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. As such, an indicative 12 months of further Internal Medicine Training (IMT) has been incorporated into specialty training leading to dual Certificate of Completion of Training (CCT) accreditation at the end of training.

Table of 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.

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.

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) programmes), the UK-wide stakeholder group (Clinical Academic Training Forum) and an academic trainee representative. The full responses are distributed here along with a proposal for immediate actions to further investigate issues identified and provide solutions to them.

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.

Results

287 responses were received of which ~90% appear to have been from the target demographic representing an overall response rate of ~40%. Review of the attached results shows that respondents had a good geographical distribution, a wide specialty spread and a wide spectrum of research approaches. Respondents showed roughly equal gender representation and a distribution of ethnicities broadly similar to the UK medical workforce. As such these responses represent high quality representative data on the views of this group of doctors in training and require careful consideration by those responsible for its oversight.

Discussion

The results of the survey show considerable concern among academic trainees as to how the integration of internal medicine into specialty curricula will affect their academic training, their clinical training and their future academic careers.

One possible 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 focussed communication to this specific group. For those already training in Internal Medicine (IM) the new curriculum does not mean a loss of recognition of all that has been undertaken to date or indeed that the extra requirements that may be perceived would result in an extension to training. It is anticipated that any new requirements should be implemented in a proportionate way compared to the remaining time of training.

The indicative training time overall in most specialties has not changed, apart from in neurology and cardiology where it has been extended by a year. However, for traditional group 1 specialties there will no longer be the option of dropping internal medicine and for new group 1 specialties there will be additional competencies required to meet the internal medicine requirements. 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 or will leave academic training and this should be explored in more detail. As the curricula are competency based there is the possibility of accelerating clinical training, however, for Clinical Lecturers who have 50% of training time in research this would require achieving all competencies for two specialties in 2 years equivalent (2.5 years for neurology and cardiology) as well as academic commitments to maintain parity with clinical colleagues.

This survey specifically targeted those academic trainees in Integrated Academic Training. There are however a large number of medical trainees who are currently out of programme in research who will be considering an academic pathway and the views of this cohort have not been included in this study but will be valuable in planning future changes to academic medicine training pathways.

Recommendations

Short term (4-6 months)

1. More needs to be done to establish an effective way of communicating changes with academic trainees and stakeholders involved in academic training including local training program directors.
2. 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).
3. Focus groups, facilitated by professionals experienced in focus groups, should be used to identify long term solutions with all stakeholders (academic trainees/GMC/RCP/NIHR/HEE).

4. Long term (12-24 months)

Should be guided by the outcomes of the focus groups. A flexible approach to training must be maintained where possible.

JRCPTB _ InterACT survey

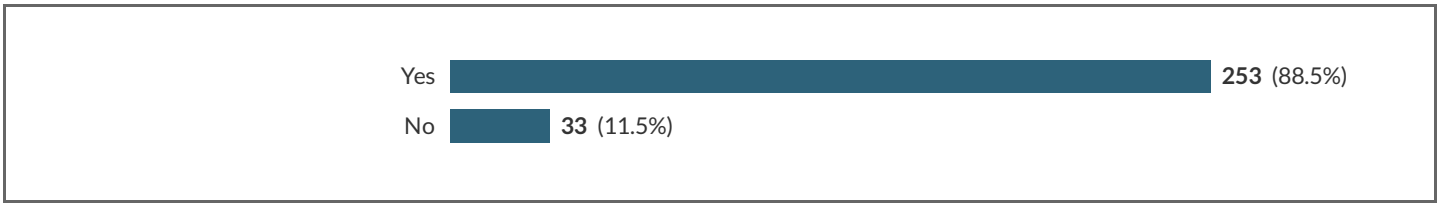
Showing 287 of 287 responses

Showing **all** responses

Hiding question **30**

Response rate: 287%

1 Are you a clinical academic trainee following a clinical training curriculum overseen by the Joint Royal Colleges of Physicians Training Board?



2 What is your age? (indicate if you prefer not to say)

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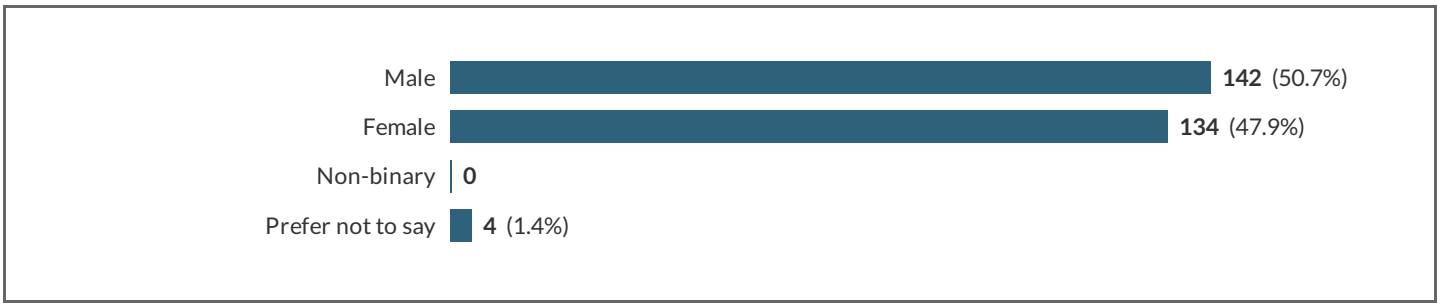
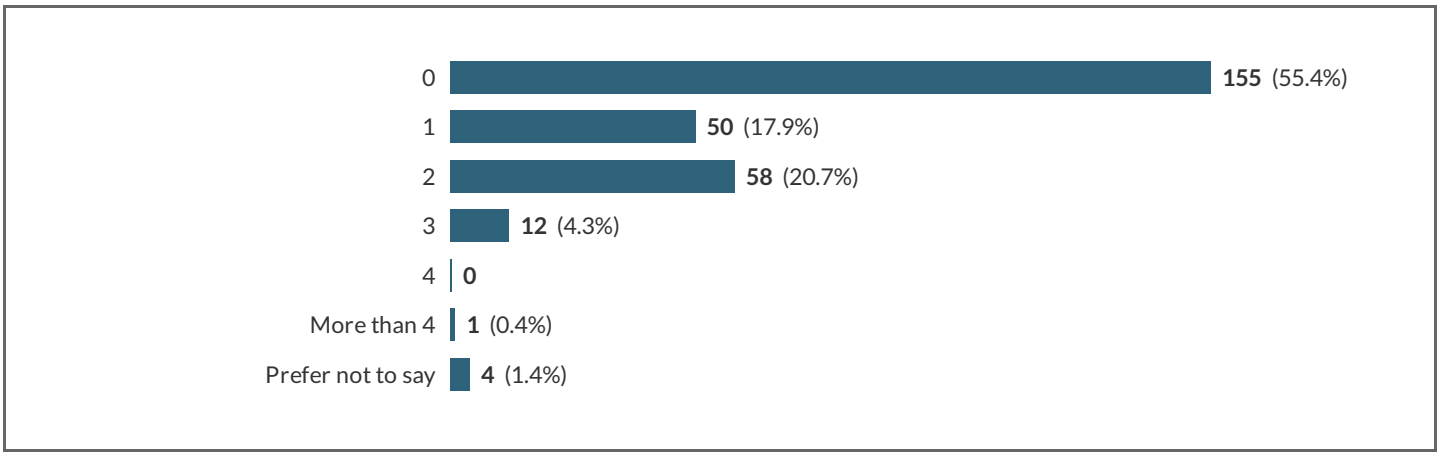
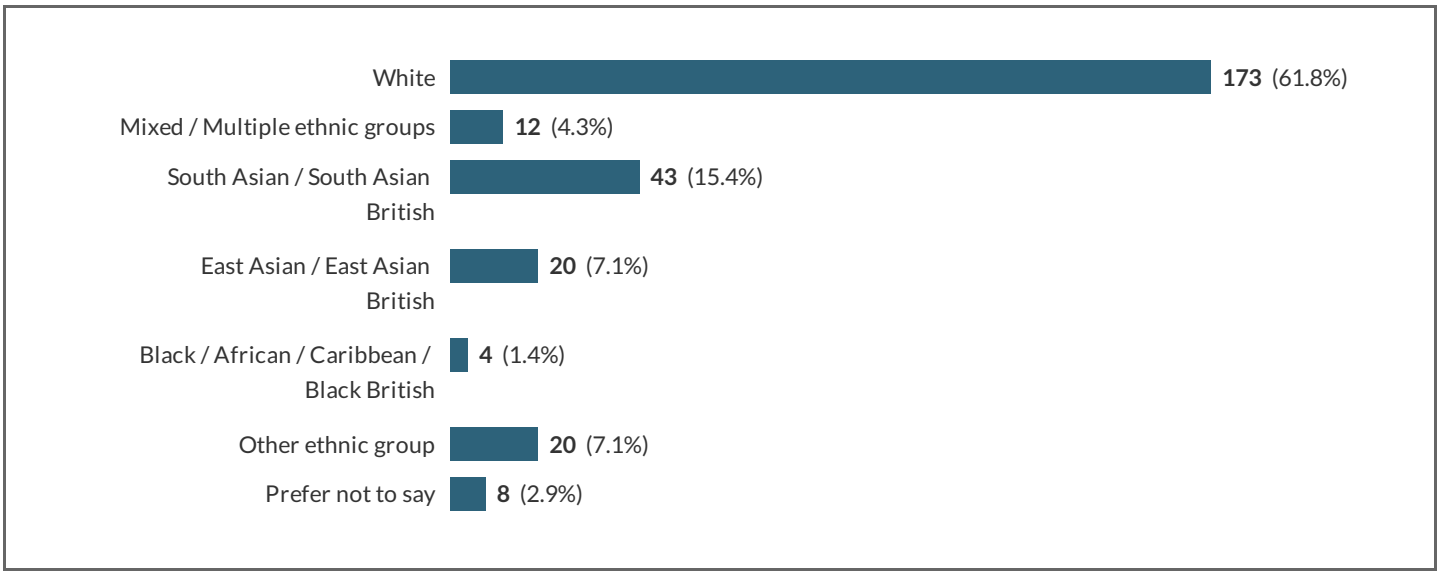
2.a What is your gender?



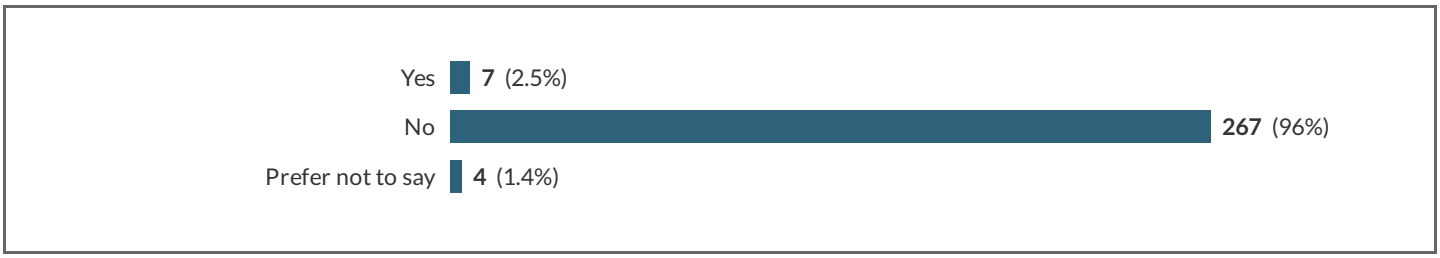
2.b How many dependents do you have?



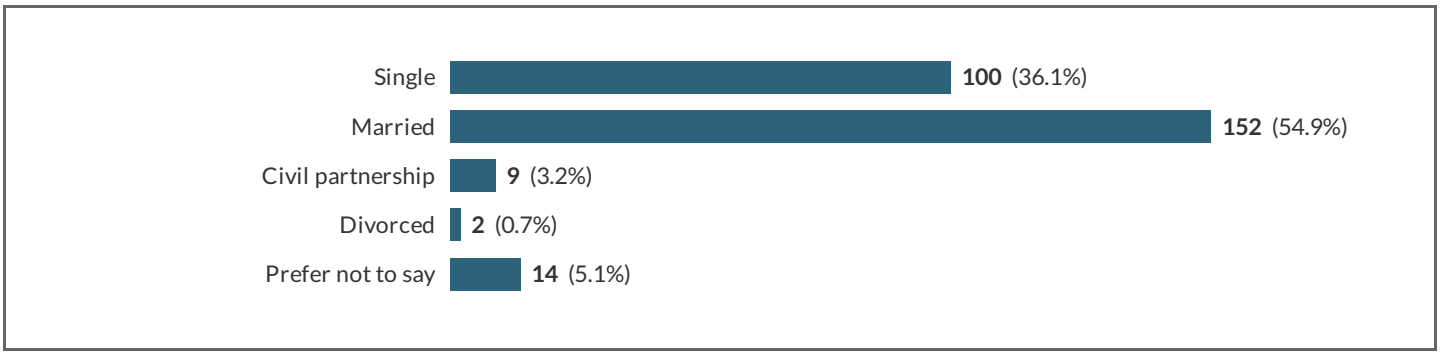
2.c What is your self-identified ethnicity?



3 Do you consider yourself disabled?



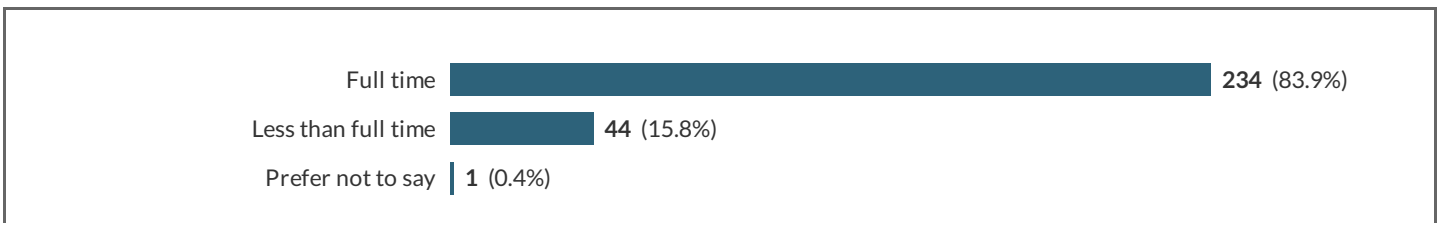
4 What is your marital status?



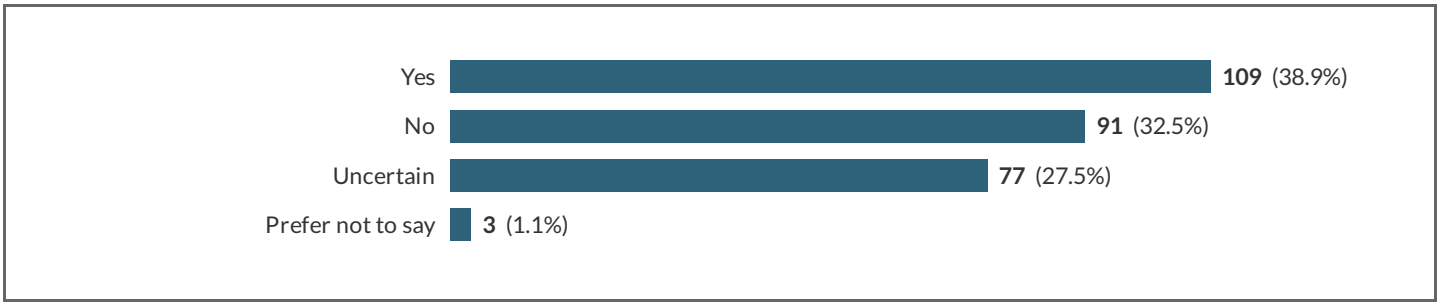
5 Have you previously taken parental leave?

