Changes to the UK foundation programme add further challenges for doctors pursuing clinical academic careers

The recently announced changes to how academic foundation jobs are allocated will not remove the barriers that prevent clinicians from pursuing research, write Marina Politis, Kate Womersley, and Charlotte Summers

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The UK Foundation Programme Office (UKFPO) recently announced major changes to the specialised foundation programme (SFP)—an academic pathway for newly qualified doctors. Applicants will no longer be able to select academic jobs for which to interview; instead, these jobs will be assigned by a computer ranking system that’s not linked to applicants’ previous achievements. The introduction of this preference informed allocation system for the main foundation programme was met with frustration in 2023. The decision by UKFPO to extend it, and to incorporate the SFP into the allocation process for the main foundation programme rather than having a separate application, will make the NHS a less attractive place to train for doctors who are considering a clinical academic career.

The current allocation process assesses candidates for the SFP according to educational achievements and interviews. It is admittedly not a perfect system and risks favouring students from universities that deliver six year courses with strong research components and those from more privileged backgrounds who could afford to undertake optional research attachments and intercalated degrees. Yet the UKFPO’s decision to implement a preference informed allocation system for all foundation doctors was made despite several senior academic clinicians raising concerns, and any further consultation process about the change has been opaque. The proposal is apparently motivated by a desire to widen participation in research training. But the change will “level down” by ignoring the previous achievements of applicants, rather than “levelling up” by tackling the structural barriers to attainment.

False guise of widening access

The change effectively randomises who will receive academic training, rather than taking action to ensure that research careers are accessible to all—for example, by introducing academic time for all foundation trainees—or tackling critical factors that limit applicants’ opportunities, such as financial hardship in medical schools. Furthermore, introducing preference informed allocation does not get to the root of why a declining number of students are undertaking intercalated science degrees—a problem that was highlighted by the House of Lords Science and Technology Committee in an inquiry into clinical academics in the NHS.

If the UKFPO wants to widen access to research training and build a community of committed and engaged clinician scientists, then there are several interventions that are more likely to facilitate this. They could increase the number of available research opportunities (currently, only 5% of all foundation programme places offer research time). The provision of mentorship programmes would help candidates without contacts to gain access to networks and opportunities. Offering bursaries would also help to remove the financial barriers that prevent medical students and foundation programme doctors attending conferences to present the outputs of their work.

Established crisis in clinical academia

Clinical academia is already in the grips of a workforce crisis. Despite the number of hospital consultants increasing, the number of clinical academics has declined. The situation is particularly dire in primary care, where clinical academics comprise less than 0.5% of all general practitioners. There are further threats to the clinical academic workforce: one third of clinical academics are over the age of 55, and it’s not clear whether there is a workforce available to continue their work when they retire. At a time when there is a stated aim to increase the amount of research undertaken in the NHS, as it is recognised to benefit both patients and the UK economy, it would be helpful to introduce incentives, rather than obstacles, for early career clinicians who want to build research careers.

The introduction of a random allocation system might also reduce the likelihood of clinicians undertaking high quality research during the SFP by thwarting the advanced planning that goes into developing a research project. Crucial stepping stones to conducting research, such as connecting with like-minded seniors working on a shared topic of interest, building support networks, and designing a feasible project, are all often started in advance of the SFP.

The changes to the SFP will prevent medical students from steering the direction of their careers and perpetuate a growing theme in NHS medical training of treating applicants as inputs for an algorithm rather than individuals with diverse skills, interests, and needs. More robust selection processes that consider individuals’ contexts would improve access to clinical academia.

Scope for further disadvantage?

Providing places in the SFP to people not interested in, or well suited to, research will deprive other candidates of a limited opportunity. We know that
women are under-represented in clinical academia, and data suggest that women exposed to research early in training are more likely to pursue a research career. The change proposed by the UKFPO might reduce opportunities for motivated and able early career women for whom it is often more challenging to catch up later in their careers because of the caring responsibilities they disproportionately take on. Black people and those from ethnic minority groups also remain under-represented in clinical academia, with black women considerably under-represented.

The new allocation system fails to tackle the under-representation of people from specific groups in clinical academia and might mean that those who succeed in academia do so increasingly by relying on existing networks of advantage.

Growing research activity in the NHS requires more researchers across the healthcare system. We need to remove the barriers that prevent people with the excellence and drive for a clinical academic career from pursuing their ambition. The introduction of preference informed allocation, although a cheap fix, does nothing to aid this goal.

Competing interests: None declared.

Provenance: Not commissioned; not peer reviewed.

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