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Another one bites the dust

Stephen B Hanauer

It was just 6 weeks into our academic year; we had said goodbye to graduating Fellows and begun indoctrinating the incoming class. I was, therefore, rather taken aback when one of our (now senior) Fellows sheepishly let me know that he was accepting a job in private practice.

This should have been no surprise—most specialty trainees enter private practice. Nonetheless, virtually all applicants enter our training programs with a 'commitment' to 'academic medicine', and, being ensconced in academic medicine, organized medicine and medical education, I was miffed.

Many applicants have already been exposed to research and most expound upon their desire to continue in academic medicine, to do research and to teach. This commitment to academic medicine is a notion that I am becoming rather immune to as, frankly, most applicants know nothing else. In addition, the mantra of applicants has gradually changed; at present the catchword is 'clinical research'.

Being a clinician, educator and 'clinical researcher', I am beginning to comprehend this shift. My insight dates back to when several of my peers entered specialty training programs committed to bench research. If, and when, they failed (to get grants, promotion or make progressive accomplishments) they decided to become clinical researchers. Unfortunately, it doesn't work that way. The skills needed for clinical research are different from those needed for bench research. Indeed, unless they actually 're-tooled', these individuals rarely achieved success in clinical research.

The 'hedge' that current applicants are using to gain a fellowship training position is a 'commitment to academia', with an accepted entrée being the mention of 'clinical research'. The clinical component of this statement allows applicants' mindsets to maintain the commitment to academic medicine while retaining the patient-care component that protects them from the possibility of academic failure, or loss of will.

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We can begin to understand their reasons. The number of specialists has expanded greatly, even within academic medicine and practice. At the same time, the competition for NIH grants has expanded to the point that less than 15% of applications are accepted. Funding within gastroenterology divisions has become more dependent upon clinical productivity, but academic medical centers are not user-friendly for clinicians and, as has always been the case, remuneration for clinicians in academic centers falls substantially short of salaries in private practice. For individuals considering their options in the face of greater than US$100,000 debt, marriage and young children, it is not surprising that the balance tips in favor of the certainty of success and a better lifestyle and finances.

Our graduates cannot be blamed for selecting a career that will eventually ensure support for their families, but this leads me to be concerned about our ability to replenish the ranks of future academics. If we can no longer recruit the best and the brightest individuals into our academic programs, we will diminish our intellectual capital. There are no easy answers, but to re-establish the ability to recruit there needs to be a better balance between practice and academic medicine in terms of the risks and rewards.

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Competing interests
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