

Summary of Public Consultation Outcomes

The Practitioner Fellowships Scheme

Population of Respondents

252 people responded to the Research Fellowship questionnaire which also included questions relating to the Practitioner Fellowship Scheme. Some respondents did not answer all of the questions. Population statistics worth noting include:

- Six Practitioner Fellows responded to the questionnaire;
- Four respondents had unsuccessfully applied for a Practitioner Fellowship;
- 44.1% of respondents were current NHMRC Research Fellows; and
- 34.1% of respondents did not hold a NHMRC or any other type of People Support Award. Of these, 60% were greater than nine years post-doc with 34% of this group indicating having previously applied for a NHMRC Research Fellowship.

Issue 1

Link Between Research and Practice

Question 21 – Is the current policy appropriate, that the research area should complement or relate to the clinical or public health practice of the applicant?

77% of respondents (145 out of 188 that responded to this question) agreed that the current policy was appropriate, and that the research area should complement or relate to the clinical or public health practice of the applicant. There was a small number (5) of current Practitioner Fellows that answered the question; four of these believed that current policy was appropriate. Of the four respondents who had unsuccessfully applied for a PF, two thought the Policy was appropriate.

Question 22 – Do you have any additional comments relating to the preceding question?

[Click here](#) to view the Raw Comments to this open question.

Question 23 – Is the description of the requirements for PF research areas in the Instructions to Applicants clear?

82% of respondents (130 out of 158 that responded to this question) thought that the description for PF research areas in the Instructions to Applicants is clear. Five current Practitioner Fellows answered this question, three of whom thought the descriptions were clear. Three of the four unsuccessful PF applicants who responded also thought the descriptions were clear.

Question 24 – Do you have any additional comments on the preceding question?

[Click here](#) to view the Raw Comments to this open question.

Outcome

The link between research and practice was the original intention of the PF Scheme therefore the Research Committee endorsed the current policy that a Practitioner Fellows' research must be linked to their practice.

The Research Committee however felt strongly about encouraging clinical or public health practitioners to pursue excellence in research, regardless of whether the research has strong ties to their practice. Therefore the Research Fellowships policy has been modified to enable Practitioners, whose research does not link to their practice but who can demonstrate they have a clinical or public health practice, to apply for a Research Fellowship on a part-time basis.

Issue 2

Change to a Career-Based Scheme

Question 25 – Do you consider that there is a problem with the career structure of the current PF Scheme?

47% of respondents (78 out of 167 that responded to this question) considered there was a problem with the career structure of the current PF scheme. All six current Practitioner Fellows said there was a problem with the career structure of the current PF scheme. Three of the four unsuccessful PF applicants who responded, also said there was a problem with the career structure of the current PF Scheme.

Question 25a,b&c – If Yes: Are the problems related to:

- a) Lack of a career-based PF Scheme?*
- b) The need for a system of promotion in the PF Scheme?*
- c) If No: Should the Scheme continue to maintain an “open competition” model for both Initial Appointment and Renewal?*

81% of respondents (71 out of 88 that responded to question 25a), believed that the problems with the career structure related to the lack of a career-based PF scheme.

79% of respondents (64 out of 81 that responded to question 25b), believed that the problems are related to the need for a system of promotion in the PF scheme.

The six current Practitioner Fellows all said the problem related to the lack of a career-based scheme and that there was a need for a system of promotion in the PF scheme.

73% of respondents (77 out of 98 that responded to question 25c), thought that the Scheme should continue to maintain an “open competition” model for both Initial Appointment and Renewal. Of the six Practitioner Fellows 33% agreed that the Scheme should continue to maintain an “open competition” model for both Initial Appointment and Renewal.

Question 26 – Do you have any additional comments?

[Click here](#) to view the Raw Comments to this open question.

Outcome

The following changes have been made to the Practitioner Fellowships 2006 Funding Policy:

- Practitioner Fellows may apply for a second five-year appointment either in their fifth year of the existing Fellowship or at a subsequent time; and
- Initial applicants and those applying for a second appointment will apply in “open competition” with no differential advantage at any time.

Note that the two current levels, PF1 and PF2, remain unchanged.

Issue 3

Entry Level of Initial Appointment and Promotion

Question 27 – Should an Initial Applicant retain the right to nominate their appointment level for consideration?

94% of respondents (165 out of 175 that responded to this question), believed that an Initial Applicant should retain the right to nominate their appointment level for consideration. Five current Practitioner Fellows and four unsuccessful PF applicants responded to this question and all answered that an Initial Applicant should retain the right to nominate their appointment level for consideration.

Question 28 – Should the RFC have discretionary power to appoint an Initial Applicant to a level that differs from that requested?

94% of respondents (165 out of 175 that responded to this question), agreed that the Research Fellowship Committee should have discretionary power to appoint an Initial Applicant to a level that differs from that requested. This included five current Practitioner Fellows who responded and three of the four unsuccessful PF applicants who responded.

Question 29 – Should the policy be altered to allow applications for Promotion from PF1 to PF2 during the lifetime of an existing award (instead of every 5 years)?

84% of respondents (143 out of 170 that responded to this question), believed the policy should be altered to allow applications for Promotion from PF1 to PF2 during the lifetime of an existing award (instead of every 5 years). All the Practitioner Fellows and unsuccessful PF applicants agreed that the policy should be altered.

Question 30: Do you have any additional comments?

[Click here](#) to view the Raw Comments to this open question.

Outcome

The Practitioner Fellowships 2006 Funding Policy states that Practitioner Fellows may apply for promotion during years two and three or when applying for a second appointment.

Research Committee Members considered if applications, where an inappropriate entry level has been selected, should be rejected and whether the Research Fellowships Committee (RFC) should be able to change the level of the application at the initial review meeting or following interview. Whilst supporting this concept, Members requested the Office of the NHMRC obtain legal advice about this proposal. Until the Legal Services Branch of the

Department of Health and Ageing has provided this advice, the policy will not give the RFC power to consider an initial applicant at a level that differs from that originally requested by the applicant.

Issue 4

Broaden the Scheme to Include Career Development Awards

Question 31 – Should the PF Scheme be broadened to include more junior levels?

62% of respondents (104 out of 167 that responded to this question), believed that the PF Scheme should be broadened to include more junior levels. Three of the five current PF's and two of the four unsuccessful PF applicants who responded believed the Scheme should be broadened to include more junior levels.

Question 32 – Should the PF Scheme and the Clinical or Population Health CDAs be merged into a single scheme that provides a single structure for PF career development?

