Background

Following the Shape of Training review, changes to medical specialty curricula were introduced in August 2022 by the Joint Royal Colleges of Physicians Training Board (JRCPTB) following approval by the GMC. The demographic changes of an ageing population with multiple co-morbidities has endorsed the importance of generalism within specialty training. After consideration by the GMC (via the process of the curriculum assessment group) the physician specialties were divided into two groups: group 1, which would train in both internal medicine and specialty and group 2, which would train in specialty alone. For the group 1 specialties an indicative 12 months of Internal Medicine Training (IMT) has been incorporated into higher training leading to the award of the Certificate of Completion of Training (CCT) at the end of training.

Table 1 - Specialty training pathways before and after curricula changes

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Specialty Training prior to 2019 (Group 1 specialties)

CMT 2 years
HST 4-5 years of which an "indicative" 24-48 months spent in internal medicine.
Option to drop internal medicine training for integrated academic trainees.

Specialty Training prior to 2019 (Neurology, Cardiology, GUM, Palliative Care)

CMT 2 years
HST 4-5 years with no additional internal medicine training

From August 2022 (Group 1 specialties – now includes Neurology, Cardiology, GUM, Palliative Care)

IMT 3 years
HST 4 years of which an "indicative" 12 months of internal medicine
(5 for neurology and cardiology)
No option to drop internal medicine for integrated academic trainees.

In England prior to the curricula changes academic trainees in integrated academic training (IAT) programmes are awarded either Academic Clinical Fellowships (ACF) during IMT or Academic Clinical Lectureships (ACL) during higher specialty training. ACFs combine 25% training in academic medicine with 75% training in clinical medicine. ACLs combine 50% training in academic medicine with 50% training in clinical medicine. Since the curricula have changed all times for training are indicative and progression in training is based on the demonstrable acquisition of capabilities as defined by the capabilities in practice (CiPs) outlined in the curricula.

A voluntary survey was undertaken by academic trainees in IAT to explore their perception of the impact of the medical specialty curricula changes on their careers. This survey was co-produced by the JRCPTB and academic clinicians representing the National Institute of Health Research, InterACT (the committee of local leads of Integrated Academic Training (IAT) programs), the UK-wide stakeholder group (Clinical Academic Training Forum) and an academic trainee representative. The responses are distributed here along with a proposal for immediate actions to further investigate issues identified and develop mechanisms by which they may be addressed.

Methods

The survey was targeted at the four nations' equivalents of Academic Clinical Fellows and Academic Clinical Lecturers in England training as physicians. Overall, we estimate there were 600 potential respondents. The survey was distributed by IAT leads in England and through similarly placed individuals in Wales, Scotland and Northern Ireland. The survey was open between 31st May and 15th July 2022.

Most questions in the survey invited respondents to select an option from a range of fields provided. In addition, three questions seeking written comments were included:

1. *Has the coupling together of Internal Medicine and specialty training in the new group 1 curricula impacted on your specialty choice? If you selected Yes, please indicate in what way.*
2. *Will / would your career aspirations be affected by the changing curriculum? If you selected 'Yes', please explain how.*
3. *Please feel free to comment on how you perceive the introduction of the new Internal Medicine Training stage 2 curricula will affect your career as an academic clinician and/or how academic clinical training might be facilitated?*

All open text responses were analysed and coded against the themes described in table 1. Some respondents' comments included more than one theme.

Table 2 – Summary of themes used to code open text responses

Theme	**Description**
Impact on training	Reduced time available for training; training prolonged overall; increased pressure on trainee.
Impact on research	Less time available for academic training; less likely to do research.
Considering leaving clinical academic medicine	Considering pursuing research only, medicine only, moving abroad or to industry.
Less likely to pursue group 1 specialty	Considering pursuing a group 2 specialty instead of group 1.
Positive	A positive comment about the impact of the changes.
Neutral	A neutral comment about the impact of the changes.
General disagreement	A range of negative comments about the impact of the changes, such as considering GIM not to be relevant for a particular specialty, or not seeing the need to dual train with GIM.
Changing plans	Expressing relief at being able to remain on the old curriculum.
Uncertainty/confusion	Unsure of the impact of the curriculum changes.

Respondents

287 responses were received of which 252 appear to have been from the target demographic representing an overall response rate of ~40%.

Survey respondents' age ranged from 27 to 45 years old, with a median age of 32 years old. 48% of survey respondents identified as female, 51% as male and 1% preferred not to provide this information. 55% of respondents had no dependents, and 44% had at least one dependent. 83% of respondents worked full time, with 16% working less than full time. The distribution of ethnicities amongst respondents was broadly similar to the UK medical workforce.

44% of respondents were Academic Clinical Fellows in England or Northern Ireland, and a further 34% were Academic Clinical Lecturers in these nations. 3.6% were academic trainees in Scotland and a further 2% were trainees in Wales. There was representation in the survey from trainees based right across the UK, with the highest proportions in London (17%), the South East of England (17%) and the East Midlands (11%).

83% of respondents worked full time and 16% worked less than full time. 38% of respondents anticipated working less than full time at some stage in their training career, and a further 29% were uncertain about whether this might occur.

Survey respondents were training in a wide range of medical specialties, with the highest proportion of respondents pursuing neurology (18%) and cardiology (16%). 80% of respondents indicated that they were training in a group 1 specialty.

Respondents were asked to indicate the nature of their research. 41.4% reported that their work included basic science, 38.8% informatics, 40.6% said their work required access to patient samples and 50% described their work as experimental medicine, requiring access to or recruitment of patients or subjects. 15.1% of respondents indicated they were involved in large scale trials. 14.4% of respondents felt their research fell into other categories; these included qualitative or mixed methods research (4.0%), epidemiology (3.6%); public health and policy / implementation (2.9%); big data / modelling / artificial intelligence (2.5%).

As such these responses represent representative data on the views of this group of doctors in training and require careful consideration by all those responsible for its oversight.

Views on the impacts of changes to specialty training

Future career aspirations

Survey respondents were asked to indicate their future career aspirations. 70% indicated their intention to pursue predominantly an academic pathway, with 22% indicating predominantly an NHS pathway. 2% of respondents indicated industry. Similar results were seen when comparing group 1 and group 2 trainees.

