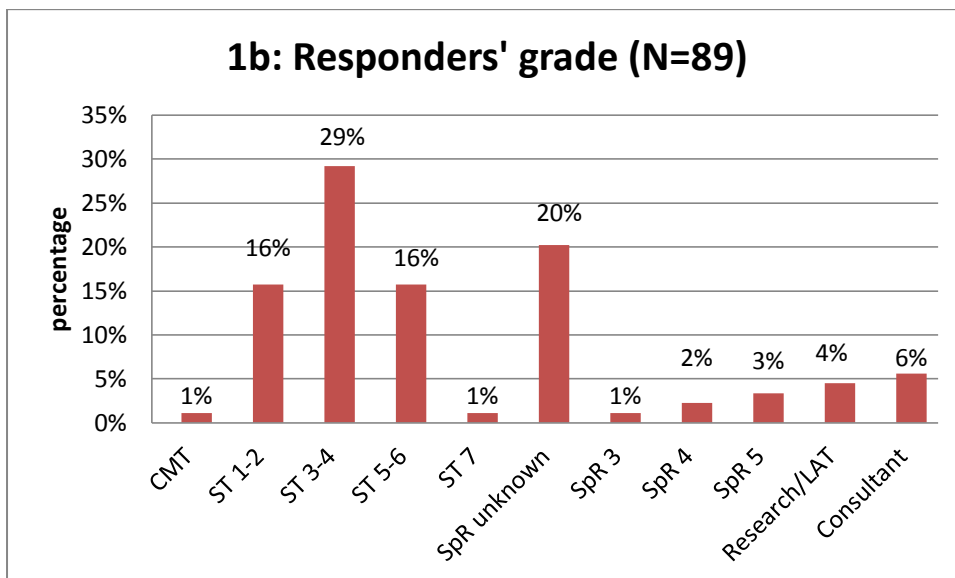
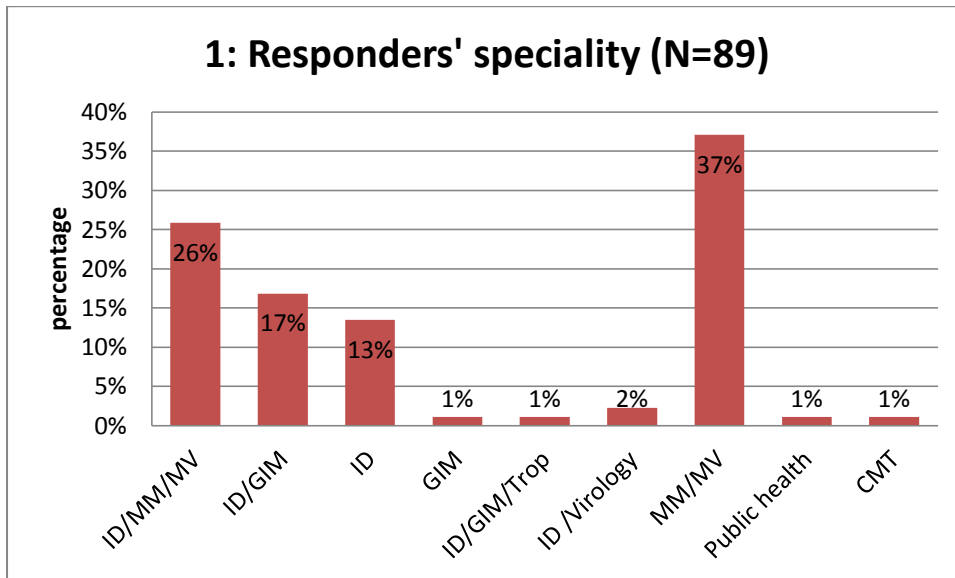
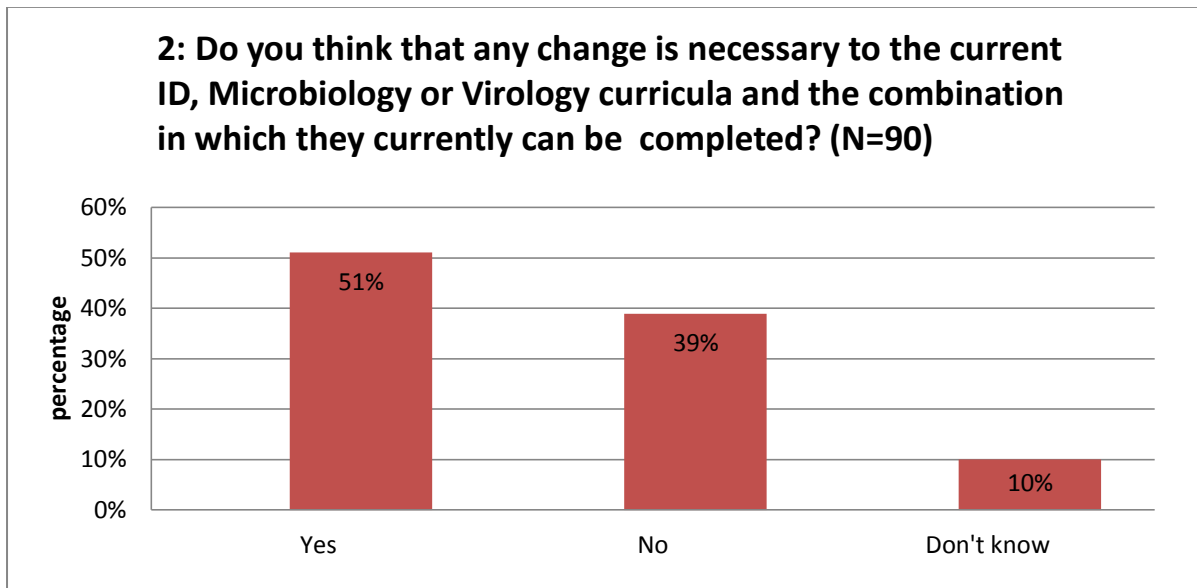


Results of the BIA trainees' survey on the proposed new Infection curriculum-
August 2011

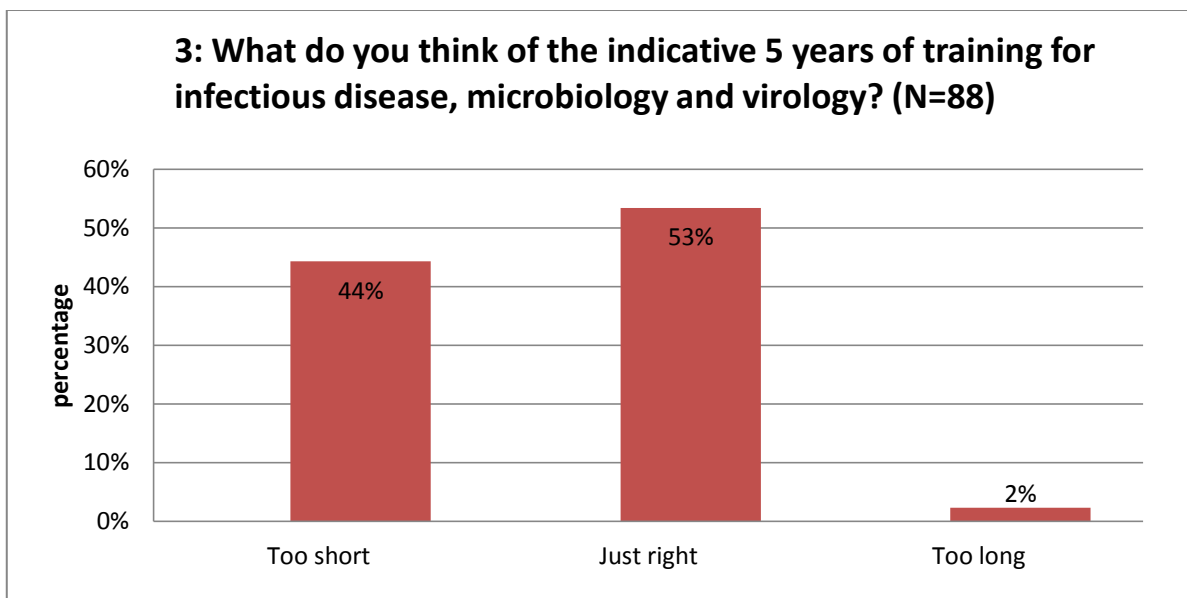
1: what is your speciality and grade?



