7 October 2024

Professor Inam Haq MBBS MD FRACP FRCP (UK)
Executive General Manager | Education, Learning and Assessment
Royal Australasian College of Physicians (RACP)
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Dear Professor Inam Haq,

Subject: Development of the Clinical Immunology and Allergy Advanced Training Curriculum

We thank the Royal Australasian College of Physicians (RACP) for identifying the Australasian Society of Clinical Immunology and Allergy (ASCIA) as a key stakeholder in the development of the clinical immunology and allergy advanced training curriculum. We appreciate the opportunity to review and provide professional insights, with the redesign enabling development of best practice education and assessment models.

In compiling this feedback we have sought input from the ASCIA Directors and Chairs of the Adult Practice, Anaphylaxis, Drug Allergy, Immunodeficiency and Paediatric Practice Committees.

We have collated our feedback relevant to each consultation draft and would appreciate the RACP clarifying or considering the following points.

Proposed learning, teaching and assessment programs summary

Entry criteria

The current entry criteria enable a prospective trainee to enrol in Advanced Training in Immunology and Allergy with the RACP, without having been appointed to a position that is accredited for core clinical training in Clinical Immunology and Allergy. Could the RACP please provide clarification on how it defines “an appropriate Advanced Training position”, and is there any time limit on how long a trainee can be enrolled in Advanced Training in Immunology and Allergy without being appointed to a position that is accredited for core Immunology/Allergy training? At present, a trainee can enrol with the RACP as an Advanced Trainee in Immunology and Allergy (and present themselves as such) and without appointment to an accredited training position have no realistic prospect of completing their training. While these trainees will ultimately not progress through training and transition to Fellowship, it would be preferable for the trainees and supervisors if this situation was avoided by addressing this situation at the point of entry to training.

We propose that the RACP may consider a time-limited “provisional” enrolment in Advanced Training in Immunology and Allergy for those trainees who have not been appointed to an accredited training position; this would align with ASCIA’s approach when considering membership applications in the Trainee category, which is only offered to trainees who have been appointed to a position accredited for core Immunology and Allergy training.

If a trainee can enrol in Advanced Training in Immunology and Allergy without being appointed to an accredited core training position, how does the RACP envisage that the trainee would be able to demonstrate (and the supervisor assess) adequate progress in the proposed "specialty foundation" phase in the first year of Advanced Training? We are aware that in other disciplines, non-core training may be considered for approval only if it occurs after the trainee has completed a minimum amount of core training time (e.g. 6 or 12 months).

The revised entry criteria proposes that trainees must hold General registration with the relevant authority in Australia or New Zealand. Please confirm the following:

- If this requirement is applicable only at entry, does this means you can only commence training from within Australia/New Zealand, or do prospective trainees have to register with APHRA and obtain General registration while still overseas?
- If this requirement applies more generally to the program, how will this interact with someone completing training overseas if they do not continue to hold General registration in Australia/New Zealand for that period?

We respect that in a practical sense it probably does not make much difference, as the trainee is unlikely to be entering training from overseas, however the intent in the change is unclear and we suggest this is more clearly articulated.

Professional Experience

1. Please confirm if the need for paediatric Immunology and Allergy trainees to do six months of developmental training has been removed from the curriculum, as this is not included in the proposed requirements.

2. Our understanding is that the RACP proposes requiring 24 months of core training in accredited adult immunology and allergy positions for adult medicine trainees (and 24 months in accredited paediatric positions for paediatric trainees). To avoid any misunderstanding, we suggest clarifying this within the "24 months minimum FTE" section of the Proposed Requirement. We also request that the RACP confirm that where an accredited adult training position includes a minority of paediatric immunology and allergy practice (or vice-versa), that the full FTE in that position will be considered core training for the purpose of fulfilling the 24-month requirement and that the trainee's supervisor for that clinic has appropriate training and experience for that scope of practice.

3. Training in other settings is current provided as an example of non-core training. Please confirm that positions that include training in private, rural or remote settings will be eligible for accreditation as core training positions, subject to meeting the relevant accreditation requirements.