63% of respondents (103 of the 163 that responded to this question), thought that the PF Scheme and the Clinical or Population Health CDAs should be merged into a single scheme that provides a single structure for PF career development. Five current PF's answered, three of which also supported the concept. One out of the three unsuccessful PF applicants who responded thought that the schemes should be merged.

Question 33 – Do you have any additional comments?

[Click here](#) to view the Raw Comments to this open question.

Outcome

The response to this issue did not strongly encourage the Research Fellowships Committee to pursue a merger of the two Schemes. However it was resolved that a detailed flow chart clearly describing the career path of clinical and public health practitioners needed to be developed and available on the NHMRC web-site. The Research Committee endorsed the Research Fellowships Committee's recommendations and asked the Committee to oversee the development of this flow chart.

Issue 5

Effectiveness of the Scheme

Question 34 – Do you have general comments on the effectiveness of the PF Scheme in meeting the needs of clinical or public health researchers and comments on improving the PF Scheme?

[Click here](#) to view the Raw Comments to this open question.

Summary of Raw Comments

Link Between Research and Practice

Two open-ended questions were asked relating to linking research to clinical practice.

Question 22: Do you have any additional comments relating to the preceding question?

Respondents: Hold a NHMRC Career Development Award

Otherwise, how do these fellowships differ from ordinary fellowships.

This is probably the best way to translate research into practice. This process will occur more easily for a clinician than a scientist.

Respondents: Hold a NHMRC Career Development Award and have applied for a NHMRC Research Fellowship

Not all research has an immediate link to application in clinical practice, so as long as the policy doesn't become unrealistic, then it is important that NHMRC funded work has medical relevance.

This is means by which clinical research may be translated into practice.

Respondents: Hold a NHMRC Career Development Award and have applied for a NHMRC Practitioner Fellowship

The research focus of a number of clinically involved researchers may be of a basic science nature or somewhat removed from direct clinical application. Such individuals are disadvantaged in competing for a practitioner fellowship, even though the clinical involvement may inform the research direction and make a significant contribution (albeit indirectly) to good research outcomes. However, if the distant connections between clinical activity and research activity are too extreme, and such researchers deemed to be more appropriate to the research fellowship scheme, are such individuals then also at a disadvantage, because of their clinical involvement, when competing against full time researchers?

Respondents: Do not hold a NHMRC People Support Award and have never applied for a Research or Practitioner Fellowship

I agree with the current policy. Medical practitioners already have many advantages over scientists in research in Australia when it comes to funding, support and career options. Those medical practitioners who want to concentrate on research should be judged along with others in the RF scheme and PFs should be reserved for those where the research is clearly supporting the clinical or public health practice.

Currently it seems that this policy is applied too stringently

There is a big gap in the system. I am a Research Director in a major teaching hospital. The problem arises with the competition between clinical work (for which they receive their salary) and research. The "clinical" part is too harshly applied. There are excellent researchers with NHMRC Project grants whose research time is not protected because they have FT clinical jobs. They are discouraged from applying for Practitioner Fellowships because their research is too basic etc. I think this a big gap. The

scheme as designed may work well for clinical researchers but it is inaccessible for typical clinicians who hold NHMRC Project Grants.

This criterion is basically the only one that separates out this scheme from all others, therefore in my opinion it is very important to retain the current policy

I think it is too prescriptive and the applicant should be free to pursue research of their own interest. I don't think the current prescription necessarily facilitates translation.

Must be broad in view of clinical practice to ensure that there are non-medical applicants who can be successful - eg speech pathologists, physios etc.

Yes, but I think it is too rigid as it is. It would be better to admit people who are basic researchers, as long as their basic research has some connection with their clinical activities. As it is, a direct reading of the guidelines would discourage anybody who has ventured into say molecular biology or neurobiology in search of answers to basic questions from applying for a practitioner fellowship.

The distinction between basic and applied research (not stated outright in the guidelines but implicit) is in my view not valid when we are dealing with big questions and individual careers.

Although the issue of relevance between the research and clinical practice areas is appropriate, in our experience, an arbitrary test of "translational obviousness" is also currently applied. Particularly, those practitioners engaged in what is considered "basic" research have been excluded from consideration. As currently applied, this notion reflects a narrow view of translational research. Potential PFs working with human samples, or mouse models, may be considered, but if their research is primarily biochemical, or uses animal models such as *Drosophila*, *C. elegans*, or zebrafish, even if the test of relevance is satisfied, they are excluded from consideration. Potential PFs working in these more basic areas may well commit >20% of their time to clinical practice, and hence be ineligible for support under the Research Fellowship Scheme, but lack a NHMRC-supported means of supporting the time they devote to laboratory research. Since basic but clinically-relevant research is often attractive to capable, productive, highly motivated, clinically-trained researchers, this gap is a major flaw in the current system.

Respondents: Do not hold a NHMRC People Support Award and have applied for a Practitioner Fellowship

The problem at present is the interpretation of this policy in a narrow framework, restricting access to researchers who are doing clinical or public health research. It should be open to all medico researchers doing bio-medical research, as long as it relates to their practice. The people doing the best research and showing the best synergy with practice should be funded. Relevance should be determined by peers (ie reviewers) in the particular clinical or public health field, not the panel, which may well have no knowledge of a particular field.

This is too dependent on the subjective interpretation of the panels who may have little knowledge of the specific area of practice. It also means that a large number of medical graduates who wish to conduct significant research that is not directly related to their ongoing practice have NO scheme through which to apply.

Respondents: Do not hold a NHMRC People Support Award and have applied for a Research Fellowship

It is essential that the research complement clinical or public health practice - researchers wanting to do basic science in combination with, say, a clinical load, should be able to apply for a standard fellowship part time. PFs were established to foster high level clinical and public health research - not just to get such people into any form of health and medical research. It is part of having a balanced portfolio of career researchers in the system.

The reason for under subscription of the Practitioner Fellowships is the necessity for the applicant to

hold project grant funding in order to apply: its like advertising "fertility help: only pregnant women need apply". If someone has achieved project grant support, they are generally not in need of personal support.

In principal, these are very important fellowships: the individuals practising medicine at the coal face are in the position of absolute privilege of observing the course of disease, the way it behaves and through these observation, insights into the mechanisms and treatments for disease can develop. These, are potentially, the most important fellowships, yet who can apply? A staff specialist? Certainly few others. How many great clinician minds are out at the coal face (many with PhDs), seeing many patients (compared to the small number a staff specialist might see), who, without institutional support and quarantined time (the luxury of a staff appointment) can not get a project grant written and funded, to then be able to apply for a practitioner fellowship? How many wasted opportunities here?

A synergy between the clinical and more basic research for an individual will be easier to attain if they are in complementary areas.

The criteria of excluding clinical researchers with substantial laboratory load is unreasonable.

