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Infectious Diseases Residency in Portugal: from Paper to Practice

Internato de Doenças Infeciosas em Portugal: do Programa à Realidade

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INTRODUCTION

The Infectious Diseases specialty is what healthcare systems lean on when the ground shifts: emerging pathogens, fragile immunosuppressed populations, and the relentless grind of antimicrobial resistance. Training, therefore, is not a 'medical education' issue in isolation; it is directly tied to patient safety and staffing resilience. In the December 2025 issue of *Acta Médica Portuguesa*, Ganicho and colleagues took a timely look at Infectious Diseases training in Portugal through a national survey of residents and newly qualified specialists.[1] Their findings are hard to ignore: almost all respondents reported no protected time to study or scientific production within working hours, marked regional asymmetries were present in emergency work commitments, and confidence in the current assessment framework was strikingly low. Taken together, the message is uncomfortable but useful. If we want future-proof Infectious Diseases specialists, we cannot keep building a workforce on borrowed time.

In a cross-sectional survey of 73 respondents, predominantly residents, the authors explored the practical determinants of learning, including supervision and teaching, workload and rota designs, opportunities for study and scientific activity, and perceptions of how well the program content and assessment framework fit today's realities.[1] The strength of this approach is its immediacy. It captures the 'lived curriculum' of training, not just what is written on paper. No survey is perfect, but the pattern here is consistent, pointing to three pressure points that are difficult to dismiss: protected time, regional consistency, and assessment credibility.

Protected time is not a perk

If there is one finding in this survey that should trigger immediate action, it is the simplest: time. The most frequently reported challenge was the lack of dedicated study time within working hours.[1] That matters because Infectious Diseases is not a 'read-when-you-can' specialty: guidelines shift, evidence moves fast, and decisions land on real patients. When learning is routinely pushed into evenings and weekends, we should not be surprised if scientific output clusters in a few centers, or if trainees describe training as something squeezed around service rather than built into it.[1] The challenge is not knowing what to do; it is doing it. The updated 2025 training accreditation criteria for Infectious Diseases, developed by the Infectious Diseases College of the Portuguese Medical Association, explicitly require that at least 10% of weekly hours be dedicated to non-service activity.[2] In other words, protected time is not an aspirational 'nice-to-have'; it is now considered a minimum standard. Yet the survey suggests that, in practice, protected time is often absent, with predictable consequences for learning, quality improvement, and research output.[1] The implication is blunt: the gap is not conceptual; it is operational. If we want to fix inequities and modernize assessment, we first need to stop borrowing time from trainees and start ring-fencing it as part of the program's basic infrastructure.

One specialty, different rules

A national training program cannot be national in name only. The 2011 Infectious Diseases training program explicitly places responsibility on training bodies to ensure the greatest possible uniformity nationwide, even though this survey describes a landscape in which core experiences vary meaningfully by region.[1,3]

The most obvious example is the role of Internal Medicine in emergency care. Most respondents viewed extended Internal Medicine emergency rotations beyond the first year as detrimental, but what counts as 'prolonged' appears to depend on geography. While most participants in Northern Portugal reported doing this activity only in the first year, the majority of participants in the Lisbon metropolitan area continued it at least until the fourth year (out of five).[1] That is not a minor scheduling nuance; it is a structural difference in how training time is spent, what clinical cases trainees repeatedly see, and how much space remains for specialty-relevant learning.

The same 'postcode effect' surfaces in reported clinical

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and scientific output and even weekly study hours, with respondents in Northern Portugal describing higher volumes and more time for study than in the Lisbon metropolitan area.[1] Whether or not these differences reflect case-mix, staffing, rota design, or local culture, the implication is the same as unequal conditions create unequal opportunities. And when emergency activity dominates, it should at least be educationally aligned. Notably, most participants supported a dedicated triage model for Infectious Diseases in the emergency setting, suggesting that solutions need not be theoretical, they can be implemented nationally, with room for local adaptation.[1]

Assessment needs credibility

If training is the engine, assessment is the dashboard: it signals what the program values, and it determines what trainees prioritize under pressure. In the Ganicho *et al* survey, confidence in that dashboard is close to zero. Fewer than 3% fully endorsed the current final exam model or the curriculum grid, while around a third reported that they did not know or could not answer.[1] This is more than dissatisfaction; it is a warning about legitimacy and transparency. Importantly, respondents called for more objective criteria across exam components, less jury-dependent, an updated national topic matrix, and a greater emphasis on clinical case discussion over formalized history-taking.[1] They also questioned the disproportionate weight of a single end-point exam, favoring multiple assessment moments distributed throughout residency.[1] The same logic extends to the curriculum grid: prioritize the quality, not the sheer quantity, of research outputs, and recognize non-formal competencies and meaningful clinical and community impact.[1] In short, the direction of travel should be towards a credible system more standardized, more formative over time, and better aligned with what modern Infectious Diseases practice demands.

From signals to accountability

These findings also sit alongside previous national data. In the 2023 national satisfaction survey of medical residency, Infectious Diseases scored 2.92/4 for overall satisfaction (33rd out of 41 specialties), with comparatively lower scores for satisfaction with the training program leadership/coordination, based on a smaller respondent pool.[4] What matters is not the exact rank, but the pattern.

The relatively low scores for training programme leadership and coordination sit uneasily with the persistent 'known problems' that prompt local discussion but rarely result in tangible improvements.[4]

Zooming out, the timing of this survey does not seem accidental**.** National planning data show that Infectious Diseases has expanded rapidly in Portugal: rising from 137 to 207 specialists between 2013 and 2022, with the majority under 50 years of age and with most specialists delivering care within the public National Health Service (83% in 2022).[5] Yet the training pipeline is beginning to wobble. In the 2024 national specialty allocation and subsequent cycles, Infectious Diseases did not fill all specialty training posts (15 unfilled posts out of 82, to date), with the largest shortfall in the Lisbon metropolitan area.[6] In other words, the country is clearly investing in a larger Infectious Diseases workforce, while tolerating training conditions that make recruitment and retention harder. That mismatch is precisely where the 'learning environment' intersects with health-system infrastructure. Taken together, the message is not that Infectious Diseases training is 'broken', but that it is being asked to function inside a system that often runs on trainees' spare capacity**.** Where local leadership invests in training infrastructure, training thrives. Where service pressure routinely crowds those safeguards out, it becomes uneven; and such unevenness is now markedly reflected in recruitment patterns and career decisions, within a broader context in which the rising cost of living and particularly housing has emerged as a decisive constraint.

Three fixes, now

First, ensure that protected time is genuinely protected: set a minimum requirement, monitor it systematically, and regard persistent non-compliance as a matter for accreditation rather than an inconvenience borne by trainees.[2]

Second, standardize what 'core' looks like across the country: if external emergency work is educationally valuable, define its scope; if it is not, stop letting it displace specialty learning by default. Because a 'national' program cannot depend on postcode.[1,3]

Third, rebuild assessment credibility: move from a single high-stakes endpoint towards clearer national expectations and more formative assessment over time, aligned with what trainees themselves are asking for.[1] The cost of inaction will be paid through uneven training, weaker recruitment, and, ultimately, poorer patient care.

OBSERVATION

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AUTHOR CONTRIBUTIONS

JMatos: Article conception and design, national data review, writing of the manuscript.

JMéndez: Critical review of the manuscript.
All authors approved the final version to be published.

CONFLICTS OF INTEREST

The authors have no conflicts of interest to declare.

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