4. Interpretation of the requirement for "approved rotations in at least 2 different training settings" requires clarification. In some jurisdictions, there may only be 1 tertiary hospital at which an Advanced Trainee can be employed and effectively mandating that a trainee must relocate interstate for a period of time to complete their training may place an unreasonable burden on

trainees without clear evidence that it is necessary to achieve the required educational outcomes. In jurisdictions where there is only 1 site accredited for core Advanced Training in Immunology and Allergy, the site and their trainees are potentially disadvantaged if the trainee can only complete 1 year of their core training before being forced to resign and move interstate to complete their remaining training time. Could you please confirm whether or not the scenarios below would meet the requirement for a different training setting;

a. Non-core training in a different specialty at the same site where the trainee undertook their core Immunology and Allergy training
b. A paediatric immunology and allergy trainee undertaking non-core training in adult immunology at the same site where they completed their core paediatric training (or vice-versa)
c. A trainee working between 2 different sites with the same Area Health Service / Network (which e.g. may be considered by the Health Service as 2 campuses of the same institution)
d. Training in a diagnostic laboratory on the same site as where a trainee completed their core clinical training.
e. Undertaking clinical research as non-core training at the same site where the trainee completed their core training.

5. When the new curriculum is implemented, please confirm if trainees undertaking dual FRACP/FRCPA training will need to do two years of core Immunology and Allergy training. Our understanding is that joint trainees will not have any elective time as they will do 24 months laboratory and 24 months core clinical, given each college requires two years of core training. There are concerns this may put further pressure on training positions. Further, if a trainee is initially enrolled in dual FRACP/FRCPA training and undertakes 2 years of core Immunology and Allergy training and at least 1 year of core Immunopathology training but then decides to withdraw from FRCPA training, would they be required to complete an additional 6 months of non-core clinical training? There would be questionable value in requiring a trainee who has, for example, completed 2 years of core Immunology and Allergy and 2 years of core Immunopathology to complete a further 6 months of non-core clinical training if they have otherwise met all of the requirements for transition to Fellowship.

Learning program

We request clarification on the change ‘2 Learning Needs Analysis per core training year’ to ‘1 Learning plan per rotation’. Please confirm whether there is a specific length, or minimum/maximum length of a rotation (including if a trainee for example is at the same centre for a period of 2 years). To support effective learning planning we propose that a rotation should have a minimum length of 6 months during core training, with allowance of this rotation to occur across different sites within a coordinated training network.

Learning courses

It is unclear why Advanced Trainees are required to complete the full Supervisor Professional Development Program by the end of their Advanced Training. We suggest the RACP consider aligning with the requirements for any Advanced Training Supervisors, which allows provisional approval on completion of the SPDP 3 workshop and requires completion of all 3 workshops within 12 months to become an approved supervisor.

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Learning Activities

We support the addition of the requirement to attend an Annual Scientific Meeting (ASM) or Conference during training. The ASCIA Annual Conference is generally the most accessible and relevant meeting for Advanced Trainees in Immunology and Allergy in Australia and New Zealand. We acknowledge there are a range of other scientific meetings that are of value, and are concerned that the list provided in Appendix 1 may be unnecessarily prescriptive as it excludes meetings such as:

- Canadian Society of Clinical Allergy and Immunology (CSACI)
- British Society of Allergy and Clinical Immunology (BSACI)
- Asia Pacific Association of Allergy, Asthma, and Clinical Immunology (APAAACI)
- EAACI Food Allergy Anaphylaxis Meeting (FAAM).

While providing guidance on suitable meetings is helpful, we suggest phrasing the requirement as attending an Annual Scientific Meeting or equivalent *as approved by (insert supervisor, JCST) as meeting the educational needs of the trainee"*.

