**Fostering excellence in medical education career pathways**

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**Abstract**

High quality medical education requires committed and skilled educators, researchers, and leaders. Capacity building for future educationalists is fundamental in the pursuit of excellence in medical education. Medical education as a discipline is undervalued, underfunded, and often badmouthed. In order to pave the way to excellence, we must lay down the correct career pathways and foster a supportive climate in our specialty. In order to attract and support tomorrow’s educationalists we argue that we need to champion the field, develop integrated clinical and educational training programmes, and promote role modelling and mentorship.

**Keywords**

* Medical Education
* Careers
* Role-Modelling
* Flexibility
* Portfolio

**Introduction**

This issue of *Education for Primary Care* considers how we can develop excellence in medical education. High quality medical education requires committed and skilled educators, researchers, and leaders. Capacity building for future educationalists is fundamental in the pursuit of excellence in medical education. Medical Education has historically been considered the ugly duckling of research 1, and junior doctors are often discouraged from developing careers in medical education through badmouthing and stigmatisation. Current training systems in the UK have typically undervalued the development of medical educators, further undermining the discipline.

In this article we reflect on our experiences of badmouthing and stigmatisation of medical education careers. We argue that parity of esteem for educational careers is needed and make recommendations for how we might work towards this. We identify three key areas from our personal experiences of being junior doctors and budding medical educators.

**Stigma**

There’s this idea of fit. Of not wanting to stand out. To a greater or lesser extent, we all know what the archetype surgeon or physician looks and sounds like. So, as a trainee orthopaedic surgeon, to be academically focused on medical education is…uncommon. I was once told “those who can, do. Those who can’t, teach. And those who can’t teach go into MedEd”. Equally, in the past, I had it suggested to me that the reason I (and others) go into medical education, or have an interest in training is because we don’t have the “hands”; the implication being, if you were a great surgeon, why would you want to be training or in a lab somewhere, surely you would want to be operating all the time. There’s this weird stigma – like, telling people I am a qualitative MedEd researcher and an orthopod creates this…glitch in the matrix. Anyway, when people criticise, I tell them it’s like Top Gun. The best pilots become instructors…
Simon

There are a few issues to unpack around building a culture of respect for those who want to be clinician educators or perhaps, clinician educational researchers. Firstly, there is no clear career pathway. The Royal College of General Practitioners have, in the UK at least, led the way in the recognition and professionalisation of trainers. However, when looking to the Canadian CanMeds Clinician Educator Program2 and similar, the UK remains lagging behind in terms of recognition of medical educators. Those involved in medical education are often seen as hobbyists or are forced to wrap their education work up under the auspices of something else (quality improvement, academic research) rather than being seen for what it is – a distinct branch of medical science. If someone wants to be a research scientist (as we know it), there is a clear career path for them to take; the National Institute for Health Research’s (NIHR) Integrated Academic Training 3. This includes academic foundation program, academic clinical fellowships, and clinical lectureships. On completion of training there are opportunities for roles combining clinical practice with significant time in the lab or “doing science”. Largely, this simply isn’t the case for educators, or medical education researchers. A lack of dedicated time for educational work, funding, respect and support is reflected year on year in the GMC trainer Survey 4 and is commonplace in the lived experiences of trainers and trainees alike. Anecdotally, much of medical education research has to be re-branded for it to be seen as credible.

There is an epistemological shame around ‘being MedEd’ (especially qualitative) and this prejudice must be challenged this if we wish to build a culture whereby being part of the community who build excellent training and evidence around it is not just ok, but encouraged. We demand a clear career path for those with a passion and a drive. We require resources (time, people and money) so that it is no longer “those who can’t, teach” but rather, the very best of us aspire to a career as a clinician educator or clinician researcher.

Historically medical education research has suffered from underfunding 5, which has hindered the legitimisation of the field. In 2015 the NIHR changed their funding criteria to explicitly include medical education research, provided the research “will have the potential to have practical application”6. In recent years medical education has also been a priority research theme for NIHR integrated academic training. These are significant steps forward for the field, and we applaud NIHR for this. The increase in medical education focused academic training posts both legitimises the discipline and serves to build capacity. Those who take the first steps into such programmes will surely act as role models and encourage future educators to take a more well-trodden path.