Changes to specialty training

Awareness of the changes and route to CCT

Prior to receiving the questionnaire, 62% of respondents indicated that they had been aware of the changes to the specialty training pathway, however 37% of respondents indicated that they were not aware of these changes. A higher proportion of trainees pursuing a group 1 specialty indicated that they had been aware of the changes (66% indicated yes) compared with group 2 specialty trainees (49% yes).

Of those training in a group 1 specialty, 36% indicated that their route to CCT would be under the old curriculum, 32% indicated that this would be under the new curriculum, and 29% indicated that their route would transition from old curriculum to new curriculum (figure 1).

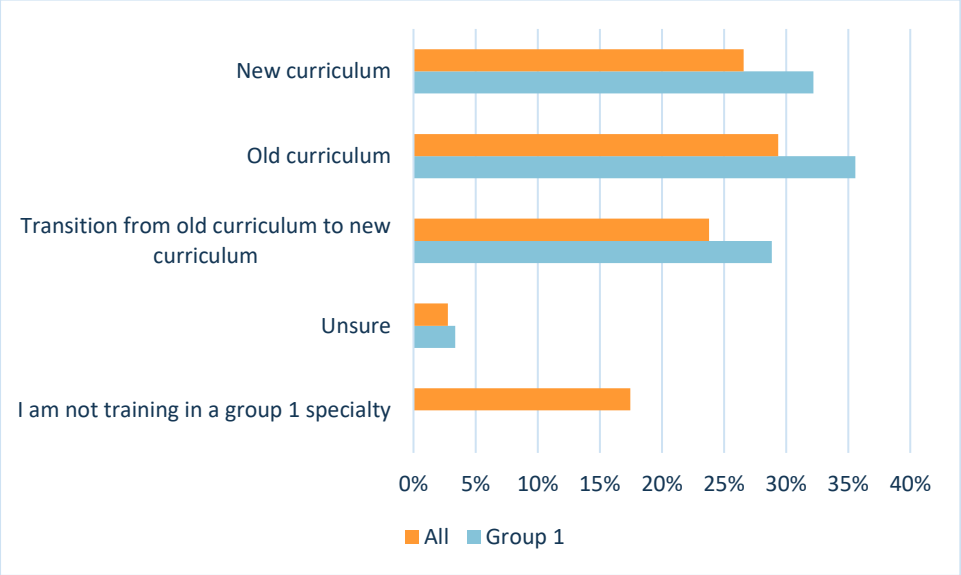

Figure 1 – Responses to the question "If you are training in a group 1 specialty will your route to CCT be under [select response]"; all respondents (n=252) and group 1 only (n=208).

Impact on specialty choice

19% of all respondents (18% of group 1 only) indicated that the coupling together of Internal Medicine and specialty training in the new group 1 curricula had impacted on their specialty choice (figure 2). However, 54% of group 1 respondents (53% of all respondents) felt that there had not been an impact on their specialty choice. 26% of group 1 respondents indicated that this was not applicable, because they will CCT under the pre-August 2022 curriculum.

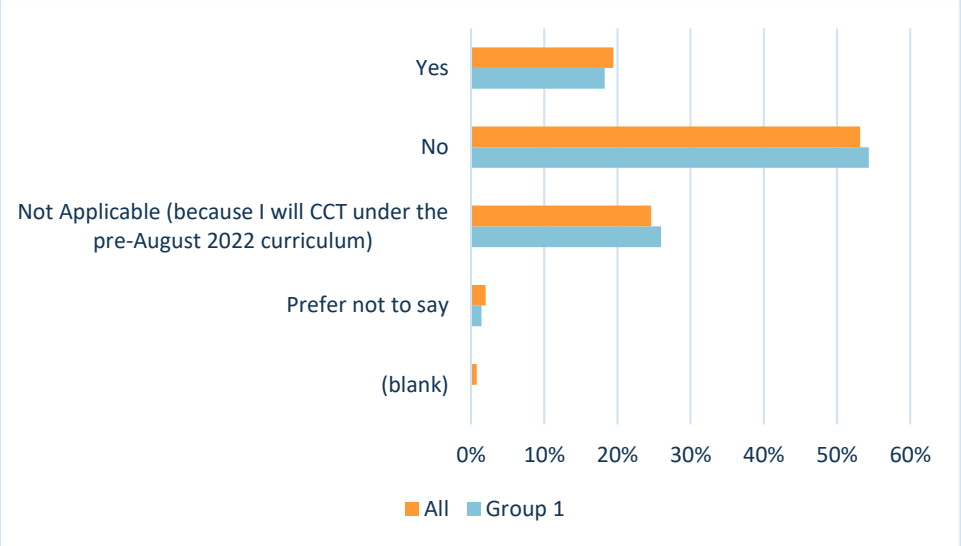

Figure 2 – Responses to the question "Has the coupling together of Internal Medicine and specialty training in the new group 1 curricula impacted on your specialty choice?"; all respondents (n=252) and group 1 only (n=208).

Of those indicating that the changes had impacted on their specialty choice, 46 respondents provided further information as to why this was the case. Nine of these respondents were not training in a group 1 specialty, and their responses are summarised below separately. Within the remaining 37 respondents training in a group 1 specialty, ten respondents indicated that the changes would reduce the time they have available for specialty training, with several commenting that it would be challenging to balance the time required to pursue training across Internal Medicine, their specialty and research. Two respondents also highlighted the additional challenge of managing family commitments alongside these changes.

"The curriculum disadvantages academics, females, anyone that takes parental leave or works LTFT." Group 1 trainee

Eight respondents highlighted the negative impact of the changes on pursuing a research career, with four respondents considering dropping their academic component as an ACF or ACL, being less likely to stay in academic medicine.

"This programme is guaranteed to degrade clinical academia in the UK. It is already an unappealing career option for many of my peers. I don't doubt the service provision pressures in the NHS, but I worry for the future of clinical research, and wonder where the senior academics are to defend it." Group 1 trainee

"I have now resigned by neurology ACF as a result of these changes." Group 1 trainee

Two respondents explained that they were considering leaving medicine altogether, and a further trainee explained that they would have left if they hadn't been able to remain on the old curriculum. Five respondents explained that they were less likely to pursue a group 1 specialty or would change to a group 2 specialty.

"Following my return to training after OOPR, I will be strongly considering re-applying to a group 2 specialty."

