

Academic psychiatry is everyone's business

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Summary

This editorial considers the value and nature of academic psychiatry by asking what defines the specialty and psychiatrists as academics. We frame academic psychiatry as a way of thinking that benefits clinical services and discuss how to inspire the next generation of academics.

Keywords

Academic psychiatry; psychiatric research; psychiatric education; psychiatric careers.

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The academic approach remains essential for the future of psychiatry, as it underpins evidence-based clinical practice, enhances standards of patient care and fosters professional satisfaction. In the face of ever greater clinical needs, we argue for the need to grow academic psychiatry, widen participation and ensure clinical impact.

What is academic psychiatry?

Academic psychiatry champions the research and educational components intrinsic to the wider specialty. The prototypical 'clinical academic' is specifically employed by universities to undertake, alongside clinical duties, research (e.g. obtaining and analysing research data) and/or educational (e.g. teaching students, medical colleagues and allied professionals) activities for which they have pursued dedicated academic training, usually with specific qualifications (e.g. PhD). The number of such clinical academic psychiatrists is small and declining: across the UK, the Medical School Council 2023 survey¹ identified only 206 full-time equivalent academic psychiatrists, amounting to less than 2% of the psychiatry workforce. In 2004, there were 330, and this decline of a third of reported clinical academic psychiatry posts occurred during major (and continuing) expansion in the number of medical schools (from 30 to 46) and in the number of medical students. The depletion of clinical academic posts exacerbates competitive difficulties in pursuing academic career paths and amplifies the intersectional need for greater diversity²: Barriers to clinical academic careers are too often encountered by people from minoritised ethnic backgrounds, women and people with children.^{2,3} Such groups are also disproportionately represented in roles such as locally employed or specialty and specialist (SAS) doctors, who are rarely afforded the opportunity to contribute to research or teaching. These issues constrain student and trainee exposure to academia and undermine nascent interest in pursuing academic careers in psychiatry, which has a broader detrimental impact on the specialty. Notwithstanding these challenges, we aver that academic psychiatry is important for us all: every psychiatrist should be confident in their critical appraisal of evolving evidence from relevant research methods and be effective at educating others.⁴ Here, we outline and emphasise the importance and value of these academic skills, not least for optimal patient care. For our profession to thrive, we must campaign for the resources to sustain and grow academic psychiatry and to involve our entire profession.

Doctors as academics, academics as doctors

Every doctor is a scientist and scholar.⁵ Psychiatrists evaluate and describe the complexity of human experience, formulate its meaning and manage and treat mental illnesses, disorders and related conditions.⁴ To do so effectively requires rigorous thinking, up-to-date knowledge and empathic communication. Academic psychiatry integrates interacting biological, psychological and social contributory factors, and interventions. Across the whole profession, including psychiatrists employed primarily as clinicians, academic psychiatry activity (e.g. research and education) enhances clinical care and outcomes, job satisfaction, recruitment and retention. Below, we highlight pathways for developing a career as a clinical academic in psychiatry and also suggest solutions to access, integrate and encourage academic involvement within clinical practice. We seek to grow expertise while maintaining the undiluted principles of academia to leverage greater and broader engagement.

Academic psychiatry covers many disciplines and approaches, including epidemiology and clinical trials, neuroimaging, psychopharmacology and both clinical and basic neuroscience. Research and teaching are at its core, but academic practice also extends to clinical oversight, writing, supervision, advisory work, governance, management, leadership and efforts to influence policy at all levels. Academic psychiatry is practiced across a diversity of settings that foster its interdisciplinary and interprofessional nature: higher educational institutions (HEIs (i.e. universities, medical schools and other research and educational establishments)) alongside many clinical service providers employ academic psychiatrists, not least to obtain research and training grants that help develop future (medical and non-medical) academics. Within the general field of mental health, academic psychiatry is essential to promote excellence in clinical practice and ensure awareness, so that mental illness and related disorders, with their distinct – often serious – manifestations, can be understood, prevented, identified and effectively treated.⁴ Academic psychiatry has been responsible for introducing transformative treatments (and has an ongoing role in evaluating emerging therapies), yet its firm medical scientific grounding is often under-recognised or misperceived, even among medical students.⁴ Academic psychiatrists have led the way in involving patients and families in clinical research, with broad beneficial impact. Strong, visible input from academic psychiatry into teaching, training and clinical practice continues to maintain and enhance standards of care. Moreover, academic psychiatry represents an authoritative conduit to ensure policymakers, service

managers, funders and society as a whole are aware of the needs of our patients, including the latest evidence-based approaches.