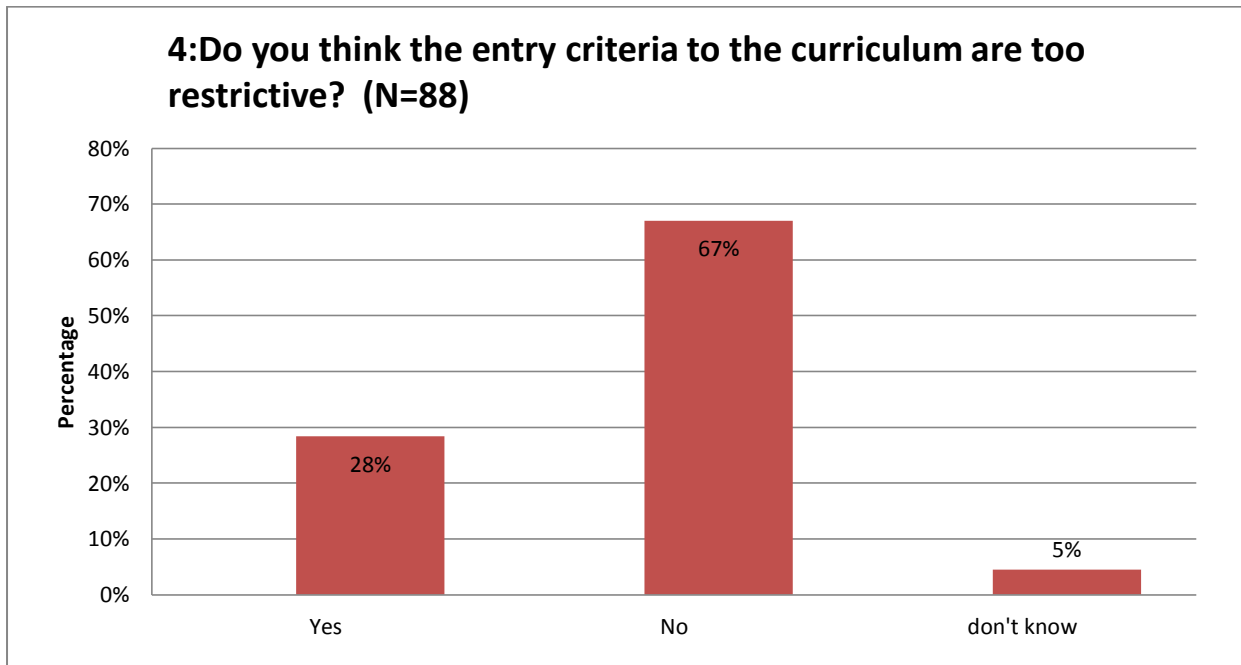
2: Do you think that any change is necessary to the current ID, Microbiology or Virology curricula and the combination in which they currently can be completed



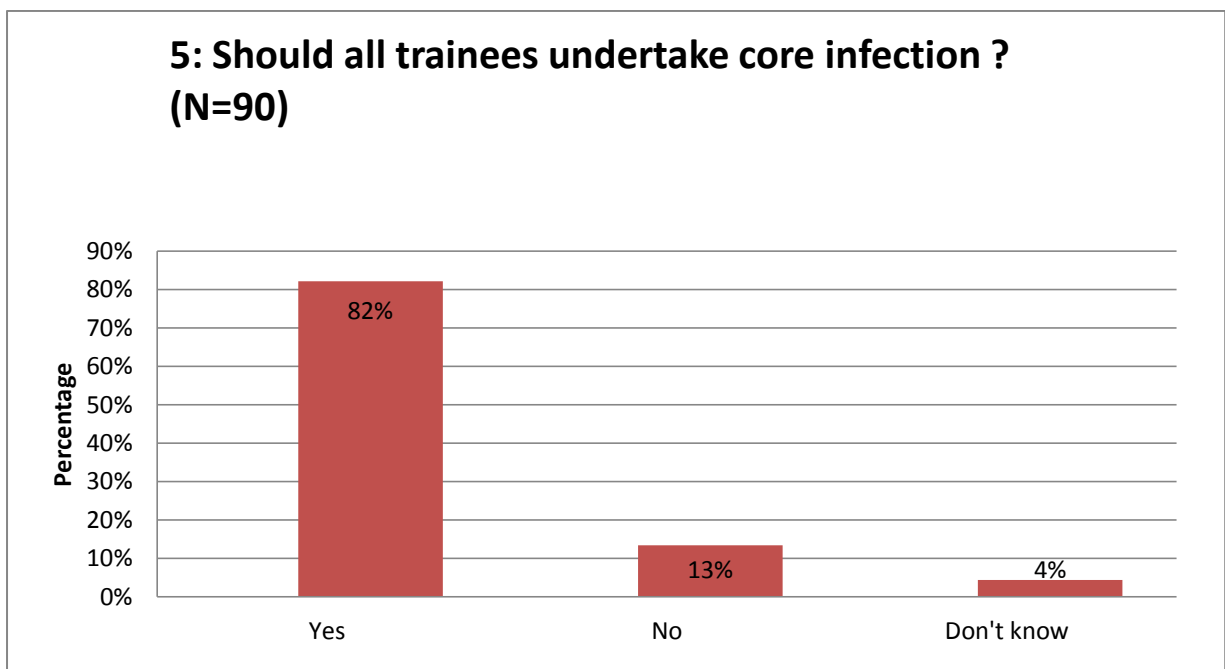
3: What do you think of the indicative 5 years of training for infectious disease, microbiology and virology?



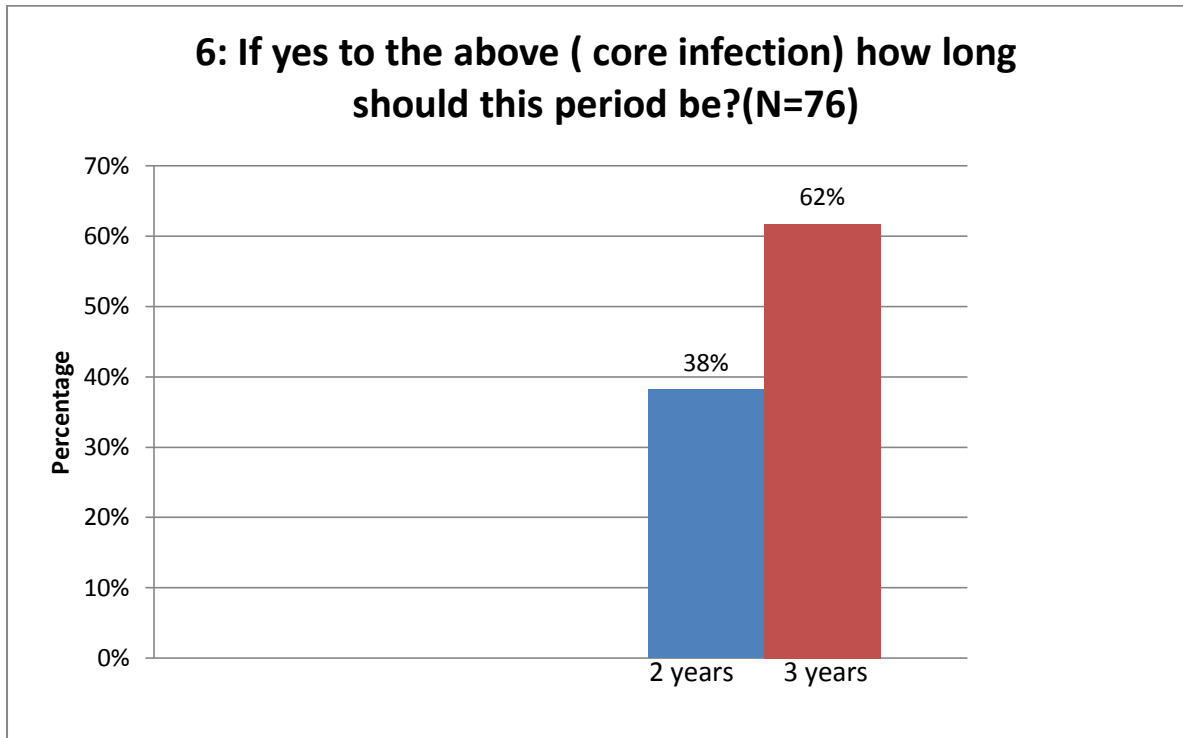
4: Do you think entry criteria to the curriculum are too restrictive? See excerpt from the Draft curriculum below. 'Competitive entry to Infection Training will be from CMT or ACCS training including attainment of the MRCP (UK). Candidates who have completed training equivalent to CMT training and can demonstrate competences equivalent to this training, and a qualification equivalent to MRCP(UK) will be eligible to apply to an Infection training programme, but would progress through the CESR(CP) route'



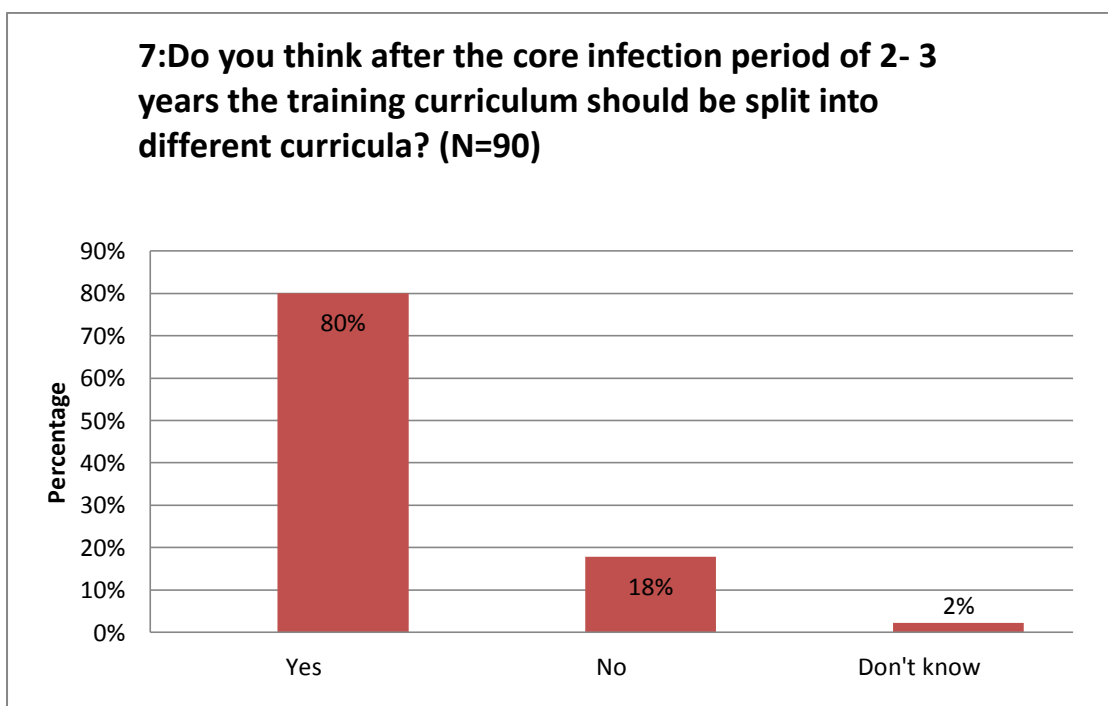
5: Do you think all Infection specialist trainees should undertake a period of core infection where there is a standardised curriculum covering microbiology/virology and infectious diseases (see summary of curriculum PowerPoint)



