

Editorial

Developments in career pathways for primary care researchers

The future of primary care research depends on attracting interested clinicians and non-clinical scientists to our universities, and providing them with high-quality research training. In the UK, the research strategy (Department of Health, 2006) developed through the National Institute for Health Research (www.nihr.ac.uk) has provided a framework through which health practitioners can engage in research via research networks. The Primary Care Research Networks (PCRN) should provide a real opportunity for clinicians in primary care to engage in research and develop careers in this direction.

The large majority of patient contacts with health services occur in primary care yet its research workforce is a very small proportion compared with secondary care. However, the three-yearly census of academic departments of primary care carried out by the UK heads of departments' group has shown little overall growth in the discipline over the last nine years, the total number of substantive posts (professors, readers, senior lecturers and lecturers) remaining at around 300 full-time equivalents (fte) (SAPC, 2004–2007). This is disappointing as the primary care workforce increased by more than 150% in the 10 years before 1998 (see Box 1; SAPC, 2002). In primary care nursing, there is an even smaller proportion of nursing professors and readers who specialize in primary care research. Indeed, in academic nursing as a whole, professors make up only 2.6% of the workforce compared with 12% across all academic disciplines (UKCRC, 2007), primary care represents a minute fraction of this.

The drop in medical academic staff between 2004 and 2007 is somewhat surprising, because more research training fellows had been recruited in the three years prior to 2004, who might have been expected to progress to substantive posts

Box 1 Staff censuses of UK departments of academic primary care (medical)

Year of census	Number of departments	Total academic staff (fte)	Medical academic staff (fte) (%)
1988	24	124	112 (90)
1998	24	299	215 (72)
2001	31	291	198 (68)
2004	33	316	207 (65)
2007	33	292	175 (59)

fte: full-time equivalents.

by 2007. The number of research fellows increased from 82 to 93 fte between 2001 and 2004, helped greatly by the Department of Health (DH) research fellowship scheme dedicated to primary care, which awarded 79 fellowships from 1999 to 2004 across doctoral, post-doctoral, and career scientist levels: 38 to general practitioners (GPs), 26 to other clinicians and 15 to non-clinical scientists. Since the dedicated primary care scheme ended in 2004 however, the number of research fellows has dropped significantly, to only 53 fte in 2007.

The numbers of medical professors, readers and senior lecturers have increased significantly since 2001 but there has been a decline in the number of lecturers. It has been especially difficult to appoint medical lecturers, partly because the 1996 and 2001 research assessment exercises¹ expected

¹The Research Assessment Exercise is a UK-wide audit of research quality across all university departments in the UK, see www.rae.ac.uk for further information.

lecturers to be returned with four high-quality publications, not easy to achieve in your first substantive post, and medical schools moved away from appointing lecturers. The problem is not peculiar to academic general practice: the Council of Heads of Medical Schools annual surveys have shown a worrying decline in numbers of academics, with a loss of lecturer posts across nearly all medical specialties since 2000 (Medical Schools Council, 2007). Specific initiatives have been mounted to tackle the decline in medical academic numbers, including a clinician scientist fellowship scheme set up by the Academy of Medical Sciences in 2001, and a new DH generic research training fellowship scheme open to all medical and non-medical disciplines in 2005, following the end of the dedicated discipline-specific schemes including the primary care scheme.

In nursing, the proportion of academic posts is similarly dismal but has a different history. Clinical nurses in the UK have traditionally had to make choices between continuing a clinical career, or entering the academic field, due to the funding streams that have supported nurse education. Few academic nurses are able to continue working clinically in primary care as part of their university post, those who do often do this work on quite independent contracts. This has necessarily stifled the potential for engaging directly with clinical problems through nursing research and for students to benefit from some of the highest calibre clinical nursing.

The most far-reaching scheme for medical academics was set up in 2006 as a result of the report of a joint working party of the United Kingdom Clinical Research Collaboration (UKCRC) and the Modernising Medical Careers (MMC) initiative, led by Mark Walport of the Wellcome Trust (UKCRC, 2005). UKCRC is a collaboration of research funders, academic bodies and UK departments of health, education and sciences, set up to tackle the problems facing health research including barriers to pursuing research careers, increasing difficulties securing funding, the challenges of recruiting patients and the increasing research governance bureaucracy, which all contribute to the waning enthusiasm for academic careers. The working party took advantage of the MMC reorganization of medical training to define a new academic career pathway dovetailed with clinical training.