Clinical care is better in research-active academic centres.⁶ Clinical academics often bring prestige and influence, attract trainees and enrich the training of clinicians. Almost all academic psychiatrists deliver routine clinical care (averaging around four clinical sessions per week in the UK⁷). Yet, in some settings, academic psychiatrists may still be viewed by colleagues with some circumspection and puzzlement, sometimes even suspicion, for their competing priorities (and employment) beyond clinical work. Academic contributions and constraints (split between teaching, research, administrative and leadership responsibilities) may still be misunderstood. However, the notion that academics 'sit in ivory towers' with scant appreciation of realities of day-to-day clinical practice must be expunged particularly in this era of high demand and limited resources.

Academic psychiatry is a way of thinking

Academic psychiatry cannot be defined by a single role or activity; instead, academic psychiatry can be defined by a critical thinking process of *how* things are done. This extends what is already central to our clinical practice, developed through long years of medical training and maintained through continued professional development. Within the UK, research and education are now core to both psychiatric training and General Medical Council (GMC) expectations for all doctors. Academic psychiatry is characterised by the continuous application of critical thinking in formulating and testing research questions, and in the communication of knowledge and ideas via grant and ethics' applications, co-production and patient and public involvement, teaching, scientific and public presentations, dissemination events and publications. These skills are cultivated by empirical scientific methodology, often complementary to medical training, which clinical academics typically absorb and hone when completing a higher (doctorate) degree. Across our workforce and clinical practice, developing and maintaining an academic mindset is beneficial and associated with transferable skills. Better doctors, teams and overall care provision arise from curiosity, systematic inquiry and being prepared to critique and evaluate one's clinical services.⁶

The view of academic psychiatry as a process nevertheless crystallises the shared experience of becoming and being doctors: we all understand what being a doctor involves – but it is not one thing, rather a large set of activities that individually may seem very different, but they are bound together. Psychiatric research identifies uncertainties, formulates questions that matter to patients and caregivers, tests hypotheses and generates and interprets evidence so that, ultimately, we can offer solutions that improve clinical care and outcomes for patients.

Education is fundamental to academic psychiatry and clinical practice. Teaching and training medical and non-medical colleagues are vital for evidence-based practice and are mirrored in how we communicate to patients and their care networks, colleagues and the public. In psychiatry, specific educational tasks (e.g. psychiatry course and curriculum design, exam-setting, marking papers, reviewing outputs and delivering lectures) are important roles that cannot be fully delegated to non-medics working in mental health. Teaching how to assess patients and how to deliver best clinical care is at the heart of training. This responsibility is shared by all psychiatrists. As doctors and psychiatrists, we are all educators.⁴ The skills we learn – taking a psychiatric history, conducting a mental state examination, considering diagnostic issues and conveying a comprehensive biopsychosocial formulation that guides our treatment plan – are acquired through both formal and informal teaching within clinical settings. Through this ability to understand,

decide and communicate with perspicacity, clinical knowledge is the fundamental aspect of the critical thinking that defines academic psychiatry and fulfils a key function for the whole discipline. Alongside evidence-based practice, evidence-informed public dissemination of knowledge is vital in an era of medical misinformation, wherein misunderstanding is often fuelled by dogmatic agendas and amplified by social media.⁴

Reaping benefits for clinical services

Engagement in academic activity provides stimulation and reward, enriching the experience and career fulfilment of clinicians, helping mitigate burnout within stretched services.⁶ Outside of HEIs, many clinicians conduct a substantial amount of teaching, and undertake, support or lead research. Frequently this may not be remunerated nor adequately detailed within job descriptions, instead relying upon good will, a sense of duty or personal development goals. Sadly, such essential work can go unrewarded and unrecognised. Conversely, even the most academically minded, well trained psychiatrist may face the competing day-to-day demands of their clinical roles, which often consume 'protected' time for learning, training and engaging in academic activities.