All nine respondents who were not training in a group 1 specialty indicated that the changes had made it less likely for them, and other trainees, to pursue a group 1 specialty.

"I am not in a group 1 specialty, but the coupling of IM and specialty training did influence my decision to choose a group 2 specialty."

Impact on academic progression

69% of all respondents felt that the coupling together of Internal Medicine and specialty training in the new group 1 curricula would make their academic progression more difficult (figure 3). This figure was slightly higher (74%) for respondents in group 1 only. 12% of respondents felt that there would be no change, with just over 1% feeling that it would be less difficult.

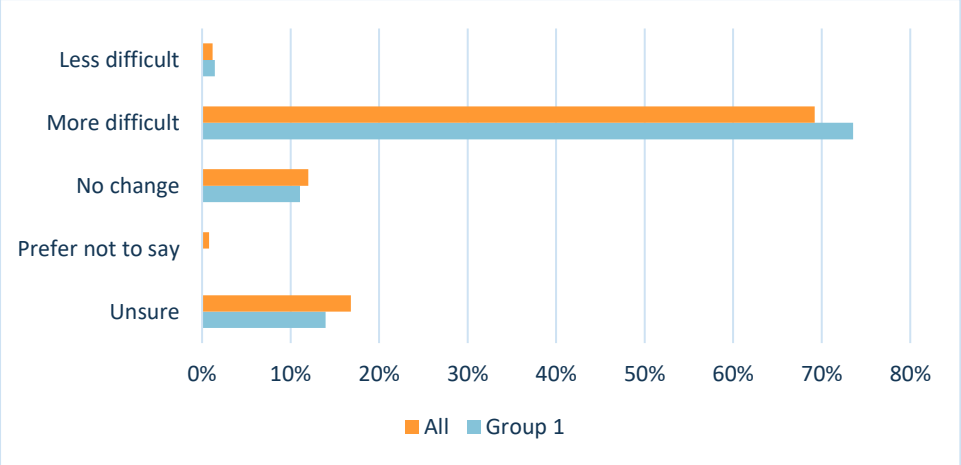

Figure 3 – Responses to the question "How do you think the coupling together of Internal Medicine and specialty training in the new group 1 curricula will impact on / would have impacted on your academic progression?" showing all respondents (n=250) and group 1 only (n=208).

42% (43% group 1 only) of all respondents indicated that, under the current specialty curriculum (pre-August 2022), they definitely would have dropped accreditation in GIM to maximise academic progression (figure 4). A further 24% of all respondents indicated that they 'probably' or 'possibly' would have dropped accreditation in GIM to maximise academic progression. 10% of all respondents indicated that they would not have considered dropping accreditation in GIM.

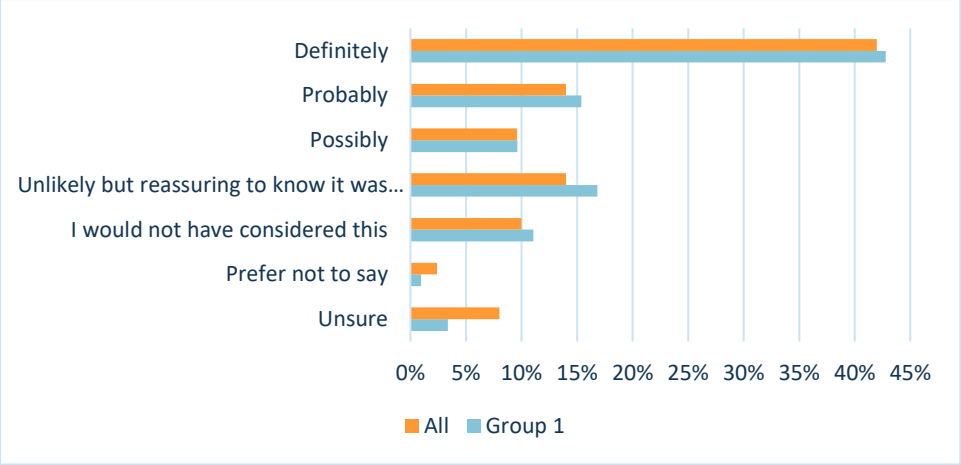

Figure 4 – Responses to the question "Under the current specialty curriculum (pre-August 2022) how likely would you have been to drop accreditation in GIM to maximise academic progression?" showing all respondents (n=250) and group 1 only (n=208).

70% (75% of group 1 only) of all respondents felt that it would not be acceptable to drop specialty training and single accredit in GIM in order to speed up academic progression to CCT (figure 5). Only 3% of all respondents felt that they would have dropped specialty training to achieve this.

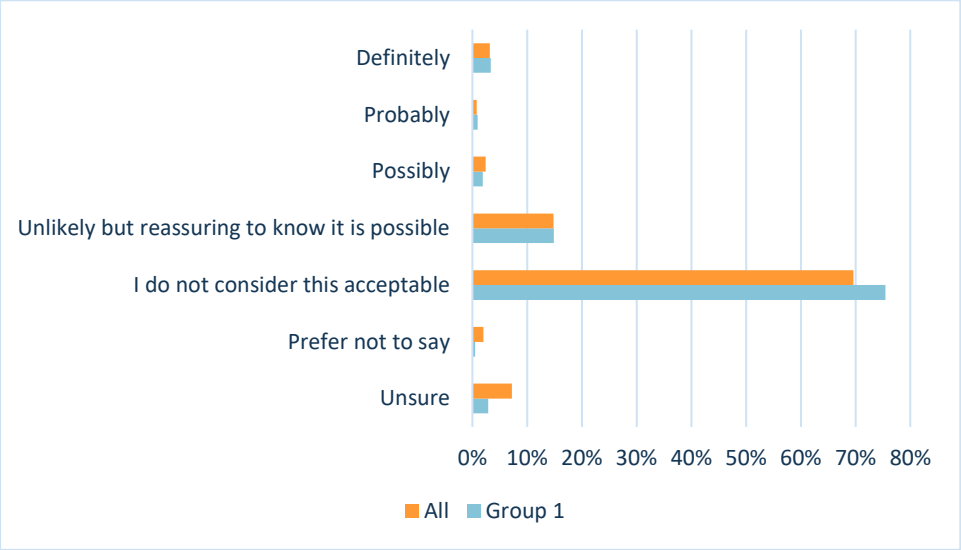

Figure 5 – Responses to the question "Under the new specialty curriculum how likely are you / would you be to drop specialty training, thereby single accrediting in Internal Medicine, to speed up / maximise academic progression to CCT?" showing all respondents (n=250) and group 1 only (n=208).

