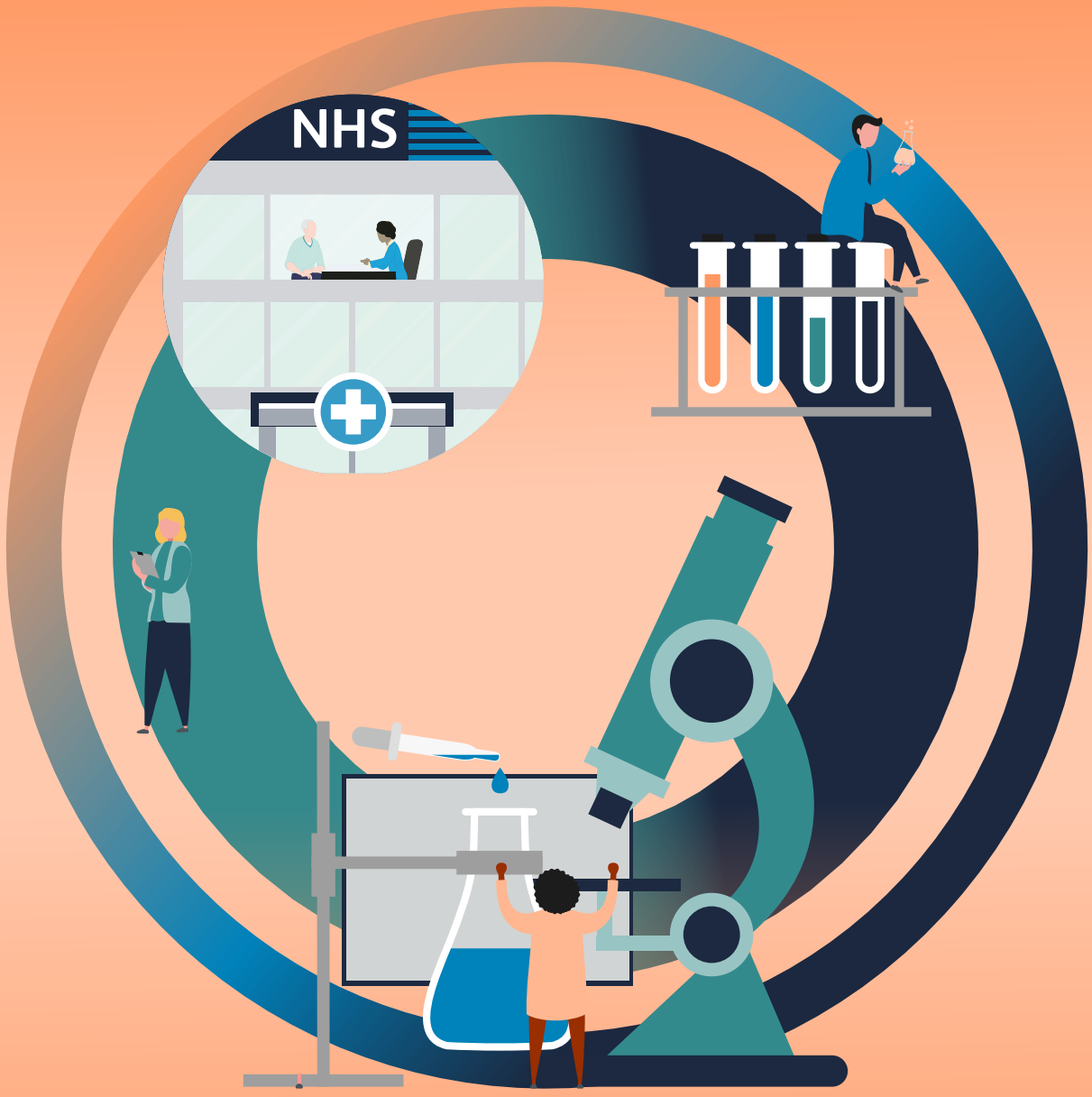
Royal College of Physicians



RCP view on supporting clinical academic careers

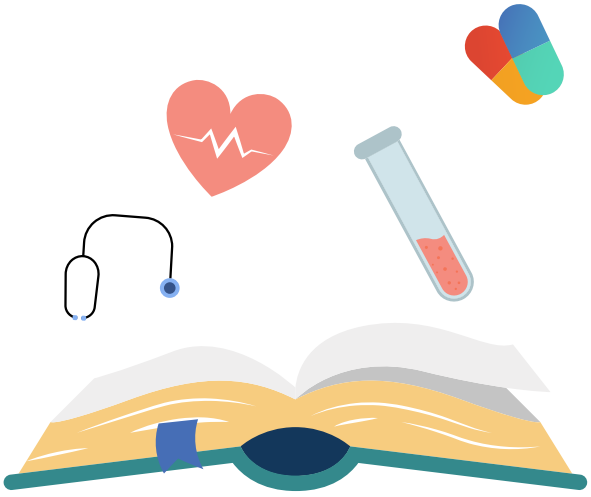
September 2026

Introduction

The UK's clinical academic workforce – qualified medical doctors who combine research and academic responsibilities with NHS clinical practice – is essential to delivering high-quality patient care, driving innovation and maintaining the UK's position as a global leader in the life sciences. But this workforce is in sustained decline, threatening future medical breakthroughs, NHS research capacity and the UK's wider health and economic ambitions.

Clinical academic consultants now represent just 3% of the senior clinical workforce; in 2012, it was double that. We also face a looming cliff edge as senior clinical academics reach retirement age – those aged over 66 now outnumber those aged under 36 entering the field. Once lost, this expertise cannot be quickly rebuilt. A 2024 survey found that, among those starting out, fewer than half of research-active resident doctors were confident that they would continue on a clinical academic pathway.

This RCP view – prepared as part of the RCP's wider submission to the medical training review phase 2, chaired by Professor Dame Jane Dacre – sets out recommendations for protecting the future of UK clinical academia, to ensure that NHS patients can benefit from world-leading research for years to come. Although there are many ways to engage with research as a clinician, the focus of this RCP view is on clinical academics, by which we mean clinicians employed by universities who undertake research alongside teaching and clinical work.



What is a clinical academic?

A clinical academic resident doctor is a medically qualified doctor undertaking structured dual clinical and academic training within a formally funded programme. This could include those on the National Institute for Health and Care Research (NIHR) Integrated Academic Training (IAT) Programme, the Welsh Clinical Academic Track (WCAT), the Scottish Clinical Research Excellence Development Scheme (SCREDS), Northern Ireland Medical and Dental Training Agency (NIMDTA)-approved clinical academic roles, or equivalent locally administered, joint university- and NHS-funded postdoctoral clinical lecturer-level posts.