6 Do you wish to declare any other protected characteristics?

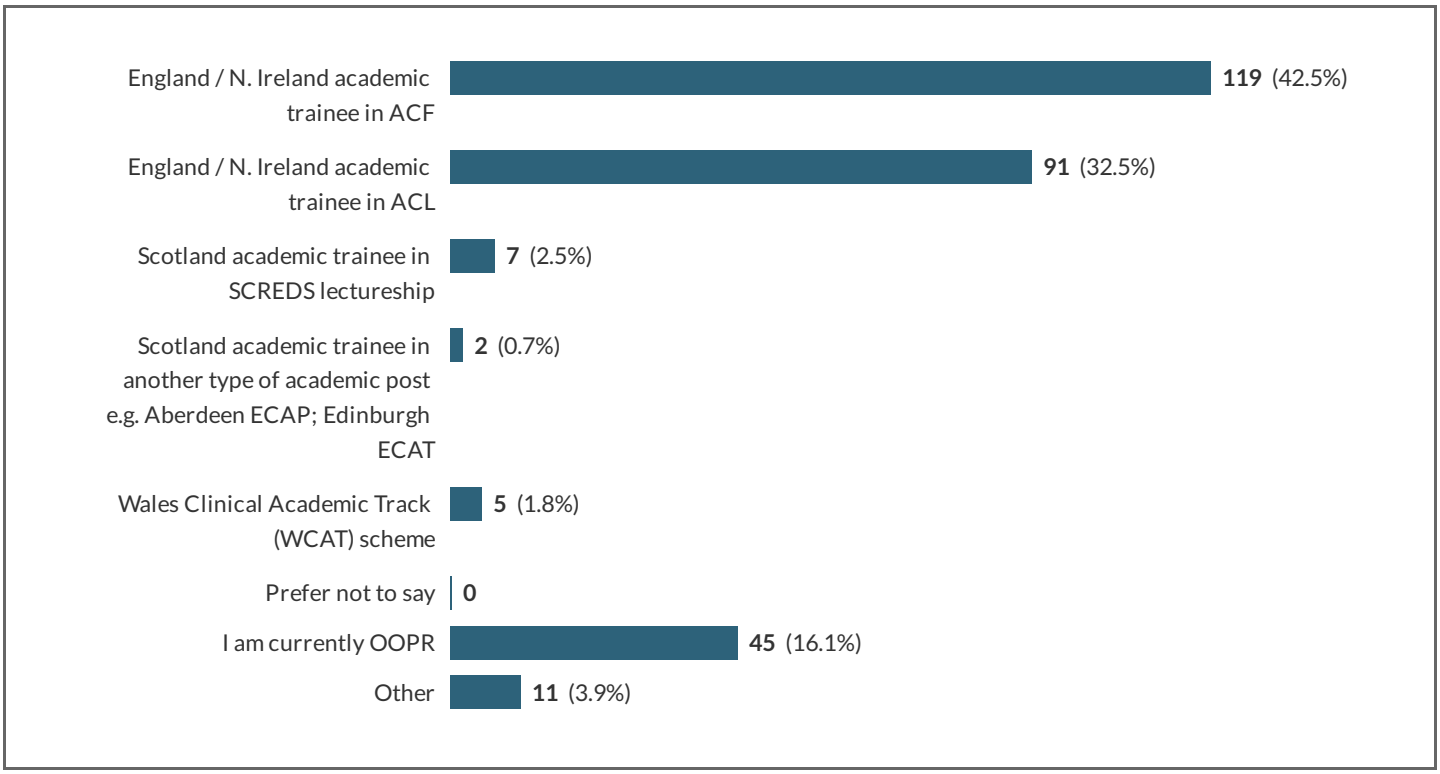
7 Do you work full time or less than full time (LTFT)?



8 Do you anticipate working LTFT at any stage in your training career?



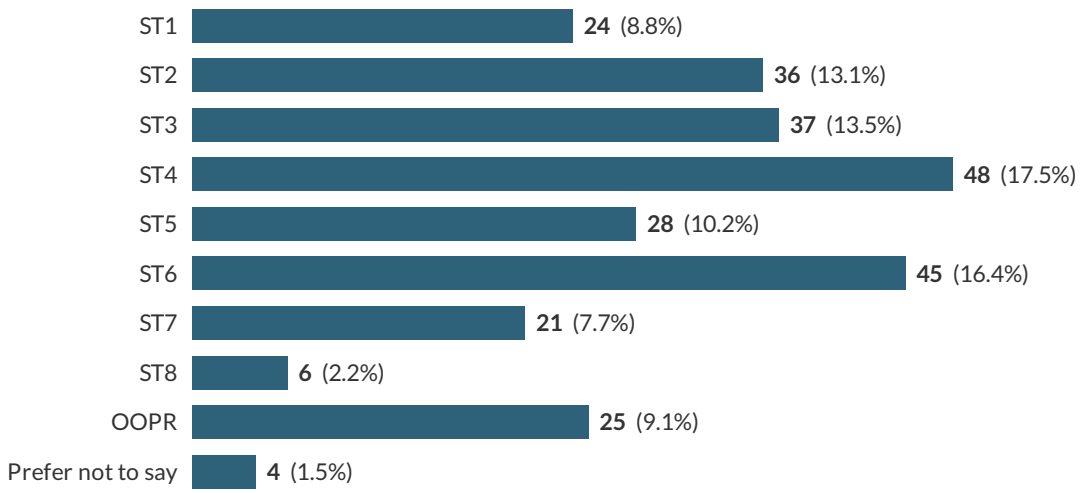
9 What is your career stage?



9.a If 'other' please specify:

Showing all 11 responses	
Consultant with clinical research time award	
Post CCT fellow	
Post cct fellow	
GP completed training	
Newly appointed consultant	
OOPR - PhD fellowship	
Recently completed OOPR moving into a non-academic IMT post having changed specialties	
Non Academic trainee	
F2	
OOPP	
Academic F2	

10 In May 2022 what year of training were you in?



11 Which is your home Deanery?

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NiMDTA	
East Midlands North	
Northern Ireland	
West Midlands	
South East Scotland	
Scotland	
oxford	
Oxford	
Thames Valley	
Thames Valley Oxford	
Thames Valley	
SES	
South east scotland	
Thames Valley	
Northern	
South West Peninsula	
Wessex	
Wessex	
North East	
Yorkshire and Humber	
Yorkshire and Humber	
Yorkshire and Humber (South)	
Peninsula	
Peninsula	
London	
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Northwestern, Merseyside	
North West	
London	
North West	
KSS	

Yorkshire and Humber	
Kent, Surrey & Sussex	
Thames Valley	
Thames Valley	
Oxford	
Yorkshire and Humber	
Mersey	
North West	
London KSS	
North Central / North East London	
West Midlands	
East Midlands	
South London	
East midlands	
Health Education North West	
East Midlands (South)	
London	
Northern	
East Midlands	
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LNR	
Yorkshire and Humber	
London	
Oxford/ Thames Valley	
Yorkshire and The Humber	
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East Midlands	
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Mersey	
Cardiff & Vale	
East Midlands	
Northern	

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East of Scotland	
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Mersey (NW)	
Yorkshire	
London	
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West Yorkshire	
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Mersey	
Scotland	
NW London	
Wales	
London	
London	
KSS	

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London north east	
North East Thames	
West Midland	
West Midlands	
North central thames	
North West (Mersey)	
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West Midlands	
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Yorkshire and Humber
Peninsula
Scotland
North East Scotland
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East Midlands South
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East Midlands (South)

East Midlands (South)
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Yorkshire and the Humber
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Thames Valley
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EoE
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12 What is your current / intended medical specialty?

Showing all 278 responses
Neurology
Gastro but currently an IMT stage 3
Cardiology
Endocrinology and Diabetes
GASTROENTEROLOGY
Renal Medicine
Respiratory Medicine
Respiratory / GIM
Haematology
Medical Oncology
Neurology
cardiology
Infectious Diseases
Clinical genetics
Cardiology
Respiratory
Cardiology

Gastroenterology	
Clinical neurophysiology	
Diabetes and Endocrinology	
Neurology	
Respiratory and GIM	
Neurology	
Clinical Neurophysiology	
Cardiology	
Palliative care	
Cardiology	
Diabetes and Endocrinology	
Diabetes and Endocrinology	
Histopathology	
special care dentistry	
Cardiology	
Rheumatology	
Palliative Medicine	
Cardiology	
GIM / Geriatrics	
Palliative Medicine	
Genitourinary Medicine	
Renal Medicine	
Endocrinology and diabetes	
IMT -> Cardiology	
Cardiology	
Neurology	
Respiratory	
Restorative Dentistry	
Cardiology	
Cardiology	
Cardiology	
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Rheumatology	
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Clinical Oncology	
Renal Medicine	
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Respiratory Medicine/ GIM	
Dermatology	
Emergency Medicine	
Renal Medicine	
Medical Oncology	
Renal and GIM	
Nephrology	
Neurology	
Neurology	
Neurology	
Neurology	
Medical Oncology	
Cardiology	
Neurology	
Diabetes and Endocrinology	
Neurology	

Neurology
Gum hiv
Infection / Microbiology
Infectious Diseases/Microbiology
Infectious Diseases
Renal
Palliative Medicine
Palliative Medicine
Neurology
Neurology
Respiratory
Clinical oncology
Neurology
Neurology
Endocrinology and Diabetes
Anaesthetics
Neurology
Infectious Diseases with General Medicine
Neurology
Gastro/GIM
Neurology
Geriatric medicine
Clinical oncology
Cardiology
Respiratory
Acute medicine
Prefer not to say
ID/Micro
Diabetes & Endocrinology
Nephrology and transplant immunology
Renal
Paediatrics - metabolic bone
Gastroenterology/Hepatology

Gastroenterology/Hepatology
Renal
Haematology
Immunology
Neurology
palliative medicine
Neurology
Cardiology
respiratory
Diabetes and Endocrinology/ GIM
Medical oncology
Neurology
Neurology
Dentistry, Periodontology
General Practice
id/gim
Neurology
Radiology
Respiratory
Histopathology
Respiratory
Medical Oncology
Neurology
Renal
Emergency medicine
Endocrinology and Diabetes
Gastroenterology
Medical oncology
Haematology
anaesthesia
Cardiology
Cardiology
Cardiology
Infectious Diseases

Infectious Diseases	
Respiratory	
Neurology	
Neurology	
Neurology	
Infectious diseases and virology	
Cardiology	
Neurosurgery	
Endocrinology & Diabetes Mellitus	
Cardiology	
Geriatrics	
Rheumatology	
Infectious Disease/Medical Microbiology	
Renal	
Gastroenterology	
ID/Microbiology	
Cardiology	
Gen med now, haem specialty	
Diabetes and Endocrinology	
Respiratory Medicine	
Gastroenterology	
Diabetes and Endo	
Medical Oncology	
Renal/GIM	
Renal	
Medical Oncology	
Geriatrics	
Oral Surgery	
Current: Neurology. Intended switch to a group 2 specialty given unfortunate addition of Neurology to group 1 specialties.	
Infectious diseases	
Gastroenterology	
Respiratory Medicine	
Endocrinology and Diabtes	

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Neurology
Gastroenterology
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Paediatric Nephrology
Infectious Diseases - Microbiology
Renal
Infectious Diseases/Microbiology
Gastroenterology
Infectious Diseases
Neurosurgery
Medical Oncology
Chemical Pathology
medical oncology
Respiratory Medicine
Neurology
Palliative Medicine
Medical Oncology
Neurology
Cardiology
General Surgery
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Neurology
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Renal/GIM
Renal/GIM
Geriatric Medicine
Respiratory

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Gastroenterology
Cardiology
Hepatology
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Paediatrics
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Obstetrics and Gynecology
Plastic Surgery
Ophthalmology
Renal
Obstetrics & Gynaecology
Rheumatology / GIM
Cardiology
Respiratory
Dental
Endocrine and Diabetes
Rheumatology
Gastroenterology
CSRH
Renal Medicine
Neurology
Neurology
Neurology
Neurology
IMT/Clinical Pharmacology & Therapeutics
Cardiology
Neurology
Neurology
Dermatology
Neurology
Rheumatology
Endocrinology
Psychiatry

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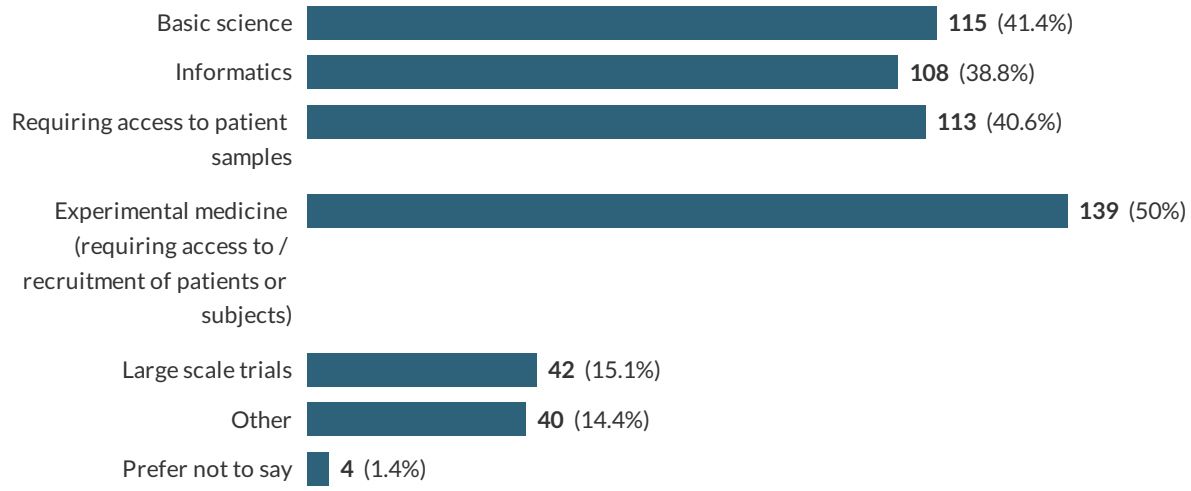
Cardiology	
Paediatrics (current), Paediatric Cardiology (intended)	
Endocrinology and Diabetes	
Clinical Pharmacology	
Gastroenterology	
Psychiatry	
Geriatrics	
Rheumatology	
Psychiatry	
Neurology	
Cardiology	
Respiratory	
O&G	
Neurology	
Medical Oncology	
Cardiology	
Respiratory medicine	
Medical Oncology	
Respiratory + GIM	
Medical Oncology	
Geriatric Medicine	
Intensive Care/Respiratory Dual	
Renal Medicine	
Haematology	
Infectious diseases with GIM	
Rheumatology	
endocrinology	
Rheum	
Rheumatology/General (Internal) Medicine	
Cardiology	
Rheumatology	

13 Is this a group 1 specialty? [Acute Internal Medicine, Cardiology, Clinical Pharmacology & Therapeutics, Endocrinology & Diabetes Mellitus, Gastroenterology, Genitourinary Medicine, Geriatric Medicine, Infectious Diseases (except when dual with Medical Microbiology or Virology), Neurology, Palliative Medicine, Renal Medicine, Respiratory Medicine, Rheumatology and Tropical Medicine (except when dual with Medical Microbiology or Virology).]