61% (64% of group 1 only) of all respondents felt that Internal Medicine training would be detrimental to their academic progression (figure 6). A further 14% were neutral on this issue, and only 3% of all respondents felt that Internal Medicine training would be helpful to their academic progression.

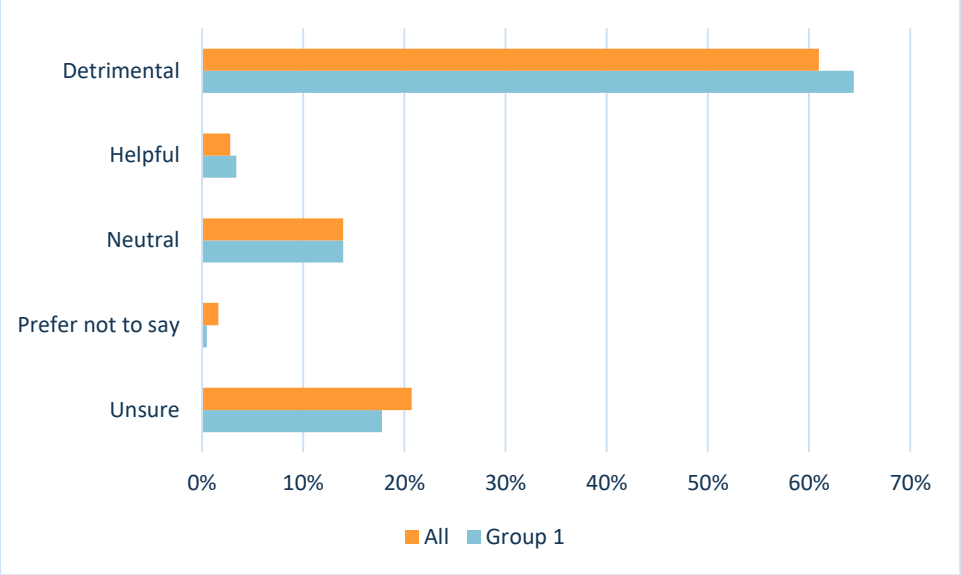

Figure 6 – Responses to the question "Under the new specialty curriculum what will be / would be the likely impact of Internal Medicine training for your academic progression?" showing all respondents (n=251) and group 1 only (n=208).

29% (31% of group 1 only) of all respondents felt that, under the new specialty curriculum, specialty training would have a helpful impact on their academic progression (figure 7). A further 22% of all respondents were neutral on this issue. However, 21% (24% of group 1 only) of all respondents felt that specialty training would likely have a detrimental impact. A high proportion of all respondents (27%) indicated that they were unsure about the likely impact on their academic progression.

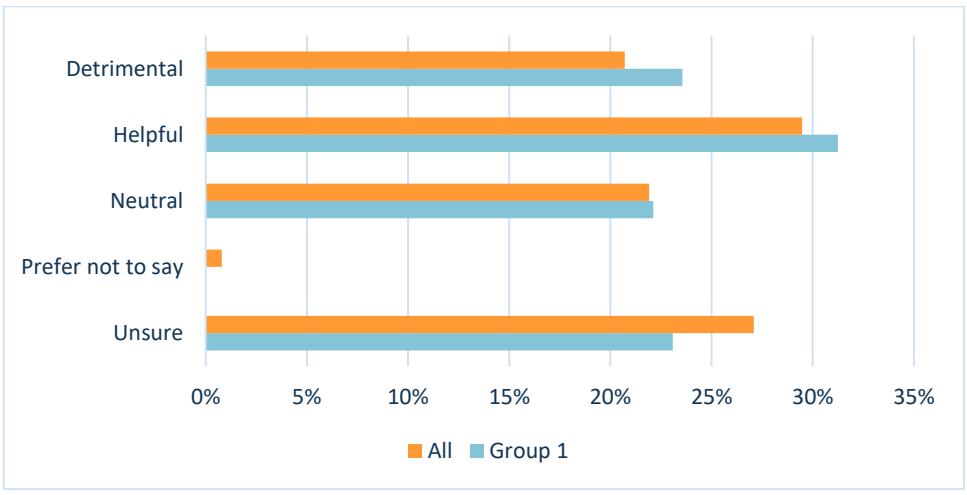

Figure 7 – Responses to the question "Under the new specialty curriculum what will be / would be the likely impact of specialty training for your academic progression?" showing all respondents (n=251) and group 1 only (n=208).

Achieving an NHS consultant post

23% (26% of group 1 only) of all respondents felt that, under the pre-August 2022 curriculum, dropping GIM training would reduce their likelihood of achieving an NHS consultant post (figure 8). In contrast, 16% (17% of group 1 only) felt that dropping GIM training would improve their likelihood of achieving an NHS consultant post, under the pre-August 2022 curriculum. A further 39% of all respondents were neutral on this issue, and 20% were unsure.

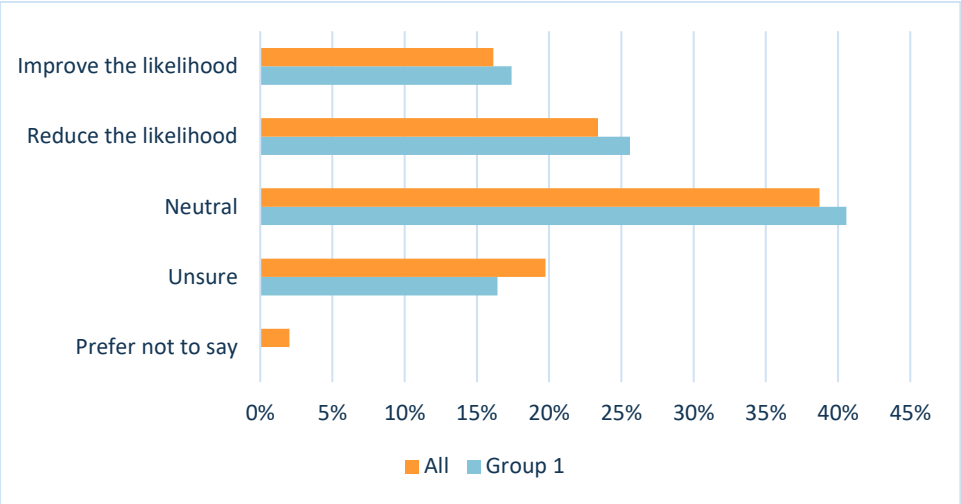

Figure 8 – Responses to the question "Under the pre-August 2022 curriculum what impact do you think dropping GIM training would be / have been on your likelihood of achieving an NHS consultant post?" showing all respondents (n=248) and group 1 only (n=207).