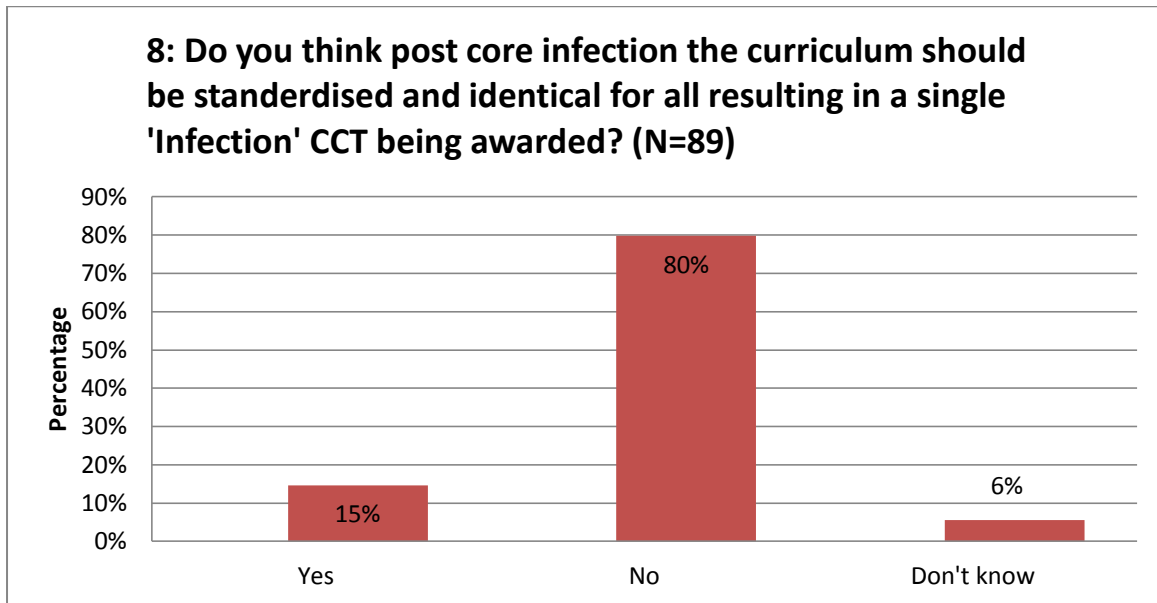
6: If yes to the above how long should this period be?



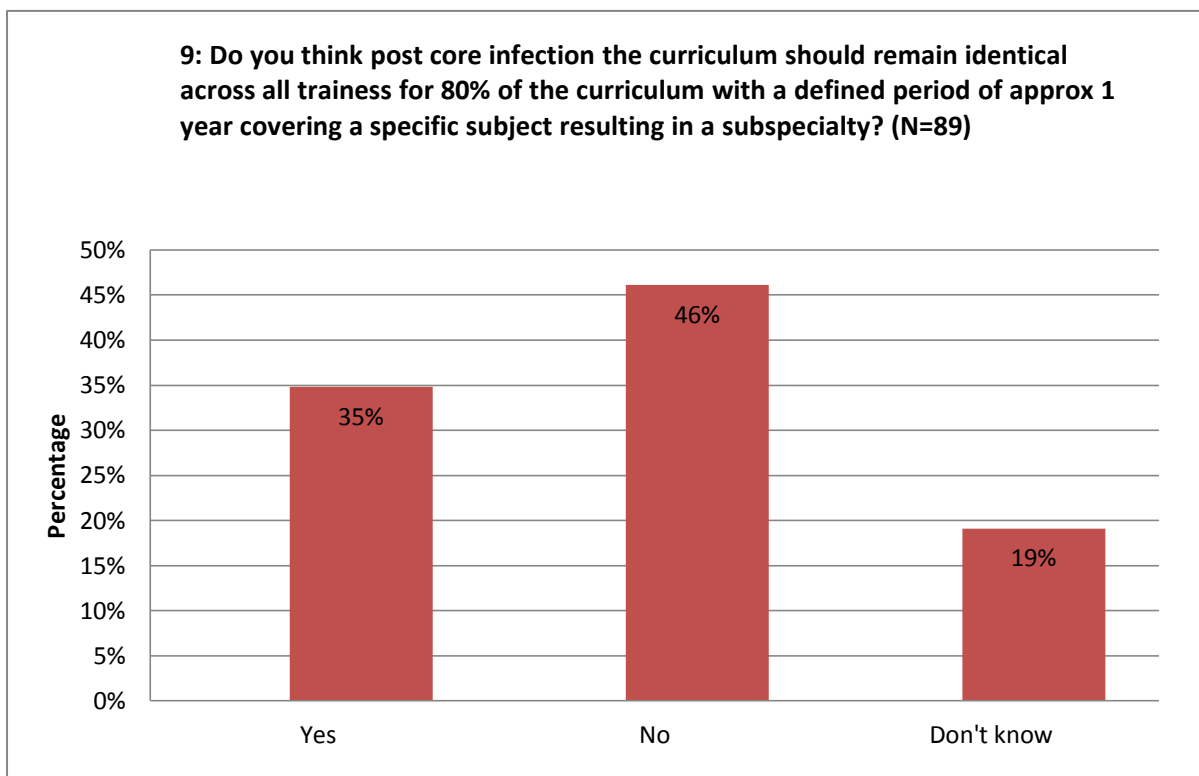
7: Do you think after the core infection period of 2- 3 years the training curriculum should be split into different curricula where a further 2-3 years is need to complete ID and Microbiology, ID and GIM, or Microbiology or Virology? (See statement from IDSAC chairman - Dr Miller)



8 : Do you think post core infection the curriculum should remain identical and standardised for all covering microbiology/virology and infectious diseases with training in 'Infection' resulting in a single CCT being awarded?



9: Do you think post core infection the curriculum should remain identical and standardised covering microbiology/virology and infectious diseases for 80% of the curriculum with a defined period of approx. 1 year covering a specific area resulting in an 'Infection' CCT with a subspecialty. E.g. Infection with sub speciality in microbiology?



10: Please add any further comments in relation to questions 2-9

1.	The need for MRCP is a nice idea but will put off many able clinical microbiologists	Fri, Aug 5, 2011 10:39 AM
2.	<p>There were previously several very good microbiology trainees who had come into the specialty from paediatrics with MRCPaed rather than MRCP. This seems to discriminate against them quite heavily.</p> <p>I think that the amount of knowledge required to be up to date and specialist is considerable, especially for those who want to triple accredit - I think that the number of training years required needs to reflect that, especially as CMT is only 2 years long.</p>	Fri, Aug 5, 2011 2:07 AM
3.	8 - Probably, but that would depend on the clinical content of the prior core training time. One year is not enough time to gain either the specific lab knowledge and training, or the clinical experience which currently define the difference between microbiologists and infectious diseases physicians. I still think there will be a clinical need for microbiologists and infectious diseases physicians. If a decision has been made to make generic infection specialists we stand to lose a lot, but I guess we may as well have a unified curriculum throughout.	Wed, Aug 3, 2011 3:46 PM
4.	I think that a period of training post "core infection training" should be at least 3 years in the chosen speciality and the CCT should be specific to micro/virology or ID.	Sat, Jul 30, 2011 7:15 AM
5.	I think sub specialisation should be encouraged due to the important lab skills necessary for micro/virology which are different to the clinical skills required for ID.	Wed, Jul 27, 2011 6:51 AM
6.	<p>If training really has to change, and I don't see why it does, the deal would be a 2-year core covering bacteriology/virology and ID, then 3 years specialty. Different or sub/specialty CCTs. 1 year to reach specialisation is an insult and will lead to a cohort qualified in nothing. I would not recruit one of these generic infection healthcare workers as a consultant colleague. The current joint training model of 6 years, is extremely pushed, and the 3 years in microbiology is only sufficient for the most able and committed trainee (who really wants to do micro). For those who lean to ID and who do not really engage with the micro, it is insufficient to give them a really thorough training that will enable them to be a jobbing microbiologist.</p>	Tue, Jul 26, 2011 8:05 AM

7.	much in favour of a yes to question 6. the 'compromise' suggested by the SAC recognises the importance of core training but I feel a specialism is needed after that and that at least 2 years is required to develop this.	Tue, Jul 26, 2011 1:55 AM
8.	Agree with idea of core infection training but disagree with the remainder of the curriculum being combined to result in a generic infection consultant. Different trainees have different attributes and interests e.g. Interest in bench side microbiology versus dealing with patient with meningococcal septicaemia in A and E resus. We should appreciate that although there is a lot of overlap between the infection specialities, individuals have generally chosen one area to play to their strengths and interests. We should harness this individuality rather than making us all the same!	Mon, Jul 25, 2011 12:22 PM
9.	I think it would be very hard to feel confident in ID or micro with that limited amount of training. Current concept of 4 years from ST3 for ID (w/o GIM) feels too short, and I would wish this lengthened - and this is with 6 months micro /virol. Your best learning is time seeing many patients - if this is shortened to broaden your skill base you will lose depth of knowledge needed to be an ID consultant (or micro consultant).	Mon, Jul 25, 2011 11:07 AM
10.	<p>Q4) I think clinical medical training and MRCP are important, but if candidates have training equivalent to CMT/ACCS, they can demonstrate competencies to this effect and we believe in a competency-based assessment process, then why should they not also be eligible for a CCT?</p> <p>Q6-8) I think that a combined CCT in infection would be appropriate, without the need for a 'sub-specialty' category. The opportunity to develop a specialty interest during HST by giving trainees the chance to pursue their individual interests through flexible specialty modules would however be ideal, and would enable them additionally to respond pragmatically to the fluctuating specifications of the job market. A trainee's sub-specialty interest is likely to be clear from the rotation/attachment choices made at this stage of training, without the addition of a further "MM/ID/MV" label.</p>	Mon, Jul 25, 2011 8:26 AM
11.	Post core infection training, 2 years' training in a specific field is insufficient to provide appropriate experience for independent practice as a consultant.	Mon, Jul 25, 2011 6:35 AM
12.	Keeping the curriculum standardised after 3 years would create a generation of consultants who were mediocre and not particularly specialised in any of the areas outlined in Dr Miller's document. By all means get the CCT in Infection as a name,	Mon, Jul 25, 2011 4:51 AM

