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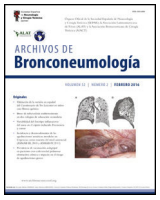

Editorial

Areas of Specific Subspecialization (ACE) in pulmonology☆

Áreas de Capacitación Específica (ACE) en neumología

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It has been clear for years that in clinical specialties with a very wide area of activity, such as respiratory medicine, highly specific areas of knowledge and sophisticated techniques will emerge over time[1]. This calls for formal recognition of this specialization to ensure that the positions offered in National Health System hospitals cover the specific developmental needs of each respiratory subspecialty.

The Spanish Ministry of Health, mindful of the evidence and necessities, has been working to regulate specific subspecialization areas (*Áreas de Capacitación Específica* [ACE] in Spanish). In this respect, there are plans to approve a decree-law on subspecialization, to regulate this, currently unrecognized specialties, and to make a new attempt to establish or strengthen the core syllabus in general-internal medicine[2], now known as "transversality". Although the latter is equally controversial and probably calls for a SEPAR position statement, this editorial focuses only on ACEs and how they should be implemented. It appears that the initial plan was to include subspecialization in the already tightly packed 4-year residence period, although, paradoxically, the subspecialization period is specified as 1–2 years.

It is obviously impossible to train a pulmonologist in general respiratory medicine and in a subspecialization at the same time, as basic specialist training would be already reduced to a scant year and a half (and this time includes duty rosters and vacations), leaving it squeezed in between the core syllabus (18 months) and the proposed subspecialization. As things stand, then, it is impossible complete the current general specialist training program[3,4]. In fact, SEPAR has been calling for years for a 5-year residency in basic specialist training in respiratory diseases[5,6].

To contemplate a period of subspecialization during the current 4 years of residency, of which almost 3 are dedicated to other topics, is not simply difficult and problematic, it is clearly impossible and foolhardy. The logical approach would be to subspecialize separately after the period of residency for the basic specialization in respiratory medicine, that would last 5 years, as is already the case in other European countries and in North America, and often demanded here[5–8]. Furthermore, training in both the general specialty and subspecialties (ACE) should be harmonized with our neighboring countries, and this probably calls for regulatory convergence and a drive for initiatives such as HERMES[9].

Another bone of contention is what scientific and/or technological area would be a suitable ACE and who should put forward the proposal. On the one hand, certain areas of expertise often have dedicated hospital units and might aspire to be considered a subspecialization or specific area of respiratory expertise. These include, for example, severe asthma, interstitial pathology, smoking cessation, lung vascular disorders, lung transplantation, and semicritical patients. On the other hand, some areas of expertise require specific training in both theoretical aspects and in instrumentation skills. This is true not only for some of the aforementioned areas, but also for interventional pulmonology, highly specialized respiratory function units that perform both standard and exercise tolerance testing, and units that study respiratory sleep disorders. We believe that both approaches may be correct, and that the National Health System and scientific societies must clearly define their needs in order to facilitate prioritization. The system must also be flexible enough to adapt to unexpected situations, such as the Covid-19 pandemic and the implementation in Spain of numerous intermediate respiratory care units. However, for the time being, the order in which the ACEs should be established, their requirements, and who should propose them all remain unclear.

A third important issue is to determine where the subspecialization should be available, and what the training program should consist of. Will it be offered in all units that are accredited for resident training? Or only in tertiary centers with previously accredited specialist units led by renowned professionals? In the latter case, who will accredit them? Moreover, will all respiratory medicine

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residents be able to subspecialize, or only those working in suitably accredited centers? The ideal training program, we believe, should be based on the acquisition of skills, possibly inspired by the SEPAR Continuous Professional Development (CPD) program. This also means that the criteria for acquiring ACE skills and qualifications must be clearly defined, and it should not simply be a matter of following the training program as is currently the case with obtaining qualifications in medical specialties.

A fourth controversial issue is to decide when a resident can choose to be either a general pulmonologist or a subspecialist in one or more ACE. The initial idea behind the proposed decree is that the resident makes this decision at the time of selecting their internship, although at that time the applicant (usually a recent graduate in medicine) obviously cannot know what area of the specialty they are going to find most attractive, or if they want to practice as a general specialist or acquire a subspecialty.

Finally, another aspect that can also cause controversy is the possibility of accessing a specific ACE from different medical specialties. This may be admissible in some cases: for example, general training in sleep disorder studies may be accessible to both pulmonologists and neurophysiologists, while pulmonary hemodynamic training could be made available to cardiologists and pulmonologists, but in many other cases it could lead to encroachment into specific areas of a specialty. Whose decision will this be? Who will make the proposal? It seems clear that scientific societies, such as SEPAR, should lead the debate.

Despite the importance of this topic for the future of both respiratory medicine and thoracic surgery, the authorities seem intent not only on rushing through legislation to resolve these uncertainties, but on arriving at a "low cost" solution without giving scientific societies the chance to calmly debate with the regulatory authorities the issues in question. SEPAR needs to state its position and try to ensure that such a laudable and necessary goal as the accreditation of subspecialties is implemented following a methodology that encourages excellence in subsequent professional practice.

The aim of this editorial is to put some of the key questions for the future of respiratory medicine in the spotlight and to generate the much-needed debate. The National Health System requires a solution to the subspecialization issue as soon possible, but this must be a quality solution that has been evaluated and debated by all the sectors concerned, and as far as possible, it should be the fruit of consensus.

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