Finding the Path Back to Patient-Oriented Research in American Medical Academia

Roy S. WEINER, M.D.¹

The journey through medical school to residency to fellowship to a junior faculty position should lead more often to sustainable careers in Patient-Oriented Research (POR). American Medical Academia must examine the forces that threaten our prominence and leadership in POR. How can academia foster the development of our talented clinical scholars? How can we enhance career development while managing the pressures to “grow” clinical volume? How can we preserve the reservoir of financial resources needed to fuel early career development? How can we enhance the partnerships needed to facilitate the translation of “concept” to “product”? I hope to stimulate the thoughts and actions of APOR members and others to work as individuals and to work together to ensure the prominence of POR in American academia.

First, let us point out some recent system enhancements with very positive potential. The American Board of Internal Medicine has designed a research track to board qualification that permits individualization and focus for the physician scholar. Six years after graduating medical school, an aspiring POR scholar can be eligible to sit for the boards in internal medicine and most subspecialties. Of the 6 years, three can be devoted to research. POR scholars can complete a K30 curriculum and, in many cases, emerge with a master’s degree or a doctorate. This track is undersubscribed and used less by those committed to the POR arm of translation than those oriented more toward the laboratory arm. National Institutes of Health (NIH) grants for training “T” and career development “K” would encourage academic leaders to recruit more vigorously for this track, though recruitment would acknowledge a clear distinction between “trainees” and the clinical work force in academic medical centers.

Another enhancement is the K30 support mechanism launched by the NIH more than a decade ago. The Clinical Research Curriculum Awards fueled programs that are richer in content than those which had been embedded within the clinical research centers. These programs now established within the Clinical and Translational Science Awards (CTSAs) and in academic medical centers without CTSAs provide both tools and mentorship for scholars headed toward clinical research careers. Yet, the gratifying increase in “trained” clinical researchers has not vaulted American academia into POR prominence. The global impact of the K30 program has been limited by “K-type” funding to support the scholar’s time and by the availability of committed mentors capable of guiding and supporting the scholars toward independent and sustainable careers. Moreover, faculty “packages” have been scarce and meager for trainees committed to POR. And, extramural support for career building faculty initiated research has been hard to find.

The CTSA initiative has supported transdisciplinary communication and interaction and has fostered a new, more integrated infrastructure for research in academia. While the CTSAs have tremendous potential, their impact on POR is, as yet, less apparent.

What can be done to keep this pipeline of trained talent flowing to reconstitute POR productivity in American Medical Academia? There may be a bright future in developing and promoting public–private partnerships for many of the dimensions of POR. First, the translation and development of therapeutic interventions may be expanded and accelerated through partnerships with industry. Industry, however, needs to see American academia as a facilitator rather than a barrier to progress. Institutions, their Institutional Review Boards (IRBs) and industry must develop models jointly that preserve the highest standards of patient protection while accelerating the testing and development of new therapeutic options. More and more therapeutic research at all stages is carried out in Europe and Asia. When the research reaches the level of registration trials, American academia is often bypassed in favor of the community medical practices. This trend will dilute American academia and compromise the career development of our talented trainees. How can we address patient protection, intellectual property, and institutional indemnity so that POR can return to prominence in American academia and nourish the pipeline of medical progress and the talent that produces it?

The issue of IRB workload has surfaced recently with arguments favoring the outsourcing of institutional IRB activity to commercial sources for research involving multiinstitutional trials. If a satisfactory model could be developed to permit the institutional IRB to focus its limited resources on investigator initiated and single institution trials, the time to trial implementation would decrease and the American academic medical center would be a more attractive research site for industry. The groundwork might thus be established for partnership fostering translation and POR within American academia.

Partnerships among academic institutions, the public sector, and industry may provide the funds necessary for both discovery and development, protect the clinically trained patient-oriented researcher from the pressures of clinical service, and provide the support necessary to develop sustainable careers in POR. American academia will need to refocus on therapeutic development as it has focused on discovery. Industry will need to see the advantage of consolidating discovery and development within academia. The resulting investment of funds will support the careers of talented trained patient-oriented researchers.

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¹Associate Dean for Clinical Research and Training, Tulane University, New Orleans, Louisiana 70112, USA.

Correspondence: RS Weiner (rweiner@tulane.edu)

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