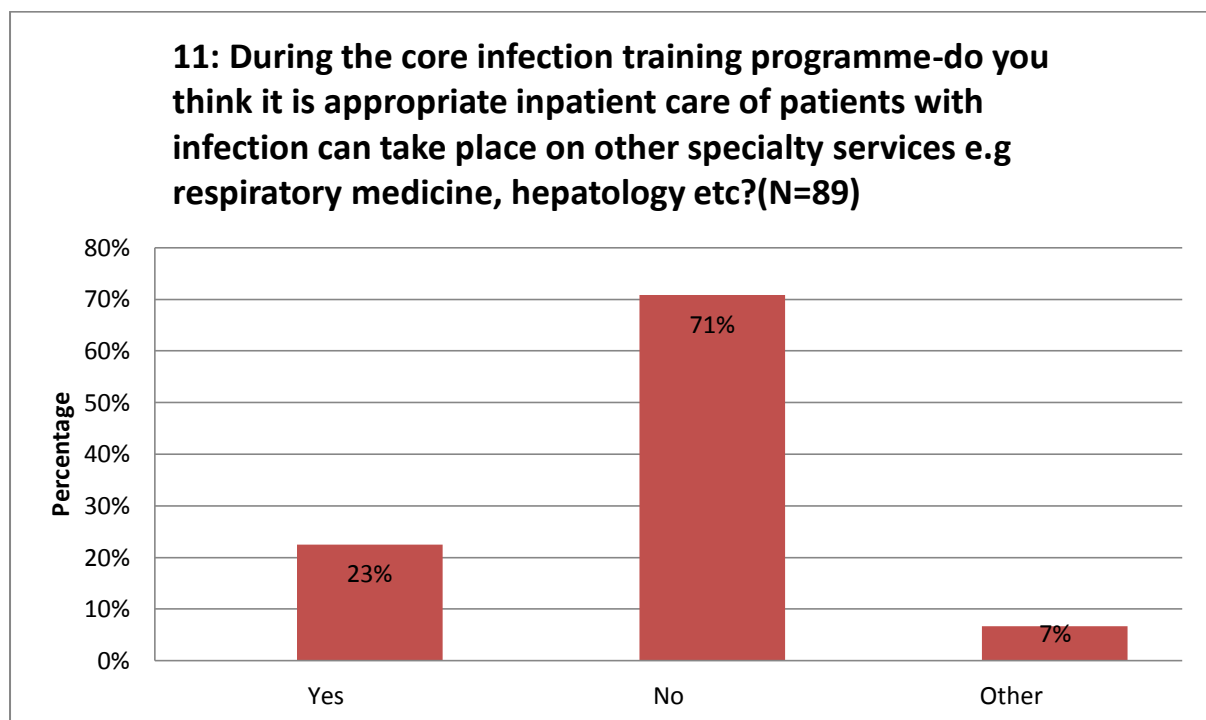
	with subspecialisation, but then allow trainees to get that sub specialisation!	
13.	Both options 7 and 8 appear reasonable - they key being the amount of flexibility that is possible. We should indeed avoid the duplication that is currently in place but also ensure the quality of training in all subspecialties is equivalent to that of the current joint curriculum.	Tue, Jul 19, 2011 5:16 PM
14.	1 year is too little time to acquire all skills and knowledge that would be outstanding, as CIT will broaden the training so much for all.	Tue, Jul 19, 2011 9:03 AM
15.	For trainees that are aiming to be working as "attending" physicians with responsibility for inpatient care of complex infection issues (not just consult work), need to have adequate exposure to ward and clinic based management of these cases under the supervision of infectious diseases consultants. I think this should be minimum 2 years possibly 3. This time would ideally be spread across their specialty training i.e. some within core infection training some just prior to their CCT. Ward based infection management within other specialties e.g. respiratory could be an adjunct, but should not replace experience in an infectious disease department. Clearly not all trainees attaining an Infection CCT would be able to get that much exposure to inpatient infectious diseases so the split between trainees pursuing "attending" physician infection CCTs and those pursuing MM/MV infection CCTs would have to be relatively early in the core infection training. Those doing MM/MV should also have exposure to inpatient infectious disease management but the time spent there would not need to be so great.	Tue, Jul 19, 2011 1:46 AM
16.	is one year long enough to sub specialise?	Mon, Jul 18, 2011 2:14 AM
17.	I totally reject the idea of 'core infection training'. It will just dilute the already poor training we have already. Why would spending a year in a GUM job help you be a better microbiologist? Whilst I realise a short time would be useful, these developments feel like the whole of infection training will be dumbed down.	Sat, Jul 16, 2011 12:04 PM
18.	1 year is no where near long enough to specialise. Specialisation is essential otherwise we will lose expertise in these complicated areas and consultants will not be experts in their field	Sat, Jul 16, 2011 4:49 AM
19.	From a microbiologist's perspective, I do not think a year (in addition to the CMT)	Thu, Jul 14,

	would be adequate to gain enough experience of the specialty	2011 8:38 AM
20.	80% is too high	Thu, Jul 14, 2011 8:09 AM
21.	If Infection specialists are to have responsibility for managing patients then Internal Medicine training remains extremely important. Removing this entirely from the specialist training will give specialists who can advise on clinical management of patients but will not have the necessary skills or experience to manage their care	Thu, Jul 14, 2011 8:00 AM
22.	Microbiology with infection control needs to be 2-3 years post core training. 1 year is not sufficient.	Thu, Jul 14, 2011 1:59 AM
23.	I feel that the training program as currently proposed will lead to trainees with a poorer understanding of laboratory microbiology/management, and that the current MM program generally provides. I do not think that the likely future lab centralisation means that less laboratory knowledge is necessary.	Thu, Jul 14, 2011 1:30 AM
24.	core infection training as a concept is great. however entry requirement are too restrictive, time frames too short (people make a career of microbiology - hard to squeeze into a year!!!) but most of all deliverability is a huge problem which will result in geographical bias and discrimination in terms of training and consultant prospects	Wed, Jul 13, 2011 6:31 AM
25.	I think a 6 year curriculum with 2 years core - 6 months ID, 12 months micro / virology and 6 months GU / public health, followed by 4 years advanced with 3 years in the main area (micro / virology or ID) with the other year in the other area. As an aside, the new GIM curriculum (2010) requires 3 years of GIM experience during higher specialist training (post MRCP), which would be very difficult to fit in to this scheme.	Tue, Jul 12, 2011 3:35 PM
26.	I think that if training is properly structured a lot can be achieved in a final specialist year which will build on the generic first section. I think completely separate CCTs negates the whole point of curriculum revision.	Tue, Jul 12, 2011 2:24 AM
27.	Covering ID, MM and MV in 5 years will result in trainees who have not had opportunity to develop their interests due to heavy requirements for examination (MRCPPath) - trainees completing the proposed curriculum would, I suspect, not be	Tue, Jul 12, 2011 2:04 AM

