Is there a threat to academic medicine? A forward look to 2048

It is often forgotten that the idealism of a National Health Service (NHS) incorporated not only notions such as 'universal coverage' and 'free at the point of delivery' but also an over-riding perspective: the medical workforce will be trained to high standard, fulfil a leadership role, and be open to, and imaginative about, new approaches to patient care. The preceding 1944 White Paper suggested a 'specially constituted corporation or similar body (perhaps largely made up of members of the medical profession) which would….direct and supervise the service' (Ministry of Health, 1944). Henceforth consultants would be recruited via proper appointment processes, employed directly, and expected to fulfil these expectations.

In 1948 apprenticeship style medical education and training was deeply embedded in medical culture, male dominated, and London-centric. Oxford and Cambridge provided pre-clinical degrees, followed by external clinical placements; provincial universities followed a mixture of similar patterns; and in Scotland, where medical educational structure was more evolved, clinical teaching was ward- and role model-based. The 1944 White Paper said little about research, other than that the Medical Research Council (MRC) could organize. Neither the emerging philosophy of clinical trials, nor discoveries such as antibiotics, already changing the face of medicine, was mentioned.

Academic medicine: success story?

Against this background, academic medicine in the UK has succeeded beyond all expectations. The idea that some doctors – de facto chiefly consultants – would be employed by medical schools, and spend more time than their colleagues on 'academic' medicine (education, teaching and research) gained ground rapidly. Indeed the 'merit award' system encouraged academic activity, eschewing private practice rewards. The slight tension between these 'medical academic' doctors and their 'fully NHS' colleagues – who often also took part in academic activities – was balanced by perceived positive impact of 'academic' activities for such colleagues. Perhaps the enhanced opportunities for this were an attraction of the 'teaching' hospital.

Over the past 67 years there have been many innovations. When governance became more desirable academic medicine developed its own unique structure: the recommendations of the Follett Review (Follett and Paulson-Ellis, 2001) gave formal expression to the dual role of doctors designated explicitly as both clinical and academic. When medical education was perceived as lacking a holistic perspective, medical schools changed emphasis to recognize the work of sociologists, and to respect patient input. Medical ethics was also absorbed into curricula. When medical careers were 'modernised', the Walport schemes (Walport, 2005) ensured that recruitment to academic medicine was structured and facilitated, providing validation of an academic career pathway for junior doctors. Formation of a National Institute for Health Research (Department of Health, 2006) emphasized the NHS's commitment, complementary to the role of the MRC and research charities.

The success of UK academic medicine is perhaps illustrated by the Research Excellence Framework (REF) outcome where 60% of researchers achieved the highest level (4*). The REF incorporated not only output but also impact, and these two attributes are also reflected in how biomedical research is recognized as a major contributor to the national economy. But academic medicine has not been passive and complacent. Issues about health inequalities, public health, and the balance between health and social care, have been placed repeatedly on the public agenda. A personal idiosyncratic selection – monoclonal antibodies, biological therapies, AIDS research, cell cycle research, the human genome project and its byproducts – illustrate our strengths.

Academic medicine: at risk?

Given successes, it may sound churlish to argue that UK academic medicine is threatened. But unless risk factors are identified and tackled effectively, the centenary of the NHS – within the working lifetime of today's medical students and junior doctors – might not reflect as much success for academic medicine as since 1948.

Doctors are not endowed with Harry Potter-type qualities. Politicians seem to believe that a crisis tomorrow in 'omphalology' leads the next day, as if by magic, to the medical profession providing a cohort of 'omphalologists' – at whom government can throw money and resources in the very short term. For 'omphalology' read the current favourites – emergency medicine and general practice – where shortfalls in recruitment are 'going to be tackled' without any apparent cognisance of questions like who trains new recruits, how long will it take, and what impact will a new priority have on other specialities?

One welcome development has been recognition that medical workforce education is a continuum. Consequently the General Medical Council (GMC, 2010) has overview of all stages. A concern, however, is that the GMC has been so engaged in evolution of appraisal and revalidation that it has taken its collective eye off the fact that at every stage there needs to be adequate provision of educators, and associated time and facilities. Even with increased access to online educational resources, surely there must be a critical mass of medical academics needed per undergraduate and junior doctor? Surely the shortage becomes self-perpetuating, because lack of exposure to medical academic career role models has an inevitable impact on career choices?