Multi answer: Percentage of respondents who selected each answer option (e.g. 100% would represent that all this question's respondents chose that option)

14 What is the nature of your research? (please tick all that apply)



Multi answer: Percentage of respondents who selected each answer option (e.g. 100% would represent that all this question's respondents chose that option)

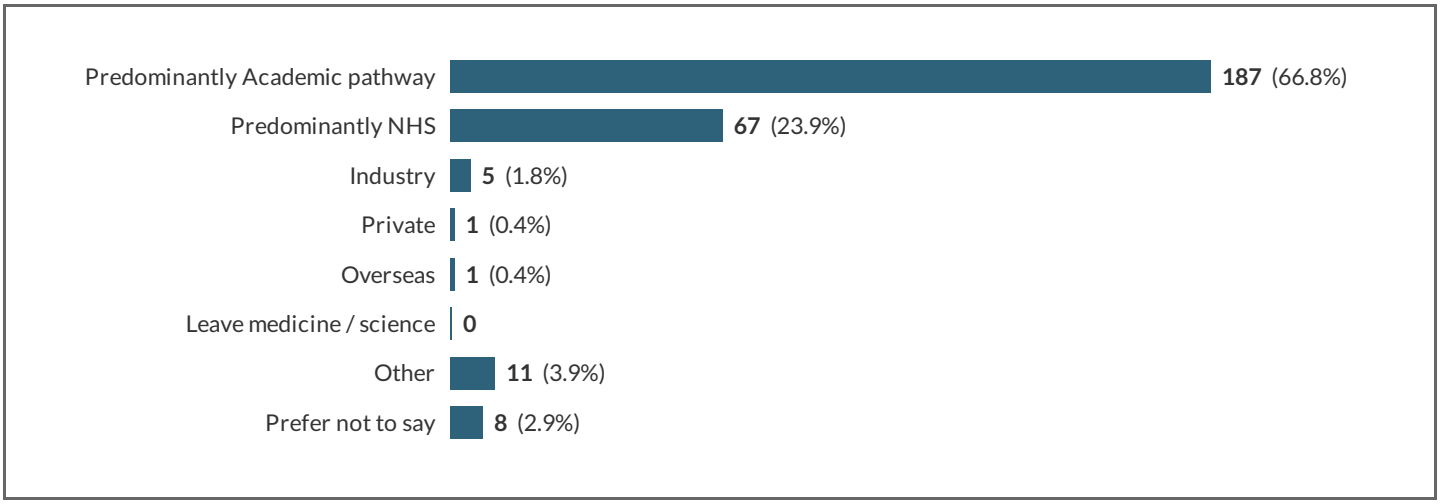
14.a If 'other' please specify:

Showing all 40 responses	
Qualitative, pilot work	
Qualitative research with healthcare professionals	
Systematic reviews, observational studies	
Mixed methods	
Qualitative research	
Implementation Research	
Big data	

Big data	
Machine learning artificial intelligence	
qualitative and mixed methods research in addition to translational	
Observational research on real-patient data	
Big data epidemiology/ real world data Medical statistics	
computational/simulation	
Epidemiology / health services research	
Biomarkers	
Qualitative research, systematic review	
AI for endoscopy	
Epidemiology	
health services, mixed methods, qualitative research	
Translational/ Implementation research	
Epidemiology/observational/translational	
Clinical database	
Implementation Science	
Clinical research Health policy and public health Standards of care	
Epidemiology and qualitative currently. Will lake move to basic science and requiring access to patient samples	
Translational	
EDI	
Mixed methods focused on care homes	
public health	
epidemiology/data science	
Qualitative research - oral cancer	
Epidemiology	
Machine Learning	
Development and validation of diagnostic prediction and classification models - requiring patient access for recruitment, questionnaire completion	
Neuropathology	
Integration between primary and secondary care	
Medical Education Research	

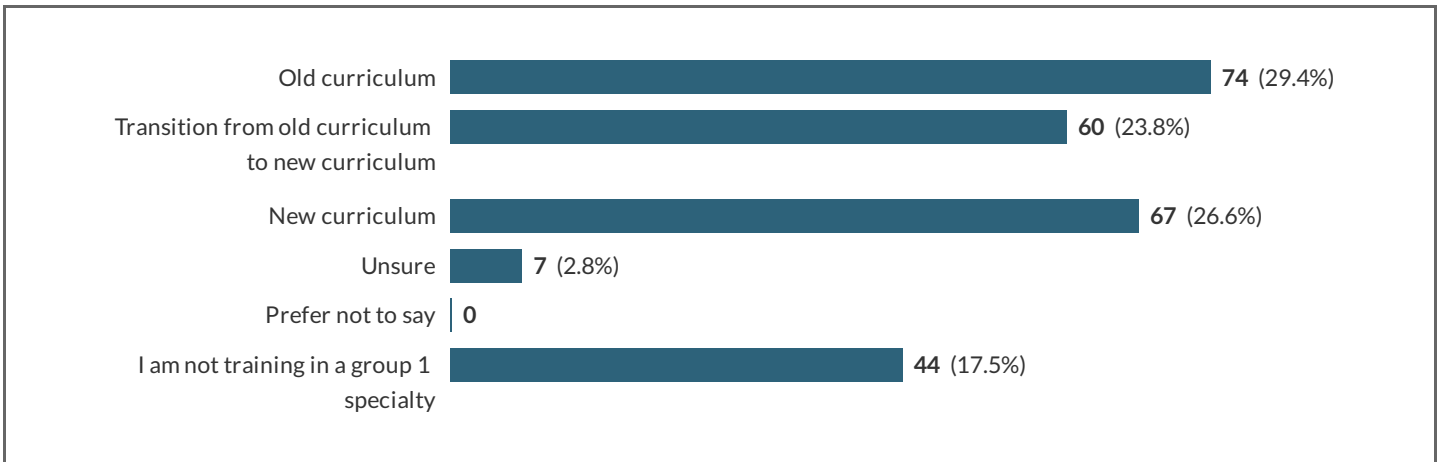
Medical education
Applied health services research
epidemiology
Epidemiology

15 What are your future career aspirations?

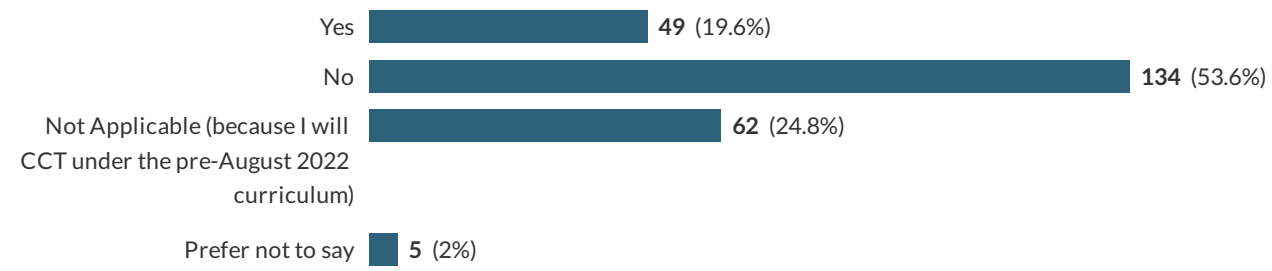


16 Before receiving this questionnaire were you well informed about the changes occurring in the physicianly curricula?

17 If you are training in a group 1 specialty will your route to CCT be under the:



18 Has the coupling together of Internal Medicine and specialty training in the new group 1 curricula impacted on your specialty choice?



18.a If you selected Yes, please indicate in what way:

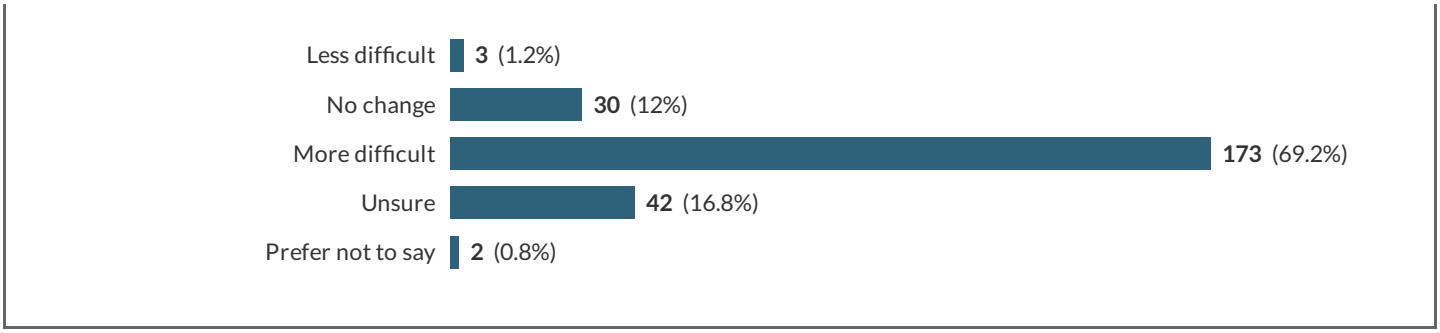
Showing all 46 responses	
I always did GIM but the new cirricula has added requirements which are not realistic for me to attain as I will have less than 20month training left in August 2022 and plan to finish early with competencies signed off. As I am half clinical (half academic) this means that I have less than 10mins clinical time to attain the new cirricula requirements. I just discussed this at arcp and am applying for an exemption to stay on the old cirricula.	
Note I started specialty training in Medical Oncology pre-Shape of Training, but it would have enhanced my selection of this specialty	
I was previously a rheumatology academic trainee, told that I would have to dual accredit with GIM and would not be able to drop general medicine as had been the case when I started training. This would have been completely impossible to combine with research, a young family and a husband with a significant on call burden also. I felt that the only way I could continue was to switch to a specialty that did not include GIM, hence I restarted training at as an ST3 in genetics	
Pushed me away from neurology and towards clinical neurophysiology	
I have continued to pursue a career in palliative care, however its place as a group one specialty very nearly made me stop and change to another path, such as GP or oncology. I remain unsure whether I will complete the training programme given the significant amount of time now required in GIM.	
I have now resigned by neurology ACF as a result of these changes.	
More requirements on GIM would inevitably prolong my training	
training will take longer and less time available for specialty specific competencies to be achieved.	
Previously considered Palliative Medicine but has also been affected by curriculum change	

curriculum change	
Following my return to training after OOPR, I will be strongly considering re-applying to a group 2 specialty.	
The lengthening of IMT was a strong detterant!	
I'm exhausted and don't need anymore hoops to jump through, the reality of the medical take is it's minimally supervised and therefore limited training actually occurs beyond service provision and learning on your feet.	
Considering dropping Academic component of programme as not feasible to maintain with GIM	
Yes I do not think it is reasonable/ feasible to try to train in and do (as well as also be good at) all three specialties (rheumatology, internal medicine, research). Ultimately the internal medicine will take priority (as that is what is most time/ effort consuming with the shift work etc) meaning we will not have time to develop the specialist skills required by our specialty and also progress in the academic field. I feel doing both specialty and academic medicine is challenging in itself but they complement each other as the research in often in the same field as the specialty. I do not feel the additional internal medicine training will add to anything not already gained from doing internal medicine in foundation years and core medical training (4 years). During core medical training, after obtaining MRCP, we had to step up as medical registrar and lead cardiac arrests, medical take, ward rounds etc. I aspire to be a clinical academic in my specialty. I do not intend to practice internal medicine as a Consultant. Therefore I am not sure why so much time and effort needs to be invested in this during my training at the expense of my specialty training and academic progression.	
Terrible decision.	
Having completed the vast majority of the GIM requirements on the old curriculum pre OOPR and maternity, the new curriculum will invalidate most of my prior training and potentially add years of training in new sites, require me to do work I am currently not contracted/paid for plus impact majorly on both speciality training time and academic progress. The curriculum disadvantages academics, females, anyone that takes parental leave or works LTFT.	
Prior to the new curriculum, I would have worked 9-5 with 20% protected research time & no oncalls, as single accreditation for nephrology alone. With the new curriculum, I have to do GIM oncalls and renal oncalls along with GIM training, meaning I have much less protected time for research and half the time to train in nephrology.	
Offputting because of balancing the demands of the acute take with an academic career	
For neurology trainees, internal medicine is integrated throughout the specialty training and also extended to ST8, previously ST7.	
It has made me think more deeply about continuing to ACL after my ACF post. I'm finding it difficult to understand if I will be able to complete both my cardiology, academic and then GIM requirements alongside doing a PhD in a reasonable acount of time	

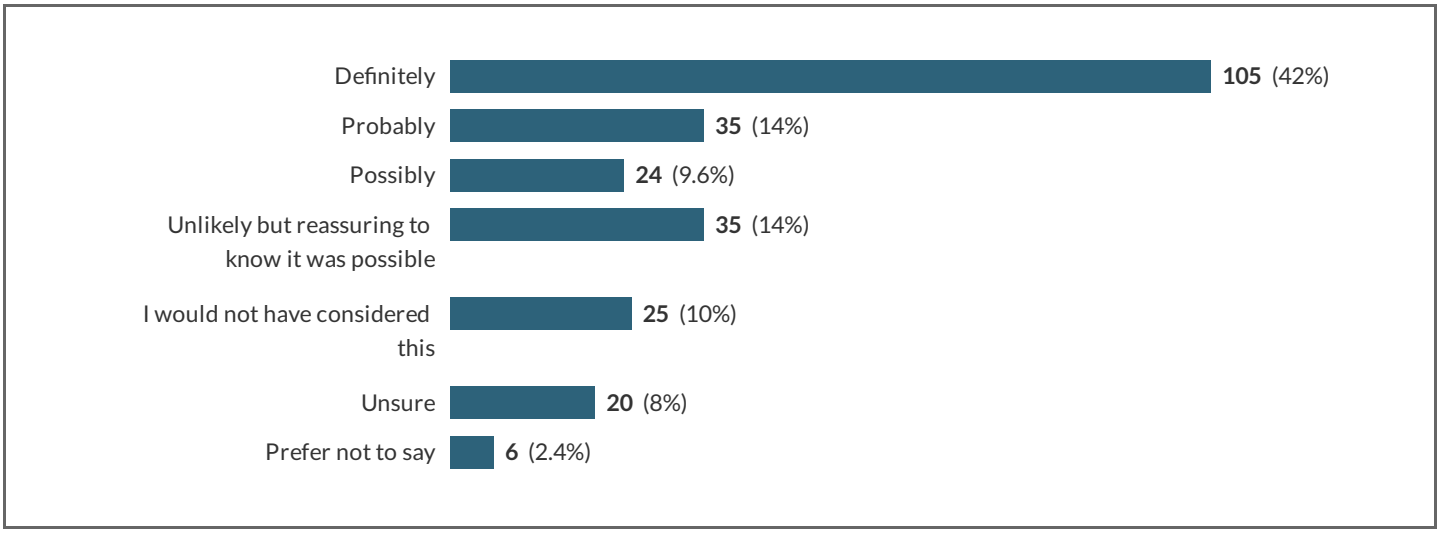
PhD in a reasonable aount of time.	
Difficult to know whether if I take time out for PhD I will need to transition to new curriculum, resulting in prolonged training. If this were to be the case would likely leave medicine.	
Medical oncology chosen to allow for balance between clinical and academic work. Focussed clinical care in area of interest to complement academic work.	
Applied without having another year out of training, as worried Haematology may also become group 1 at some point	
Difficult to balance GIM, cardiology and academic training (rota problems, reduced cardiology training time)	
Not really for me - but I disagreed with extending core medical training (or IMT now) to three years - feel this will put off medical trainees, and extend a period of training that already felt too long in the 2 year CMT programme.	
Not my specialty choice but the prospects of remaining in academic medicine are inifinitely more difficult with additional training in general medicine now made compulsory	
I already took a long training route (ACF in a related speciality, LTFT and mat leave x 2) and went through several curriculum changes. I eventually CCT'd (having delayed my fellowship application as the timing for applications did not align with my LTFT training times and eligibility) and decided to retrain in an allied specialty with mors stability. Choosing virology over gen med was very much a conscious decision based on both my clinical experience to date but also so that it wouldn't be impacted by these changes. I did, however, take a huge pay cut and am fortunate that my husband and I have been able to (just) afford for me to take time to undertake this PhD. My earnings will probably be over a decade behind my peers and academia is not financially renumerated when starting consultant posts. My husband feels strongly that I should leave both medicine and academia for a better paid profession!	
Forces general medicine onto Cardiology, lengthened training time by extra year, reduces training time for Cardiology procedures	
Because of the constraints of the new curriculum I have now dropped GIM and will single accredit.	
I will have less time in my speciality . Academic trainees should be provided to get more exposure to specialist areas rather than increasing internal medicine time.	
I had chosen my specialty prior to the new curriculum	
I think forcing Neurology trainees to dual train in Neurology and Internal Medicine is a very unfortunate decision. Imposing the same to ACF trainees is even more detrimental. I will regretfully be looking at discontinuing my current post (ACF in Neurology) because of these reasons, and I will consider a group 2 specialty.	
I was both interested in gen med training/knowledge but extremely concerned with impact on research career	

