

TRAINING IN INFECTION

Comments from the SAC in Infectious Disease and Tropical Medicine

INTRODUCTION

Patients in hospital with infections have traditionally received their care under two distinct models. In one, their primary named consultant is an infectious disease (ID) physician who orchestrates their entire episode of care and is primarily responsible for that episode. He may take advice from other specialists (including medical microbiologists) but he is the primary “attending physician”. In the alternative model, the patient with an infection is in hospital under the primary consultant care of another clinician (eg surgeon, geriatrician, cardiologist etc) and advice about management of the infective aspects of the episode of care is derived from infection specialists (either ID physician or medical microbiologists/virologists - MM/MV). In practice many district general hospitals will not have ID consultants on their staff and so in these hospitals, the second model of care is universally adopted. Even in those institutions that do have ID consultants, not every patient in the hospital with infection would (or should) be under the direct care of ID consultants.

It has long been appreciated that there is a great deal of commonality and overlap between the training and the career roles of ID physicians and medical microbiologists/virologists and some form of joint training has been under discussion for well over 20 years. About 10 years ago, a joint training programme was established and has proved to be extremely popular and successful. It involves trainees following the curricula of both ID and MM/MV and achieving appropriate competencies in both specialties. Training takes an indicative period of 6 years after completion of core medical training and on completion, successful registrars are awarded a CCT in both ID and MM/MV. It is not possible to combine training in general internal medicine with this dual training.

Potential drawbacks to the current combined programme are:

- Lack of clarity over career pathway on completion and attainment of CCT. In practice most of those with a dual CCT will end up practising predominantly either as ID physicians (perhaps with some additional laboratory responsibility) or as medical microbiologists/virologists (perhaps with some additional clinical roles). There has only recently been a post advertised (at Southampton) where an individual holding a dual CCT was specifically sought.
- The inability to combine this training with GIM and in effect obtain a triple CCT. Many trainees (especially those who train in Oxford) would like to be able to train additionally in GIM both for the job satisfaction and potential career openings that it provides.
- The frustration, time and expense involved in following two separate curricula administered by 4 separate Royal Colleges with 2 separate eportfolios and 2 separate assessment strategies. This should not be underestimated and it says much for the popularity of the overall package that trainees are prepared to put up with these problems in order to follow the joint training pathway.

CURRENT TRAINING

Currently, a trainee who wants to pursue a career in the management of patients with infection has the following options:

- He may train in ID alone - unusual except perhaps for someone who was pursuing a purely academic track. (Tropical Medicine is just ID with an additional year spent overseas in clinical training and the completion of an approved DTM&H course but otherwise, the curricula of ID and TM are identical.)
- He may train in ID and GIM
- He may train in Medical Microbiology (or Medical Virology)
- He may train in both ID and MM/MV

IMPETUS FOR CHANGE

There were two principal drivers for change in the training of the infection based specialities

1. It was perceived that there was a difficulty in recruiting to MM jobs both at consultant and trainee level whereas there was no shortage of good candidates coming forward to train in ID or ID/MM/MV combined.
2. It was recognized that the role of infection doctors in hospitals has changed over the last few years with increased concerns about healthcare associated infection (MRSA and C diff for example), increasing antibiotic resistance and increased numbers of patients with compromised immune systems (both due to HIV and cancer treatment). Medical microbiologists are increasingly moving out of the laboratory into the wards and ID physicians are often taking on roles previously the exclusive preserve of medical microbiologists (eg infection control doctor, ICU consults etc)

These, combined with the recognized shortcomings of the current dual CCT approach (detailed above) led to the establishment of the Academy of Royal Medical Colleges Infection Training Working Group (AoRMC ITWG) in 2007 to examine the feasibility of developing a better approach to joint training.

WHAT IS GENERALLY ACCEPTED AND SUPPORTED

The majority of ID physicians and medical microbiologists/virologists would support the idea of a “core infection training” curriculum where trainees spend 2-3 years of training in both the clinical and laboratory aspects of infection. Clearly an ID physician has to understand laboratory aspects of infection, principles of infection control and antimicrobial stewardship and a medical microbiologist has to be familiar with clinical features of infection.