Can't see how it would be successfully managed if there was a divergence between the two unless superman or superwoman was applying

Respondents: Hold a NHMRC Research Fellowship

Emphasis should be on research excellence.

If the research area does not complement the practice of the Applicant then there is no reason to restrict these Fellowships to people with these types of jobs. The Fellowship would be a part-time Fellowship with no restriction on what the Fellow does the rest of the time.

As a physician/scientist and a practicing clinician, it is perhaps worth noting that the initial general information sought, makes no attempt to identify the recipient's background, clinical versus non-clinical. The point of question 3 is unclear when there is no question about whether one holds a medical degree or a specialist qualification. To me the Practitioner Fellowship Scheme makes a great deal of sense and is embedded in the health sector. A key aspect of this is that clinicians actively involved in clinical practice bridge research to practice. A component of that is clinical research and arguably public health research for which the Fellowship Scheme in the past has probably been difficult. But the application of the guidelines has in some cases been curious in the last few years and has perhaps reflected some intrinsic biases of the relatively small cohort of people on the panel governing this section of the Awards. In many cases, policy has been made either by clinicians/public health practitioners with a specific agenda or by scientists virtually devoid of insight into the nuances of clinical or public health practice. Thus one would argue strongly in support of any move to strengthen this program. It, unfortunately, is in part a response to the failure of the Health Departments, both Commonwealth and State, to adequately support research in the institutions and personally I feel strongly that the money for this Scheme should actually represent new money from the Health Departments, but that is probably pie in the sky. Given that this is a competitive scheme and given it would be naïve to pretend that there will not always be shades of grey, the only way to deal equitably with appointments is really around a range of criteria, a matrix if you will. The major issues of direct relevance will be weighed against quality, local impact, relevance to practice, etc. I believe that a properly constituted, preferably broader panel will get this answer right more often than not. A similar concept has been initiated in both the Training Awards (which actually preceded the Practitioner Fellowships) and in the Career Development Awards and I believe they have been very successful and the sort of selection problems alluded to in this discussion paper have not majorly materialised.

Again some form of access committee could advise potential applicants whether they would best submit their application to the PF or RF scheme. This would prevent applications falling between the cracks and would remove much of the responsibility for making judgements on particular applications

from the PF committee.

Get rid of the question - it is clearly being interpreted way too narrowly. Had an oncologist/scientist done the Nobel Prize winning work on the cell cycle in yeast I am sure the current committee would have barred them from a Practitioner Fellowship because there was no relationship between their science and clinical practice - there in lies the absurdity of the issue. Should make this requirement broader to include any research relating to clinical or public health practice

The relatedness required at present is too stringent. However, there should be some link ie an oncologist working on parasitology would not be suitable.

It is sufficiently challenging to get clinicians to do research in the current climate of pressures on the health system. Any research that they are interested to do, as long as it fits the quality criteria, should be allowed.

If a practitioner is conducting scientific research not based in their practice, then I do not see why they should not be considered with other research fellows, as there is no more potential for direct clinical application of the results than with normal research fellows. However, the research should not be required to have direct clinical component, as related basic research may also have flow on effects in clinical or public health practice. More flexibility for part-time RFs may address the problem with people "falling between" the RF and PF schemes.

This should be one of the main drivers of research by NHMRC.

This might cut out a proportion of talented young researchers who work in basic research and where the clinical/public health outcomes take many years to emerge from their work.

'Yes' is the ideal answer, but the NH&MRC must understand the pressures and demands of public hospitals on clinician-scientists. NH&MRC, like the Colleges, should insist on 'minimal requirements'. PFs should be embedded within a clinical team of 'critical mass', which values their special role, rather than being expected to have two jobs. PFs, in my view, should not normally be heads of hospital departments unless their resources are sufficient to allow them to concentrate primarily on their clinically-related research.

Yes but. Are not all fellows supporting this initiative. The question arises why should there be a distinction and are PFs as effective in their research output. If so there is justification for this division, if not, given the constraints of the scheme should PF be dropped in favour of further support for the RF scheme.

The current requirements are fine. If the proposed research is not directly related to the applicants current clinical practice, then the applicant should seek a part time research fellowship under the current fellowship scheme, and not apply under the practitioner scheme. the practitioner scheme should be only for those where a direct and obvious synergy occurs between their proposed research and their clinical practice.

The clinical area and the research area must be linked very clearly.

More flexibility is needed here. Some fellows are very basic in their research and NOT obviously clinical.

It is important to have very bright clinicians involved in either basic or applied research, because such individuals are the ones who will see the best ways to implement and to apply the latest advances to clinical practice.

Provided a broad view of being related is taken, this should remain an essential criterion

There should be a degree of relationship, but everyone considers that the panels have grossly over-interpreted the degree needed.

Respondents: Hold a NHMRC Practitioner Fellowship

It is very important that the practitioner fellowship system should support translational research. There is a real shortage of true clinical research in Australia and the PF scheme should actively support such research. PFs in clinical practice should be undertaking CLINICAL research related to their area of practice not in vitro or animal model research in their area of interest. This is how true synergy with clinical research can be promoted. Similarly public health practitioners should be undertaking public health research relevant to their practice.

There should continue to be a visible link between an applicants clinical practice and research. It need not be close.

It is interpreted too narrowly. Current clinical practice dominated by service delivery - very difficult to do research. Protection of research time and research excellence should be guiding principles. NHMRC should take broad view of translation and encourage clinician-scientist involvement across the whole spectrum of research. Clinician-scientists doing more basic research, but in clinical practice for >20% of time, currently ineligible for RF, even if research is outstanding. This is a crazy outcome.

Respondents: Hold a NHMRC Training Fellowship

I couldn't find the conditions of awards for fellows but for training awards income can be generated from another source for up to 10% of working week. If this is similar in fellowship conditions maybe a clause allowing a slightly higher percentage (eg 20%) for clinical fellows would enable research in a 'uncomplimentary area' and a clinical career to be pursued.

Respondents: Hold a Career Award or Fellowship other than NHMRC funded

Clinicians who are also operating at a high level in basic science within their specialty must be considered eligible and the application not prejudiced relative to other applicants within clinical or public health research. The quality of the science must be the aspect by which applicants are ranked, not the field of science/clinical medicine.

How does one accurately assess relationship to clinical or public health practice. A lot of basic research eventually goes on to have clinical public health practice relevance, which was not initially obvious.

It would be better to award practitioner fellowships to clinicians researching in their area of practice to stop people working locum positions as GPs getting practitioner fellowships over people who are treating patients as well as researching the disease the patients are suffering from.