Nobody goes into academic medicine for financial reward. But some avoid because of financial disadvantage. Exacerbated by undergraduate medical education costs, medical academic careers imply longer training, prolonged periods spent on lower

pay points, and a riskier future. Skills and competencies drivers are no doubt valuable to maintain standards, but the downside is narrow focus on purely 'clinical' competencies. Ease of flexibility, which is inherent in academic pursuits, can be lost.

Although 'academic activities' are encouraged on paper, the real focus of management seems to be day-to-day service provision. Never mind that service quality depends upon the educational and research environment in which service is delivered. Excellence awards are biased increasingly towards service. Patient throughput is the major parameter – in terms of time and money – despite patients (and families) often saying they do not have the time to express themselves and to grasp information that their doctor is trying to convey.

Service pressure is reflected in several ways. The 'programmed activity' (PA) provision for PAs not devoted to direct patient care may be whittled away. Extending hours of service provision may lead to academic activities being marginalised, or being regarded as 'out of programme' – terminology unfortunately already in vogue for junior doctors in full-time research. There is an intriguing example in infectious diseases: although the overall number of consultants has been maintained, these are now chiefly physician-based rather than laboratory microbiology- or virology-based, perhaps implying a shift even within medical academia towards the more easily identifiable service role. This speciality also highlights other problems: the medical academic troubleshooting at the bedside or clinic, i.e. easily recognized service, has difficulty in getting parallel recognition for troubleshooting in the laboratory itself, the critical telephone call, and the clinical perspective discussion with non-medically qualified scientist colleagues.

It is important to recognize that 'threat to academic activities' is not confined to medical academic contract holders. The Keogh Report (2013) into mortality, and the Berwick Report (2013) into health service provision, both emphasized this in different ways. The hospital failing in patient care is the hospital where the medical staff are demoralized, with no sense of a 'research culture', asking questions and trying to find answers, both at individual level and in population and public health terms.

The British Medical Association's Medical Academic Staff Committee and the academic leads of the Royal Colleges have shared these concerns. An outcome consensus view document (to be published shortly) is that every doctor is both a scholar and a scientist.

So is British 'academic medicine' threatened? Maybe academic medicine is not threatened, but 'medical academics', those who are expected to deliver, are. It is the individual medical academic who feels undervalued and demotivated, and unable to fulfil his/her appropriate leadership role when confronted with provider, managerial and government pressures.

2015–48: the way forward

What is the solution? Surely a useful starting point is that consultants, including medical academics, should seek – both collectively and individually – to uphold the principles of professionalism as central to their daily work. From this starting point the boundaries between service, teaching and research become artificial. All doctors should take pride in doing a job well, paying attention to detail, and take personal responsibility for their actions and their consequences. They should develop and improve their skills, be dissatisfied with substandard results, be prepared to acknowledge mistakes, learn from them and take appropriate steps to prevent recurrence.

In this scenario medical academics can fulfil their potential in leadership. This encompasses the patient in the clinic, the population of the local authority in which they are based, and future patients and populations. Curiosity is fostered. There is time and space to research into new techniques and medicines that can address patient need more effectively, to innovate so that services better satisfy patients and populations, and to educate and train others in order to ensure that the NHS, as well as all other health-care providers, have the doctors, nurses and allied health-care professionals necessary for effective care delivery. In this environment the medical academic would become a respected colleague. Surely committing to foster this agenda would be a useful benchmark starting point, even if as idealistic as commitments in 1948? BJHM

KEY POINTS

- The creation of a National Health Service in 1948 led not only to radical change in health care delivery but also to evolution of robust conditions for academic medicine to flourish.
- Since 1948 UK academic medicine has adapted to changes in governance and career structure, education and training; and made many significant internationally recognized contributions.
- External pressures of service provision, loss of flexibility in career structures, increased emphasis on acquisition of defined specific skills, less direct contact with academic peers, and potential financial disincentives, have create a sense of unease about the future for the individual medical academic.
- Continued success for UK academic medicine depends on recognition of medical professionalism, and on ensuring changes are benchmarked against impact on education and training, research and innovation.

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Professor DR Katz is Deputy Chair of the British Medical Association's Medical Academic Staff Committee, but this article represents his personal views.

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