These individuals typically hold an academic national training number (NTN) and progress simultaneously through NHS general and specialty training and academic research. Their employer may vary between the NHS and universities, depending on career grade and geographic location. Once they have obtained a PhD or MD, they will typically progress to university-employed academic clinical lecturer (ACL) posts or equivalents in devolved nations. It is this group that is particularly under threat.

These academic training programmes are the UK's principal pipeline for developing clinical research leaders. Though small in number, clinical academics who complete these pathways often go on to shape entire fields of research by generating the evidence base that drives innovation in patient care, winning the highly competitive funding that supports the science, health and technology sectors, and educating the next generation of research-active clinicians.

The RCP is clear that, beyond these clinical academics, all physicians must have protected time for research, and that many doctors take alternative or self-directed academic routes and make valuable contributions to the workforce. However, the recommendations in this RCP view are made specifically in relation to clinical academic resident doctors in recognised research training programmes.

Recommendations

Capability-based training and annual review of competency progression (ARCP) for clinical academics

On paper, curricula are capability based, meaning the focus is on demonstrating that a doctor has achieved the required curriculum competencies, taking account of previous experience. However, we routinely hear that, in practice, progression still hinges on time served and numerical requirements, such as fixed numbers of supervised learning events (SLEs) and non-specialty outpatient clinics. This lack of flexibility can have a particularly negative impact on clinical academics, as the framework does not recognise clinical capabilities that may have developed through academic activity. As a result, doctors may be unable to progress towards their certificate of completion of training (CCT), even when they have demonstrably achieved capability. This can particularly affect clinical academics who work less than full time. Curricula should be delivered as intended; progression should be genuinely capability based.