Current application of the policy is ludicrous, with a Medical Oncologist, who treats patients with breast cancer and researches breast carcinogenesis in the laboratory, rejected without interview based on a tenuous interpretation of this policy in 2003. Similarly, for an haematologist researching blood cell development in 2003, and a Clinical Haematologist researching the pathogenesis of the second most common haematological malignancy, lymphoma in 2004.

Clearly, different people interpret the policy totally differently. The problem is not the policy, but its detail, and the apparent lack of the assessing panels' abilities to objectively adhere to it. Therefore clarification is required. Exclusion of the above researchers arbitrarily allegedly based on the above examples is an indictment of the application of the current policy.

Question 24: Do you have any additional comments relating to the preceding question?

Respondents: Do not hold a NHMRC People Support Award and have never applied for a Research or Practitioner Fellowship

See above. I think there is ground for confusion in defining what sorts of research are allowed for a Practitioner Fellow.

It puts good people off applying as the link between their clinical work and the research has to be too immediately clinically relevant.

The descriptions of the requirements for PF research were clarified for 2004 applications relative to the 2003 descriptions, but the effect of this clarification has been to more explicitly exclude from consideration those potential PFs that fall in the gap described in (22) above. The problem is in the application of points 9 and 10 under "Aims of the Practitioner Fellowship Scheme".

Respondents: Do not hold a NHMRC People Support Award and have applied for a Practitioner Fellowship

This question is not really clear. The description for applicants is ok, with the caveats outlined above re scope. A bigger problem is the inconsistency between description for applicants and the Instructions for Assessors. The latter restricts the scope of activity for applicants even further by using very selective use of the language used in the policy.

Respondents: Do not hold a NHMRC People Support Award and have applied for a Research Fellowship

My personal view is that 30% is probably not enough time to maintain a high level research career in any field. I'd put the minimum at 50%.

Respondents: Hold a NHMRC Research Fellowship

Some more details could be added - perhaps some examples.

No needs updating, broadening - many people applying here would not want to apply to RF Scheme per se. They would not see themselves as full-time biomedical researchers - they are clinical researchers.

A super track record is required and yet potential applicants are advised that they should not be well-established researchers! Such people are guided to the RF scheme (with all its problems), where they are expected to be full-time, although PF must be part-time in research.

I think the issues are covered in my response to Question 22. I don't believe the wording of the instructions is such a big deal. The big issue is the composition of the panels and that some of the decisions made by the panel may have been questionable.

Respondents: Hold a Career Award or Fellowship other than NHMRC funded

See above. While it seems clear to applicants, the assessing panel views it with a different perspective.

As above, the current scheme is designed to favour public health applicants.

Summary of Raw Comments

Change to a Career Based Scheme

Question 26: Do you have any additional comments?

Respondents: Hold a NHMRC Career Development Award

If the reason that Fellows find these fellowships useful is to "free up time away from clinical practice for research" this is an expensive way to liberate clinician/researchers. There is clearly a health department and human resources issue here that needs to address a clinician's freedom to undertake research. In the US clinician/researchers are appointed and remunerated to undertake both research and clinical practice. If the clinician is an academic researcher then the University and hospitals have an obligation to provide time and resources to the clinician to enable him/her to undertake research. The researcher in return provides income to the institution in infrastructure from grants. Should there really be an obligation for NHMRC to support clinician/researchers?

Respondents: Hold a NHMRC Career Development Award and have applied for a NHMRC Research Fellowship

The NHMRC should not be obliged to provide a career structure for PF when Universities already provide the opportunity for promotion and a career structure.

Practitioners should be incorporated into the general Fellowship scheme, at a possible part-time level

Respondents: Do not hold a NHMRC People Support Award and have never applied for a Research or Practitioner Fellowship

This is a major issue at the moment with many fellows soon to seek renewal. There is really no need for a "double standard" with the fellowship scheme. PFs are just as needy of a career structure.

The PF scheme should be essentially parallel to the fellowship scheme and provide career opportunities for practicing doctors.

Ultimately there is no reason why the PF scheme shouldn't be a career based one. However, there is also no reason why a researcher who has been successful in the PF scheme couldn't then apply to the RF scheme, as long as the RF scheme can cope with a practitioner having to maintain a reasonable level of clinical practice; if RFs can't do that, then the PF scheme probably should be modified.

The PF scheme should not become an alternative RF scheme for medical practitioners who want to also do some research.

I would like to see the scheme expanded to provide for half time career fellowships for excellent researchers who are also practicing clinicians. The research need not be even related to the clinical area - though mostly it will be - the important part is that we do not lose researchers by lack of a career path for these people. The hospitals can not fund them to do half time research. They can not live on a half time salary so they quit research.

I think the current system whereby the appointment is contested every five years is somewhat inimical to commitment to a career and the establishment of a career in investigative medicine/public health/allied health.

Practitioner Fellows warrant the same career structure offered to Research Fellows – their potential contribution to clinical and laboratory research needs to be underpinned by a career structure that is secure if the same criteria of productivity, competitiveness and achievement relative to opportunity are met.

Respondents: Do not hold a NHMRC People Support Award and have applied for a Practitioner Fellowship

It should be open competition. NHMRC should fund the best PF researchers in the country.

Respondents: Do not hold a NHMRC People Support Award and have applied for a Research Fellowship

At a time when translational research is developing rapidly we need strong incentives to encourage clinician-researchers. Recognition that managing both clinical and research load is enormously challenging and needs additional support.

The PF scheme has been a real innovation. It is essential that clinical and public health practitioners can have a long term career in research. The PFs are ideally placed to foster the translation of research into practice and policy - and this almost never can occur in a 5 year time frame.

Presumably the best PF holders will develop to be competitive in the main fellowships scheme.

It really depends on what the outcome is, is it interim support or career support

Open competition should take into account the nature of research, that is there may be periods of reduced productivity of Fellows due to circumstances beyond their control or ability.

Respondents: Hold a NHMRC Research Fellowship

The PF Scheme should be incorporated into the CDA or Fellowships Scheme.

Why shouldn't PFs have the same opportunities for continued career structure as RFs? To deny them this opportunity seems likely to discourage ongoing high quality clinical researchers.

The major problem is that the scheme has been too inflexible to meet the very real needs of clinically trained individuals who want to do research.

A career structure is important for all Fellows. However, the criteria governing whether the appropriate category for the researcher is "Practitioner Fellow" vs "Research Fellow" would need to be vigorously reviewed. It would not be appropriate to provide a career structure within the "Practitioner Fellows" scheme if the performance criteria were any less than that applied to Research Fellows or if no realistic career structure exists for RFs.

