for which clinical experience can be recognised on a par with academic requirements. This should mean that the attainment of a doctorate is no longer essential for the post, but that it might be a flexible outcome of the post and could be achieved on the basis of publications and other metrics. Some specialities which have an emphasis on or requirement for translational research and which lack the necessary medical academics to lead and facilitate this, could be possible locations for the development of academic posts suitable for mid-career entrants to medical academia.

#### **Concerns over the Research Excellence Framework (REF) which encourages universities to hire established researchers over mid-career entrants to medical academia**

Universities work hard to maximise their Research Excellence Framework (REF) scores, and as a result, medical academic researchers are under intense pressure to generate significant research and grant income. The REF scoring process does not allow for the fact that most medical academics do not work full time in academia; their productivity scores are calculated as if they were full time academics. In some specialties, it is possible for researchers to achieve satisfactory REF scores, but in others, the nature of the research prevents the production of large volumes of research activity.

Some universities have made researchers redundant because they could not generate the REF score they desired. In light of this pressure, and the unrealistic expectations universities have for medical academics, clinical staff may not consider medical academia an attractive prospect.

REF also encourages universities to employ researchers with a solid track record of research production and income generation, both of which will maximise their REF scores. A mid-career entrant to academia will be at a major disadvantage in the job selection process because they lack a research track record.

Aspiring mid-career entrants should, therefore, be aware of the need to produce high profile output and of the need for team-working to that end. A mid-career entrant should seek to build on their existing networks by joining an existing relevant research group or programme in order to maximise their input into research and raise their profile in reviews.

Further, a change in the attitude of the NHS towards research will help entrants and aspiring academics by encouraging them to develop the skills needed to be able to strive for and obtain high REF scores for their projects.

There is an urgent need to promote a research culture in the NHS. The NIHR and other equivalent NHS research bodies in the devolved nations have helped to develop a research culture in the NHS. However, this culture is not yet a dominant force in driving the NHS forward. Improving the profile of research in the NHS would continue to drive up quality, improve patient outcomes and make medical posts within the NHS more attractive. An improvement of the profile of research in the NHS will help to create the environment in

which doctors in the middle of their careers could seriously consider taking up academic posts in either the NHS or the Higher Education sector

### Financial factors

#### **The difference in pay and conditions between university and NHS employers**

Pay differentials (or perceptions of adverse pay differentials) remain a disincentive to entering academia. For example, the implementation of the consultant contract in England in 2003/4 initially led to most NHS clinicians receiving salaries for 12 programmed activities per week, while their academics counterparts were paid for 11. It is extremely important that academic consultants retain pay parity with their NHS counterparts. To this end, both the criteria for CEAs and the number awarded need to adequately compensate clinical academics for their vital contributions to the NHS.

The DDRB's December 2012 report on consultant pay and merit awards showed that medical academics are proportionately more likely to achieve higher awards than their clinical colleagues. This increased income is important in making the financial reward from academic posts equivalent to that of the best clinical posts, countering the effect of the longer training programme, and helping to attract and retain the best doctors in academia.

However, the DDRB report also proposed an increased focus on local CEAs, and that the national awards be time limited. As the work carried out by medical academics generally goes beyond local boundaries and priorities, they may be less likely to achieve local CEAs. Employer-based award committees are often concerned with using incentives like Employer-Based CEAs to achieve local objectives.

The revision of CEAs locally and nationally must ensure that medical academics (including senior academic GPs) can still achieve the awards, so that academic medicine can remain an attractive prospect to existing and potential medical academics. This means having academic components to the criteria for local awards or performance pay. It is also vital that any posts liable for additional management payments are open to academic doctors and that there are equivalent posts in the academic sector. Failing to ensure these things would serve as a strong disincentive to pursuing a medical academic career, especially later in a career, and enhance the factors leading to the shortage of medical academics.

There is clearly a case for a fresh, if not revolutionary approach to flexibility in career paths for medical professionals generally. Pay and conditions need to be aligned throughout the career in order to facilitate movement between academia and the NHS.

#### **Concerns over stability of employment, with universities facing cuts in funding**

Employment in the NHS has generally been more stable than within the higher education sector. Universities and grant-making bodies can suffer cuts in funding, and as medical academic staff salaries are usually significantly greater than those of non-clinical academic staff, there is a strong temptation for university managers to make clinically qualified staff redundant.

As medical care is increasingly provided by a range of allied healthcare professionals, they can teach elements of the curriculum to medical students; they also cost less to employ. The new medical schools announced in March 2018 potentially provide increased job opportunities for medical academics, but they must be at the agreed terms and conditions to avoid a damaging race to the bottom. Furthermore, medical schools have been merging and splitting, adding to uncertainty about job security for medical academic staff.