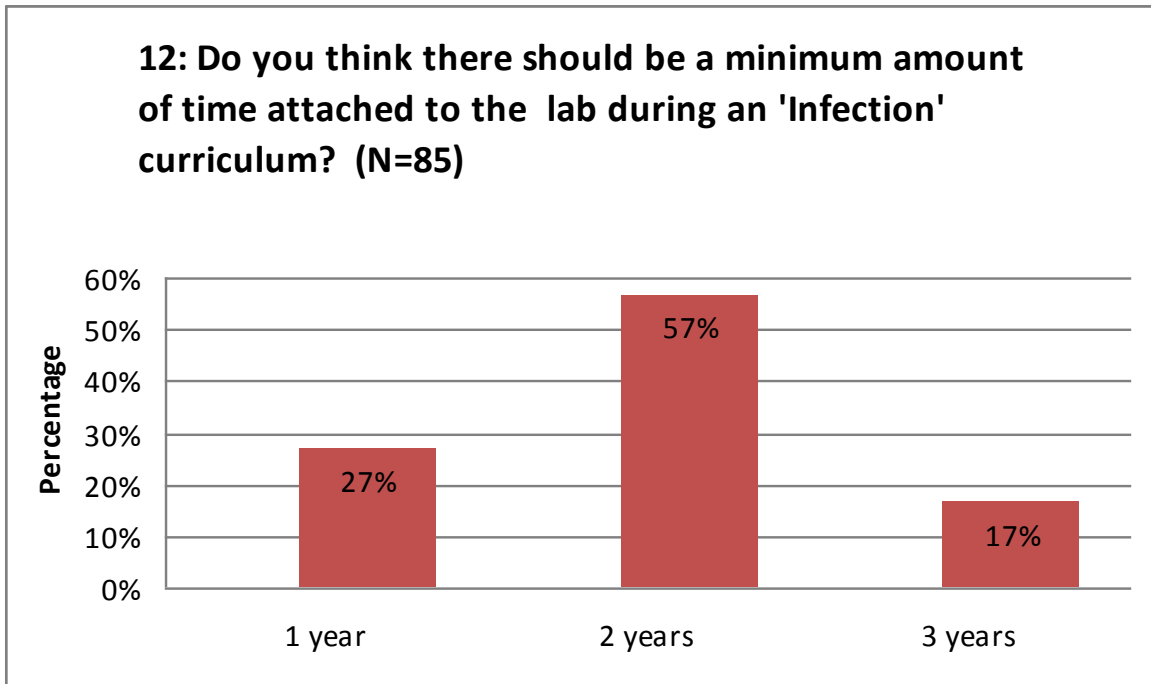
	<p>prepared for work in tertiary centres, but be much more general and more closely resemble current microbiologists than infectious disease physicians. The proposal that ID training can be done under medical subspecialties is weak, especially for trainees not aiming to get CCT in GIM - most work in these specialties will be GIM, but I anticipate that infection trainees would lose out in experience to respiratory/gastro trainees, who would be prioritised by those specialty consultants.</p>	
28.	<p>You forget that microbiologists and ID physicians have a very different mindset and often personality. Although we share a common interest in infection, our skills are fundamentally different. I think all you will accomplish with this new 'infection' CCT is to generate 'jacks of all trades, masters of none'.</p>	<p>Mon, Jul 11, 2011 8:37 AM</p>
29.	<p>I think that it is good/essential to have 3 years core infection training, but then one should have a further 3 or more years in the branch of infection that interest you most, i.e.)MM/MV/ID. There are overlapping skills sets but also specialty skill sets that you need longer than a year in which to become a true specialist. It is madness that at present some ID trainees will only have done 6 months HIV yet run HIV clinics, also that some joint trainees who get jobs as clinical microbiologists may only have done 2 yrs of micro. A lot of people go into joint training as there are not enough ID posts and then feel disheartened at the lack of jobs, if aloud to do GIM as well one could be a general physician with an interest in infection running a consult service, giving antibiotic advice, running OPAT from MAU. Rather than pidgin holing clinicians in a lab based job or having non clinically biased doctors doing consults with which they feel uncomfortable. The new proposed curriculum, seems to somehow dumb down both so you would get a set of doctors that can do neither proficiently.</p>	<p>Mon, Jul 11, 2011 7:43 AM</p>
30.	<p>I believe the first 2-3 years should cover the same curriculum, the after this period specialisation in ID/Micro, ID/GIM, Micro, or Viro should occur, with different specific curriculums.</p>	<p>Mon, Jul 11, 2011 7:21 AM</p>
31.	<p>Yes, and the ID year should be in a recognised ID training unit with the appropriate range of OP clinics and adequate number of acute infection admissions</p>	<p>Mon, Jul 11, 2011 6:44 AM</p>
32.	<p>Infectious Diseases is an extremely broad and diverse specialty and while it is correct that the early infection training is broad and universal to all infection specialties it should also be possible to sub-specialise. Unfortunately all the deaneries do not have similar opportunities to train in all sub-specialties (especially true for HIV, TB, bone infection, transplant infection and tropical medicine). I would encourage the development of competitive fellowships not restricted to deaneries whereby trainees that develop certain interests can pursue them toward the end of their training</p>	<p>Mon, Jul 11, 2011 6:34 AM</p>

	outside their deaneries if need be. Alternatively deaneries could combine to ensure all sub-specialties are available to trainees.	
33.	<p>I think core infection training is a very good idea as will give ID physicians good grounding in micro and microbiologists better clinical exposure. Then I think specialty training should be c.4 years.</p> <p>I agree that trainees going into infection training should have good clinical training beforehand e.g. CMT, however I am not sure why they need to be physicians - especially if going to end up doing microbiology. Most complicated microbiology consults I come across are from surgical or paediatric specialties -not medical. I have had minimal training in paed/surgery prior to entering specialty training and find this aspect quite difficult. Maybe it could be incorporated into the core infection training?</p>	Mon, Jul 11, 2011 6:23 AM
34.	I have a major concern about the quality of training when combining all the specialities in one core training.	Mon, Jul 11, 2011 6:09 AM

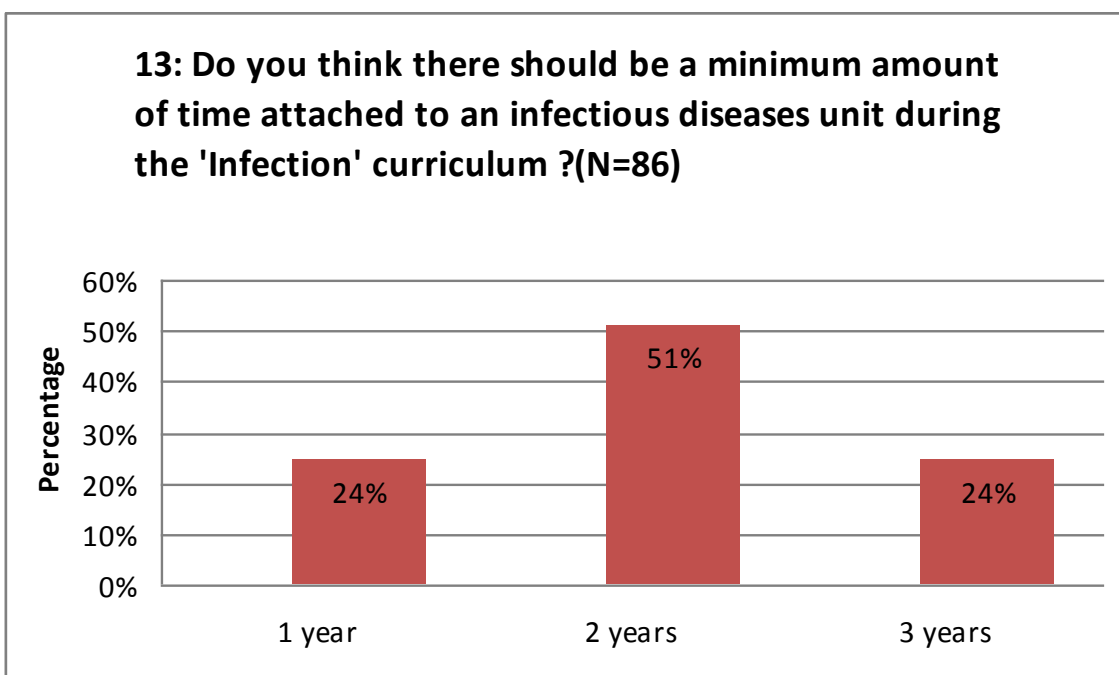
11: During the core infection training programme- Do you think it is appropriate the curriculum states ‘training in inpatient care of patients with infection can take place on other specialty services e.g. respiratory Medicine, Hepatology, Gastroenterology, MAU, ITU and elderly care’?



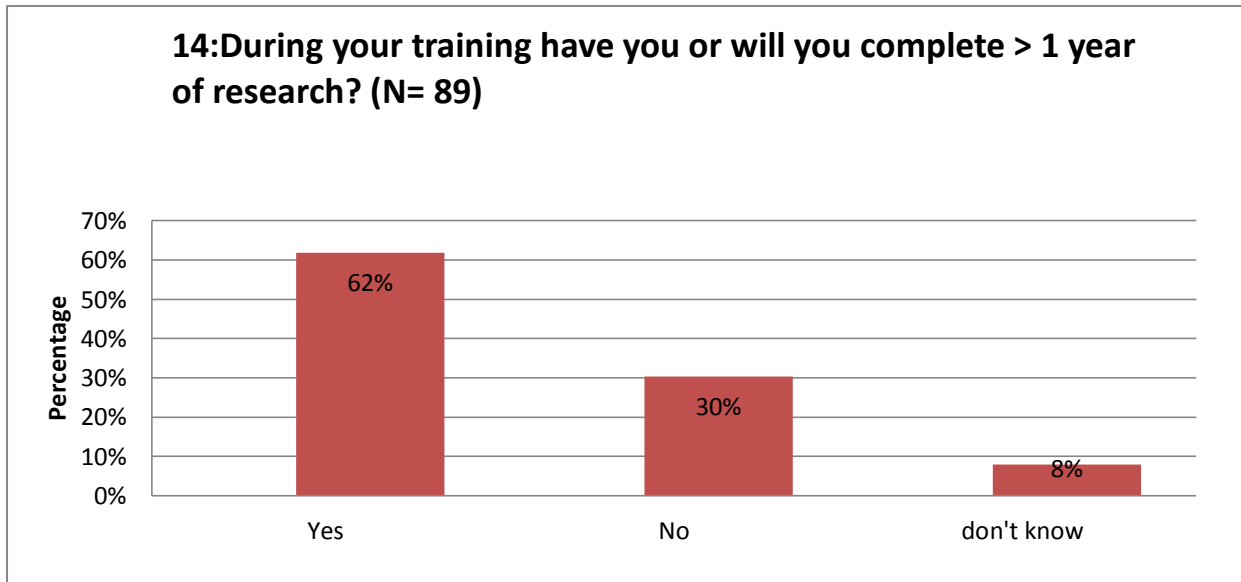
12: Do you think there should be a minimum amount of time attached to the microbiology and virology lab during an 'Infection' curriculum - assuming the curriculum results in a single Infection CCT?