There is already a career based scheme that allows for part-time research commitment

We need to encourage motivated clinicians to engage in research. The correct place to accommodate senior practitioner fellows is within the research fellowship scheme itself. To do this there may need to be some flexibility about the proportion of quarantined research time (say 60% rather than 80%). Of course, the career structure of the Research Fellowship scheme needs to be restored first. It is quite inappropriate to try to design a new career path before restoring the viability of the original.

Unlike the fellowship scheme, the practitioner fellow are (possibly) more likely to alter their employment arrangements by changing the ratio of research to clinical work. This should be continuously reviewed, in open competition.

PF could be considered for the RF scheme if their research becomes their main activity.

Funding should be based on record of research achievement. It should not be competitive, it should be funded if it is good enough

The current arrangement is identical to the current research fellowship scheme: ie: open competition every time you apply for renewal. It is not clear why you would have to change anything to make it a career scheme when this arrangement is claimed to provide a career scheme for the research fellowships.

In principle, I think providing a career scheme for practitioner fellows would be desirable. It should be closely modelled on whatever scheme is considered appropriate for the fellowship scheme.

One fellowships scheme incorporating practitioner fellows (with added flexibility) would be better than creating a new parallel system.

The PF Scheme is not currently a career scheme. If it is to become a career scheme then perhaps this should be as a part of a more flexible Research Fellowship scheme that allows part-time Fellows and ranks them accordingly.

Should be set up within the existing Fellowships and CDA frameworks, not invent a new system. Career structure should not be different between systems.

One cannot justify instituting a career structure for Practitioner Fellows unless one is reinstated for Research Fellows. With some flexibility, the Research Fellowship scheme could provide a following career path for Practitioner Fellows.

I see the PF system as filling a fundamentally different role from the RF scheme. If PFs wish to continue in the system for more than 2 cycles they could try to join the RF scheme.

People in the Scheme performing well should be retained - loss of such people generally destroys many existing research teams, interrupts programs and postgraduate training.

As long as performance is assessed to be consistent and of high quality internationally people should be retained in the RF system. If the individual cannot raise or obtain funding by some mechanism for their research they should go.

This group potentially could make the strongest contribution to altering clinical or public health practice. There needs to be a career structure so that suitably qualified individuals consider a research involvement with their clinical work to be a viable career option which is worth the time and salary forgone.

Also, it is part of the mission of the NHMRC to see knowledge translated into benefits to the health of the nation. A career structure for clinicians who also do research would be a tangible vehicle for this mission to be realised.

This is an entirely different scheme to the Research Fellowships scheme and as many health practitioners as possible should have access to this scheme.

Should be identical to RF scheme. No barrier to reapplication/open competition and appointments at the level of SPF-A through to SPPF (ie SRF-A to SPRF equivalents)

As for RF

I believe the days of the clinician scientist are already past. Very few excellent young clinicians who have also done excellent PhDs and post-docs overseas are able to compete in research on their return home, and not just because of clinical pressure, but also because excellent full-time researchers already struggle to compete. Research is no longer a gentlemanly part time job, nor can it be delegated by clinicians to a lab manager who is inevitably not a top quality scientist. Better to encourage clinicians and scientists to collaborate fully in an equal partnership. Fortunately the Program grants encourage such clinical collaborations by scientists.

I believe that the problem is in attracting young medical graduates into the scheme. They obviously cannot compete as it stands. The effort should focus on getting more MBBS students into concurrent PhD programs and increasing the stream to fellowships like this but implementing them for recent graduates also. Having a career structure like this would encourage medical students into a career in medical science.

The current main fellowship scheme is the avenue for a full career structure for this strand of NHMRC personnel support. Note it is a relatively new scheme and the appointments within it rather diverse: they should be reviewed and categorised to guide future policy.

The reality is that the Practitioner Fellowship Scheme must be developed as a parallel career stream to

the regular Fellowship Scheme. There is an opportunity early in the Scheme to put in place some innovative exit strategies through negotiation with the relevant clinical and public health service providers. There is a need to recognise that the model can apply equally to both senior and junior researchers. There is also a need to develop a model or mechanism by which people may, as alluded to the discussion document, move between both Fellowship Schemes. I have colleagues at the PRF level who arguably could be more appropriately funded through this scheme.

The fundamental problem with the question asked is that it immediately implies that the organisation asking the question has actually not mapped out nor has an insight into the career path that a Practitioner Fellow might take. This in many ways is a disturbingly naïve question.

The problem with the career structure which no one wants to face is that it is not a fair funding system because it does not provide a fair playing field for research scientists. If there is a career structure all scientists who are defined as 'excellent' using any reliable criterion should be included. If the system cannot do this then it is failing the profession. Have you spoken to any of the young competent scientists to see what they think? What profession is there where 'excellence' is not a sufficient criterion to be selected?

Respondents: Hold a NHMRC Practitioner Fellowship

The current system, where there is no clear career structure for PFs, seems to imply that the PF is a 'bridging fellowship' where Fellows will eventually find a tenured position with a university or hospital. Such positions generally do not provide the amount of protected time for research that is provided in the current Practitioner Fellowship. If the NHMRC wishes to continue supporting clinical/public health professionals, then it is vital that the scheme be maintained & developed so that there is some form of career structure that parallels the Research Fellowships.

It is just as important to provide a career structure for PFs as it is for RFs. Promotion of and maintenance of excellence in clinical research and public health research requires that a career structure be provided if excellence is to be maintained and supported. I believe that the statement arguing for a RF career structure is just as applicable to PFs, especially given the dearth of translational clinical research in Australia. ie "To attract highly skilled and committed individuals to [clinical] research and to retain the [clinical] researchers that consistently perform at the highest levels, it is fundamental that the [PF] Scheme offers a career path that is sustained, rewarding and nurturing".

There is no path for clinician investigators to follow after 5 years of PF other than a return to full time clinical practice. Flourishing research may then suddenly stop through time constraints. This should be addressed by enabling excellent PFellows to reapply for a further 5 years.

Not clear that 5 year renewals possible.

Respondents: Hold a NHMRC Training Fellowship

Should be in-line with whatever is decided for the Research Fellowship Scheme

Respondents: Hold a Career Award or Fellowship other than NHMRC funded

PF's are an excellent innovation. Having benefited from a similar scheme at RCHRI/MCRI for over 10 years (involving Geoff Tregear and Kerin O'Dea), I am delighted to see it in place.

One issue which needs serious consideration, is how to ensure that the time commitment for the fellowship can really be protected from clinical demands. This deserves the attention of a specific working party, with members who understand the demands of clinical research and the demands of clinical service provision.

The problem here is DIFFERENT to the Research Fellowship scheme. Career progression is catered for, and for many Pract Fellowship holders greater exit strategy options are available of RFs.