This question I'm not sure makes sense. I am already in a training programme so my specialty choice won't change	
The coupling of IM with GUM/HIV actively dissuaded me from pursuing this specialty.	
I was not keen on doing a Group 1 speciality anyway, but the thought of adding more GIM work has put me off more. This is why I am aiming for Chemical Pathology and Metabolic Medicine after IMT, although frustratingly they wouldn't accept my previous competencies in O&G so I have to start at CT1 again.	
I was considering leaving training as being medical reg was not something I ever thought I had to do. Suddenly I was forced to do it. my career plan completely changed.	
less time in a speciality	
I will be intending to re-apply later this year to histopathology training with the intention to CCT in neuropathology	
I do not want to - or feel it necessary - to dual train with internal medicine or stroke - given my narrow clinical and research interests (I intend to be primarily an academic)	
It's appalling to push academic trainees to do GIM - extremely difficult to find balance-*	
Please note that had it not been possible for me to remain on the old curriculum and therefore single accredit in Gastroenterology, I would have sought alternative employment. It would not have been possible to achieve my academic career potential when dual accrediting in GIM, without this having g a significant negative effect on my family and my own health.	
It was a negative factor, but it hasn't stopped me from choosing to pursue Neurology	
Note - 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.	
I am significantly less likely to pursue extensive respiratory practice after CCT, as I will be transitioning my main area to ICM. This is driven by being 'fiorced' into GIM as a component of training despite heavy resistance to this in 2018 when consultations were held.	
It is literally impossible to excel in all three disciplines - academic, rheum and GIM. Rheum training is already inferior to continetal Europe where there is little/no GIM. 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.	

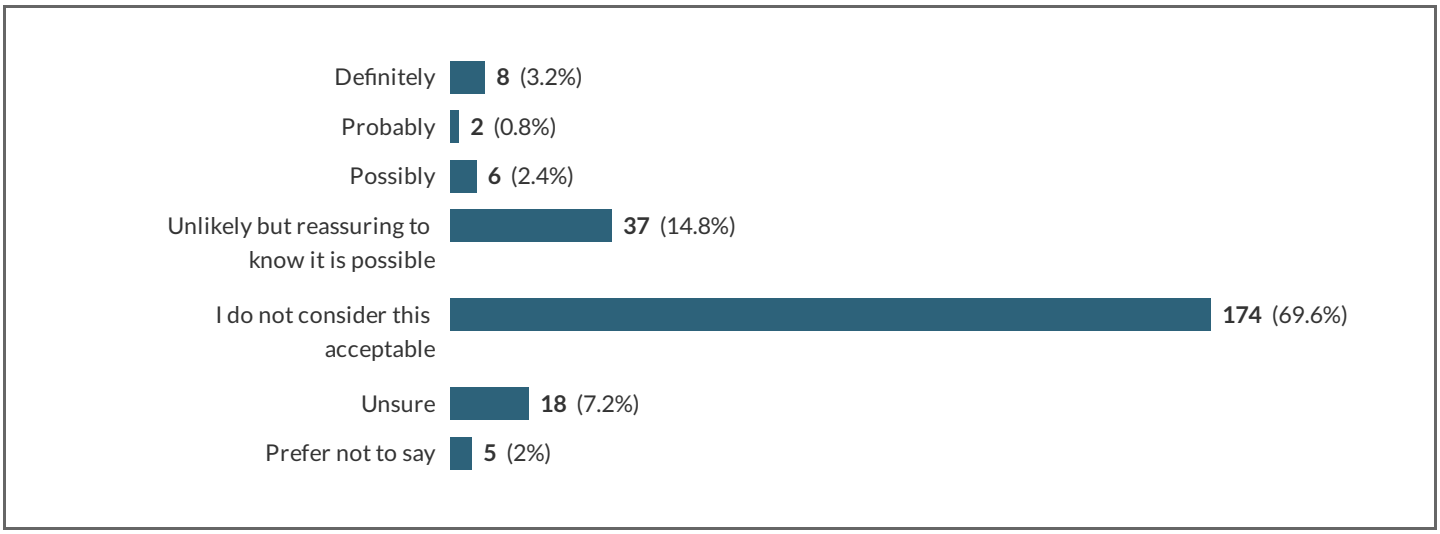
19 How do you think the coupling together of Internal Medicine and specialty training in the new Group 1 curricula will impact on / would have impacted on your academic progression?



20 Under the current specialty curriculum (pre-August 2022) how likely would you have been to drop accreditation in GIM to maximise academic progression?

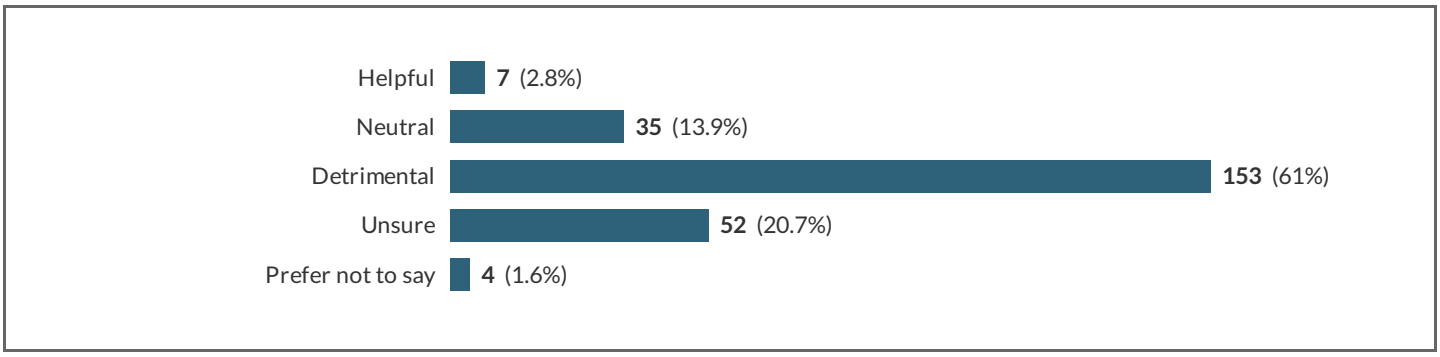


21 Under the new specialty curriculum how likely are you / would you be to drop specialty training, thereby single accrediting in Internal Medicine, to speed up / maximise academic progression to CCT?

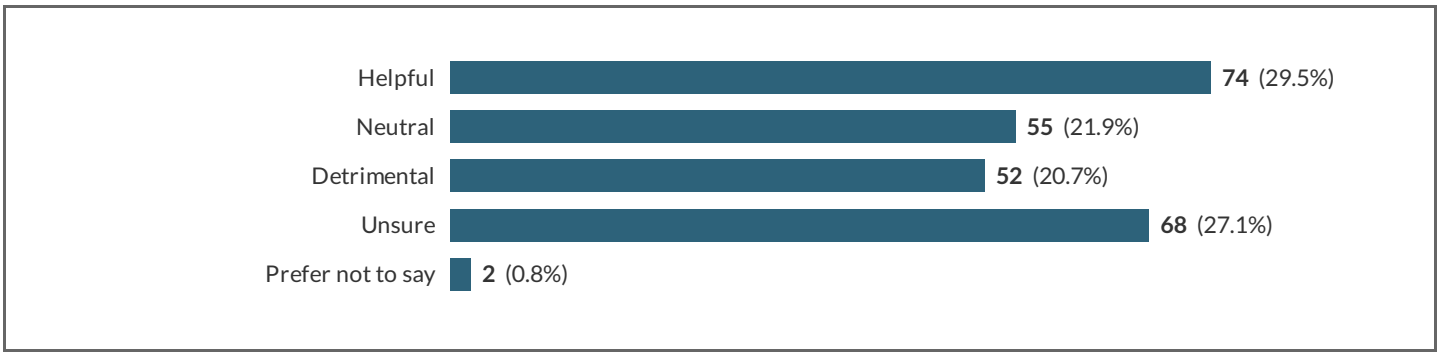


22 Under the new specialty curriculum what will be / would be the likely impact of Internal Medicine

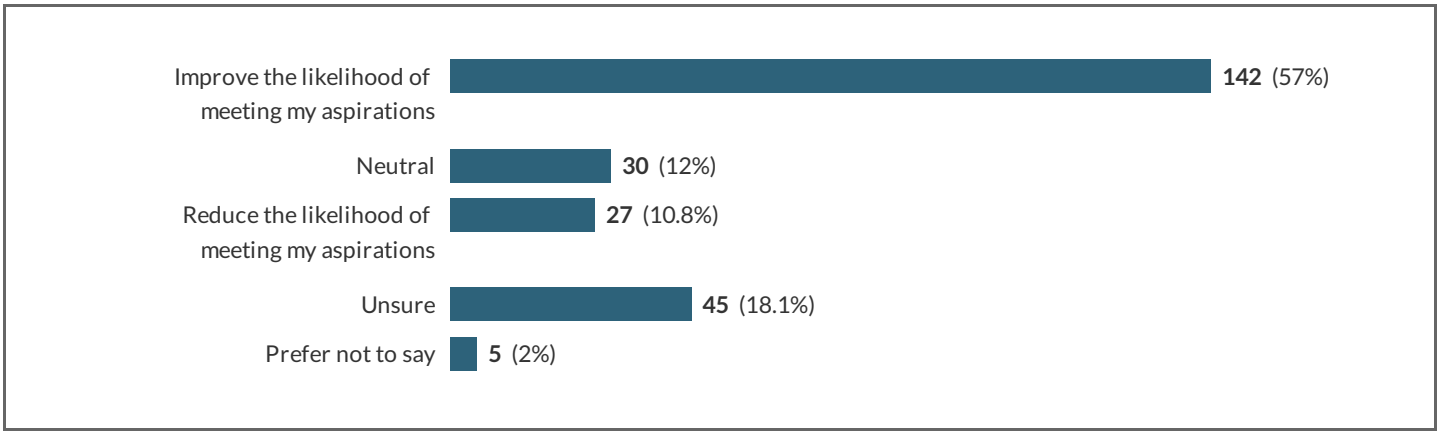
training for your academic progression?



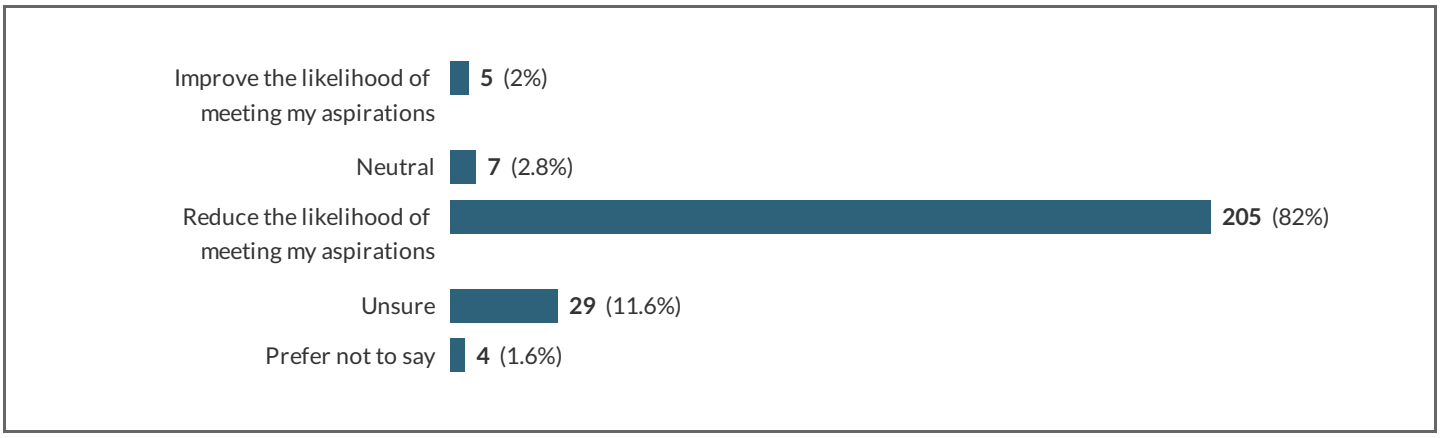
23 Under the new specialty curriculum what will be / would be the likely impact of specialty training for your academic progression?



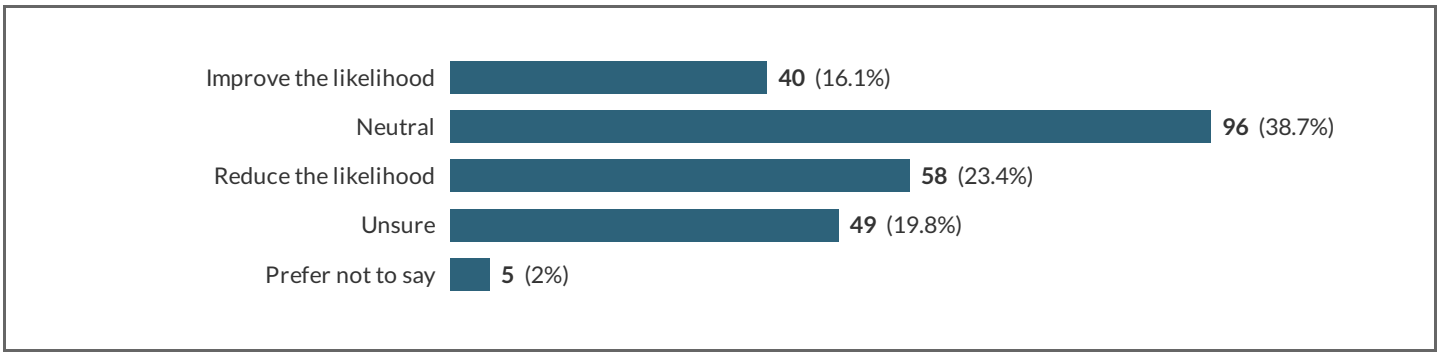
24 Under the current specialty curriculum (pre-August 2022) what impact do you think dropping GIM training would be / have been on your likelihood of achieving your career aspirations?