Teaching program

We request clarification around the changes to the definition of 'supervisor' (Page 3). Initially, a supervisor is described as a "Fellow in Immunology and Allergy" and subsequently in the same document as a "Fellow of the RACP in Immunology and Allergy". We suggest the RACP clarify whether it intends to exclude an overseas-trained specialist who has been recognised by the Medical Board of Australia as a Clinical Immunology and Allergy specialist but is not a Fellow of the RACP from being a supervisor; we suggest considering wording such as *"Fellow of the RACP in Immunology and Allergy, or registered as a Clinical Immunology and Allergy specialist with the Medical Board of Australia."*

Assessment program

Please provide further detail regarding the assessment tasks (Page 3), specifically, what is involved and what are the time requirements? From review, it is our understanding that for each phase (12 months) the required assessments are:

- 12 observation captures
- 12 learning captures
- 4 progress reports

We are concerned that these assessment requirements may prove to be quite onerous for the supervisors who are already managing a significant workload, however it is not possible to provide an informed comment on the appropriateness of the proposed requirements without having further information about the nature of these assessments.

We do not support the removal of the requirement that the trainee complete a research project in Immunology and Allergy, and request that the requirement be amended so that an Advanced Trainee in Immunology and Allergy complete a research project that is directly related to their area of specialty training.

The requirements for trainees to demonstrate experience in training and supervision of other health professionals and students are demanding, and there may be limited opportunities for trainees to achieve this compared to other inpatient-based specialties that supervise larger numbers of medical students, RMOs and basic physician trainees.

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Curriculum Standards

Professional behaviours

While we support the concept that all Advanced Trainees should consistently behave in line with all 10 domains of professional practice, the Progression Criteria matrix implies that these behaviours do not evolve and improve over the duration of training (i.e. they are at Level 5 throughout) and it would be preferable to reflect the development of the competencies related to these domains as a trainee progression through the phases of their training.

Entrustable Professional Activities (EPAs)

These are defined as outlining the essential work tasks trainees need to be able to perform in the workplace, and could therefore be interpreted as intending to specify what a trainee needs to be able to do to ultimately transition to an independently practicing specialist in Immunology and Allergy.

As a general observation, however, the EPAs are non-specific and are a series of somewhat generic statements that may prove difficult to assess. It may be preferable for the RACP to map the clinical conditions that fall within the scope of Immunology and Allergy training on to the relevant EPAs and then create a summary of the essential tasks that a trainee needs to be able to demonstrate to provide expert clinical care for those conditions. While this represents a significant amount of work, it would potentially provide a more robust framework against which supervisors could assess trainees' progression through phases of Advanced Training.

Some additional specific feedback was provided:

1. Section EPA 9: Prescribing – page 48, the only mention in the whole document of ASCIA Action Plans is under "Communication", where it states "provide standardised action plans, such as the Australasian Society of Clinical Immunology and Allergy anaphylaxis management plan". Although we acknowledge that is supposed to be a general, high level structure, it is vitally important that prominent discussion around the fact that *every* patient with IgE-mediated food allergy *needs* either an ASCIA Action Plan for Anaphylaxis or an ASCIA Action Plan for Allergic Reactions is considered as part of the curriculum. This would be best placed in relation to management of anaphylaxis and IgE-mediated allergy. Additionally, we emphasise the importance of referring to national best practice standards around the management of patients in the community - with some examples like https://allergyaware.org.au/schools/best-practice-guidelines-schools , https://allergyaware.org.au/childrens-education-and-care.

2. Section EPA 10: Investigations and procedures – where it states 'venom and/or aeroallergen desensitisation protocols', we suggest amending this to, *'venom, drug and/or aeroallergen desensitisation protocols'*

Knowledge Guides

1. Knowledge Guide 1: Foundations of immunology, diagnostics, and therapeutics – page 64, in the 'Investigations, procedures and clinical assessment tools' section where drug and latex are referenced, we suggest adding to the points listed:
   - Drug desensitisation
   - Assess cross-reactivity between drugs

- manage drug hypersensitivity reactions especially severe cutaneous adverse reactions

It is also our opinion that the "drug and latex" component should be listed under Knowledge Guide 4 - Allergy and Hypersensitivity reactions.