Summary of Raw Comments

Entry Level and Promotion

Question 30: Do you have any additional comments?

Respondents: Hold a NHMRC Career Development Award

The description of pre-requisites for the award may need to be improved. There is some misunderstanding that the award is for people at least 9 years post-doc. Some applicants seem to think that this can also mean 9 years post FRACP.

Respondents: Do not hold a NHMRC People Support Award and have never applied for a Research or Practitioner Fellowship

This should not be made into a career path for medical practitioners in competition with the RF scheme. It should remain as appointment in particular situations where appropriate for periods where appropriate, with no expectation of reappointment unless appropriate.

Prefer a scheme of promotion like the typical Full time RF scheme

Since PFs are offered for 5 years, there is every chance that the achievements of PFs will cross the line for promotion in a 5-year period. Furthermore, clinically-trained PFs typically enter the mature phase of their career later than RFs owing to the long period of training required (for example, they will typically have undertaken an undergraduate medical degree, postgraduate specialist training for an FRACP or FRACS, and are required to have a PhD or equivalent, and to have demonstrated independent, productive research capability typically commensurate with senior post-doctoral level achievements. For this reasons, their opportunity for career advancement should not be retarded unnecessarily.

Respondents: Do not hold a NHMRC People Support Award and have applied for a Research Fellowship

Just to highlight the need for long term appointments to this scheme(reviewed of course every 5 years). Possibly consider more than just 2 levels.

Respondents: Hold a NHMRC Research Fellowship

Keep the rules the same as the RF scheme. Keep things simple.

As in my response to question 26, I believe this Scheme should broadly be brought into line with the more general Fellowship Scheme. Obviously there will be some subtle differences but I think the broad principles should be the same.

RFC should have discretion to appoint at lower level, but not higher.

As noted in Q26, the scheme should be modelled on the fellowship scheme. Personally I believe only those who applied for promotion at their last renewal and were renewed without promotion should be permitted to apply for promotion mid-term. All other appointments should be required to run their 5 year course.

Not sure if this comment fits here but it seems to me that there is no promotion within the career system. Most fellows operate one but probably two levels below their fellowship level.

Respondents: Hold a NHMRC Practitioner Fellowship

If the general Research Fellowship scheme changes so that renewals are awarded for 10 years, with a performance review every 5 years, the PF scheme should follow suit.

Respondents: Hold a NHMRC Training Fellowship

The promotion scheme should be complimentary to the Research Fellowship Scheme (ie 4 levels)

Respondents: Hold a Career Award or Fellowship other than NHMRC funded

Many clinical/PH applicants will know little about fellowship logistics. They will be inclined to choose levels which provide equivalent salaries to their clinical/PH scale. They should be at liberty to apply, but the RFC should be able to offer an appointment at the level deemed appropriate according to criteria laid down.

Summary of Raw Comments

Broaden Scheme to Include Career Development Awards

Question 33: Do you have any additional comments?

Respondents: Hold a NHMRC Career Development Award

Not all CDAs in population health and clinical health should be expected to fit the PF approach. At least some should be of the type that would naturally progress to the RF track. To force all CDAs in population and clinical health into the PF scheme would greatly and unfairly disadvantage applicants who wanted a full-time research career rather than a practitioner-researcher mix. I won't speak for clinical health, but population health certainly needs BOTH types of researchers. I would strongly argue that the CDA scheme be set up to feed both RF and PF schemes.

My understanding is that practitioners can already currently apply for a CDA - certainly these are already available at a 60% level.

The aims of the CDA are quite different to the PF. The PFs just do a bit of research on the side, the CDAs are full time researchers trying to have a long term research career.

Respondents: Hold a NHMRC Career Development Award and have applied for a NHMRC Research Fellowship

My understanding was that PF scheme was developed was to ensure that PF weren't competing against full-time (pure-scientifically) trained bench-scientists - therefore it makes sense to encourage this stream - given the importance of having clinicians involved in research.

Respondents: Hold a NHMRC Career Development Award and have applied for a NHMRC Practitioner Fellowship

To include Career development awards and include in the PF scheme will discourage the development of clinicians who undertake basic research or research where the clinical-research connections are "distant".

Respondents: Do not hold a NHMRC People Support Award and have never applied for a Research or Practitioner Fellowship

At the moment apart from not having the very senior levels the scheme is similar to the RF scheme. ie Career Development Awards are different to the Fellowship scheme.

Applicants for PFs are expert clinicians (i.e. they are accredited as specialists) or they have clearly documented high level expertise in other areas (e.g. in public health, allied health. Their problem is that their scientific development in many cases lags behind, so that they would do well to have a career development award.

There are some excellent researchers who do not hold a PhD - there should be a scheme that supports and encourages these researchers too.

The PF scheme is a valuable component of the NHMRC portfolio of career support. However, it needs refinement to ensure that some of our most committed and productive clinician-researchers with laboratory research interests do not fall in to cracks in the spectrum of support offered.

Respondents: Do not hold a NHMRC People Support Award and have applied for a Practitioner Fellowship

Particularly for clinically trained researchers, there is a difficulty in requiring high level research output to gain an award designated for early-mid research career. By the time one has a competitive CV for the application, an early career award is no longer appropriate.

See notes above, there are major and critical gaps between schemes and inconsistencies such that it is possible to apply for a more senior scheme when considered too junior to apply for a more junior scheme! Eligibility criteria for medical graduate schemes should be developed separately from non-medical schemes as the career positions (measured in schemes currently as post doc years) are not equivalent. The status of someone who is 2 years post doc having a basic science qualification needs to be assessed quite differently from someone who has completed specialist medical training, often with a research component, worked in the field and also completed a Phd.

Respondents: Do not hold a NHMRC People Support Award and have applied for a Research Fellowship

It is unclear how a merged scheme (Q32) would work alongside a proven Fellowship scheme. To establish it would set up a rather unfortunate division among health and medical researchers.

This is a critical time in career development

What is unique about the PF, is that, potentially, individuals in private practice can apply (the minutia of obtaining project grant funding noted). An excellent number of clinicians specialists with PhDs and an excellent record in research and publication do not hold staff specialist positions but could contribute greatly to clinical research. One question begs asking: do the large basic science institutes that often have "medical research" on their front doors produce results that translate to changes in clinical service delivery and amelioration of disease? How does that compare with clinical research findings? The answers to these questions may broaden our understanding of the need to fund more research where workers are at the coalface of disease, observing it, tackling it on a daily basis. These individuals often are heavily credentialed and would be expected to meet "standards of excellence" as applied elsewhere. The current criteria for application to PF can be directly seen to inhibit entry of these individuals.