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Academic clinical fellowships (ACFs) provide funding to lengthen GP training from three to four years, securing time to prepare applications for doctoral fellowships from the Medical Research Council, the Wellcome Trust and other charities, or the DH. Clinical lectureships (CLs) provide 50% funding for four years to allow GPs with a doctorate to develop independent research and secure post-doctoral or career scientist fellowships. In addition to the ACF and CL posts, new funding allows 5% of doctors in the second year of Foundation School (postgraduate training immediately following graduation) some exposure to research for four months. Finally, 200 ‘new-blood’ medical senior lectureships are to be funded over five years, 50% by the Higher Education Funding Council for England and 50% by the DH.

In 2006–07 seven departments in England secured programmes, which between them provide a total of 45 ACF and 29 CL posts for GPs over five years (NCCRC, 2007), helping to increase academic staff towards the 2001 level. Other departments are developing GP AF2 posts, and although none has so far been awarded a new-blood senior lectureship, the Walport scheme holds out hope for the continuing development of academic general practice.

Similarly, the DH have examined modernizing nursing careers and as part of this Prof. Finch chaired a committee on academic clinical careers for nursing that published its recommendations in August 2007 (UKCRC, 2007).

It recommends:

- 200 new posts per year at masters’ level, involving novel contracts combining 50% academic work with 50% clinical over two years full-time or equivalent part-time.
- 50 new three-year doctoral-level posts in strategic areas, for PhDs or professional doctorates.
- 20 three-year post-doctoral career fellowships.
- 10 three-to-five-year senior clinical academic fellowships.

The Finch report recommendations aim to develop the potential of research nurses in networks and clinical research facilities, nurse practitioners and nurse consultants, to develop and lead programmes of research and education, combining this with clinical careers through new

session-based contracts. It is anticipated that a proportion of posts arising from the initiative will benefit primary care nursing research. It is just a first stepping stone in changing the academic career structure for primary care nurses. However, the experience of Canadian nurses is an interesting comparison. In 2003 the Canadian Journal of Nursing Leadership (2003) published the findings from an Office of Nursing Policy report that put forward the challenges for developing the nursing research capacity building exercise:

- increasing the pool and critical mass of nurse scientists;
- maximizing career trajectory;
- aligning focus of research with sources of research funding;
- enhancing linkages between practice and science;
- building research programs evaluating scientific productivity, and recognizing individual scientists;
- capitalizing on nursing research opportunities;
- investing in leadership and succession planning.

These are challenges that we face in primary care research in the UK across nursing and medical research. We need to be positioned to face these challenges and to utilize the opportunities that are emerging from Walport and Finch to work collaboratively so that primary care research and ultimately patients are the beneficiaries.

There is still much to do. Firstly, the new generation of clinical academics arising from the UKCRC schemes need high-quality training, mentoring and guidance, facilitated through national meetings and peer support groups, led by the host departments and the School for Primary Care Research² and the PCRN. Secondly, UKCRC should next consider the allied health professions that have an important perspective to bring to primary care research. Thirdly, better career pathways are needed for non-clinical researchers too, the statisticians, epidemiologists, psychologists, sociologists, health economists, etc. who bring vital research skills yet often face lower pay and short-term contracts, which prevent them from applying for grants as principal investigator

²The National School for Primary Care Research is an England-wide initiative consisting of five academic departments of primary care, led by The University of Manchester and funded by NIHR

(Working Party, Executive Committee, SAPC, 2008). The Society for Academic Primary Care (SAPC) should consider developing a code of good practice in the employment of non-clinical academic staff and allied health professionals, encouraging the move towards permanent contracts and timely promotion, and lobby funding agencies to change their policies to allow more clinical and non-clinical researchers to develop as research leaders. These strategies, along with the substantive funding that has been recommended, should help to secure and sustain a stronger clinically focused primary care research workforce for the future.

Tony Kendrick
Professor of Primary Medical Care and
Chair, Heads of Departments Academic
Careers Sub-group
University of Southampton
Southampton, UK

Sally Kendall
Professor of Nursing and Director
Centre for Research in Primary and
Community Care
University of Hertfordshire, UK

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