Current annual review of competency progression (ARCP) structures compound these issues. We hear that ARCP panels often default to decision aids and assessment structures designed for linear, full-time clinical pathways, resulting in rigidity and duplication that do not reflect the reality of a clinical academic career. Resident doctors report that ARCP panels are reluctant to acknowledge meaningful clinical experience gained during research periods. Academic resident doctors in the RCP short-term working group on clinical academia reported that their research time is sometimes referred to as their 'time off', demonstrating a lack of understanding of the value and demands of academic work. Communication between clinical supervisors, educational supervisors, academic supervisors and training programme directors (TPDs) is also frequently fragmented, resulting in a limited shared understanding of a clinical academic resident doctor's training needs, and expectations being managed in parallel rather than in partnership.

> **Recommendation 1:** A single, unified personal development plan (PDP) for clinical academics should be established, jointly agreed between clinical/educational and academic supervisors at an in-person or virtual meeting, with the resident doctor and both supervisors in attendance. This should take place at the start of the academic year and/or at an equivalent key time point (for example, on return to clinical training) and should support integrated planning and coherent progression across both training areas. This collaboration should help to ensure that there is a single, shared vision of each clinical academic's individual training needs.

> **Recommendation 2:** To realise capability-based progression in practice, PDPs for clinical academics should identify what SLEs are required throughout the year and what opportunities will be available to demonstrate capabilities across both clinical and research settings. Supervisors, TPDs and ARCP panels should be explicitly empowered and expected to assess and sign off capabilities evidenced through both clinical and research activity, including planned and unplanned learning opportunities and out-of-programme (OOP) activity.

- **Recommendation 3:** Building on existing guidance, such as the *Rough guide to internal medical training*, practical guidance should be developed for supervisors, TPDs and ARCP panels on how to assess clinical academic training. The Federation of the Royal Colleges of Physicians of the UK commits to co-developing a 'rough guide to clinical academia' with stakeholders, including clinical academic resident doctors. Guidance should be developed to support decision making throughout the training process and should include:
  - the structure, expectations and value of clinical academic training pathways
  - how academic activity contributes to clinical capability and progression
  - defining reasonable flexibility in assessment timing, evidence types and capability sign-off for clinical academics.

- **Recommendation 4:** Deaneries must deliver a single, unified ARCP process for clinical academic resident doctors that functions as a joint clinical/academic assessment, involving an academic supervisor and an educational supervisor. This is in line with a key Follett principle that applies to senior clinical academics, where a single joint appraisal is undertaken with both an academic and a clinical line manager present. Recognising the additional complexity of delivering an ARCP that considers both clinical and academic work, the written ARCP exercise should be replaced by a face-to-face exercise, either in person or virtual, in which the academic supervisor, educational supervisor and clinical academic resident doctor are all present. There should be an expectation that academic supervisors have a strong input into progression discussions, ensuring that academic expertise informs the process and supports a balanced assessment of clinical academic development.

- **Recommendation 5:** Greater flexibility should be ensured for those at ACL level, allowing curricular requirements to be tailored proportionately to anticipated future scope of practice. Clinical academics should continue to develop and maintain strong generalist capabilities, with flexibility in how these are achieved and evidenced, particularly recognising capabilities met and maintained through routine inpatient, outpatient and cross-specialty clinical experience. Participation in ongoing acute unselected take should be proportionate and tailored to educational need.

Flexible training

The erosion of supernumerary status – where a clinical academic doctor's role is additional to clinical staffing requirements and must not be used to fill workforce gaps – and rigid OOP rules are limiting training flexibility and access to academic opportunities. Clinical academic resident doctors are increasingly used to fill service gaps, restricting rotation according to training need and undermining protected academic time. These issues are compounded by insufficient numbers of clinical academic posts at clinical lecturer and consultant levels, and limited access to academic mentoring. Expanding the number of these roles will require universities, the NHS and funders to work together to create flexible funding arrangements that support a larger and more sustainable clinical academic workforce.