**Flexible training**

I have long known that I want a portfolio career combining clinical work in general practice and a role in medical education. I’m fortunate to have had great role models that have shown me different ways this can work in practice. However, it appears very difficult to combing these roles simultaneously before completion of clinical training. I was keen to start my clinical career as I meant to go on, and combine less than full time training with a part time role in medical education. Opportunities to do this have not been forthcoming. I was interested to hear on a previous TASME (Trainees in the Association for the Study of Medical Education) Twitter chat that this is a challenge many junior doctors are facing and finding difficult to overcome. It seems to me this is a real missed opportunity.
Eliot

There is significant interest amongst junior doctors in developing teaching focused careers in medical education 7,8. Development of careers in medical education has historically for many been serendipitous 9, and opportunities for teaching development integrated with clinical training are scarce. Increasing numbers of trainees take time away from training programmes to undertake clinical teaching fellowships (CTFs)10. These are developmental posts that are typically fixed term for one to two years and are predominantly focused on teaching and educator development 11. Some posts include a proportion of the job plan (usually up to 0.5 full time equivalent) as time spent on clinical duties. This clinical time, however, does not contribute to specialist training, and the posts are fraught with challenges which are inevitable when placed outside of formal, protected training programmes 12. Competencies developed during this clinical work are not easily translated across to training programmes, which contradicts the principles of competency based medical education13 and leads to trainee frustration at lack of progression.

For doctors interested in pursuing careers in medical education research there are now opportunities to undertake academic clinical fellowships in medical education, combining clinical training with protected time for educational research. While these programmes may have additional, often informal, opportunities to develop teaching skills, the focus is on research development. For those that aspire to careers in education delivery and leadership, rather than research, there are fewer opportunities for integrated clinical and educational training. Over the last decade there have been a growth in clinician-educator tracks for postgraduate trainees14. Trainees’ experiences of these have been reported to be very positive. These roles have contribute to the development of personal and professional identity as educationalists, with transferable skills to clinical practice being noted.15 Increasing numbers of higher training programmes are facilitating transference of competencies, both clinical and educational, developed during fellow roles, offering promising flexibility.

Most recently the Royal College of Physicians’ have piloted Flexible Portfolio Training, which does include both medical education and research, and demonstrates another promising innovation 16,17

We know that fewer than half of foundation doctors apply for training jobs straight from the foundation programme 18. Reasons for this include that trainees perceive full time clinical training to be too rigid and can feel like being on a conveyor belt.19. One option for those interested in developing education careers would be to undertake less than full time training and simultaneously hold a part time teaching position. There are, however, strict eligibility criteria for less than full time clinical training 20. Category two criteria (lower priority) include ‘unique opportunities’, but whether teaching fellowships are considered unique opportunities is subject to local interpretation. If approved for category two criteria, less than full time training would usually be for a fixed term period.

We argue that the development of trainees as educators should be valued, and that integrated posts (like those described by Cope & Alberti 15) should be developed on a national scale and available to all specialities to offer combined clinical training and educator development. We anticipate these posts would be attractive to junior doctors and would improve retention and workforce development.

**Role modelling**

When I was at medical school, my peers used to say to me: ‘What, you want to do dermatology? Don’t you want to become a proper doctor?’ Years later, preparing for an interview, I explained my love for medical education. “But now you’re going to become a proper dermatologist, aren’t you?” they asked. Career stigma exists across all specialties: this I was used to. But their next question threw me. “You want to do both dermatology and medical education? How are you going to do that? Who even does that?” It’s difficult to see the career path ahead of you when there are few who have taken it before. Where would I find the right role-model?
Jonathan

It may well take more than the introduction of more flexible training to promote excellence in medical education careers. Role-modelling is a powerful driver for career choice 21, as role-models can provide not only infectious enthusiasm for their specialty, but practical advice on how to navigate the career ladder. Effective mentorship and role-modelling, from early stages of medical school, through to postgraduate training, will likely be required, as specialty decision making is complex and fluctuates throughout the early career continuum. Educational leaders of diverse career stages and backgrounds should be encouraged to ‘share their stories’, to provide positive examples for the emerging generation of medical educators to aspire to, as well as to encourage establishment of formal mentorship structures within their institutions. Local examples of such initiatives exist: it should be the duty of leading organisations to reward educators for excellence in educational mentorship and establish national support frameworks. The Association for the Study of Medical Education (ASME)’s mentoring scheme launching this year will help to facilitate this.

**Conclusions**

The future excellence of medical education research depends on developing medical educationalists today. To pave the way to excellence, we must lay down the correct career pathways and foster a supportive climate in our specialty. In order to attract and support tomorrow’s educationalists we argue that we need to champion the field, further develop integrated clinical and educational training programmes, and promote role modelling and mentorship.

**Declaration of interest**

The authors have no conflicts of interest to declare.

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