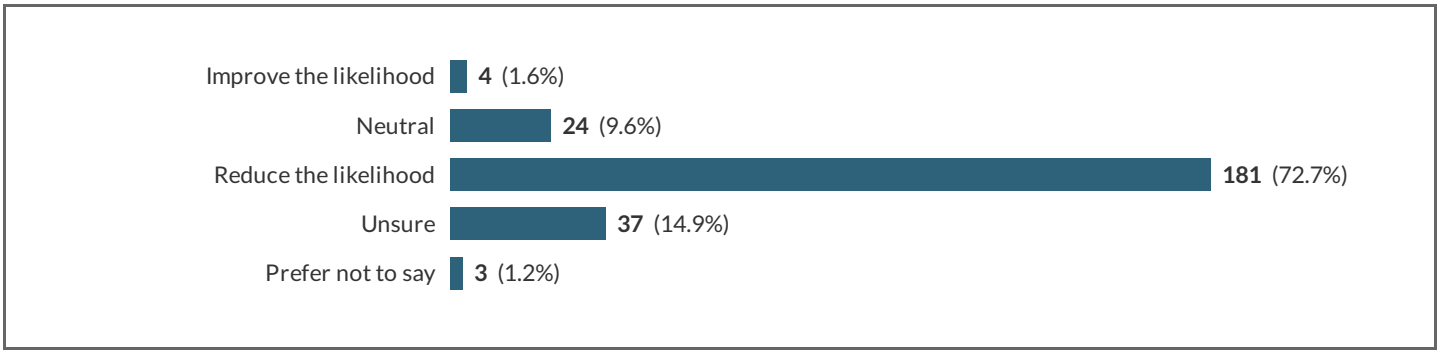
25 Under the new curriculum what impact do you think dropping specialty training would have on your likelihood of achieving your career aspirations?



26 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?



27 Under the new curriculum what impact do you think dropping specialty training would have on your likelihood of achieving an NHS consultant post?



28 Will / would your career aspirations be affected by the changing curriculum?

28.a If you selected 'Yes', please explain how:

Showing all 91 responses	
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.	
They already have been-I changed from a group 1 to a group 2 specialty in August 2021 to be able to balance clinical medicine, a family and research. This would have been impossible alongside general internal medicine, which at the time that I started training I was allowed to drop, but was told that after my PhD and maternity leave, dropping GIM was no longer allowed. I would never have started training in a specialty that had compulsory GIM, knowing that this would be impossible alongside research. The new training fits fine for people who follow a linear career pathway, but significantly disadvantages those, particularly female academics, who spend a long time in training due to a combination of research, parental leave and LTFT. It seems that our views have not been considered in the new curriculum.	
Would consider leaving NHS trainig programme / follow CESR route or train abroad. Do not think it would be feasible to combine GIM/Neuro/academia and not willing to drop neuro or academia.	
I wouldn't pursue academic medicine. I would either drop clinical medicine and be an academic or drop academia and be a clinician. I don't think becoming a clinical academic and having a family life are compatible if you have to be a specialist, a generalist and an academic. Or it might be possible but you would not be at the standard you'd want to deliver for any of the categories.	
If significantly prolonging CCT due to delays because of academia I would consider stopping my academic route in order to finish. Being on a heavy on call rota with nights and weekend is tiring as age progresses and delays in training progression significantly impacts on work life balance	
Managing the requirements and competing priorities of an academic career in a chosen specialty are already extremely demanding. However the prospect of a career as an academic consultant in the specialty I am passionate about would be strong motivation. Adding the requirements of GIM makes the prospect of achieving all requirements very daunting,	

GIM makes the prospect of achieving all requirements very daunting, maybe impossible. Specifically for palliative care, this tends to attract doctors whose strengths are in softer communication skills/rapport/detailed and delicate patient conversations, and who do not thrive in the emergency settings of GIM. This is another barrier which I fear will prevent me from completing specialty joint training, as the task feel insurmountable. Similarly, I do not feel the skills gained in GIM are necessary to be a strong palliative care doctor. I would not be willing to drop academic or palliative care work as these are my passions. I worry about my next steps if I am unable to balance academic work with palliative care work and also GIM work.	
If I cannot successfully juggle academic + cardiology + GIM training, I would need to consider my options. Unfortunately, given the lack of job security that would accompany being an academic without a CCT, this would likely have to involve prioritising clinical training over academia.	
I have now accepted a Histopathology ST1 offer	
Delays CCT	
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.	
I planned on aiming to potentially dual train with ICU if that was an option by the time I returned to training post PhD but I will not be able to now if already dual training	
My career aspirations are to be an independent academic clinician, contributing to important research in the field of genitourinary medicine. Although I appreciate that internal medicine is likely to be helpful in practising medicine with an ageing population of people living with HIV, it is very unclear how one is expected to pass all the clinical competencies associated with HIV and GUM, as well as internal medicine, whilst also having the scope to produce meaningful academic output. Given that GUM is already a heavily under-subscribed specialty, which will likely be exacerbated by enforcement of dual accreditation with internal medicine, there will be an inevitable switch away from training towards service provision. As a result, I will be seriously consider whether GUM is a suitable specialty for me, and would consider re-applying to either a different group 2 specialty within medicine, or a non-medical specialty (e.g. GP, public health)	
Lengthening/increasing the burden of clinical training will ultimately reduce ability to develop skills that might i) pursue interests and ii) develop skills helpful for an academic career (or otherwise). Lengthening of training increases the ‘sunk cost’ and ‘outstanding cost’ of completing the training pathway- and therefore increases risk profile of taking time out of clinical training to develop	
I had never envisaged myself as a general internal medic but as an academic respiratory consultant alone.	
The requirement to dual accredit in GIM makes it much harder to also pursue an academic track.	

It will be harder to continue academic work alongside cardiology training with the increased GIM requirement.	
The uncertainty is the killer. In the event there are additional hoops to jump through I will drop it	
A great deal of time and energy will be dedicated to GIM commitments with the new curriculum. This will mean that I have less time and energy to dedicate to developing sub-specialist rheumatology skills and research activities, both vital to my application for an externally funded fellowship. I will have clinical (GIM) commitments to complete after my ACL finishes in 2026 - this will impact and delay my ability to transition into an academic position.	
It is already incredibly challenging to fulfil cardiology specialty training requirements as an academic trainee without dramatically lengthening the time in training. 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. It is evident that the new curriculum has not adequately considered the circumstances of clinical academic training.	
Likely to drop Academic component of training later on as not possible to accommodate in conjunction with GIM, whilst maintaining specialty training	
Increased difficulty in progressing from an academic and clinical point of view due to extra pressures of requiring CiPs etc. in general internal medicine.	
I have aspired and worked extremely hard to pursue a clinical academic career since medical school and have followed the NIHR clinical training pathway to date (intercalated MPhil at medical school, AFP, ACF, NIHR doctoral fellowship). 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 do not think it is feasible or reasonable for someone to be able to progress and complete all the required skills in all three fields especially if they have other commitments outside of work e.g., children etc. Therefore, 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. I am currently very concerned if I would be able to achieve my career aspiration of becoming a clinical academic in my field with the new curriculum. I am also not sure how I am going to achieve all the GIM competencies in the remaining two years of clinical training that I have, as well as also meeting my specialty and academic competencies. I personally feel this will either lead to failure (i.e., not achieving goal of becoming a clinical academic) or burnout. Also after I come back from my OOPR, I would have had >6 years away from doing GIM training. I think with such a big gap more support than what is already available from the deanery (e.g., return to work support	

etc) is needed as guidelines/ ways of working etc change a lot within 1 year let alone >6 years especially when you have been working in a completely different area.	
To do academic and clinical work in a speciality is difficult enough. Adding in GIM is too much and will make spread my expertise far too thin.	
More willing to explore other non-medical career avenues if dual accrediting becomes incompatible with my personal/work balance	
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.	
If I had to dual accredit, I may have decided against speciality or against academia	
If forced to rotate far, do unacceptable hours, or increase my already long training time substantially I may well resign!	
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.	
Much more difficult to have an academic career if have to cover the acute take and well as a clinical speciality.	
Would consider Palliative care; but will never do a group 1 specialty (as I do not enjoy the culture and lifestyle associated with GIM)	
Reduced chance to become an expert sub specialist.	
Unlikely to proceed with training	
More likely to focus on academia to secure a consultant job	
I will need to complete my clinical training ASAP in order to avoid transitioning to the new curriculum, which impacts on my academic training time	
Absolutely no chance that enough people will be able to do speciality + GIM + academic. The last person out of UK academia should turn off the lights	
It would not have been possible for me to do higher specialty training in neurology and general medicine while also keeping my research going.	
Under the new curriculum, neurology trainees are expected to train in Neurology, GIM and Stroke medicine. This is like to reduce the opportunities available for academic training.	
Reduced neurology training meaning less time learning subspecialties relevant to academic career goals and less time doing what I enjoy and what I applied for this job to do.	
It would detract from ambitions to develop sub-specialty neurology expertise applicable to my academic ambitions	
Find it impossible to triple accredit in neurology, GIM and academia, whilst raising a future family + lack of pay restoration/loss of earnings whilst	

pursuing an academic career. It does not make financial sense to pursue a career in academic neurology, despite that being my aim	
As mentioned above once I complete my ACF I will have to think very carefully about whether I will take on an ACL role. I fear that with this and GIM training the whole process may take too long. I may have to try to pursure an academic career outside the career progression pathway which is very sad as I have done an AFP and am now an ACF.	
I think it's going to be much harder to stay in academic medicine...and if I'm not doing academic medicine, much harder to come up with convincing reasons to stay in clinical medicine vs a career in industry	
If had had to transition would have looked at leaving clinical medicine.	
This would make my current career pathway impossible - basic science has greatly increased in complexity and requires a significant time commitment, that is simply not achievable with dual accrediation.	
Unlikely to pursue medicine	
I think I would feel spread too thin and not able to do everything to my satisfaction. It would also impact on my family planning choices and any decisions to go LTFT.	
Juggling speciality training, academia and raising a family is already challenging. Adding in having to do GIM training as well would make this incredibly difficult. Even with the highest ambition and desire to follow academic training this change to the curriculum would make it incredibly difficult.	
Reduce specialist training time, increase GIM on call commitments against trying to progress academic work. In a landscape where more and more specialist input is being needed (model of European countries and America) moving towards specialist input to GiM take with their specialist knowledge rather than true general medics managing everything.	
More difficult to become expert in clinical and academic area of interest. Academic interest therefore likely to be deprioritised in order to fit in GIM clinical commitments.	
I will have to spend time collating training requirements in GIM that has no impact on my future practice especially if I want to train a craft area of my specialty (eg cardiology Intervention). It will be almost impossible to balance academic, GIM and craft specialty. It is almost certain that my future practice on CCT will never involve GIM anyway.	
I will return from OOPR in April 2024 having left programme in April 2021. I will have 2 years left of Cardiology training though received outcome 10.1 in my 2020 ARCP due to the pandemic. I retain a wish to dual accredit to be recognised as 'board certified' in both internal medicine and cardiology - i think this is a minority view but I have tended to look broader afield for where the overall employment opportunities may be in the years/ decades ahead, including at PI level/ industry/ system leadership level rather than singular NHS and clinical/ specialist focus. The lack of a dedicated 'personalised' route to CCT is worrying and excelling	

in one or more areas does not seem to be recognised as a way to counter-balance mandatory requirement in competencies which won't be practiced at consultant level in many workplaces e.g. level 3/4 echocardiography is not really needed by cardiology consultants unless they wish to specialise in imaging. Even with the CIPs, there appears to be a framework created to ensure a 'homogenised' and safe consultant workforce... how do we incentivise and reward excellence/ innovation? We are meant to be harnessing diversity of thought and experience? Anecdotally, newer gen of medics who have drive/ entrepreneurial spirit etc are increasingly leaving medicine as the training is too long with less autonomy/ more frequent hospital rotations and 'mercenary working' than in the past.	
The implications of dual accreditation in GIM is detrimental to both specialty training in neurology and academic progression. The neurology curriculum is already difficult to achieve within a 5 year programme due to the sheer breadth and the need to gain hands on experience in the clinic setting, which remains the key arena for management of neurologic disease. Waiting times to see a neurologist as an outpatient are already unacceptable and GIM dual accreditation will only worsen the service provision despite claims that more neurologists at the acute interface of hospital care will offer a reprieve of those wait times. This is a false economy as hospital admission prevention is fundamentally controlled by adequate and safe outpatient care. Further, for academic trainees, dual accreditation will mean it is insurmountable to obtain sufficient competencies for two curricula at 50% training capacity. I would have envisioned that the new curricula would have been detrimental due to the need to focus on additional ARCP requirements of two large dichotomous disciplines (acute inpatient vs outpatient predominant specialty). This would ultimately have meant I would have quit neurology to escape GIM dual accreditation and would have transitioned to a group 2 specialty, this would have been with the motivation to gain adequate protected research time as research remains a key passion and is integral to my career plans.	
Training is unnecessarily prolonged. Trainees are forced to practice in jobs with high on call commitments and no relevance to career aspirations. It which significantly reduces time spent progressing academically and within specialty of academic interest.	
Makes it harder to commit to speciality and lengthens training - makes me more likely to consider committing to solely NHS or academic work, or considering something in the industry instead.	
I think it makes me consider whether the current academic clinical training programme is the best route for me to develop as the academic and clinician I aspire to be.	
Likely to drop Academic Training later to accommodate GIM & specialty training as otherwise does not seem feasible	
Because of the restrictions of the new curriculum (removing flexibility to	

single-accredit at a later date) I have had to drop GIM now, and this will mean that I am no longer eligible to apply for CL posts.	
I will have to consider additional fellowship years to add to my specialist training. This will impact my future career choices.	
Less academic time	
As an academic renal trainee hoping to work in a specialist renal centre - GIM would not be necessary. Now however I will have to duel accredit (will be in training for longer as a result) - the caveat to this is that even at specialist renal centre new job plans require renal physician to work in acute medical units so the likelihood of obtaining a job with single accreditation only would be debatable.	
I now feel forced to offer general service provision due to lack of trained clinicians for this purpose. I feel that sacrificing 2 years of Neurology training for general medicine is not fair. More generally, these changes are likely to have a negative impact on recruitment to Group 1 specialties. A lot of my colleagues are reconsidering their choice of specialty because of the very unfortunate forcing of general medicine into the training.	
I would actively avoid dual accreditation in IM. I think the increasing move to force clinicians to dual accredit in GIM is driven entirely by service provision needs and is ultimately accelerating trainee burnout.	
Duel crediting in internal medicine would vastly decrease the availability for achieving academic outputs, specialty-specific competencies and increase the risk of burnout. It also impacts the value of UK academic medicine on the world stage by further diluting opportunities in favour of blanket service provision.	
As above, I don't feel a Group 1 speciality is an option for me given the onerous GIM requirements.	
I am staying on the old curriculum. I would have significant reservation about transitioning and dual accrediting so late in my speciality training, particularly in a speciality (GIM) for which I have no say/ choice over. Future job prospects will remain uncertain, particularly if competing for hospital jobs with those whom, in future, will be dual accredited.	
Academic training will be extremely challenging/impossible under the new curriculum	
I have a huge issue with the new curriculum. I am a cardiology ACF appointed in August 2018. As I was an ACF I was posted to a tertiary cardiology centre ST3 to current and therefore made to work a speciality cardiology rota. In view of this, I didn’t work on a GIM rota. I was told by the GIM TPD that if I wanted to CCT in GIM I would need to EXTEND MY TRAINING BY 3 YEARS to meet the criteria. With the prospect of this and the require subspeciality 2 yrs of cardiology training I have left, I felt forced to drop GIM. If this new curriculum mess continues I will not continue with my aspirations to be a cardiology consultant and clinical academic. I will leave medicine. This new curriculum has caused me so much upset, stress and distress.	
It means pursuing an academic career becomes impossible, unless perhaps it’s in gen med which would be very limiting, and not the purpose of me pursuing an academic career! The new curriculum particularly penalises parents (esp women) who will need additional time out of training for	