All ID physicians and many MM/MV would accept that doctors looking after patients with infection should have adequate clinical training and experience. Certainly the concept that the only entry for core infection training (CIT) is from Core Medical Training (CMT) or possibly Acute Care Common Stem (ACCS)

(and therefore with full MRCP) would have universal support from ID physicians and probably widespread (but perhaps not unanimous) support from the MM/MV community.

All ID physicians would feel it essential that infection doctors remain essentially clinically based doctors and there is unanimous support in the ID SAC that any new proposals for ID training must allow trainees the opportunity to acquire a CCT in GIM as well as in "infection"

WHAT IS LESS UNIVERSALLY SUPPORTED

Some have suggested that in future, all management of infection will follow the second model above - ie it will be a purely "consult based" service and ID physicians will no longer be the primary consultants with responsibility for individual patients. Although this model may be appropriate in some institutions, most ID consultants would oppose its becoming the only model.

Some have suggested that ID training can be achieved by attachment to other medical units (eg chest medicine, geriatrics etc) but the ID SAC believes strongly (with only a single dissenting voice) that it is essential for at least 12 months of the core infection training programme to be under the direct supervision of ID physicians.

There is considerable controversy as to what should happen on completion of core infection training. There is agreement in the ITWG that following 3 years of core infection training, trainees should complete another 2 years of training but not all would follow identical tracks so that individuals can develop a bias towards a laboratory/infection control/clinical emphasis. However, the view of the ITWG is that irrespective of the path followed a single CCT in "Infection" should be the outcome. This concept of a single CCT is neither universally supported by ID physicians nor by medical microbiologists and virologists. There is some suggestion that it would be more difficult to have the single CCT approved by the GMC and recently there has been disagreement between RCPs and RCPATH about who would lead on the joint CCT and therefore there has been a suggestion from the Colleges that separate CCTs should be maintained.

The problem of having core infection training followed by 2 separate CCTs is that this would actually be a retrograde step in that currently it is possible to train and achieve 2 CCTs but in the new proposals that may no longer be possible. If core training continues to be administered by separate Colleges we shall have failed to remove any of the problems described above.

SUGGESTED WAY AHEAD

As noted above, there seems to be widespread support for a more clinically based training for medical microbiology and the concept of the core infection curriculum. There is less widespread support for the fact that ALL infection doctors should have an identical training and curriculum. One suggested compromise would be as follows

- All entrants for infection training would do CMT (or ACCS) and obtain MRCP
- All would then go into a core infection training programme. (Indicative duration 3 years). The exit from that would be acquisition of all core infection competencies assessed by a combination of work based assessments, educational supervisors' reports and success in an exam (which would be equivalent to an MRCPATH Part 1). During this period all trainees would follow a single

curriculum with a single eportfolio.

- Those who want to achieve a CCT in GIM additionally would do an extra period of training during their core infection training (?6-12 months)
- After core infection training trainees would enter higher specialist training and that could be either
 - 2 years of clinical ID training (+/- an additional year for tropical in a very few cases)
 - 2 years of medical microbiology training (or MV)
 - 3 years of combined ID/MM/MV
 - 3 years of ID/GIM (+/- an additional year for tropical in a very few cases)

The best thing (if the GMC would allow it) would be that all achieve a CCT in infection (+/- GIM) but that there would be a suffix in parentheses – ID/MM/MV). This would help employers get the message that they should be designing job descriptions for infection doctors rather than ID physicians or medical microbiologists/virologists. If this proved insurmountable with the GMC then we may have to accept that 3 separate CCTs would remain.

I believe that this suggestion would preserve the best and generally agreed portions of the ITWG work and take out the more contentious and divisive elements. It would still not allow people to train in ID and MM and GIM but I am not sure there is wide support for that concept – I think at some stage people have to make a decision as to whether they see themselves as predominantly laboratory or predominantly clinically biased. I would suggest that CIT is an RCP administered programme with an RCP eportfolio and that once higher specialist training (HST) is entered, then RCPPath would obviously supervise the MM/MV training and RCP would look after ID training. Clearly there would need to be enhanced MM/MV input to the ID SAC (although we already have such representation anyway)

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