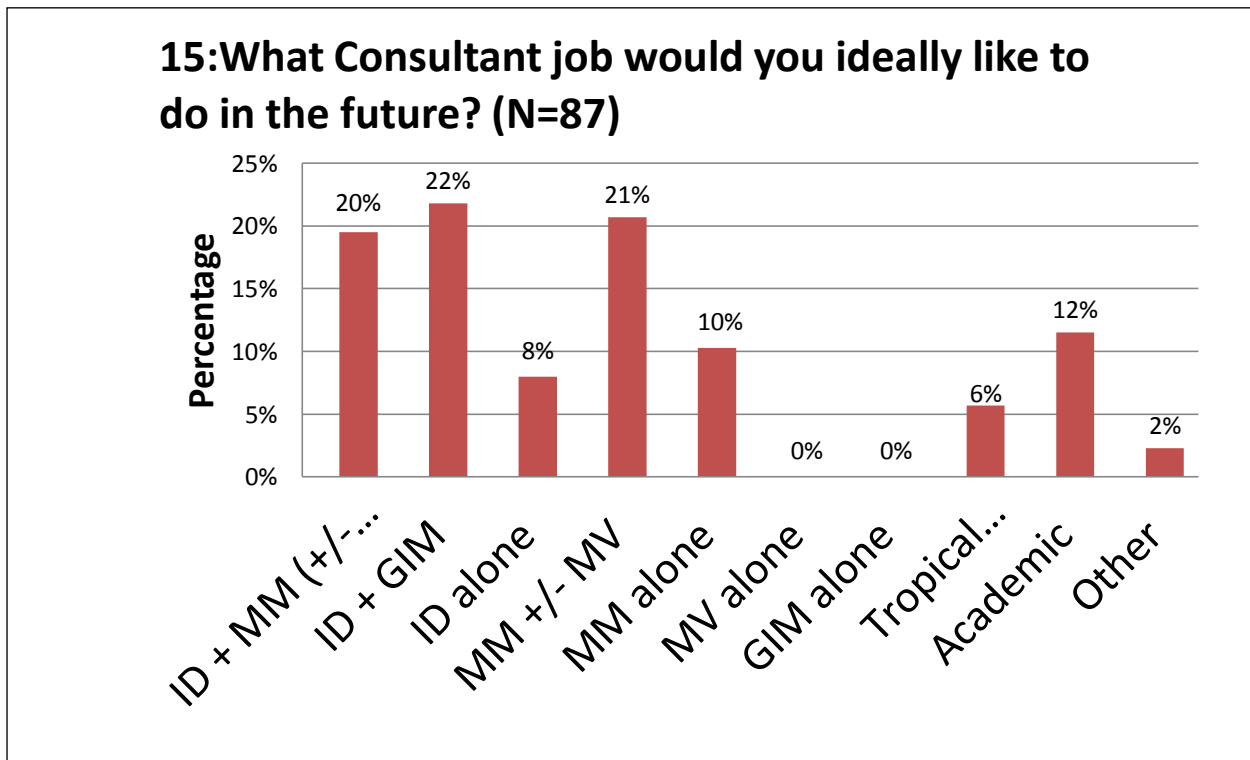
13: Do you think there should be a minimum amount of time attached to an infectious diseases unit during the 'Infection' curriculum- assuming the curriculum results in a single Infection CCT?



14: During your training to-date have you completed > 1 year of research (either in programme or out of programme) or do you plan to undertake a significant period of research (> 1 year)



15: What Consultant job would you ideally like to do in the future?



16: Any other comments that you want us to feedback to the infection training working group committee?

<p>1.</p>	<p>Infectious diseases trainees by tradition are more clinically focused and Medical Microbiology trainees are more laboratory focused. In my opinion, it is not possible to merge the 2 into a single 'infection trainee' without loss of valuable experience and expertise (be that in the range of presentations of ID or the finer details of laboratory diagnostics) that will make these trainees competent Consultants who can work independently in the future. The key to moving this forward would be to foster closer working links and establish an 'infection team' made up of core multidisciplinary personnel- the lab technicians, the Medical Microbiologists and Virologists and the Infectious diseases physicians and nursing staff responsible for ward based patients and other ID consults across the hospital. This group should include academic members with links to the University, research and teaching. They should operate as a multidisciplinary team (with clearly defined and distinct but complementary responsibilities) with close working links and regular interactions, ideally based in the same 'Infection Department' that houses the diagnostic labs with close access to the ID ward and in-patients. They are then ideally placed to provide the hospital and community with a broad infection service that will benefit from each member's unique expertise, experience and interests and allow for people to develop their own career pathway and interest rather than being forced to follow a combination of bits and pieces from different areas of infection and end up not knowing where their niche is.</p>	<p>Mon, Aug 8, 2011 5:38 AM</p>
<p>2.</p>	<p>In the interests of maintaining the bridge of communication and understanding between the laboratory and the ward, I support the current way of doing things apart from the need to fill 2 portfolios and pay 2 colleges for life. I do think Micro assessment (FRCPath part 2) could be modernised (assessed wet practical should be replaced entirely by workplace based assessments with specific skills listed in the curriculum and signed off by your supervisors. Clinical interpretation and liaison skills can be more simply and cheaply tested in other ways e.g. MCQ and OSPE.) I think the current proposals would possibly fulfil the aims of reducing beaurocracy for the joint trainees but at the risk of producing doctors who are neither familiar with the fundamentals of practical microbiology (therefore not fit to accurately interpret the lab findings for the clinician) nor capable of managing an outpatient with HIV let alone a sick inpatient with AIDS (after their 'infection' training on a haematology ward.</p> <p>The current system is expensive and time consuming (portfolios that is; not the 6 years training time which seems to me a bare minimum of time in which to achieve the learning objectives) for the joint trainees and I grumble about it but I am very glad that I am lucky enough to experience real microbiology training and real</p>	<p>Fri, Aug 5, 2011 10:39 AM</p>

	infectious diseases training. I pity the drs who will miss out on that.	
3.	<p>I'd be concerned that at the hospital level, the direction that the trainee ends up taking in stage 2 will be driven by service requirements rather than their preferred route. In stage 1 the actual posts that would be filled would be tenuously related to infection, and that you could emerge having done some care of the elderly ip, dermatology clinics and GUM and be expected to be give a specialist infection opinion.</p> <p>The FRCPATH is an extremely robust exam, especially part 2. It covered a broad infection spectrum, and it was taxing - it required a high standard of knowledge, and I feel that I have proven something in passing it. The ID exit exam is not an equivalent to this, or anywhere close currently. If this is to be replaced, it needs to be closer to the FRCPATH model than the speciality ID exam.</p>	Fri, Aug 5, 2011 2:07 AM
4.	I still think there's the need for ID physicians and microbiologists. I don't think it will be possible for many to be really good at the clinical and the laboratory sides - it's too wide. There must be adequate training time to specialise appropriately that microbiologists can be really competent with the lab related stuff and ID physicians have enough clinical time to get adequate experience with Hep B, C HIV, TB, Travel - this will take time, but would not be necessary for a microbiologist. They need the chance to do the GIM elements of a rounded physician's training....even if they're not planning to do General Medicine.	Wed, Aug 3, 2011 3:46 PM
5.	The idea of a joint core medical training is great with the option to specialise following this period. However, if we are expected to work in general medicine, all training posts should be able to get a broad coverage of training; not just in the larger centres e.g. London	Wed, Aug 3, 2011 2:13 AM
6.	<p>For combined ID + GIM, the addition of just 1 year of GIM training seems ludicrous. A trainee will not be at consultant GIM level after just 1 year!</p> <p>Training in management can be done to some extent in other specialties, but not solely. Trainees need to be supervised by infection specialists, if that is what they are expected to become.</p>	Wed, Aug 3, 2011 2:11 AM
7.	The training needs to be reasonably flexible to attract and keep the wide variety of trainees with their different skills that ID/micro/HIV/GUM/Virology currently attracts. A single CCT in 'infection' risks being too generic and not allowing trainees to explore their strengths and interests, and makes it harder for competition at consultant job level to distinguish the top candidates. For example I hope to CCT in	Thu, Jul 28, 2011 6:00 AM

	ID/GIM and Tropical medicine and would not want to spend a significant portion of my training in a virology lab, and I would expect my CCT to reflect my training skills and interests.	
8.	I am extremely disappointed that Public Health Medicine (particularly Health Protection) has been completely excluded from these considerations. A fair proportion of public health trainees already hold the MRCP and spend 2 to 3 years focusing on health protection, infectious disease epidemiology, communicable disease control, immunisation and related fields. There should be options to combine public health medicine with one of Infectious Diseases, Medical Microbiology/Virology, GUM/HIV, or Tropical Medicine. High-calibre training is obtainable at the Health Protection Agency in infection control, epidemiology and diagnostic sciences; and more.	Wed, Jul 27, 2011 2:05 PM
9.	I think that periods of research should still be able to count for up to one year of the training period. I am currently spending 4 years on a masters+Phd and I think it would be unreasonable for people doing this long period of training+research not to get this recognised as part of the infectious disease training - your power point says "OOPR is encouraged" : the best way to encourage it, is to recognise that it contributes to training !	Wed, Jul 27, 2011 7:21 AM
10.	I am a joint trainee in MV and ID and think it is fair to say myself and other joint trainees find it hard to cover both specialities in 6 years. Therefore I think it very important this is taken into consideration with the new 'infection' training. If you want a trainee really competent in all 'infection' this needs to be an extensive and thorough training program. I feel it much more appropriate to have sub specialisation and focused training.	Wed, Jul 27, 2011 6:51 AM
11.	I think the compulsory CMT is probably a good idea, although has it been considered that there could be entry to infection training at ST1 level, with a mix of laboratory infection and G(I)M from early on (still leading to MRCP)? I think that the core infection training will result in higher quality training in both MMV and ID. I think the core infection training needs to be 3 years to achieve this aim; otherwise these will be short secondments rather than true training in large areas of the curriculum. My fundamental concern is that there is a lack of clarity about what consultant jobs are envisaged. Whilst (in my opinion) a fully integrated infection training pathway (or something very close to it) is the way to go, the majority of new ID consultant posts recently have been linked to heavy G(I)M / acute medicine commitments. The working group needs to clarify the position of G(I)M in all this - I don't think it is feasible (or appropriate) for someone to be trained to consultant level in ID, MMV	Tue, Jul 26, 2011 4:57 AM