73% (78% of group 1 only) of all respondents felt that, under the new curriculum, dropping specialty training would reduce the likelihood of achieving an NHS consultant post (figure 9). Only 2% of all respondents felt that dropping specialty training would improve their likelihood of achieving an NHS consultant post.

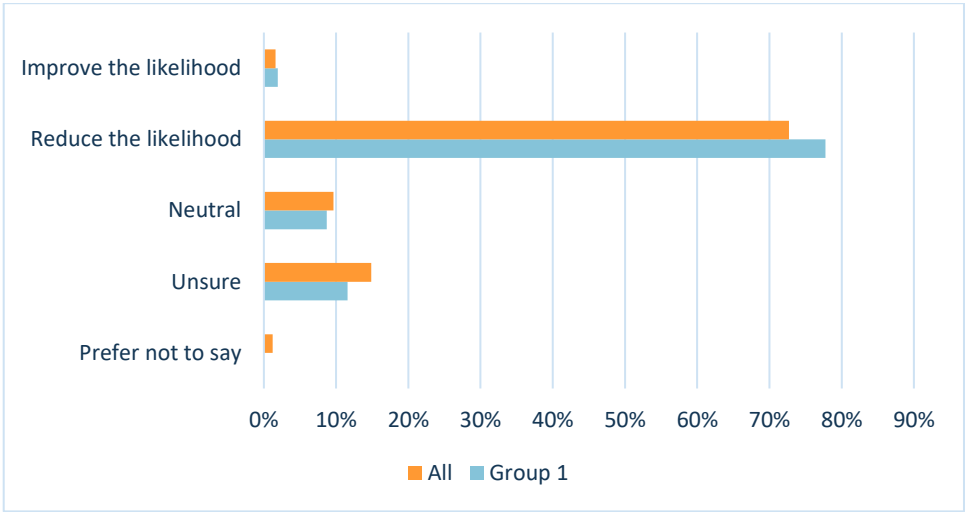

Figure 9 – Responses to the question "Under the new curriculum what impact do you think dropping specialty training would have on your likelihood of achieving an NHS consultant post?" showing all respondents (n=249) and group 1 only (n=207).

Achievement of career aspirations

57% (61% of group 1 only) of all respondents felt that, under the current specialty curriculum (pre-August 2022), dropping GIM training would improve their likelihood of meeting career aspirations (figure 10). A further 14% were neutral on this issue, and 18% were unsure. Only 10% of all respondents felt that dropping GIM would reduce the likelihood of meeting their aspirations.

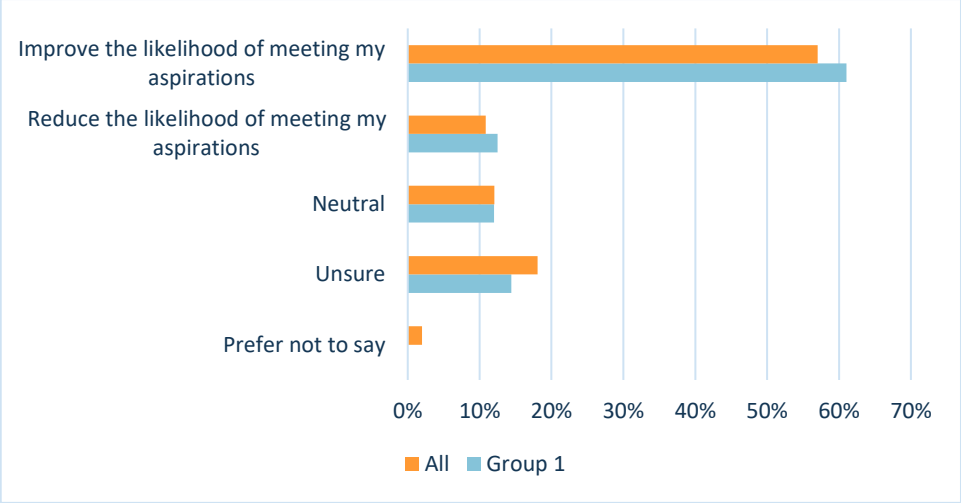

Figure 10 – Responses to the question "Under the current specialty curriculum (pre-August 2022) what impact do you think dropping GIM training would be / have been on your likelihood of achieving your career aspirations?" showing all respondents (n=249) and group 1 only (n=208).

82% (87% of group 1 only) of all respondents felt that, under the new curriculum, dropping specialty training would reduce the likelihood of meeting their career aspirations (figure 11). Only 2% of all respondents felt that dropping specialty training would improve their likelihood of meeting career aspirations.

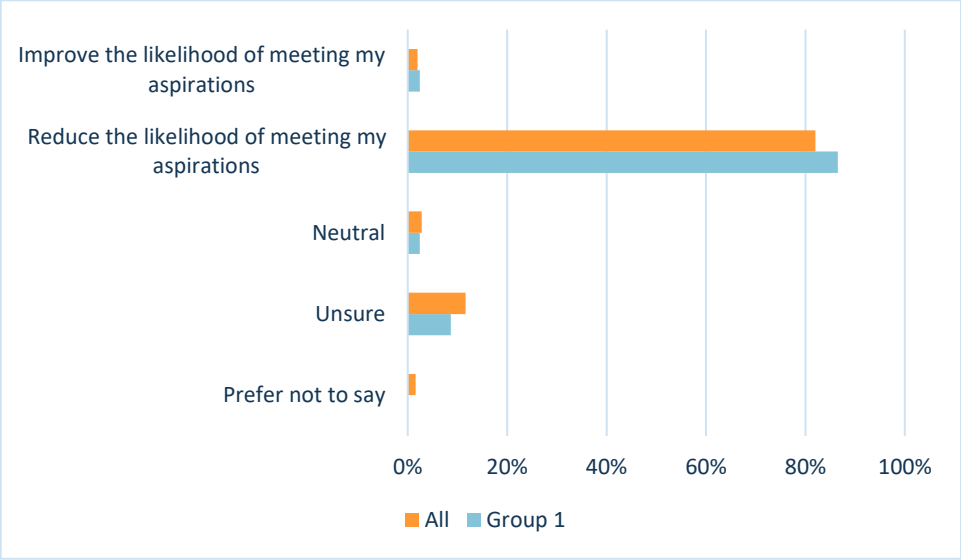

Figure 11 – Responses to the question "Under the new curriculum what impact do you think dropping specialty training would have on your likelihood of achieving your career aspirations?" showing all respondents (n=250) and group 1 only (n=208).