parents (esp women) who will need additional time out of training for parental leave (having a family v being a Doctor shouldn't be considered a 'choice' although I know this view remains popular amongst people in charge of our future)	
It is not possible to become a clinical academic in a specialty without being a clinical expert in that specialty. It is not possible to be a clinical expert in a specialty and a clinical academic in a specialty while also training in general medicine. Out of hours and in-depth specialty work is crucial to specialty training. This is true of most specialties to some extent but vastly more true of Cardiology than most specialties. Being a clinical academic in a specialty but carrying out clinical work only in general medicine is so obviously a ridiculously and grossly problematic and detrimental situation for all parties and stakeholders except those only interested in service provision of general medicine at the exclusion of all other benefits.	
Mandatory dual accreditation with GIM would mean reducing my training time in cardiology and academia. It is already extremely challenging to reach consultant level competency in a procedural specialty whilst maintaining academic career progression. Accreditation in GIM necessarily reduces the available training time.	
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	
I have always wanted to do academic neurology and possibly to research abroad. With the addition of gim I feel like master of non and going out will prolong the training even longer. It has already added 2 years. So I will try to hurry through the program as fast as possible not enjoying the next 5years/8years so I can drop the gim component as fast as possible.	
Academia no longer attractive	
it is possible that by forcing us to do GIM I may consider leaving NHS work all together	
Making GIM mandatory extends the overall time in training for an academic trainee, who would have taken time out at several points in their career (e.g. intercalation, OOPR +/- extras) to pursue academia. The prospect of this taking even longer made the career pathway unappealing, and encouraged me to think of alternatives.	
I will be intending to leave GIM/Neurology in order to pursue academic medicine in neuropathology	
I may have to reconsider neurology, and instead pursue a group 2 specialty - unfortunately	
I expect acute/internal medicine will be incorporated into consultant neurologist contracts	
difficult to achieve academic aspirations	
If I had to do GIM I would have reconsidered my career choices.	
I will be at least 43 when I complete training (3 maternity leave, LTFT work, PhD, Lectureship). I often wonder if it is all worth it and I think that the	

PhD, Lectureship). I often wonder if it is all worth it and I think that the addition of more general medicine could well have tip my decisions away from this already challenging career path. Luckily I will remain on the old curriculum!	
I would have been less likely to follow an academic career	
I would not have applied for a CL post.	
If I have to train in Neurology and GIM alongside the academic pathway I will seriously consider leaving the UK to train in North America.	
The new curriculum encouraged me to apply for a group 2 specialty and to avoid dual accreditation.	
Cardiology is the only medical speciality with competencies that require us attending ×2 lab sessions and 1×echo session a week. No other medical speciality has these many time consuming skills to achieve, while doing 60% GIM. Meaning its harder for me take much study leave as they all come out my cardiology time. My study leave ends up taken up during research. Even attending GIM clinics comes out of my cardiology time. It is hard enough to find time to attend cardiology clinics let alone GIM. I think academic trainees should have more support - on the chart showing time split between GIM/cardiology we only need to do 30% GIM in ST3, ST4 - but I am doing more than 60% given that my annual leave, study leave and training days come out of cardiology training time and not GIM. So at the least higher powers should consider imposing those percentages locally for academic trainnees. Or an alternative strategy would be that if I achieve my GIM competencies earlier, I should be allowed to drop GIM time in following years once I have been signed off for the curriculum. Furthermore, if we have achieved DOPS in CMT years, we shouldnt need 2 DOPS again - what is the point of getting those competencies I CMT if they do not count for training. Again getting 100 CPD hours all come out of my cardiology training - even though its a GIM competency.	
Will not be able progress in my academic career	
More likely to leave NHS due to onerous nature of transition process having already committed significant time to the "old curriculum"	
The new curriculum will introduce a mandatory service aspect via GIM which will only serve to lengthen non-academic, non-specialty training, and will decrease academic productivity.	
I have multiple grants and >80 publications and was on track for a successful clinical academic career. Truth is I'm currently exploring leaving for industry.	
As a trainee who is on OOPR to do a PhD with an eventual aim to obtain a clincal 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. I am left with the uneviable position of having to do all three of my speciality, research and G(I)M which will prolong the time it takes for me to CCT, take away from my research time, and postpone my ability to become an independent researcher, or drop my speciality (which is my main interest and is connected to my research interest) and CCT in G(I)M alone in order to facilitate time for my research.	

29 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?

Showing all 137 responses	
I think this will lead to women leaving academia. I think it will lead to people from diverse backgrounds leaving academia because they cannot afford to remain on a trainee salary for a much longer time period. I think many trainees will not even consider pursuing an academic career. A possible way of facilitating successful academic training would be to consider academic plus specialty training as dual accreditation. I.e. academic training does not involve triple training.	
Very disruptive. I have been in speciality training since 2011 & had enough changes to contend with on the eportfolio. I will miss being able to stay on the old curriculum by 2 weeks fte but effectively 5 weeks as am 40% clinical & they fact I don't CCT until 2025 means my programme director won't consider letting me appeal, althoguh again this is just 1 yr 2 weeks fte. I already got for weeks without certain speciality clinics / endoscopy due to being 40% FTE clinical and any disruption to this current model due to the need to do entra GIM will be detrimental. Ultimately we are just being spread too thin across academia / speciliaty training / GIM and it is tiring having to keep catching up with the moving goal posts all the time when you had met the requirements that were set at that time.	
This new cirricula definitely makes clinical academic training more difficult, particularly for those near the end of their training.	
Note these questions are largely not applicable to me as I am in a group 2 specialty.	
I am not mandated to transfer and elected to avoid this as I felt achieving clinical competence in GIM, neurology and stroke, whilst maintaining my academic career would be very difficult.	
It's crazy and I feel for the new guys coming through. It's not possible to be on top of your game in the basic science wet lab in the morning, then on top of your game in the cardiac catheter lab in the afternoon, then on top of your game in the medical take that evening.	
Specialty time is already precious for academic trainees in Scotland who agree to 20%+ academic sessions in lieu of clinical work, without extending CCT date. The majority of specialist trainees in craft specialties already require a post CCT fellowship to reach the required standard for consultancy. I have real concerns that GIM commitments particularly in the latter years of training will compromise specialty competence and academic trainees will be more vulnerable to this.	
We have had almost no information on the new curriculum	
I feel I am less likely to take time out of training at the end of IMT2 when traditionally many ACFs paused training to do a PhD after CT2. End of IMT2/CT2 no longer feels like a natural place to take a break and means applying for PhDs will be more challenging during IMT3 when I will have	

less academic time to prepare any applications and will be adjusting to the role as a registrar.	
I am not transitioning to the new curriculum.	
There is inflexibility already in clinical training and its impact on academic careers. I have finished my ACL early due to lack of ACL post availablility post CCT	
With new curriculum there is one year less of clinical training in the chosen specialty - combined with 25%-50% reduction in clinical time as ACF/CL I was told that it would not be possible to achieve competences without prolonging training, making the ACF not much different to time out of training (where time spent in academia automatically means adding this time to clinical training)	
I don’t think we have been given sufficient time to plan to add in IMT as well as complete academic training. We have been told it will extend CCT despite all requirements that the new curriculum should not extend CCT. I feel research is being discounted as an important area of interest and to force everyone to pursue IMT will significantly restrict academic training capability. I would prefer to be given the option to drop IM to pursue an academic career.	
I do feel that the significant additional requirements of an academic career need to be acknowledged. I personally feel that the option to reduce or drop the GIM component of training would be appropriate for academic trainees, in order to ensure they are able to progress without negative impact on either their wellbeing, clinical competence, or academic progress by spreading them to thinly.	
My overriding ambition is to be an academic interventional cardiologist. I have had a clinical and academic focus in this area for the last 10 years. Academia + interventional cardiology might just be possible but academia + interventional cardiology + GIM feels like too much to master. I worry that by having to try and juggle all three, I will become a mediocre academic, mediocre cardiologist and mediocre IM physician. If I cannot drop GIM, I may therefore need to discontinue the academic track to at least achieve a partial goal. Obviously, without clinical accreditation I cannot reliably proceed in any aspect of my career so would have to sadly prioritise this over academia, which would be a great shame given the time and effort (6 years out of clinical training) I have put into this so far. I quite strongly feel that as academic trainees we already have a challenge keeping up with everything and this may be the straw that breaks the camel's back.	
I have now abandoned my intention to become an academic neurologist as a result of these changes. It seems to be an effort to get everyone to do GIM/the acute take as much as possible.	
It will be much harder for trainees to juggle academic work alongside clinical commitments	
I feel that it will take me longer to achieve the academic and clinical specialty training I need.	
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. Respect for academic time needs to be upheld from both GIM and	

Respect for academic time needs to be upheld from both GIM and speciality training with solid guidance on time proportions.	
Unfortunately, my perception of the introduction of the new internal medicine stage 2 curricula is that it is more focussed on having more medical registrars to fill rota gaps, than it is on actually improving training. Individuals flourish when they have more choices, not less. In GUM, if some posts were dual-accredited and some were not, you would allow flexibility for trainees to choose what they want. Unfortunately, lack of choice will simply drive people away. For academic clinical training to be facilitated, the best option would be for mandatory dual accreditation to be stopped. Without that, the best that can be done is to strictly ring-fence academic time and provide more support for academic clinical trainees.	
Hard from me to give a wholistic opinion here as I don't know much about the stage 2 curriculum changes. But to offer some general thoughts: mandating that trainees spend time training in areas towards which they are relatively less enthusiastic comes at a cost to developing in areas of interest or strength (both clinical and academic). This would be generally detrimental for nurturing, attracting and retaining academic interests - and in my view should be left to trainee preference. The UK clinical training pathway is extremely lengthy, hence extra-curricular development is implicitly discouraged by way of high pathway cost (particularly when factoring in time for academic training, family, parental duties etc). In general, actions that permit faster progression through clinical years are likely to improve opportunity to develop academic skills - and this might be most effectively achieved by shortening of the more junior 'SHO' years where training opportunities are more limited. With regards to IMT Stage 1 - which I recognise is a little out of scope of this question - I am sorry to disclose that I feel that IMT (stage 1) is a largely inadequate clinical training programme. The lengthening of IMT - reflecting in total lengthening of training for Cardiology and Neurology - is, in my view, a step in the wrong direction. It may be that replacing the IMT2 year with a role better aligned to that of IMT3 might offer better clinical training opportunities and therefore improve academic training opportunities.	
In neurology, in tertiary academic centres neurologists do not even manage the entire spectrum of neurological disease - they subspecialise in stroke, movement disorders etc. Academic neurologists generally do less on call than their counterparts meaning they need less of a grasp on general neurology. Under the new curriculum though not only will we be expected to have the same knowledge of neurological disease but also a working knowledge of general medicine. It seems like encouraging neurologists to generalise in neurology rather than adding general internal medicine would have been useful. The time developing and maintaining competencies in general internal medicine will obviously negative impact my academic neurology training aspirations.	
I'm now much more likely to permanently move overseas	
The requirement to dual accredit in GIM makes it much harder to also pursue an academic track - there is less time to pursue academic activity, it is more difficult to achieve speciality competences (which was already difficult in cardiology), and it will lead to more time spent in DGHs and away from specialty centres	

away from specialty centres.	
I will likely leave academic training after out of program research period.	
The new changes are a complete disaster and have not been well thought through. It is yet another example of top-down reform which does not reflect the training requirements or aspirations of trainees. I expect that this will put off talented candidates from applying to Internal Medicine specialties and it will result in a work force shortage in the near future.	
Stifle	
Trainees in an ACL programme should not have to complete GIM competencies alongside their medical specialty and their research commitments. It is far more challenging to balance specialist clinical skills alongside research skills and GIM commitments. I suspect the requirement to complete GIM, specialty, and research activities discriminates against people who work LTFT, with disabilities, and who have caring responsibilities. The UK's clinical research training programme and translational research infrastructure is the envy of the world - this drive by medical bodies to put everyone onto the general medical rota will damage the current and future prospects of this infrastructure. The powers that be have an opportunity to allow clinical academics to focus on research, not general medicine - of course, some people claim that trainees will "choose academic medicine to get out of general medicine" - I can assure anyone that completing a PhD and securing external fellowships is not "the easy way out".	
I have dropped GIM for the sole purpose that it is not feasible to achieve my academic aspirations as well as my clinical specialty training in cardiology were I to continue with GIM.	
It is not possible to accommodate academic training, GIM and specialty training without a lot more extra time being required. I feel Academic trainees are required just as much as trainees who can do the general unselected medical take, and there should be 2 separate categories for the 2, otherwise many clinician scientists contributing to forefront research will unfortunately be lost	
I think that the new curriculum will be detrimental to cardiology training - and will make academic cardiology training almost impossible.	
The requirement to do GIM as well as specialty medicine will make the ability to combine academic (eg. as an ACL) and clinical work more difficult (especially when the speciality requires practical skills eg. cardiology). The new cardiology curriculum also no longer mentions academic cardiology within advanced training. Cardiology CCT now requires an extra year which will increase training even further, alongside academic training time.	
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.	
Introduction of the separate IMT3 year has delayed my plans to continue with my academic pathway, especially when I factor in wanting to take parental leave. I feel I need to complete IMT3 before starting a PhD so this has affected my	

plans for applications.	
As mentioned in my comment above, I feel the introduction of the new curriculum will have a detrimental impact on my career as a female BAME academic clinician who aspires to also have a family/ fulfilling life outside of work. I do not foresee how I will be able to progress in my academic field whilst having to do two other specialties (rheumatology and GIM) as well as also balancing caring responsibilities/ parenthood etc. I understand the importance of juggling but feel this is too much/ something will be compromised (e.g., my health, my well-being, my family life, my ability to pursue an academic career) at the expense to taking on additional GIM responsibilities. I am certain that I do not plan to practice GIM as a consultant so unsure why I need to invest so much additional time, energy and effort into it during my registrar training despite having already done and worked hard to do over 4 years of it during AFP and CMT training and achieved many/ most of the same competencies then. I do not think that the argument that doing GIM will help you manage other specialty conditions is necessarily valid. As a specialist consultant, if I encounter a patient with a problem from another specialty I will still always contact that specialty for advice/ refer to them for management even if I know what the management is because follow up/ monitoring etc needs to be done by them and guidance is always continually changing so may be different to what I was doing as a medical SpR during training. This is also the safest option for the patient. If clinical academic trainees who have shown clear commitment and progression in the academic field can remain on the old curriculum/ drop GIM that would help create more clinical academics especially helping those who are females/ have other caring responsibilities etc helping with widening participation in clinical academia making it a more fairer process for all etc.	
It’s just a terrible idea all round. There are no upsides for me only downsides and it has definitely made me reconsider where I work. I am a lot more likely to go abroad because of the changes.	
Delayed progression through academic training, less likely to achieve milestones such as grants and career progression, less likely to become a clinical academic as a consultant	
devastating	
It is detrimental - as GIM takes a LOT of time and does not contribute to furthering my academic objectives - it is not related at all. Neurology is very broad and overlap with GIM is minimal - so unless one's clinical & academic interest is in acute neurology - then simply there are too many horses to ride. I do not know nor have heard of a successful academic neurologist who also would also run acute medical take. Many therefore reassure me that it is unlikely I will be contracted to GIM hours as a consultant - but accrediting in something for years and then dropping it immediately upon qualifying is just madness. Possible solution would be accreditation in stroke as on-call contribution for neurologists, but guidance on this from ABN/ BASP is less than clear and I'm uncertain whether anyone has actually	

