Centre of Academic Primary Care
Polwarth Building,
Foresterhill
Aberdeen AB25 2ZD
Scotland
United Kingdom
Tel: +44 (0) 1224 437264
Fax: +44 (0) 1224 437285
url: www.abdn.ac.uk/capc

29 September 2014

Professor Andrew Morris
Chief Scientist
Chief Scientist Office,
Scottish Government Health Directorates,
St Andrew's House,
Regent Road,
Edinburgh, EH1 3DG

Dear Professor Morris

Scottish Government Health Research Strategy

Thank you for inviting comment on the draft Scottish Government Health Research Strategy. I have contributed to the response you will receive from the Scottish heads of GP departments, but write here personally, as a GP whose crossover from full-time clinical work to a senior academic role was made possible by CSO's investment in primary care research capacity. My comments relate solely to this as raised in section 5.4 and question 16.

I concur with the positive account of CSO's historic investment. By my reckoning 5 of the 9 senior clinical academic GPs appointed in Scotland in the last 10 years have come through these schemes. We were part of the research networks / practices movement of the late 1990s and some of us used this route because other early career research opportunities had not been available.

There is now a cohort of Scottish early career GPs who have been successful in obtaining doctoral fellowships, largely with CSO. They have done this by using NES schemes such as SCREDS lectureships and Clinical Academic Fellowships in order to become competitive at application. Some of this group will be candidates for post-doctoral fellowships in the next few years and in the long run have the potential to move to leading academic roles. It is important that there are opportunities for them, but current options are limited:

- NIHR fellowships are the main post-doctoral route taken by academic GPs in England. They are relatively flexible about time after completion of clinical training (CCT) reflecting the fact that even 12 months after CCT, GPs may have only two years of in-discipline clinical experience compared to between 3 and 5 years for ST4s in most other clinical specialties.
- Wellcome and MRC fellowships are highly competitive and depend on a substantial track record of publication etc. While some academic GPs follow an academic track during undergraduate / early postgraduate years and then move to general practice (so can acquire this track record), many choose a clinical route and then cross over to academia and pick up publications later. This hurdle applies to both doctoral and post-doctoral fellowships.
- Primary Care Research Career Awards have provided a solution in the past. They were particularly suitable for GPs who were partners in practices and needed to drop clinical

commitments to build their research. In some ways this is now mirrored by the NRS fellowships for secondary care clinicians who may have completed a doctorate in training, moved to service delivery and now respond to opportunities to cross back over to research. The picture in primary care is now rather different with fewer GPs moving straight from training into partnership. The shorter GP training compared to secondary care specialties means that GPs do not complete a PhD as part of their training, and only complete one afterwards if they are committing to an academic career path. Thus, at the post-doctoral stage many will be ready to progress directly along a clinical academic track.

- During informal discussions with CSO I have heard a view of "only one fellowship from CSO". I do not know if, or how rigidly, this is applied, but while I appreciate the need to avoid funder dependency, I think this could present a problem in relation to primary care academics whose opportunities for other clinical doctoral or post-doctoral fellowships are limited.

There will shortly be a need for post-doctoral fellowships for GPs. It seems highly likely that the Scottish universities will be looking to support individuals through such fellowships and then to replenish their academic GP staff from the most successful ones. Candidates entering such fellowships will be more securely established within university departments than was often the case in the past, and the posts could probably be clinical post-doctoral fellowships without needing a special primary care name. However they would need to be available to candidates with a CSO doctoral fellowship. An alternative may be for CSO to "buy into" the NIHR primary care fellowship scheme. This might avoid having a different set of CSO rules for GPs.

However CSO decides, a solution will be needed to avoid a much needed group of highly able emerging GP academics either heading south or failing to progress in their careers.

Yours sincerely

Christopher Burton MD FRCGP

Senior Lecturer & Lead for Primary Care Research
01224 437256
c.burton@abdn.ac.uk