38% (41% of group 1 only) of all respondents felt that their career aspirations would be affected by the changing curriculum (figure 12). 29% of all respondents felt that their career aspirations would not be affected, and a further 31% were unsure.

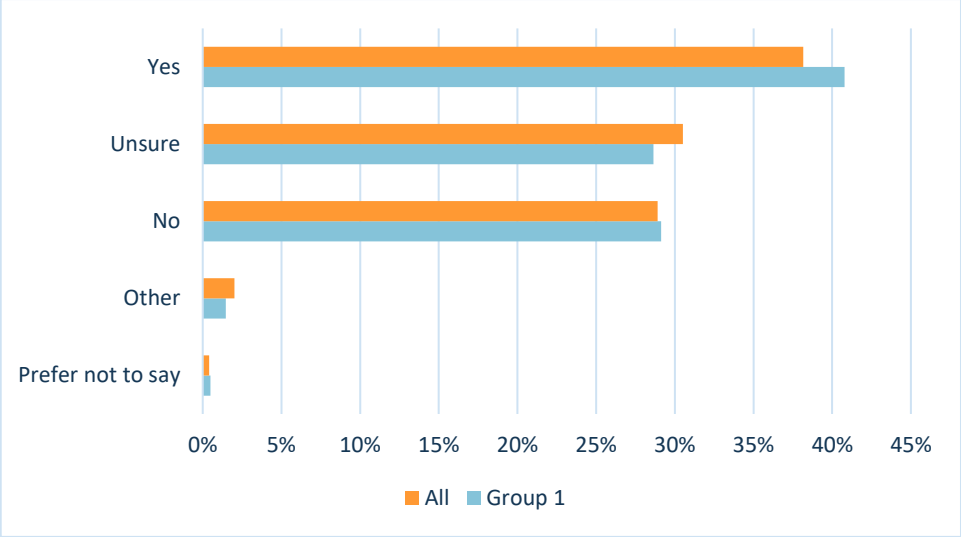

Figure 12 – Responses to the question "Will / would your career aspirations be affected by the changing curriculum?" showing all respondents (n=249) and group 1 only (n=207).

Of those indicating that their career aspirations would be affected by the changes, 91 respondents provided further information explaining why this was the case, 80 of whom were training in a group 1 specialty. Each comment was analysed and coded against the relevant theme, as shown in figure 13.

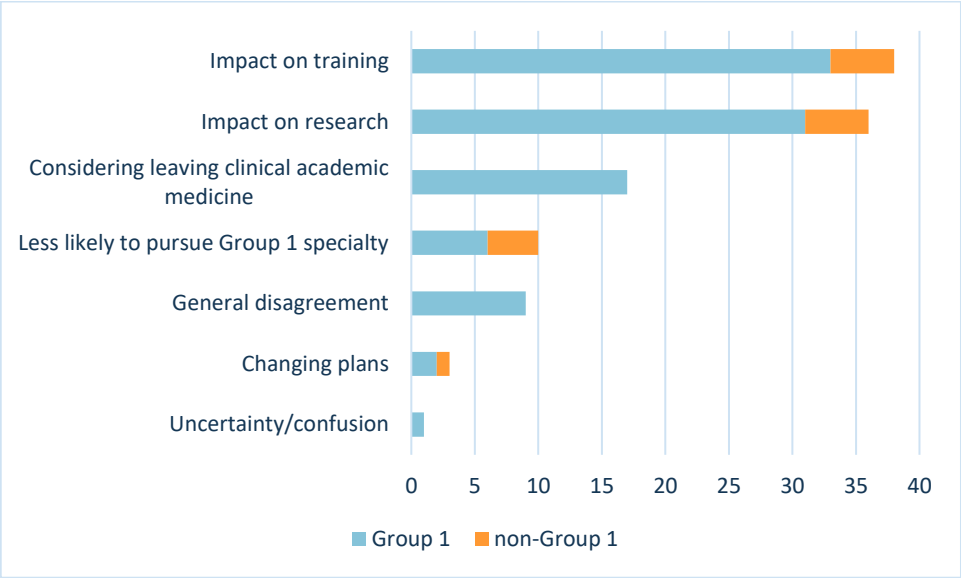

Figure 13 – Number of written comments received from respondents who had indicated that their career aspirations would be affected by the changing curriculum group 1 only (n=80) and non-group 1 (n=11). Comments were coded by theme (see table A2 in appendix 2), with respondents' comments including more than one theme. N.B. no positive or neutral comments about career aspirations were made.

38 respondents (33 from a group 1 specialty) commented on how the changing curriculum would have an impact on their overall training. The most frequently mentioned impacts were the reduced time available for training, that training would be prolonged overall, and that there would be increased pressure on trainees due to the commitments of pursuing training in their specialty, GIM and academia, with some highlighting the additional commitments of their family and childcare.

"As a trainee who is on OOPR to do a PhD with an eventual aim to obtain a clinical lectureship, the mandating of G(I)M in order to CCT with my speciality of choice (or to choose between the two) will prolong the time it will take for me to CCT and will most likely interfere with my ability to pursue my research interest which is intimately tied to my speciality of choice." Group 1 trainee

"As an LTFT trainee I think it would be extremely difficult to perform well in specialty clinical medicine, GIM and academia. Therefore if forced onto the new curriculum I would feel pressured to drop one, or feel dissatisfied with all. This is a huge disadvantage for LTFT trainees and I suspect will reduce the numbers conducting research." Group 1 trainee

"I will be detrimentally impacted by having much less protected research time to fulfil my academic ambitions and much less time to train in my speciality training, making me potentially a less experienced nephrologist overall." Group 1 trainee

36 respondents (31 from a group 1 specialty) provided a comment describing how the changing curriculum would have an impact on their academic training. The most frequently mentioned impacts were having less time available to do research, and being less likely to pursue a career as a clinical academic.