Clinical needs are increasing, and psychiatric practice is becoming more complex. To deliver a high standard of clinical care, all psychiatrists need opportunities to grow the skills and knowledge to navigate the constantly evolving field of psychiatry and challenge barriers to developing and implementing effective evidence-based psychiatric treatments. The insights gained from decades of neuroscientific research are now entering and affecting clinical practice, tethering psychiatric disorders and their treatment to measurable parameters. This is the time to build upon such scientific advances. Local psychiatric care provision and wider healthcare systems undoubtedly benefit from well trained and enthusiastic clinicians with academic skills and knowledge that they can apply to their patients and communities and share with multidisciplinary colleagues. Academic psychiatry itself will be strengthened from better inclusion of our diverse workforce in research and education. Addressing barriers to access academic career paths, and ensuring full recognition of academic work, will increase the talent pool from which our best future leaders might arise.^{2,3}

Patient care and clinical practice are enhanced by a broad academic psychiatry culture and mindset, through which relevant learning is widely disseminated to affect policy. Trainees and allied health practitioners are attracted to work in such enriched environments, where organisations and services are imbued with positive recognition.⁶ However, we need to value and foster this type of culture, which requires nurturing and investment to allow trainers and trainees the space to engage in academic activity and hone their skills in research and education as part of a dynamic ongoing process. Psychiatry is a field of clinical medicine and cannot be reduced to the formulaic application of algorithms or a series of steps that can be automated and only reliant on guidelines.⁴ Exposure to academic frameworks and processes is preferably acquired early in medical training but, importantly, requires repeated reinforcement throughout ongoing professional development as a psychiatrist. Critical thinking is the essential skill that must be fostered and maintained. We recognise the uniquely wide opportunities to explore and exploit the entrancing elements of our speciality that arc from the most intricate neuroscience to the philosophy of what it means to be human. Psychiatrists are the only medical speciality attending to the whole person, as expressed from conscious experience to contextualised behaviour. Perhaps, more than other medical specialities, how we engage our patients matters as much as what we

presently know. We therefore must empower patients and carers in our shared clinical decision-making. Psychiatry has rightly led the promotion of compassionate care and co-design of services, but we should now focus on cultivating the academic growth necessary for knowledge to blossom.

All psychiatrists should be inspired to remain abreast of new knowledge, assist in the development and evaluation of novel interventions and provide leadership within teams.⁴ Even those psychiatrists not immersed in research should be able to access, appraise and appreciate research advances, and apply this to day-to-day clinical practice. It is necessary to instil an accurate understanding of what research is, how it is conducted and its strengths and weaknesses. This requires research knowledge and training in the methods and the process of critical thinking, for which there needs to be provision of sufficient ring-fenced time within clinical practice to teach and learn.

Inspiring the next generation

How then do we inspire the next generation? First, it is important to note that, among those first entering medical school, psychiatry has long been regarded as the most intellectually stimulating of medical specialities, with the most interesting subject matter. However, this interest commonly diminishes throughout medical training and is possibly forgotten by the time they qualify as doctors.⁸ Why is this? Medical students may be taught psychiatry by non-psychiatrists, and consequently the art and science of psychiatric practice – from psychopharmacology to phenomenology – can be attenuated. Neuroscience and experimental psychology teaching can seem distanced from psychiatry as a medical speciality. Moreover, despite patients with mental illness suffering disproportionately more physical health problems, and the increasing scientific evidence for a closely dependent interaction between the mind, brain and body, psychiatry can often feel separate from other areas of medicine. Broader issues, including stigma and obfuscation of the concept of mental health across wider society, contribute to a misunderstanding of psychiatry's role in the prevention, care and treatment of mental symptoms and psychiatric conditions.^{4,8}

The interest in psychiatry, evident in new medical students (and earlier), needs to be rekindled. Young doctors should be reminded that psychiatry offers interesting and unique insights and experiences and helps the vast majority of patients – effect sizes attesting to the ability of psychiatric treatments to alleviate symptoms are typically equal to, or exceed, treatments in other medical disciplines. Yet, we still need to develop new treatments to reduce suffering; existing treatments do not always work or may have adverse effects, and some disorders still lack well evidenced treatments. Psychiatry inspires the imagination by combining neuroscientific methods with a deep humanistic understanding of the fragile human condition. This arguably helps doctors improve their own sense of self as they serve the clinical needs of their patients. The combination of biomedical and psychosocial sciences provides a privileged window into all minds (patients and practitioner) and allows psychiatrists to help people at the most personal level. At the same time, psychiatry remains a vibrant specialty within an exciting interdisciplinary landscape driven by clinical need and enriched by co-production. Here, huge innovations are occurring within areas such as neuroimaging, genetics, consciousness science, computational modelling and precision medicine. Psychiatric research and education are at a pivotal time with many new treatments on the horizon, emerging, for example, from the integration of psychiatry with the scientific study of sleep, gut, metabolic and cardiovascular medicine.






