CDAs are full-time, and I hope many of the clinical and public health fellows will be competitive in the standard RF scheme after 5 years - or earlier.

I think once you offer "Career Structure" people Expect to be supported

Respondents: Hold a NHMRC Research Fellowship

The funding requirements of public health and epidemiology are obviously so different from those of investigative, hypothesis based research, that the system of funding the two should be formally separated again. The experiment has failed, with significant dissatisfaction arising from both sides.

Such a change should only be considered if all CDAs were merged into both RF and PF schemes.

There should be a single scheme whether you are a PhD, MBBS or anything else. You should be judged on your RORA pro rata and funded pro rata.

In my view, clinical and public health work are not similar and they should not be grouped together and treated as one. I would prefer career schemes for both be developed separately for clinical fellows and for public health fellows. Each should encompass career development awards as well as career fellowship support.

I see problems with multiple schemes, rules and structures. Performance in different types of 'medical and health' research can be tracked in single schemes: provided that there is sufficient funding and

sufficient policy to guide the decision making!

I am a little disturbed by the tone of the questions here. The CDA Awards and indeed some of the Training Fellowships should not be seen as part time awards. This is a misnomer. They assume a full time career of which the funding is pro-rated to support the research component while support for their professional component is garnered from elsewhere. It is very important to make the distinction between this and a part time award in which no assumption is made about how the rest of the time is used. As noted, I believe this scheme should be run in parallel with the other schemes. That was the intention of the Clinical and Public Health CDA Awards as conceptualised and just as it is in either whole time research or in the biomedical areas. I think the challenge in public health and clinical is that the career pathway is not as well defined as that for biomedical and people in some cases seem to leap levels and in other cases stall, in each case, while still being productive. I would rather, for instance, see people who hold CDA's able to apply say early in their CDA for a Practitioner Fellowship perhaps in the third year of their CDA.

The criteria that should be used to judge these two areas are different and would be difficult to merge. Both should be retained independently

Could be done by letting Clinician/Scientists apply for existing Fellowships eg RD Wright etc.

Do not try create a new career scheme. Fix the original and adapt it to accommodate PFs

Too much overlap in the current CDA and PF schemes

Respondents: Hold a NHMRC Practitioner Fellowship

I would support the inclusion of the CDA's as the junior rung of the PF scheme.

Maybe the whole fellowship scheme (RF and PF) should merge and provide more entry level opportunities and flexibility at all levels.

The two schemes have different criteria and aims, and target researchers at different levels. They are best kept separate.

Respondents: Hold a NHMRC Training Fellowship

I think the CDAs should be kept separate to ensure that this money is retained for junior levels and does not get taken by senior scientist and their 10 year fellowships.

This is a great idea and should be seriously considered for the CDA/RF scheme also.

Respondents: Hold a Career Award or Fellowship other than NHMRC funded

This would create an even bigger problem for people who are eligible for CDAs.

This would give the RFC a better overview of the work force, and enable it to better foster career development in the earlier years. If career development at higher levels can also be supervised by this committee, a genuine career path may evolve under its guidance.

Separate population health, as the ranking beside clinicians also undertaking basic science is difficult.

Summary of Raw Comments

Effectiveness of the Scheme

Question 34: Do you have any general comments on the effectiveness of the PF Scheme in meeting the needs of clinical or public health researchers and comments on improving the PF Scheme?

Respondents: Hold a NHMRC Career Development Award

I think it may be easier to meet the needs of clinician-researchers than population health practitioner-researchers. I'm not sure why - perhaps it's because of the sessional nature of clinical work and the difference in the relationship with employers for the two groups. It is also harder to describe population health practice than clinical practice, and there is a much longer tradition of clinician-researchers than population health practitioner-researchers. I think that all may make it difficult for population health practitioners and researchers to envision a career as a practitioner fellow.

The outcomes should be evaluated. I think they are less likely to provide good value for money.

It will be interesting to see whether the scheme has indeed succeeded in providing translation of research to clinical practice (judged when the current fellows are up for renewal). It is not clear whether this kind of funding is an expensive response to government pressure. Time will tell. It is likely that funds are better spent at the lab bench.

Respondents: Hold a NHMRC Career Development Award and have applied for a NHMRC Research Fellowship

All researchers should be considered on their merits together, whether practitioners or basic researchers.

I am not aware of any special benefits of this scheme.

The pendulum has shifted away from funding basic science research to clinical research in recent times due to pressures imposed by the government to translate research findings into clinical practice. This has also occurred in the US with limited success. The funding of basic science research remains the best investment of NHMRC monies in benefiting Australian health.

Respondents: Do not hold a NHMRC People Support Award and have never applied for a Research or Practitioner Fellowship

Too early. But it is clear that there is a (small) body of clinicians/public health people who want to contribute good research, and we should foster them.

I think it is too early to tell - I think it is a most exciting scheme that needs to be evaluated at the end of the first period of appointment (ie after 5 years) - essential that there is a career structure - otherwise the clinician researcher will disappear (see BMJ/Lancet initiative on the crisis in academic medicine).

Excellent scheme with wide impact. Very important to work out a career structure ASAP

The success of the scheme is partly dependent on the willingness of health care facilities to relieve their staff of some of their clinical load to do research - I don't know how this can be improved.

Currently to few awarded

The ideal career stage at which doctors should have the capacity to join this scheme is at a time point shortly after they have completed their post doc training i.e. after their Neil Hamilton Fairlie post doc

fellowship, from which it would make a suitable progression for suitably qualified people

Practitioner fellowships are a great idea! Keep them going as is

Its seen as a second rate scheme at present - neither fish nor fowl. What's needed is a longer term commitment to protected research time in clinical practice (through purchase of relieving staff or whatever).

To attract medical graduates into research they need to have a taste of it early without binding themselves irrevocably. 1 year appointments either as clinical fellows or some such title is the best way to encourage young medical graduates into research both clinical & basic.

Respondents: Do not hold a NHMRC People Support Award and have applied for a Practitioner Fellowship

The option of a full-time research fellowships for clinically trained researchers should be considered. Allocating these applicants to the RF scheme does not take into account the paucity of clinically trained researchers and the difficulty these applicants may have in 'open competition' with science trained researchers. For example, clinical research is less likely to be published in high impact journals than basic research notwithstanding its importance and clinical researchers are likely to shoulder a greater undergraduate teaching load.

Colleagues who have these PFs seem very satisfied with them. NHMRC must have a scheme whereby part-time researchers/part-time practitioners can be supported if they are doing world-class research. Currently, it would seem that the policy is just about correct, but the way it has been applied has been too focussed, and needlessly exclusory.