"If I had to do general medicine and specialty training I would not pursue an academic career. Training is already too long. Financially and personally it would be too much of a sacrifice. There is no way it would be possible to run a successful basic science lab while dual training and being the primary caregiver to two small children." Group 1 trainee

"I feel this new curriculum (with the compulsory inclusion of GIM) will have a major irreversible detrimental impact on clinical academic trainees (such as myself) wanting to progress in both their specialty as well as academic fields. I feel it is the females (especially those who do not have support for childcare etc) who are going to be impacted on the most, going against the current momentum in support and develop female clinical academics." Group 1 trainee

"I would have likely discontinued academic training entirely to push on with my clinical training alone, were I not allowed an exception to drop GIM." Group 1 trainee

17 respondents, all from a group 1 specialty, commented how the changing curriculum could lead to them leaving clinical academic training, or leaving medicine altogether.

"…makes me more likely to consider committing to solely NHS or academic work, or considering something in the industry instead." Group 1 trainee

"I'm much more likely to leave the NHS to work abroad or consider working in industry to do just what I enjoy and want to do, not be forced into a box by a system falling apart." Group 1 trainee

"It is possible that by forcing us to do GIM I may consider leaving NHS work all together." Group 1 trainee

10 respondents (6 from a group 1 specialty) described how the changing curriculum would make them less likely to pursue a group 1 specialty, considering group 2 instead.

"I […] would consider re-applying to either a different group 2 specialty within medicine, or a non-medical specialty (e.g. GP, public health)." Group 1 trainee

"A lot of my colleagues are reconsidering their choice of specialty because of the very unfortunate forcing of general medicine into the training." Group 1 trainee

"I changed from a group 1 to a group 2 specialty in 2021 to be able to balance clinical medicine, a family and research." Non-Group 1 trainee

Impact on academic clinician careers

At the end of the survey, respondents were asked to comment on how they perceive the introduction of the new Internal Medicine Training stage 2 curricula will affect their career as an academic clinician. 137 respondents provided written comments to this question, the majority of whom (127 respondents) were pursuing a group 1 specialty. Each comment was analysed and coded against the themes shown in figure 14.

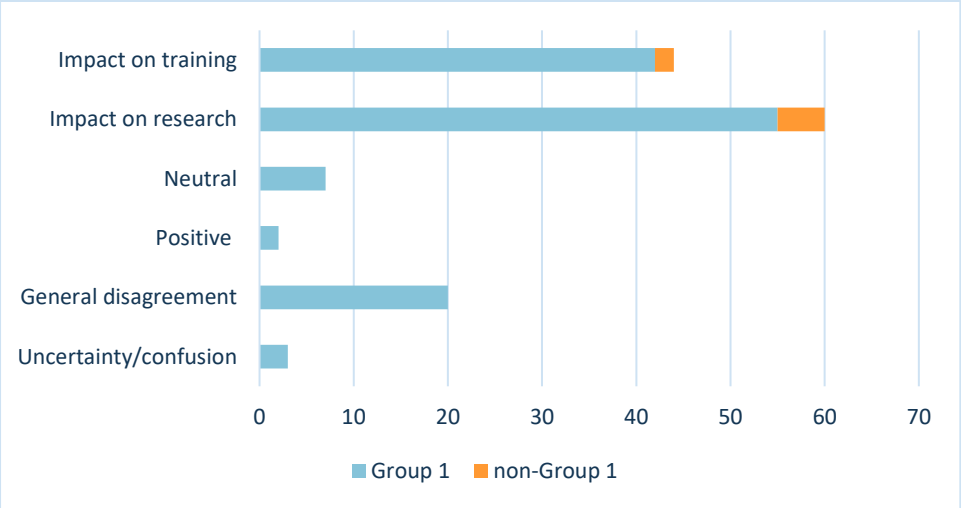

Figure 14 – Number of written comments received from respondents describing how they perceive the introduction of the new Internal Medicine Training stage 2 curricula will affect their career as an academic clinician – group 1 (n=137); non-group 1 (n=10). Comments were coded by theme (see table 1), with some respondents' comments including more than one theme.

55 respondents from a group 1 specialty provided a comment about the impact of the new curriculum on their research. A selection of comments is provided below:

"I think the introduction of joint GIM curriculum is a retrograde step and will make academic training more challenging and less appealing to new trainees, particularly those who need to work LTFT or have caring responsibilities." Group 1 trainee

"I think that the new curriculum will be detrimental to cardiology training - and will make academic cardiology training almost impossible." Group 1 trainee

"My concern is that academic training will be further pushed to the back-burner and seen as less important than achieving specialist and general medical competencies." Group 1 trainee

"The changes are going to make academic training even more difficult than it already is and I am not sure I will be able to pursue an academic career now especially with building a family." Group 1 trainee

42 respondents from a group 1 specialty also commented about the impact of the new curriculum on their training overall. Many comments emphasised the challenges of balancing their time on pursuing training in their specialty, GIM and research:

"I feel it would [be] extremely challenging for a trainee to maintain a Specialty and GIM portfolio alongside academic duties. This could severely impact on the quality of specialty training as well as the quality of research." Group 1 trainee

"It places additional strain and burden on a career pathway as now, not only does one have to develop expert knowledge in their chosen specialty, and develop high level academic technical skills and networks, but one now is also expected to be a highly competent and well experienced internal medicine clinician." Group 1 trainee

"I worry that by having to try and juggle all three, I will become a mediocre academic, mediocre cardiologist and mediocre IM physician." Group 1 trainee

A large proportion of respondents who provided generally neutral or negative comments indicated their relief at being able to remain in the old curriculum. Two respondents commented that GIM was always going to be part of their clinical practice. Only two respondents provided a positive comment about the curriculum changes:

"I had already completed CMT training so IMT did not affect me. The new curriculum appears less onerous so I think it might be easier to achieve competencies." Group 1 trainee