	and G(I)M.	
12.	If period of core training needs to take place in another specialty - no more than 6 months. Should have ID supervisor and undertake ID related project.	Mon, Jul 25, 2011 3:23 PM
13.	Where does current exit exam fit into Infection training? Where does Tropical Medicine fit into this? Parallels can be drawn with Haematology as a Speciality in that they are lab based and also ward based, but there isn't a GIM part of their training. How about the model in the USA? ID is a big speciality there. What about GU medicine and HIV, does this come under General infection training too?	Mon, Jul 25, 2011 12:22 PM
14.	I strongly feel that a post in geriatrics/respiratory/haem etc. should not count as training in infectious diseases - I agree they can see a lot of complex infection, but I feel it is very important to learn to manage these under an ID consultant not other physician. Learning mx under general physician as the potential to lead to poor antibiotic stewardship... Infection training should be done on a ward run by infection specialists. There is very good learning to be had on these other wards (and time on them could definitely be useful, particularly for ID/GIM trainees), but our training in INFECTION would be suboptimal on them.	Mon, Jul 25, 2011 11:07 AM
15.	Current upheavals has parallels with what happened in haematology 40 years ago. They got it right by making haematologists doctors first and foremost.	Mon, Jul 25, 2011 9:00 AM
16.	Q9) The experience of infection in other medical specialties is a valid training experience, but should not form the only means of infection training and should not be a replacement for some experience on an infectious diseases unit. Q10) The attachment to the microbiology/virology laboratory should involve clinical review of patients as part of a consult-based service, as well as training in bench techniques and acting as a source of advice for community healthcare professionals. Q11) 12 months may be a difficult requirement for settings in which there is no specific ID unit/ward. I think that with appropriate supervision, hands-on clinical involvement with ID/micro in-patients as part of a consult-based service and experience with infectious diseases out-patients as part of a general medical service then this period could potentially be shortened to 6 months. Appropriate supervision and documentation of competencies to identify any gaps would be very important in this context.	Mon, Jul 25, 2011 8:26 AM

17.	The proposed training will lead to a dilution of expertise in the individual areas.	Mon, Jul 25, 2011 6:35 AM
18.	The skill sets of ID physicians and microbiologists should complement each other, and the specialties are too large to expect every trainee to become an expert in both with a single mandatory curriculum of 5 years. If the sub-specialisation is not allowed in the later stages of training then essential skills will be lost from both sub specialties. A specialist in infection cannot gain the skills needed by completing the clinical part of training with no exposure to an ID unit.	Mon, Jul 25, 2011 4:51 AM
19.	"Do you think it is appropriate the curriculum states 'training in inpatient care of patients with infection can take place on other specialty services" - It needs to be ensured that this is not used to employ ID trainees as general med trainees at the expense of their ID training . . .	Mon, Jul 25, 2011 2:34 AM
20.	What is the main difference between the proposed new single CCT (infection + suffix) and the existing systems of multiple CCTs? In particular, does it imply that a holder of the new CCT in infection/micro should be competent in running an ID unit; and a holder of the new CCT in infection/ID should be competent in running a microbiology laboratory service? If so the training has to be longer and more intense. If that is not implied in the new infection CCT, then one will have the question what is the difference between that and the current individual CCT in micro or CCT in ID.	Sun, Jul 24, 2011 9:12 AM
21.	Regarding Q9 - I think there although one can gain infection experience in general wards etc., there needs to be a defined minimum period of time attached to a dedicated ID ward as well.	Wed, Jul 20, 2011 5:06 AM
22.	I am very strongly opposed to in-patient infection training being delivered by non-Infection specialists. By analogy, Haematology - which is the discipline we should be aspiring to mimic - does not expect e.g. coagulopathy training to be delivered by hepatologists or ICU physicians. The situation is different for outpatient care - joining specialised clinics e.g. TB clinics run by respiratory physicians or viral hepatitis clinics run by hepatologists would be greatly beneficial, but certainly not spending 6 months on the respiratory ward. The latter can be done at SHO/CMT level instead!	Tue, Jul 19, 2011 5:16 PM
23.	Does the RCP and GMC really think that a CCT in GIM can be achieved in only one year?	Mon, Jul 18, 2011 2:14 AM

24.	There is no longer a shortage of good microbiology candidates for MM jobs and it appears that because there are no ID consultant jobs, this is a strategy to create more jobs for ID doctors. The difference in 'personality' between ID and MM physicians is significant and people are still going to choose a definite pathway and end up one or the other....so really, it won't bring anything particularly new. Core training for 2-3 years, then specialisation into MM will mean that going forward, the doctor will practice MM and it would be unsafe to then 'dip into' ID at any time just because they did a short period of core training.	Sun, Jul 17, 2011 4:20 AM
25.	Why not just do as clinical haematologists have done, and make us truly clinical pathologists? Perhaps more joint training in ID/micro - or all posts become ID/micro, including existing ones.	Sat, Jul 16, 2011 12:04 PM
26.	'Jack of all trades, master of none' is the resounding phrase when surveying the curriculum	Sat, Jul 16, 2011 4:49 AM
27.	I do not support Joint infection training. In my opinion these are all very separate jobs with very different roles and responsibilities. Training should remain separate.	Fri, Jul 15, 2011 12:26 PM
28.	I am concerned about the implications of this new curriculum/CCT on existing Medical Microbiology Trainees. What are the options for trainees who do NOT wish to transfer to the new curriculum? How is it going to work with job prospects in 5-6 years time?	Fri, Jul 15, 2011 1:14 AM
29.	I am not clear whether Q10 relates to purely being in the lab, or a mixture of benchwork and clinical liaison. If only benchwork, one year would be sufficient. If both, 3 years.	Thu, Jul 14, 2011 8:38 AM
30.	Calling all doctors as infection doctors will may it easier for other specialities from point of view of referrals.	Thu, Jul 14, 2011 1:59 AM
31.	One reason given for driving this change is given as 'difficulty in recruiting trainees and consultants to Microbiology.' From what I understand, the competition ratio for Microbiology training is in fact much higher than that for many other specialties. Reading between the lines of the information given, it appears that an important driving force might be the lack of consultant positions for ID trainees. This is not a good reason to completely overhaul the curriculum of two/three training schemes. I would think that trainees who have done 'core infection' because they want to do ID, are no more likely to want to do a job very similar to that of a Microbiologist,	Wed, Jul 13, 2011 5:00 AM

	<p>than they are to want to do Microbiology training in the first place.</p> <p>I do believe that Microbiology/Virology trainees would benefit from more 'hands-on' clinical experience in managing infection (such as placement in ID, and possibly other departments such as respiratory/paediatrics/haematology and oncology), as part of their training, in the same way that current ID trainees get placements in Microbiology.</p> <p>Surely this, combined with limiting the number of ID trainees so that they are able to find a consultant job, would be far simpler than what is currently proposed. The comment is made that trainees will have to make a decision as to what kind of 'infection doctor' they want to be. This already happens, but it happens earlier on, so that those who want to do microbiology/virology do not waste time and money on clinical exams, and those who want to do ID are not taken down an 'infection' path only to find towards the end of training that unless they do 'infection subspecialty microbiology' they won't get a job.</p> <p>Additionally, I can't see why MRCP in particular is the 'other' exam that is needed - why not MRCS/MRCGP/MRCOG etc. It is of concern that the only examination that will show competence in infection is an exam equivalent to MRCPath part 1.</p>	
32.	Good luck!	Tue, Jul 12, 2011 3:35 PM
33.	<p>By including the option of having elderly care/gastro etc., you run the risk of just being part of service provision with not much good quality infection. Dedicated time on chest specific to infection (not COPD/asthma mx, or cancer), or on haematology (specifically the 'infected' or pyrexial patients' rather than devising chemo regimes) would be useful and interesting but not in place of ID under the guidance of ID physicians. Time on ITU is invaluable, and time on MAU inevitable.</p>	Tue, Jul 12, 2011 2:25 PM
34.	<p>As I understand it the key thinking behind curriculum change is that the Modernising Lab Careers means much of the responsibility taken by microbiology doctors at present will pass to scientists. I think this means the training structure needs to be flexible so that as needs change trainees can respond to that during their training. Hence I disagree with maintaining completely separate CCTs and prolonged "specialisation" periods a 5 year scheme should be completely capable of producing people who are equally at home in ID or micro without having to choose. I can see that areas such as Medical Virology may need extra time and in that case the final specialist year can be so adapted.</p> <p>It should be perfectly feasible to produce trainee graduates who have "Infection"</p>	Tue, Jul 12, 2011 2:24 AM