made any solid plans.	
It is a disaster to academic trainees. Less so if you are in a speciality where GIM is tightly aligned to your main speciality (eg: AIM, COTE), but not for crafty specialities like Cardiology. There is no way I will ever practice academia, interventional cardiology, general cardiology and find the time to do GIM. What a waste. I am lucky to have dropped GIM early on; but colleagues coming onto the training scheme are having to choose between academia or high calibre cardiology training, because GIM absorbs the majority of their time. 'Say no to GIM' - (if you are an academic trainee)	
Academic training should be protected and given the credit it deserves. Either acknowledgment via CCT in Academic Medicine and pay protection at consultant stage to account for loss of earning in extra time or no one will do research in the future. How many academics participate in acute unselected take or work purely in Internal Medicine at consultant grade to justify these changes?	
New curriculum requirements likely to mean changed onto more GIM on calls and lose speciality time and make it more difficult to complete academic time.	
This is absolutely detrimental to my career as a clinical academic & more so because in Wales we have even less protected research time than my counterparts in England. It's terrible that clinical academics have not been protected from these changes in any way.	
For academic neurology 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. I think this was a cynical move to improve staffing of general medical rotas and did not have training needs and improving the care of neurology patients at its heart. I believe academic trainees (and others) should have the option to single CCT in neurology only.	
The addition to IMT to neurology training will be very detrimental and will generate consultants not fully prepared to work in there parent speciality without taking significant extra training time.	
Negatively - much more difficult to have an academic career if have to cover the acute take and well as a clinical speciality.	
Reduced SpRs on rota as some will be on both stroke and medicine. Extra pressure to cover already stretched rota by academic trainees. Suspect it will reduce training opportunities. For those entering into the new curriculum, they will have 4 years to be an academic, learn the medicine curriculum and the entirety of the neurology curriculum. This does not seem feasible.	
. There is a worry that adding a third job (i.e. general medicine) to speciality and academic work will come to the detriment of academic productivity. Inevitably, there will be a reduction in the time available to acquire pilot data, develop robust research project, write successful grant applications and lead large research projects/trials. This may render the	

applications and lead large research projects/trials. This may render the new generation of UK-trained academics less competitive on an international scale and, ultimately, slow down scientific development. By forcing dual accreditation, doctors will not be given the opportunity to acquire a second CCT in a field of choice/more related to their own speciality training and academic research.	
This will adversely affect my colleagues in future. I will remain on the old curriculum without GIM trianing. I fear that this will be very damaging to translational clinical neuroscience in future. Without a clinical science pipeline to translate innovations our ability to advance medical care will be hampered. It raises a concern that talented would-be clinician scientists will not remainin the UK /within medicine if compelled to become general physicians at the ame time as becoming scientsits & expert neurologists.	
Already challenging as a trainee who has taken time out for parental leave as well as research to reach CCT (i.e. training prolonged) - addition of GIM competencies would make this incompatible with my personal circumstances - I would not be able to pursue academic training	
It has decimated trainee numbers in my specialty (GUM/HIV) and will likely lead to the eventual complete decline of HIV GUM as a speciality career which is hugely upsetting and will have a terrible impact for patients	
For academic trainees in later stages of training, there is now a need to complete training fast to avoid transitioning which which impact the academic pathway	
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. I also feel that the likelihood of additional out of hours on calls (acting as a medical registrar) will put more strain on the time I am able to dedicate to my academic career goals and research. In the future, post cct I aim to be employed as an academic and palliative medicine consultant, however again my concern is that palliative medicine consultant job plans will change, requiring additional out of hours and general medical on call work which will also negatively affect my academic career goals at this later stage.	
I have always aimed to dual CCT. However, if for any reason extra training time was added due to GIM I would have dropped it, as it would potentially delay me taking consultant posts and affect me being able to focus on securing an external fellowship after ACL. These changes clearly have huge potential to inadvertently affect academic progression by increasing trainees being forced to rotate away from tertiary centres where ongoing research projects may be based. It further is likely to separate trainees and academic mentors & advisors. It is unclear to me how forcing academic clinicians into GIM if they don't wish to pursue the specialty is in the best interests of either trainees or patients. It's also unclear why academic medicine is not counted as a specialty that	

you dual CCT in alongside specialty of choice (with option for accrediting in GIM too if circumstances allow & trainee wishes).	
I believe the introduction of GIM at Stage 2 will definitely have a negative impact on my academic training. Despite the new curriculum been capacity based, there is still set minimum criteria to fulfil per year. In addition, to keep up the clinical competencies to be a competent medical SpR, in addition to be a neurology SpR. I believe that academic neurology clinical trainees should be exempt from GIM training, to provide more protected integrated research time.	
It is not my desire to be a medical registrar as neurology is the specialty I have chosen and wish to work in. I fear we may be forced to take on GIM due to NHS demands to fill med SpR posts.	
I am fortunate in being able to opt out of the new curriculum, as I started ST3 in 2017. It is therefore unlikely to impact me as I will continue on the old curriculum.	
Please see above	
Context: part of a perfect storm of factors (Brexit/Horizon, UKRI funding, Wellcome funding reduced) that are going to make academic medicine incredibly difficult as a career. HEE are also moving training numbers outside of London, which makes it harder to train in places with superb research facilities. It feels like the UK is shooting itself in the foot. As well as harming healthcare provision, I think this will be to the detriment of the life sciences industry in the UK as well. Specifically - reduced training time in specialty, increased proportion of general medicine, longer training pathway, salary sacrifice of an academic career in the face of long term below inflation pay rises make this much more challenging than previously.	
If had had to transition would have looked at leaving clinical medicine. This survey is being done far too late, opinions and perceptions should have been sought prior to implementation!	
The transition from old to new curriculum for existing academic trainees is not very clear.	
The introduction of a new internal medicine training stage is a poor decision. It completely ignores the fact that many trainees do not want to do this, and are not suited to it. Medicine attracts individuals of all personality types and will all kinds of different aspirations. Some will thrive in acute medicine, others will not. Internal medicine will put off strong candidates for specialty and research careers and may be psychologically damaging to some. 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.	
Had I been required to switch to the new curriculum I don't see how it would have been feasible to essentially triple accredit in palliative medicine, GIM and academia. I have already lost clinical training in palliative medicine to academic time, and if I had to spend another 25% in GIM I wouldnt gain sufficient experience of anything to be an academic, specialist, or generalist.	
Specialty training + basic science lab work (including long hours in tissue culture for example) would no longer be possible to complete in the	

allocated training time. The increased sign off load and the greater rigidity of on call work will significantly eat into research time. The ability of clinician scientists to be able to gain sufficient experience to lead their field and compete with non-clinicians in areas of basic science research will be considerably eroded. Other than exemption from the GIM curriculum, there are no realistic solutions to perserve academic training at its current level of performance, unless the aim of the programme is to create clinicians that can be employed as helping hands by universities.	
It will make it more difficult for me to feel confident as an academic and a clinical specialist. I feel all my skills will be diluted, and my training time may be increased. If I ever chose to go LTFT, that would further exacerbate the problem. 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.	
A main reason for pursuing neurology has been my interest in a clinical academic career. If I had been obliged to also do GIM this would simply not have been feasible and I would have left medicine.	
Thankfully i started speciality training before being forced into GIM dual accreditation. It is hard to see how dual GIM training for a neurology SpR who also does acute stroke can benefit their academic career. The only exception would be if their research involves general internal medicine, which I imagine is quite rare. Speciality acumen will also be compromised by GIM training.	
The change will not alter my direction but will make meeting the curriculum goals more challenging. There is more evidence required for GIM, some of it retrospective. This will leave less time for academic work.	
I cannot see how single accrediting in GIM would enable a trainee to develop appropriate specialist experience to complement a specialist academic interest and patient recruitment etc required for a consultant level job / career. I found the JRCPTB meeting for trainee on new curriculum very dismissive of academic trainees and attitude of some presenters appeared to relish the additional difficulties being created for academic trainees. It was very disheartening as an academic trainee that would plan to dual accredit.	
As I'm in a group 2 specialty I don't think this will impact my career or training	
As previously mentioned this is a very poor change, with concerns on not meeting requirements as shown by our national survey for all clinical-only trainees (BJCA). This effect is absolutely compounded for dual academic trainees who are effectively being asked for 3 different qualification streams. Something will have to give. It is not possible. I suspect this will decrease the number of academics who have a high procedural requirement (eg intervention); which is already a problem. This is without even discussing the impact on currently disadvantaged groups (female trainees, parents, ethnic minorities, physically and mentally disabled). I am not qualified to speak about this but these individuals have told us that training pathway needs to be more accessible for them.	
1. I also feel there is a clear difference in transferrable skills gained between	

doing a basic sciences PhD and research versus doing applied health research/ trials/ health informatics. The skills gained in the latter fields are directly relevant to changing routine clinical care/ innovation and perhaps NIHR/ others should be funding more opportunities in the translational/ sharp end of clinical research which may be more cost-effective given scope for immediate patient benefits, rather than traditional basic sciences research where salary costs of clinicians are always higher than those without clinical backgrounds. 'Time taken out' to do research may be recognised differentially in training programmes/ sign offs if they have material difference in impact for patients or service design? 2. ARCP in absentia / ARCPs - not enough protected time for consultants or TPDs/ PGDs to really delve into the careers of the next generation. Instead just a quick 30mins or less to check against tick boxes and mandatory forms. Each higher trainee should have at least(!) 1 hour of face to face time per year at ARCP panel, which should be a tone of 'professional development and summative assessment' rather than just latter which can feel like an administrative exercise for both parties.	
I believe the new curricula will negatively impact on clinical academia for previously non-GIM disciplines due reduced capacity to subspecialise. Specific expertise of complex tertiary services will eventually suffer. It would seem critical that the Academic clinical training route be protected as much as possible from the negative impacts. This might include optional exemption from the on call rota during academic blocks, extension of NIHR or local funding periods above the 4 years previously allocated.	
I want to be a clinical academic, but as I am approaching the end of my ACL it is difficult to say which will be my major focus. I am still on the old curriculum so am unsure of the impact of the new one.	
It is very short sighted. If anything has been learnt from the past two years is that medicine cannot progress without excellent science. Most people would agree with this statement but what are the realities on the ground ? Academic trainees are payed less, forced to dual train, and opportunities to engage in research are reduced. If they want the same opportunities then their training must be prolonged. These conditions are a huge disincentive and it is no wonder many people either give up on research or leave the NHS altogether to join industry where they are better valued.	
It won't impact me directly but I fear for colleagues coming through the rigid system who will be even more constrained esp financially, than I have.	
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. I aspire to be excellent in the roles I fulfil, and by adding this additional responsibility to a specialist academic clinician, it feels like I will have to redistribute time from the specialist work I hope to delve deeply into, to ensuring I am a safe generalist internal medic as well - which is also a role with specialist skills and training, and so will require an	

which is also a role with specialist skills and training, and so will require an opportunity cost of developing as a specialist academic clinician, and instead ensuring I keep up the skills in order to be a safe generalist clinician.	
Likely to not pursue academia further due to difficulty in doing this in tandem with dual GIM & specialty training	
Too much expectation, needing to fulfill internal medicine training requirement, specialty training requirement and academic requirement. Doctors in Academic clinical training should be given an option to choose academic and specialty training over internal medicine training	
I feel it would extremely challenging for a trainee to maintain a Specialty and GIM portoflio alongside academic duties. This could severely impact on the quality of specialty training as well as the quality of research.	
The Internal medicine curriculum does not help with my academic training. I would rather have limited IMT in initial years and then focus on my specialist interests with academic training.	
I will not be doing IMT stage 2	
Not sure of changes made and what impact it will have on my last year of training when I return to NHS	
Academic training is time pressured. Balancing academic training with internal medicine and specialty training, alongside being less the full time with a family is particularly challenging. I used to love general medicine but now I find it the most stressful part of my job. I have a chronic mental health condition and aspects of the environment working in acute general medicine often trigger or exacerbate symptoms. I will be unlikely to have a general medicine aspect of my job in the consultancy posts I hope to apply for (tertiary centre specialist hepatology with an academic component). I think it is deeply unfair to force people to duel accredit for group 1 specialties - instead improve the working environment in acute general medicine to encourage us to want to continue to train and work across specialties.	
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.	
Less time fr academic committments and therefore less time to enable me to achieve my academic goals	
Some of the questions and answer selections are poorly constructed and therefore do not accurately reflect my opinions/experience. You have not provided an option for having a partner without a legal tie. The answer 'I do not consider this acceptable' implies judgement. There is no option that suggests this would be unsuitable/untenable option. There are no N/A options for trainees who will not be switching to the new curriculum. I have therefore had to make a judgement on something I haven't really considered because it doesn't affect me.	
My intention was to train as a clinical academic with a focus on Neurology.	

Regretfully, I am now reconsidering my specialty because of the lack of flexibility in the new curriculum. I think it would only be fair not to force trainees to dual train in their specialty and internal medicine. It is not useful for any of the parties involved to have people perform a job they do not want / enjoy. I think allowing people to choose whether they want to train in internal medicine as well as their chosen specialty would produce far better clinicians. One cannot expect a Neurology trainee who sacrificed 2 years of their training for internal medicine to be as good as a trainee who spent those 2 years doing Neurology. Offering the possibility for clinical academic trainees to do research instead of Internal Medicine would be a good alternative to the current lack of flexibility.	
It's very difficult to see how integrated clinical academic training can work alongside the new curricula. ACFs we're pulled from CMT previously. Very hard to see how one would become an ACL now - especially in Hepatology with competitive entry at ST5. We are financially punished for prolonged academic training and doing a PhD. There is no recognition of this time on negotiations of nodal point scales as a consultant. I think ACLs need to evolve to cover the last year of clinical training and the first year of consultant to double both. This would be a more realistic transition and enable independence whilst not hampering pay progression and associated average pension position with it	
Unfortunately this some of the options provided in this survey were not appropriate e.g. type of research and did not give opportunities to expand, therefore limiting the utility. I was very disappointed to hear (by the RCP president himself) that academic trainees are being encouraged to drop their specialty of choice and often academic interest in lieu of focusing on GIM and service provision, instead of alternative pathways e.g. LTFT, portfolio careers being encouraged. I think this shows short-sightedness from the RCP and significantly undermines the importance of translational research e.g. health policy and public health. Academic training routes with days away from clinical medicine continue to be perceived as shirking clinical responsibilities or detrimental to others without recognizing the potential benefits.	
I have avoided switch due to concern about impact on academic work	
Ongoing lack of prioritisation of procedural training in a procedure-based specialty.	
Will pose challenges in terms of balance of specialty, gim and academic commitments. Will extend training time which may have a knock on effect on career decisions given I am LTFT and on an academic pathway - I suspect will be very old before teaching CCT. There is also the uncertainty of how I will adequately gain GIM competencies as my ACF bases me in a hospital where I work on the renal on call rota. Moving to other hospitals to do GIM would certainly impact my ability to undertake my research activities	
Impact: It is likely difficult to use time OOPR to count towards training due to the shorter specialty training time. This would also make achieving (mandatory) GIM training requirements more difficult (ie. 5 non-specialty clinics per year, 3 months mandatory ITU time). This has made me re-consider the implications of taking up an ACL post	