"I think the fact that the new curriculum is competency based allows the flexibility. It needs to be made clear it's not time or numbers based." Group 1 trainee

Suggestions for facilitating academic clinical training following the curriculum changes

32 respondents provided suggestions describing how academic clinical training could be facilitated following the curriculum changes. 19 of these responses suggested that GIM should not be mandatory for clinical academics and / or they should be able to remain on the old curriculum:

"I think academic training should be seen as dual training in itself. And I think for academics, it should be possible to drop GIM training." Group 1 trainee

"The obvious solution seems to be that academic trainees should have the option of dropping GIM, so they can combine their specialty with academic medicine." Group 1 trainee

"Remove the mandatory requirement for academic trainees to dual accredit in GIM. This would allow them to pursue both academia and specialty training, which is a dual accreditation in itself." Group 1 trainee

Four respondents suggested that more effort could be made to support clinical academics through their training, and protect their time:

"Respect for academic time needs to be upheld from both GIM and speciality training with solid guidance on time proportions." Group 1 trainee

"We need protected time to do research and to do our speciality- where will we get the time to also do GIM?" Group 1 trainee

"Could include optional exemption from the on call rota during academic blocks, extension of NIHR or local funding periods above the 4 years previously allocated." Group 1 trainee

A further four respondents suggested that changes could be made to the training pathway to support clinical academics:

"Consider actions that permit faster progression through clinical years to improve opportunity to develop academic skills - might be achieved by shortening the more junior 'SHO' years where training opportunities are more limited." Group 1 trainee

"I think academic activities, if clinical based, should be considered and potentially count towards training progression if they show that learning has occurred and competencies gained." Group 1 trainee

"I think ACLs need to evolve to cover the last year of clinical training and the first year of consultant to [do] both. This would be a more realistic transition and enable independence whilst not hampering pay progression and associated average pension position with it." Group 1 trainee

Several respondents commented about the rationale for specialists having further training in Internal Medicine:

"The way to look after patients with complex multimorbidity is to have MDT teams combining different specialists NOT trying to create a generalist and a specialist in one person (this is just not possible)." Group 1 trainee

"If more internal medicine consultants are needed, then focus should be on making internal medicine a more attractive training specialty, not forcing those in specialty posts to do it." Group 1 trainee

Discussion

The importance of academic medicine in improving patient care, the education of future healthcare professionals and its contributions to the UK economy are increasingly appreciated [1]. Recently the need to support clinical academics during and after training has been the focus of a House of Lords Science and Technology Committee inquiry [2]. In this context it is of concern that the results of the survey showed considerable anxiety among academic trainees in Integrated Academic Training posts as to how the integration of internal medicine into specialty curricula will affect their academic training, their clinical training and their future academic careers. The findings are of relevance to the large number of medical trainees who are currently out of programme in research, and others who may be considering an academic pathway.

The changes in the curricula had been highlighted at a meeting between representatives of both the academic community and JRCPTB in December 2019 which resulted in the associated publication https://www.jrcptb.org.uk/documents/integrated-academic-training-and-internal-medicine-training. The JRCPTB has also published several papers to try and demonstrate how acquisition of capabilities may be facilitated and how these can and should be recognized to allow acceleration of training [3, 4, 5]. Despite the discussions that occurred in 2019, there remained a lack of awareness among some trainees at the time of the survey of these modifications and this itself may have contributed to the concerns expressed. It is clear that more needs to be done to establish a really effective way of communicating changes with academic trainees and stakeholders involved in academic training including local training programme directors.

Another explanation for the concerns raised is that, as with all change, there is uncertainty about the precise effects of the changes and indeed how these changes will be interpreted in each locality. Furthermore, some responses suggested that there may also be a lack of clarity about what the curricula changes mean for academic trainees which may reflect the lack of a mechanism of focused communication to this specific group. For those already training in Internal Medicine (IM) the new curricula do not mean a loss of recognition of all that has been achieved to date; all capabilities acquired already would be recognized and there should be no automatic extension to training.

The indicative training time overall in most specialties has not changed, apart from in neurology where the addition of stroke medicine has extended training by an indicative year and in cardiology. For traditional group 1 specialties there will no longer be the option of dropping internal medicine training; for new group 1 (neurology, GUM and palliative medicine) specialties there will be additional capabilities required related to internal medicine. At the time of the survey many trainees perceived that it might still be possible to drop internal medicine training as had previously been the case. However, discussions with the GMC and representatives from COPMeD have reinforced that the disaggregation of internal medicine from specialty training in the group 1 specialties is not going to be possible as all those who will be looking after patients within acute hospitals in the future will require the breadth of generalist skills.

Many trainees expressed concerns about the density of training and the feasibility of achieving these competencies as well as pursuing academic medicine within this time frame. Some trainees have suggested this will alter their specialty choice to a non-group 1 specialty although the majority did not. Some suggested that they will leave academic training and this should be explored in more detail. However, as the curricula are capability based there is the possibility of accelerating clinical

training. Recognition that capabilities across the domains of practice, including those associated with academic training, should be based on individuals' capability acquisition rather than time may prove reassuring to both academic trainees and those responsible for ensuring they maintain parity with clinical colleagues. To assess this there should be a robust, pro-active monitoring system to measure the ongoing recruitment, retention and satisfaction of academic trainees (and within subgroups with protected characteristics).

Recommendations:

The key stakeholders are taking this survey and feedback from the trainees seriously. A short life Academic Training working group comprising leads from JCRPTB, the Royal Colleges, GMC, Post-graduate Deans and Clinical Academic Training Forum as well as trainee representatives themselves has been configured to provide high-level guidance and other tangible outputs, including practical examples of flexible training solutions, aimed at both those who are in academic training and those that provide such training. The experiential part of training cannot be lost but the flexibility to recognize how capability has been acquired must be a part of training programmes as we progress. The group has already met and we will report back on progress through this website and other communication channels in advance of the next round of ARCPs.

Acknowledgements

We are grateful to all those who distributed the questionnaire to clinical academic trainees in their areas and to all those who submitted responses. We thank Norman Freshney for assembling the demographic data describing the respondents, extracting the responses of those training in group 1 specialties and his analysis of their free text responses. We also thank the staff of the Academy of Medical Sciences for their help in finalising this document.

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