**Concerns about the loss of the right to an NHS Pension**

Future pension entitlements and the sources for advice on the most suitable option are also a concern. Doctors in the NHS Pension Scheme who move to employment in a medical school are able to remain in the scheme under a general direction. Individual directions should be available for those working at other higher education institutions. Nonetheless, advice should be sought and in Scotland, a further disincentive to clinical doctors considering a mid-career move into medical academia has been the stipulation that they could only remain part of the NHS Pension scheme for eight years after leaving NHS employment; at that point, they had to join the scheme of their university employer. In the other UK nations, doctors can choose to remain as a member of the NHS scheme indefinitely after leaving substantive NHS employment. It is welcome that Scotland has recently adopted this approach and sources of advice should be made available on the best option for the individual.

**Concerns about the loss of accrued maternity leave and pay and other benefits**

Working within the NHS, even between posts, allows doctors to accrue a substantial amount of service which is taken into account when calculating their entitlement to maternity and sick pay and maternity leave and other benefits. By moving from the NHS to the academic sector, doctors often lose their accrued service. Despite advice on this matter from the NIHR Trainees Co-ordinating Centre, very few universities recognise doctors' NHS service when calculating entitlements to occupational benefits, such as maternity leave and pay. This represents a significant loss of occupational benefits for trainee doctors, and for mid-career academics a loss of an even greater magnitude.

Doctors who wish to take maternity leave, or who need to take time off in order to undertake caring responsibilities, can be particularly affected by any loss of their accrued service. This may well be a reason behind the large number of female doctors who leave academia post-PhD and the paucity of women in senior medical academic positions.

The age of doctors at mid-career point usually coincides with the point at which caring responsibilities (for children and elderly relatives) increase and health issues requiring significant sick leave are more likely to occur. In order to attract mid-career entrants to medical academia, the recognition of accrued NHS service amongst academic employers must become standard.

**The lack of private work opportunities both medical and non-medical**

Almost all University employers have different contractual arrangements for clinical academics regarding the undertaking of private medical practice, and most of these arrangements restrict or prevent private practice being undertaken. For any consultant who has built up a private medical practice this would be a significant disincentive to pursuing an academic career. Consideration should be given to universities showing more flexibility in this area, particularly for mid-career entrants.

## Other issues

### **Fear that there may not be routes back to the NHS**

The Walport Report highlighted the importance of providing academic trainees with routes back into clinical medicine at a later date. This uncertainty could be overcome by ensuring that there is a clear path from academia to clinical medicine, that joint appraisal is conducted annually and that all doctors undertake continuing professional development (CPD). The Walport Report recommended a quinquennial joint review point for all clinical senior lecturers, at which transition could be planned if required.

### **The lack of part-time opportunities**

Some specialities are more amenable to part-time working patterns than others. General Practice, for example, attracts a high proportion of female doctors because it is viable for GPs to work part time. However, the nature of academic positions, whereby even a full time doctor will divide work between the academic and clinical sectors, essentially working part-time in both, makes it exceptionally difficult for part time working to be negotiated.

There is also an unhelpful perception among both clinical and academic employers that academic doctors are less committed to the work that they carry out in each respective sector, because of their commitments to the other. Working less than full time would mean that a doctor spent even less time in each sector.

In many cases, funding for research is provided subject to time constraints; it is necessary for a project to be completed by a certain date. The nature of certain experiments or studies is also time sensitive. However, a part-time medical academic may be unable to work the required number of hours within the allotted period to complete the project.

Due to the impracticality of working part time in most medical academic posts, potential mid-career entrants who need or wish to work part time are discouraged from leaving clinical roles. Enabling more flexible and more part time working in academia – perhaps by job-sharing – is likely to help retain women in the medical academic workforce and attract more doctors of both sexes with caring responsibilities, including mid-career entrants. Flexible academic posts combined with support for mid career entrants which might involve supporting these doctors within existing research teams may make a change in career into medical academia more attractive

Overall, we note that arranging part-time working is generally thought to be more difficult to achieve than it actually is in practice. This issue needs some more imaginative thinking and a real desire to change mind-sets about traditional working patterns and about what constitutes a successful and productive medical academic. MASC is keen to work with other stakeholders to devise and encourage the creation and development of more part-time and flexible working in the academic sector.

## Summary of recommendations

- Raise awareness of the benefits of a medical academic career at any career stage
- Promote the importance of research in medical training
- Encourage and enable exposure to medical researchers and research activity at all career stages
- Work with funding bodies to ensure that a sustainable and varied medical academic workforce is possible
- Ensure academic employers are aware of the importance of medical academics
- Develop pay-scales and terms and conditions that do not disadvantage clinical academics generally and mid-career entrants specifically
- Encourage flexible and reasonable expectations among both university and NHS employers of clinical academics
- Create more part time/flexible working posts and promote job-sharing to encourage a diverse population of researchers
- Ensure doctors can switch back easily to a fully clinical career
- Ensure that medical academics are able to remain in the NHS Pension scheme and appropriate advice is available to all.

**MASC**  
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**Policy**

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