	<p>CCT who can be microbiologists or ID physicians without the need to separate their training (it is only one year less than the current ID/micro training - and exactly the same length as ID/micro trainees spend in clinical training if they take time out for research!).</p> <p>I can see that in the early stages it will reassure people to have a "Infection with medical virology" sub-speciality to the CCT.</p>	
35.	<p>I support the change in training to the curriculum. The question remains about how trainees on the current MM / MV training are going to find jobs in the future. Will our CCT be competitive with trainees with an infection CCT? Will the job specifications allow for ID / MM or MM CCTs to be equivalently recognised? There is a bit of an information gap as to how things will actually work on the ground.</p>	<p>Tue, Jul 12, 2011 2:23 AM</p>
36.	<p>I recognise that "general" infection specialists will provide a needed service, but perhaps individuals aiming for these jobs can be trained in ID/MM as currently. If the proposed scheme were in place when I applied I would have had to undertake some other training programme to meet my aim of being a clinical infectious disease specialist - MRCPATH would have been an unwanted and expensive, time consuming "hoop to jump through" and would have prevented me from developing my interests as I have done (MSc epidemiology, research out of programme)</p>	<p>Tue, Jul 12, 2011 2:04 AM</p>
37.	<p>If some ID training occurs under the auspices of other medical specialties, the key issue is that the infection training side of that attachment is supervised regularly (several times / week) by an ID consultant, rather than the majority of that attachment being devoted to service delivery of that non-ID rotation. This would help ensure that attachment aids in both ID and general medicine training (of which a small proportion is probably of use to all trainees).</p>	<p>Mon, Jul 11, 2011 9:59 AM</p>
38.	<p>As previously stated, you will dilute the experience of 'infection' trainees. I think they will come out of the program much less likely to function adequately at consultant level. In my own speciality we already get too little infection control training. Why not concentrate on improving the core teaching to your current trainees rather than sweeping changes that I feel will exacerbate the problem.</p>	<p>Mon, Jul 11, 2011 8:37 AM</p>
39.	<p>If training becomes too broad and too short you do not end up with specialists. I think at present the FRCPATH is a good comprehensive exam, why change it? I think already ID/MMV is too broad and is ending up with frustrated trainees, who are not sure what they are being trained for or which way they are going. I think that a core infection period is good for trainees to develop their interests and see which area</p>	<p>Mon, Jul 11, 2011 7:43 AM</p>

	they wish to specialise in but then need a full amount of time to train in that area.	
40.	<p>It is difficult to create a consultant with a hand in every pie. It is better to create a consultant with their hand in one pie, that they can get really stuck into, considering how thinly Consultants are spread at present.</p> <p>This will also help to prioritise and organise training posts for those with that speciality interest, rather than the few posts that there are being allocated randomly and for short periods of time.</p> <p>Competition for each speciality should be at entry level i.e. ST3 with people being allowed to change across speciality during core infection training if this allows, rather than introducing another levels of competition and administration after core infection training.</p> <p>I believe that examinations should also be merged to avoid an increase in the workload of trainees with a general exam in core infection and then the exit exam in the trainee's speciality i.e. ID/GIM or ID/MMV etc.</p>	Mon, Jul 11, 2011 7:21 AM
41.	6 years total is the minimum amount of training needed. That is what core infection training is at the moment, not sure why it should be reduced? Could there be a period of core infection training of 3 years that you enter straight from FY2 including gen med, paed, micro, virology, ID, GUM etc. etc... then specialise in ID or MM/MV for 4 years after that.	Mon, Jul 11, 2011 6:23 AM
42.	I am keen on the possibility of being trained in ID, micro and GiM, however this is achieved. It seems to me that micro and GiM are obvious correlates to ID, just from different angles.	Mon, Jul 11, 2011 6:18 AM
43.	I feel cutting the period of training in microbiology from 5 years to a year or so will affect the outcome, otherwise why am I trained in virology for 5 years if you feel a year or so will be enough in a core training. I do not understand the drive in this project. I am totally against the idea but unfortunately was not involved in any discussions. I would advise open discussion on larger scale; this process will affect our career and the future of our specialties as well.	Mon, Jul 11, 2011 6:09 AM
44.	What is going to happen to FRCPATH.....are we current MM trainees spending vast amounts of time and money to get a qualification that is about to be abolished/unnecessary/irrelevant/unmarketable?	Mon, Jul 11, 2011 6:02 AM

17: Any other comments that you want us to feedback?

1.	As above please	Mon, Aug 8, 2011 5:38 AM
2.	<p>Another aspect affecting the fitness for purpose of the infection training curriculum is that the nature of pathology services is changing as we speak. There should be more transparency about this unacknowledged driver for change that is the increasing automisation and impending centralisation of pathology services which may make the traditionally trained microbiologist all but redundant. Surely there needs to be open discussion about the future pathway of management of infection services before the best method training can be decided rather than the other way round. Infection training needs to be flexible enough to adapt to the future realpolitik of the NHS.</p> <p>What models have worked in other countries? I don't think there is enough focus on the academic aspects of training in the proposed scenario. How would we (with mortgages and children) fund time OOP for research?</p> <p>In filling out this form I find myself answering a question yes or no but then realising I am contradicting my previous answer. This is possibly representative of the difficulty and circularity of argument affecting the debate thus far and possibly the fact that there are certainly no easy answers and perhaps no good answers?</p>	Fri, Aug 5, 2011 10:39 AM
3.	Dr Miller's way ahead is preferable to the current plan	Fri, Aug 5, 2011 2:07 AM
4.	Leave the curricular alone and save lots of time and money. Tweak the training arrangements locally so that micro/viro/ID trainees can share the bits of current training that overlap.	Wed, Aug 3, 2011 3:46 PM
5.	The importance of OOP and flexibility re movement into academia should be preserved where possible	Wed, Aug 3, 2011

		2:13 AM
6.	<p>I have recently completed training. I would not want to have increased my training in laboratory infection medicine (6 months). My current position allows me to offer my GIM training to the hospital as a consultant on call for medicine. There is a shrinking number of consultants willing to take part in the general medical take and in many places acute medicine is not able to expand to take on complete care of acute medical admissions. I feel it is still very important to allow people to train and gain accreditation that would allow them to continue to do this. This needs to be clarified.</p>	Tue, Aug 2, 2011 3:11 PM
7.	<ol style="list-style-type: none"> 1. How about the rapidly developing field of Travel Medicine - how does that fit into these considerations? 2. In terms of entering training to obtain an "Infection CCT", there should be clearly-stated allowances for doctors who have obtained CCT in Public Health Medicine, and who wish to engage in additional training for an Infection CCT (especially if they already MRCP or MRCPPath (or equivalent)). 3. How much full-time research time can be counted towards the Infection CCT? Particularly for doctors who wish to practice mainly as academics 4. How much credit could be granted for previous overseas training or experience - particularly for trainees who have come to the UK from developing countries in the tropics? Considering that such trainees may well have significant registrar-level (or indeed consultant-level) training and experience of tropical medicine and infectious diseases. 	Wed, Jul 27, 2011 2:05 PM
8.	<p>If you want feedback from consultants, suggest you send out the link to your questionnaire on the e-mail forum. There has been very little consultation at grass-roots level, with the whole process monopolised by those with a vested interest. The curriculum under consideration (especially the 4+1 model) has not been consulted on at all.</p>	Tue, Jul 26, 2011 8:05 AM
9.	<p>I think the removal of any credit towards CCT for time in OOPR is a retrograde step, considering the time that academic training already adds.</p>	Tue, Jul 26, 2011 4:57 AM
10.	<p>Thanks for the survey.</p>	Mon, Jul 25, 2011 12:22 PM

11.	<p>Address elephant in the room i.e. what to do with current microbiologists. The laboratory service does not need to be run by medically-trained professionals.</p>	<p>Mon, Jul 25, 2011 9:00 AM</p>
12.	<p>Having a single body overseeing the training with one portfolio, one set of workplace-based assessment forms, a uniform set of recognised exams and a single training fee would be ideal.</p> <p>Could I ask why a year in research will no longer be counted as part of training (as per Susie Alleyne's presentation)?</p> <p>Thank you for your efforts in summarising the proposed changes and in setting up the survey!</p>	<p>Mon, Jul 25, 2011 8:26 AM</p>
13.	<p>It is important to keep the ability to do the triple qualification in GIM/ID/MM for the limited number of people who want to do it</p>	<p>Mon, Jul 25, 2011 2:34 AM</p>
14.	<p>I believe a stronger clinical component than is currently the case could be delivered by including specialised clinics (e.g. viral hepatitis, HIV, TB, ID) throughout the training (whether based in ID/Micro or Virology). Also, I note there is no opportunity for feedback regarding the assessment. For an Infection specialist to be competent in Microbiology, there should be a minimum requirement/understanding of microbiological methods and newer molecular or rapid diagnostic methods. MRCPATH has previously tested these thoroughly - but I see no similar suggestion (or at least modification of current format) for the new curriculum.</p>	<p>Tue, Jul 19, 2011 5:16 PM</p>
15.	<p>Why not just make all micro posts Id/micro? Core infection training seems to offer just more general medical rota fodder. Also trainees get less experience overall before they CCT. Bad idea.</p>	<p>Sun, Jul 17, 2011 12:09 PM</p>
16.	<p>One of the stated 'impetus for change' reasons is now invalid as point 1 is no longer true regarding jobs in MM.</p>	<p>Sun, Jul 17, 2011 4:20 AM</p>
17.	<p>just the comments in box above. thanks for organising the survey Susie!</p>	<p>Wed, Jul 13, 2011</p>

		6:31 AM
18.	i will be more than happy if i can get detail feed back once this survey will get finalized	Wed, Jul 13, 2011 4:48 AM
19.	I know it's taken a long time to get to this point, but I like the way it is looking, especially with the involvement of the GUM/HIV. I think the future of HIV care has to be more integrated.	Tue, Jul 12, 2011 2:25 PM
20.	One of the obstacles I see in reforming the training pathway is that this may not be mirrored in changes in the working practice of consultants. If registrar training is more closely converged along a consult-based Infection path, the obstacle could then be faced that trainees will train in institution where this does not occur, i.e. creating a mismatch between training objectives and real-life practice. Perhaps this could be resolved in the final year of training where trainees can choose to specialise further and opt to work in hospitals that offer one service over another (e.g. ID inpatients or ID/micro ward consults or telephone based micro-led consults)	Mon, Jul 11, 2011 9:59 AM
21.	Often one spends so much time filling out surveys/portfolios/paperwork that one loses sight of training etc.	Mon, Jul 11, 2011 7:43 AM
22.	Trainees also want to know what is the driver behind these changes. Is it that training is inadequate, or is the drive political or financial? What are the circumstances necessitating change? What are the job plans that are envisaged for these trainees on completion of their training?	Mon, Jul 11, 2011 7:21 AM

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August 2011