Respondents: Do not hold a NHMRC People Support Award and have applied for a Research Fellowship

While these schemes importantly address the shortfall in research training in these areas, it is important that in the end these areas should provide more people who are competitive for entry to the Research Fellowship scheme. I name Stephen Lord and Caroline Finch as two shining examples of such individuals. While it may be important for clinicians to retain some clinical work, this has been possible for Research Fellows in the past by taking fractional appointments. The review and evaluation of these Fellows should be an intrinsic part of the Fellowships scheme itself.

As noted above, I think it has been an innovation and is attracting clinical researchers in particular, but increasingly public health researchers.

I think it is too early to evaluate the outcomes, except in terms of quality of applicants over time. Effectiveness in facilitating research transfer will take at least 10 years to evaluate.

I view it as an effective means to retain clinical researchers in the system

Respondents: Hold a NHMRC Research Fellowship

The PF scheme should support only those whose research work is directly linked to clinical practice or public health outcomes. Since it is designed to create a synergy between research and practice, assessment of outcomes must necessarily assess the success of this nexus and demonstrate impact in the clinical practice or public health arena. Just as research fellows are assessed for the impact of their research, this should be even more prominent in the assessment of practitioner fellows where this impact was explicitly required to achieve support.

I am aware of a significant number of excellent scientists supported by this scheme and believe that it should be strengthened in whatever ways the incumbents believe would best facilitate their work.

Measuring the change in research performance and/or practice outcomes of the applicants seems an

effective way to evaluate this scheme

It is an excellent scheme and should be further promoted to allow development of physician scientists so that a better collaborative links can be established between medical research institutions and hospitals. This is one of major weakness of current NHMRC funding system, Very little funds are devoted to promote hospital and research institute interactions.

The idea behind this scheme is fine. It must not become fragmented, full of additional rules and develop in to some sort of surrogate for the main fellowship scheme. Excellence is excellence! Further probing must be allowed in all fellowship appointments about the funding base that exists already for the researcher.

There are not very many PF. It doesn't seem to be an ideal scheme as it is.

I think my comments are rather encapsulated above. I mentor one colleague who has a Practitioner Fellowship and one colleague who has the equivalent CDA Award. In both cases I believe the Award has been of enormous use to them; it certainly gives them institutional leverage and protected research time. There was a good case for continuing to expand these Awards.

As noted above, it would be nice to see the money coming from the Health Departments who should really be paying for this anyway. The Scheme may benefit from having a broader oversight group drawn with at least some of its expertise from outside the Fellowships panels. Perhaps more cross talk with the other schemes, Training Awards, Career Development, Clinical Centres for Research Excellence and Public Health Capacity Building. In parts, the right hand does not know what the left hand is doing and in parts it needs to get a stronger input into the development of these schemes.

Probably too soon to tell, but the scheme should be very carefully and fully evaluated

The PF scheme has started well. However, there is an urgent need for a career-structure to be developed to ensure continued success.

The fact that the NH&MRC does not pay on-costs to hospitals for PFs presents a real administrative problem for the scheme. many hospital refuse to pick this up which effectively reduces the amount of backfill time that can be bought with the fellowship

PF are very important in encouraging practitioners to be involved in research as they connect basic and clinical research and therefore should be supported.

It has not being going long enough to comment on this.

Good - could be better by broadening and providing a parallel stream to RFs.

I don't know how well it is working, but these are talented, valuable people whom we should do our best to encourage and support to do research.

I think the scheme is doomed for the reasons stated above - it attempts to continue a type of research that is no longer viable. Clinical research ALSO needs to be competitive at an international level and clinicians need to learn to find outstanding full-time scientists who want to collaborate. rather than employing second rate full-time scientists who do not threaten the power structure of the clinician/scientist's hospital-based empire.

Emerging medical graduates are generally ignorant about a career in medical research. They need to be told there are pathways. The PF Scheme should be the model. Nations that support clinician-scientists alongside basic research will be the winners.

Respondents: Hold a NHMRC Practitioner Fellowship

The scheme is still in its early stages, but my discussions with other PFs would indicate strong support for the scheme. It has been very successful in freeing up protected research time for clinical & public health researchers.

In the next 1 or 2 years, a performance based review of the scheme should be undertaken to identify

strengths & weaknesses.

Some thought needs to go into the merits or otherwise of university based academics applying for the scheme. I am aware of at least one junior tenured academic who has been awarded a CDA - not sure if the same situation is true for PFs. An issue that needs a lot of thought & discussion.

Recognition and support of clinician scientists crucial.

The PF scheme has been an innovative and very effective scheme in providing support to excellent clinical researchers.

Review of effectiveness should include numbers of published papers, research grants obtained, postgraduate students trained in clinical research, and changes in policy and practice as a result of the PFs work. The latter criteria are more difficult to assess, but CAN be objectively documented and reviewed.

The PF is a very good scheme, which should be retained and improved - not removed.

The crisis in clinical research needs to be better coordinated with the state governments. They have to recognise research productivity by funding the gap between what the NHMRC can pay versus what a clinical staff specialist would earn if they do not take up a Practitioner Fellowship.

The remuneration from the award was much lower than my basic clinical salary and thus I could only afford to appoint a locum consultant for 0.3FTE in order to back-fill my clinical position. However, because there was no process to apply for a promotion or to increase my NHMRC time from 40% the value of the funds has gradually been eroded due to medical salary increases over the period and now barely support a consultant for 0.2FTE. I wrote several times to the committee chairperson regarding these issues. However, because there was no process to refer to it took over a year to get a response from the committee regarding whether my award could be altered.

The success afforded by the scheme is not balanced by flexibility in adjusting the award to ensure that time is available to manage the increased research load. The success could not have been anticipated at the time of the original application.

Respondents: Hold a Career Award or Fellowship other than NHMRC funded

It's a great concept, that has become flawed through misapplication of a sensible policy. RC needs to get its act together and ENCOURAGE medical practitioners who have slugged it out in research to get to Fellowship level, and who have committed to ongoing competitive, international-standard research for the benefit of their patients, current and future. Both USA and Great Britain recognise how endangered this breed is, and it is extremely frustrating to see Australia lose worthy, talented Pract Fellows from the system.

Congratulations on getting the scheme to happen. It has the potential to stimulate genuine improvements in health, and also to retain excellent academic health professionals within the service provision industry. These people are fortunately far more interested in job satisfaction and contributing to community health, than in high salaries. This provides a mechanism for them to survive and contribute - a double positive whammy - good people retained, and relevant health issues identified and investigated.

The practitioner scheme is essential for improving translational research so that it may attain similar levels of achievement to basic research within Australia.