Call to action

Research-active clinical organisations are shown to deliver better outcomes and better care, with improved staff recruitment and retention and enhanced morale.⁶ Instinctively, these are the places we seek out when we need treatment for ourselves or our loved ones. Some psychiatric and mental health services have begun to incorporate protected research and/or education time into job plans, recognising that this is advantageous for enhancing clinical care and training, recruitment and retention. We urge employing services to adopt such practices more widely, and for funders to expand the availability of academic psychiatry training posts. Universities need to work closely with clinical services and training programmes to give medical students and trainees more opportunities to be involved in research and education. The aspirations of trainees to become senior clinical academic psychiatrists should be matched by the availability of secure and sustainable senior clinical academic psychiatrist positions.

However, no two academic career paths are the same.⁹ To inspire the next generation, we must invest at all levels and across diverse populations, and in particular to include early- and mid-career academic psychiatrists. By improving job stability and opportunities, we will do better in retaining excellent clinical academics. Members of this diverse workforce will in turn emphasise their positions as role models for students and psychiatry trainees who see people like themselves represented in these stimulating and prestigious posts.² Academic psychiatry can only be enriched by those with differing perspectives and life experiences, enhancing participation and access.

Championing academic psychiatry will benefit the whole profession and enhance the care we offer to patients and families in our medical management of mental ill-health. Rather than being reflexive apologists for psychiatry, we must engage with and own the serious boundary-crossing science that leads to transformative psychiatric treatments. These messages must reach medical schools and beyond, ensuring we teach the rationale, benefits and solutions offered by academic psychiatry, while countering misinformation and prejudice. It is important for school pupils and their teachers to share the fascination uniquely afforded by our medical specialty, which looks at the whole human condition in health and sickness, by integrating biological, psychological and social evidence.

Academic psychiatry can, and must, thrive. However, we are concerned that over recent years, the numbers of psychiatrists engaged in academic work, and the important profile of academic psychiatry within and beyond our specialty, have contracted. Several factors have contributed to this, but we feel passionately that the current pressures upon healthcare systems highlight the pressing need to strengthen academic psychiatry. We all need new and better treatments and care for our patients; we all need passionate educators to inspire passionate future critical thinkers to generate and appraise emerging evidence, and to inculcate respect for research and objective thinking and to teach this to colleagues, patients and carers. There are important proximate measures to seek. These include clinical academic representation on appointment panels for all psychiatrists; re-instatement of vacated clinical academic psychiatry posts; and the mandatory presence of psychiatrists on research study applications involving patients with mental health problems. We must challenge and address barriers that limit engagement with academia. Clinical services, as well as academic institutions, need to recognise the value of creating the space, time and support to grow academic activity, which will help address the retention challenges of a workforce vulnerable to burn-out. Academic psychiatry is everyone's business.

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Data availability is not applicable to this article as no new data were created or analysed in this study.

Author contributions

H.D.C., D.K.T., G.S.M., D.S.B., S.R.C. and A.H.Y. developed the initial concept and wrote the first draft. All other authors substantially contributed to and critically edited the piece prior to submission.

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O.H. has received investigator-initiated research funding from and/or participated in advisory/speaker meetings organised by Angelini, Autifony, Biogen, Boehringer Ingelheim, Delix, Eli Lilly, Elysium, Heptares, Global Medical Education, Invicro, Janssen, Karuna, Lundbeck, Merck, Neumora, Neurocrine, Ontrack/ Pangea, Otsuka, Sunovion, Teva, Recordati, Roche, Rovi and Viatrix/Mylan. He was previously a part-time employee of Lundbeck A.V. He has a patent for the use of dopaminergic imaging. S.J. has received honoraria for educational talks given for Sunovion, Boehringer Ingelheim, Lundbeck and Janssen. He has consulted for LB Pharmaceuticals and sat on a National Institute for Health and Care Excellence (NICE) Health Technology Panel and a Wellcome Panel, and is a (volunteer) member of Council for the British Association for Psychopharmacology. 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