2. Knowledge guide 1: Foundations of immunology, diagnostics, and therapeutics – page 65, the 5th bullet point under "Important Specific Issues" requires rewriting. It is difficult to understand - reasons include the sentences are too long, the material after the initial bullet is too specific/does not seem relevant to many of the sub-points, and the sub-points overlap, for example allergen-specific immunotherapy is addressed piecemeal within multiple sub-points.

3. Knowledge guide 2: Immunodeficiency – page 67, we would like to highlight the prescriptive nature of the core knowledge list for Inborn Errors of Immunity (IEI) which include primary immunodeficiency. The definition of core knowledge needs to be included and, although it is helpful to be somewhat prescriptive, the IEI field is developing quickly. We are concerned that the list will be rapidly superseded so would prefer if the wording can be softened with a qualifier such as *"at least"* or *"included but not limited to"*.

4. Knowledge guide 3 – Autoimmunity and autoinflammatory disease - we agree in principle that paediatricians are required to know all these conditions. However, some of the conditions listed are vanishingly rare in paediatrics and in many places, are dealt with by rheumatologists in the paediatric setting. We acknowledge that this may be a distinction from adult practice. While the internal medicine physicians need to have in depth knowledge here, we are unsure how suitable it is for paediatricians given the scarcity of these conditions in practice.

5. Knowledge guide 3: Autoimmune and autoinflammatory disease – page 71, please amend 'Lawasaki syndrome' to '*Kawasaki disease.*

6. Knowledge guide 4: Allergy and hypersensitivity reactions – page 75, we request a review of the the heading "Presentations" where there seems to be a combination of symptoms and diagnoses. For example, listing "Anaphylaxis" as a separate presentation from "lower airway symptoms" and "presyncope" confuses the fact that Anaphylaxis is a diagnosis that may encompass lower airway symptoms and presyncope.

7. Knowledge guide 4 - Allergy and Hypersensitivity reactions – please amend
   a. 'nonsteroidal anti-inflammatory drug (NSAID)' to read *'NSAID intolerance or NSAID hypersensitivity'* (page 76)
   b. 'interstitial nephriti' to read *'interstitial nephritis'* (page 76)

8. Knowledge guide 4: Allergy and Hypersensitivity reactions - We request consideration of the inclusion of a section for 'Drug Allergy', similar to those listed on page 79. This should include understanding immunopathology of drug allergy including:
   a. hapten mechanism
   b. p-i concept
   c. altered peptide repertoire model

9. Similarly, we request consideration of the inclusion of a section on 'Venom Allergy' here.

10. Knowledge guide 4: Allergy and Hypersensitivity reactions – page 80, we request the inclusion of 'Drug challenges' among the list of procedures which should include:

    a. intradermal testing and delayed reading
    b. patch tests
    c. skin biopsy

11. Knowledge guide 4: Allergy and Hypersensitivity reactions – page 81, under "Important Specific Issues", the heading "Anaphylaxis – allergens, drug, and food" is confusing as it suggests that drugs and food are distinct from allergens. We would also request that context is added to the phrase "Allergen immunotherapy". Our suggestion would be to differentiate between areas where immunotherapy is accepted standard practice such is the case for Venom Immunotherapy (VIT) and aeroallergens, and areas where the practice of immunotherapy is evolving/emerging.

12. Knowledge guide 4: Allergy and Hypersensitivity reactions – page 81, with the proposed inclusion of a section for 'Drug Allergy', please consider including the following important specific issues:
    a. Assess penicillin allergy especially in light of delabelling penicillin allergy in the low risk population
    b. Management of delayed type hypersensitivity reactions including severe cutaneous adverse reactions such as SJS/TEN, DRESS and AGEP
    c. Contraindications, indications and the role of drug skin tests in investigations of drug hypersensitivity
    d. Assess cross-reactive drugs

We thank the RACP, including the Curriculum Review Group, for their commitment to the substantial and worthwhile undertaking of review and renewal of the Advanced Training curriculum for Immunology and Allergy.

We appreciate your invitation to provide this feedback on behalf of ASCIA, and look forward to your response.

Yours sincerely,

Dr Michael O'Sullivan
ASCIA President

Jill Smith
ASCIA CEO