- **Recommendation 6:** Supernumerary status for clinical academic resident doctors in recognised programmes should be explicitly protected and preserved.

- **Recommendation 7:** The current 4-year out-of-programme for research (OOPR) cap for clinical academic resident doctors should be replaced with a more flexible OOP framework.

- **Recommendation 8:** There should be increased investment in clinical academic appointments at clinical lecturer level, funded creatively by universities, NHS providers, traditional funders and industry.

Making academic opportunities more consistent and transparent for all doctors

Academic opportunities in postgraduate medical training are inconsistent, poorly signposted and often dependent on factors such as proximity to traditional academic centres, leaving many resident doctors unsure of what opportunities are available or how to access them. We hear that awareness of, and access to, opportunities are often reliant on informal connections or working in hospitals with a strong research culture.

Without a structured approach to make academic opportunities more consistent and transparent in medical training, clinical academia risks missing out on doctors with academic potential and doctors miss out on a potentially rewarding career path. It is critical that doctors are exposed to opportunities to pursue clinical academia as early as possible in their careers.

> **Recommendation 9:** Each region should identify a named academic lead responsible for academic outreach, with a focus on creating and signposting opportunities for foundation doctors and resident doctors in internal medicine training (IMT). Examples include research taster weeks, mentoring, academic events and talks. Self-development time in training must be protected to enable doctors to attend and participate in these opportunities. Resident doctors should also be supported to pursue academic qualifications, such as master's degrees.

Aligning service delivery and research activity

Current service delivery models and inflexible training structures make it difficult for doctors to combine clinical work with research activity. There are many possible models for protecting time for research, from 1 day a week to longer protected blocks of time. Flexibility is key. Resident doctors should be able to make the case for a training pattern that works for them at that stage of their career, recognising that individual circumstances may change over time.

We also know that supervisory time is stretched across the system, with particular implications for clinical academics. Strengthening supervisory capacity is essential to ensure the sustainability of the clinical academic pipeline.

> **Recommendation 10:** A range of flexible approaches should be available to ensure that clinical academic resident doctors can participate in research in ways that best suit their needs and stage of development.

> **Recommendation 11:** Supervisory and educator time should be expanded, ensuring that it is resourced and protected within job planning.

Wider conditions we need to get right

Fragmented NHS–university employment arrangements, and challenges navigating arrangements such as less-than-full-time working and parental leave provisions, create avoidable barriers for clinical academic resident doctors. This contributes directly to attrition, particularly among women and those working less than full time.

We hear from members of the RCP short-term working group on clinical academia that doctors are required to undertake duplicate mandatory employer training, complete multiple identical forms for academic and clinical employers when applying for parental leave or study leave, and sometimes experience payroll issues between employers. Action is required to address these issues by standardising arrangements and improving communication and processes between clinical and academic employers.

> **Recommendation 12:** Employment contracts and administrative processes for clinical academic resident doctors should be standardised across NHS and university employers, with particular attention to less-than-full-time working arrangements and parental leave provisions.

Conclusion

The clinical academic workforce faces significant and sustained pressures that will have long-term consequences for NHS research capacity, patient outcomes and the UK's life sciences sector.

Phase 2 of the postgraduate medical training review provides a critical opportunity to implement the reforms necessary to stabilise and strengthen the clinical academic pipeline.

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Published September 2026

This document was prepared as part of the RCP's wider submission to the medical training review phase 2, chaired by Professor Dame Jane Dacre. This RCP view on clinical academic careers was developed through an RCP short-term working group, convened to provide expert insight on addressing, and reversing, the decline of the clinical academic workforce.

The group was chaired by Professor Tom Solomon (RCP academic vice president) and Dr Sacha Moore (academic Resident Doctor Committee representative), and included resident clinical academics from a range of specialties, academic deanery representatives and representatives from the RCP's education team, the Federation of the Royal Colleges of Physicians of the UK, NIHR and COPMeD.

The RCP's Research and Academic Medicine Committee, Resident Doctor Committee and Next Generation Oversight Group were consulted on the recommendations. The final document and recommendations were approved by RCP Council prior to publication.

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