This has made me re-consider the implications of taking up an ACL post and how that would affect me achieving these dual competencies on my return to training. Suggestion: 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. Most academic trainees will go on to be academic consultants, which very rarely, if not almost never, involve GIM in the job plan.	
I am not an expert on this because I am staying on the old curriculum but as I was dual registered with ID / GIM this would not have affected me. Furthermore I explicitly wanted to train in infection and general medicine for both my clinical and research aspirations.	
Duel crediting in internal medicine would vastly decrease the availability for achieving academic outputs, specialty-specific competencies and increase the risk of burnout. It also impacts the value of UK academic medicine on the world stage by further diluting opportunities in favour of blanket service provision.	
I appreciate that it suits the health system to have more doctors who have a general, broad-based skill set rather than highly specialised knowledge. However, apart from the fact the forcing people to do it is not a good idea, I think the needs of Academic trainees has not been considered. The training pathway once you take into account OOPR, lectureships and fellowships is already very long. If I continue in academia I am looking at 10 years+ from now and I've already been a doctor for 7 years. The broad-based generalist approach does not really work for academic clinicians, who already have a lot of things competing for their time. If I could do Diabetes & Endocrinology without GIM (or the GIM component was only 6-12 months) I would absolutely pursue this, but I cannot, so instead, Chemical Pathology & Metabolic Medicine is the closest I can get to specialised Diabetes practice that wouldn't include GIM. There is also all this talk about transferring competencies if you change specialities, but I have not found anyone to be receptive to that at all and I will end up doing more than everyone else because I got my speciality decision wrong first time round.	
I would not have applied for neurology training on the new curriculum, the appeal of this specialty to me was the specialty itself and the academic component that is encouraged. I actively dislike GIM associated work and would have picked another specialty where I could become a specialist / academic without having to train in GIM.	
I believe attempting to complete dual accreditation alongside academic training will be a significant burden for those in training, particularly if dependents are factored into this. I have particular concern for current colleagues early in their ST3 ACF whom are having to essentially triple accredit in palliative medicine, GIM and academia over a 4+ year (depending on negotiation) timeframe - this, to me, feels hard to achieve/ anybody to fulfil their potential in any of these areas. If also feels like I and colleagues have completed a number of surveys stating similar concerns in recent years without any clear evidence of an appropriate plan.	
Academic training will be extremely challenging/impossible under the new curriculum	

Being a clinical academic trainee has hampered any chance of progression to the new curriculum. I feel very upset and now wish I hadn't bothered doing an ACF.	
Clearly the new curriculum is a disaster for medical academia. After all the effort that's gone into improving the incorporation of academia in to training pathways (e.g. ACF, ACL etc) and the pandemic demonstrating what can be achieved when academia and research is imbedded within clinical practise, I really find it astonishing that the desire/need to force people to staff the medical take (which people have run away from due to chronic lack of investment/ pay/ staff shortages etc) has led to the wholesale binning of academic aspirations for the UK's medical workforce	
see above.	
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	
It is too much to do all of: neurology, stroke, GIM, academia. Neurology trainees have to do stroke as well as GIM under the new system. I do not think this is compatible with academic training too, unless the stroke and GIM are "token" rather than creating a consultant truly competent in all that.	
- not enough time do neurology/gim/stroke and academic competency in the limited time. I feel more unsafe as a doctor less productive as a researcher and more stressed individual with the addition of gim. Medical training in the UK is one of the longest in the world and prolonging it even further is no solution to under staffing problem. It feels like we are trying to save a sinking ship by throwing people at it from a well well functioning ship (neurology/accademic pathway) - results will be more staff stressed overwhelmed and leave NHS /research completely. To be honest myself and other acf are worried we won't cope with this many hats with minimum requirements for all of them each year with maintaining a family life.	
I think these cahnges have reduced the autonomy of academic trainees as now rather than having a choice at the point of applying for Intermediate fellwoships of dropping GIM it will be much harder to do so.	
Neither a barrier nor a facilitator to career or training. Doing Geriatric Medicine without GIM is risky and would limit future employment options based on the configuration of clinical services/models in Scotland so this wouldn't have been appealing. Whether or not I am successful academically, I want to be a geriatrician and thus would never dream of finishing without CCT-ing in my specialty. I think this would damage clinical academic credibility.	
I think this is absolutely detrimental to clinical-academics. The suggestions of dropping speciality of choice to facilitate academic progression is an outrage. I would not be competitive in my research if I did not train in my speciality of choice as this complements my research. I have gone into a competitive speciality run-through - not academic internal medicine! This needs to be sorted asap otherwise there will be a mass decline in good quality clinical-academics from the UK. I would consider moving abroad should this not change	
[illegible]	

The new internal medicine curriculum appears to have been designed to complement IMT training. It does not make sense to transfer trainees already on the old curriculum to a new one. This especially affects academic trainees, as if I had not gone OOPR, I would not be transitioning - yet this is not taken into account. It is additional work to do gap analysis and transition when we are likely to return as lecturers and have less clinical time already.	
Less time to do academic work in an already very hard profession juggling clinical and academic duties. We need protected time to do research and to do our speciality- where will we get the time to also do GIM?	
Doing GIM, specialty training and academia just adds more work - none of my senior clinical academic colleagues have done GIM, so I can't see how I can fit this in. Already the high on call requirements limit my academic opportunities.	
I think reducing the amount of time to train in your speciality combined with the time that academic training takes up will make progressing at the expected rage difficult and likely to impact on one aspect of training (academic/internal medicine/speciality)	
I am grateful to have been granted permission to remain on the old curriculum. Having extended my overall training by 6 years cumulatively to pursue academic interests (intercalation, ACF, OOPRs) even before the extension that comes with an ACL post, I had to actively consider the impact the loss of salary that accompanies delaying consultancy would have on myself and my immediate and extended family. The new currcicula makes the academic route one that favours those from financially well off backgrounds, by mandating extra time in training which can double in length in the context of an ACL post.	
The integration of clinical and academic training pathways is falling apart as 'training' altogether is compromised in the name of extracting more labour from trainees. The curriculum changes are another means of doing this. Until training positions are treated as predominantly about training future clinicians - and not propping up a failing health service - the UK will continue to fall further behind other nations in academic medicine. The JRCPTB has been complicit throughout in this process and the ongoing disdain with which it treats its trainees is a source of growing resentment within the medical trainee body	
It has definitely got a detrimental effect on my aspiration as an academic clinician. I agree general medicine training is an essential part for my specialty training, but academic trainees will suffer disproportionally because specialty training opportunities/time will be reduced yet GIM responsibility remains. Clinical progression for academic trainees will undoubtly be delayed with the new changes.	
It will limit my opportunities. I want to be primarily research based, and continue outpatient clinics in a niche neurology subspecialty (which is as far from acute medicine as one could imagine). These new changes are making me reconsider my career plans - which I had carefully considered since early medical school and have been severely disrupted by this curriculum change	
Maintaining internal medicine competencies will add pressure and limit	

neurology (/other speciality) and academic time - I suspect that in order to achieve competencies in all three areas the training pathway will be lengthened otherwise the quality of candidate will decrease	
I have followed an academic career path and am near consultant stage thus don't have to transition to the new curriculum. However, even following the current path I am 42 and have another year to be a consultant. I need to be trained in my speciality to be an academic consultant, but compared to colleagues training overseas the path to consultant level is already extremely long and the addition of dual training makes it even longer. I think this is particularly disadvantageous to women who wish to have a family who already struggle with the time off work for maternity leaves and LTFT working for childcare. It is clearly disadvantageous for the development of our Clinical Academic workforce and the status of the UK as an academic medicine leader.	
Should not make much impact especially if it becomes competency based as opposed to time based	
Listing the same variety of medical conditions in slightly different orders in yet more documents containing 10s to 100s of pages I'm sure has it uses. But all it seems to create is yet more click boxes for trainees without affecting what or how they learn. Re-arranging the boxes just creates busy work when we need to be getting on with either doing the work, doing research, or occasionally seeing family.	
Concern about moving goalposts - I will be coming out of programme at ST6 and plan to make this count. With transition to the new curriculum I will likely need to spend longer post out of programme to CCT. It creates an element of uncertainty and extra pressure just prior to starting an OOPR. I'm not sure what the solution is other than to ensure supervisors are clued up and can have sensible discussions focussing on CIPs etc that need to be met and for the new curriculum to acknowledge the skills/experience that research gives and this is beneficial to clinical work	
I have been granted approval by the PostGrad Dean to remain on the old curriculum. But this approval was sought on grounds of living with a chronic progressive health condition. Despite doing very well during my PhD, with a first author paper in Nature Medicine and several other papers, as well as all the other things we have to do to become competitive, not only against other physician scientists and pure scientists (in the UK and beyond), I could not use my academic career goals to justify the need to remain on the current curriculum to single accredit in Gastroenterology. What is really difficult is that I started my ACF at the same time as two male colleagues also recruited to ACF posts in Gastroenterology, both of whom have 2 children (like me). They are both approaching CCT such that they automatically stay on the old curriculum, whilst I did not... simply because for my two children I had to pause my training whilst for them, their wives did. You see, there is no equity here. The decision on who remains on the old curriculum should be based on the date the entered specialist training, rather than current proximity to CCT. Otherwise it is discriminatory. On paper, I did as good as (if not arguably better) than	

these two men in terms of outcomes and impact of our PhD science. Yet they were not faced with having to declare their confidential health circumstances to people within the school of medicine.

I feel completely undervalued in the UK clinical academia as a woman. If I had not found a loop hole to use to avoid the imposed curriculum changes, it would have been impossible for me to continue.

End.

This change will be an absolute disaster for the future of UK academic medicine, and also for specialty care for the NHS. We are sacrificing so much that makes UK science and healthcare great, in order for the relatively small short-term gain of having a few more bodies on the gen med rota.

1) In the UK, we already start specialty training much later and train for much longer than comparable countries (e.g. US, Aus). This puts people off doing academia, because it will inevitably prolong your CCT date. This has consequences on finance (longer on lower salaries, an effect which is magnified if you need to be LTFT for any reason, which also has knock-on effects for pension. Again, disproportionately affecting LTFTs i.e. women). This also has consequences for how you progress in academic - with more time spent on busy gen med shifts that have little interplay with your academic focus, your academic productivity is massively diluted. Also, as your intermediate training drags out, you're stuck for longer in this limbo of post-PhD, pre-big Fellowship application. This decreases your chance of actually getting a Fellowship.

2) Loss of specialty expertise. We need generalists, yes. But we also need specialists. With the current proposed model, the balance will be too skewed towards generalism. In my specialty, neurology, most of the learning happens as a consultant, when you have long term overview over your patients' outcomes and enough time spent seeing complex neurology patients. Even now, we are seeing the deskilling in GP/ general medicine - general neurology clinics are filled with relatively standard problems e.g. migraine without even trying a first preventative drug, mild functional symptoms. This means you need MORE people with MORE specialty expertise, not less. Patients will suffer if neurologists deskill. 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).
The response to this is to do specialty fellowships, but this just extends CCT more (see point 1)

People are being put off continuing in medicine & being put off Group 1 specialties. I know of two trainees who wanted to do academic neurology, one even did a neurology ACF, and then went to psychiatry because they didn't want to do a Group 1 specialty.

The solution to short-staffing is to make the job more attractive, not to try to force more people to do the horrendous specialties.

I think introducing the new internal medicine training will impact trainees' decisions on whether to pursue academic training or post-graduate research opportunity. I believe fewer trainees would be interested in

pursuing post-graduate research due to the increased length of time needed to complete training and the difficulty of satisfying both internal medicine and speciality training curriculum for CCT	
I suspect there will be less flexibility to take time out of training for research as there is now only 4 years of specialty training - it feels much more like a conveyor belt to produce clinicians who can also cover GIM without regard for academia etc. There is also less time to e.g. find funding, develop ideas, find a supervisor and generally network.	
This feels like yet another barrier to building a successful career as an academic clinician. 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. To meet the healthcare needs of the future the system not only needs to produce more generalists but also clinician scientists, so this should be reflected in the training pathway.	
The demands of dual training are greater than when focusing on a single specialty. Hence, these extra demands will take time and energy away from other ventures, such as academic progression.	
Negatively impact the chances of progressing in academia.	
More focus on GIM leaves less time for developing academic interests, more focus on pure service provision leaving less time to within specialty to find an interest, a supervisor etc.	
I think the introduction of these changes will adversely affect academic trainees and lead them not to apply	
I do not think that the change in GIM curriculum will significantly alter my future career of clinical/academic progression, as GIM was always going to be a part of my clinical practice. The main issue is balancing my clinical and academic work to ensure that I pass both academic and specialty/GIM ARCPs (all within less clinical time).	
Having to come back to this forced group 1 specialty has made me consider relinquishing my Resp number and going into single specialty ICM or retraining as Anaesthesia. The *sole* reason I have not is the impact it would have on my academic progression - else this would have been a clean and easy decision. I have no affinity for the RCP's decision to make GIM mandatory, nor to mandate it for dual ICM/RM trainees. Physician training is already riddles with issues, fixing them does not involve making GIM mandatory. It will make people choose other specialties/routes, and importantly will then leave us short in the long term. IMT3 is a further and significant hit to ACF's entering at CT1.	
I feel very fortunate to be exiting training on the old curriculum and therefore just in time to avoid being forced to dual accredit in GIM as well as my specialty (rheumatology). I chose rheumatology because of the potential for this to be predominantly outpatient based, because I knew at the point of entry that I wished to have more of a portfolio career, than one dominated by heavy shifts and oncall burden (which GIM jobs have). I have loved juggling academic with specialty training as the two are mutually compatible, and I have been successful in securing my ideal post of 3 days consultant and 1 day research (LTFT 80%) moving forward. I simply would not have been able to do this if I were to have had to do GIM as well. For those of us who choose to work LTFT, and/or have caring	

For those of us who choose to work LTFT, and/or have caring responsibilities, I might suggest that the enforcement of GIM is additionally punitive because we are already expected to do more within shorter hours (a well known side effect of LTFT in anything, and if LTFT in clinical speciality, academic AND GIM then we will be spread even more thinly). I think this survey is really important and would support any future academic trainees who feel that doing GIM will be detrimental to their contribution to research. In addition, all the questions here are focussed on the individual gains of having a research career. What about the losses made to research when clinical academic trainees are spread so thin that they can't conduct or train in good quality research?	
I don't have any comprehension as to what the new curricula entails or how it will impact me. I consider myself on an endocrinology and diabetes training programme with GIM that for all intents and purposes will remain unchanged from how it would have progressed before these new changes.	
Overall, negatively, particularly given that G(I)M is mandated, and although the JRCPTB states that all physician-training schemes are competency-based in theory, in practice, these are de facto time-based. I am skeptical that although the new G(I)M and physicianly speciality curricula have been designed to be less "tick-box"-based and more focused on higher-level competencies, in practice that these will be used to ensure that trainees spend as much time as possible as SpRs providing service delivery - particulalry for G(I)M - before we are eligible to CCT.	
Makes my academic work much harder. The high on-call workload at unsociable hours conferred by GIM requirements means I already miss a lot of academic opportunities during 'sociable hours' or end up using my post on-call recovery days for academic work or even to catch up on JRCPTB clinical requirements. Due to GIM requirements, this will continue for the foreseeable future in my career. This is something my senior clinical academic colleagues have not done, so I find it difficult to see how GIM will fit into my workload without detrimental effects on my academic work.	