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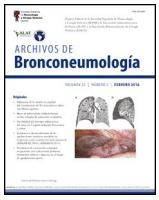

Editorial

The Core Curriculum☆

Troncalidad

Jaume Ferrer,[a,b,*] Júlia Sampol[a]

[a] Servei de Pneumologia, Hospital Universitari Vall d'Hebron, Barcelona, Spain
[b] CIBER Enfermedades Respiratorias (CIBERES), Barcelona, Spain

The introduction of the core curriculum model has been presented as the most significant change in specialized medical training in Spain since the launch of the MIR system.[1] The core curriculum was based on directives from the European Higher Education Area and had the commendable goal of improving the general training of medical specialists. It first came into law in 2003,[2] and this Act was followed in 2014 by a Royal Decree.[3] Five core specialties (medical, surgical, laboratory, clinical imaging, and psychiatry) were defined, pulmonology being one of the 21 medical sub-specialties. Briefly, doctors would choose a core curriculum teaching unit according to marks obtained in a single MIR examination, similar to the one already in place. They would then complete a 2-year core training period based on an educational program prepared by a core committee. They would be supervised by core tutors and assessed by their corresponding teaching committee. If their assessment was positive, they could then choose the teaching unit where they would study one of the specialties on offer that year. Places would be awarded in descending order, according to the marks obtained in the test determining access to that core specialty.[3] However, as a result of an appeal submitted by the Spanish Society of Immunology, in December 2016 the Supreme Court repealed the Royal Decree of 2014, due to the unavailability of an appropriate analysis of the economic impact that the core curriculum would have on the autonomous communities.[4]

In the case of pulmonology, we would like to consider the repercussions of switching from the training program currently in place to a core curriculum system. Our specialty is expanding, due to both advances in the knowledge of respiratory diseases and the technological innovations being introduced. We believe that for some time now, the competencies and skills covered in the training program are disproportionate to the 4 years assigned to acquire them. Indeed, this period has not changed in the last 30 years. During this time, we have witnessed substantial changes, with the introduction of non-invasive ventilation, sleep study units, semicritical care, lung transplantation and smoking, day hospitals, and the implementation of new techniques, such as chest ultrasound, endobronchial ultrasound, pleuroscopy, interventional bronchoscopy, hemodynamics, and other new skills that the respiratory medicine specialist must master, as specified in the HERMES European program.[5,6] Many of these advances were included in the official training program set down in the Official State Bulletin of 2008, although the training period was not extended.[7,8] The bulletin even set out competencies in lung cancer chemotherapy, analysis of respiratory samples for cytological, microbiological and mineralogical study, presentation of scientific communications, publication of scientific studies, and presentation of projects for obtaining a doctorate. This is clearly an ambitious program, but a closer look at the rotation program reveals how difficult it is to attain the required competences and skills within the current framework. It may be illustrative to compare the official programs for pulmonology and cardiology. Both specialties share a similar structure, based on clinical experience and technical aspects, but while the pulmonologist has 4 years for training, the cardiologist has 5.[9] Both programs include a generic rotation and a similar amount of time in the clinic. With respect to technical skills specific to the specialty, cardiology includes 4 rotations: echocardiography (6 months), exertion testing (3 months), hemodynamics (6 months), and arrhythmias (4 months), 19 months in total. Pulmonology, in contrast, only covers 2: bronchoscopy (6 months), and lung function and sleep studies, grouped together (6 months), 12 months in total. This is a clear underestimation of the training required both in lung function testing, which in our case also includes exertion ergometrics, and in sleep disorders, and does not provide for any rotation in right heart hemodynamics. The extra year enables cardiologists to receive training in pediatrics and cardiac rehabilitation, and offers an optional period of 4–6 months, during which the trainee specialist can acquire the programmed competencies, with sufficient flexibility to adapt their training to the different characteristics of hospitals with specialist units. In the case of pulmonology, this would include lung transplantation or cystic fibrosis units, etc. Finally, a review of pulmonology training programs in Europe reveals that Spain is one of the four countries with the shortest training periods.[10]

The core curriculum law is, in short, focused on one single aspect of resident doctor training, namely the generic phase. This was in effect extended, albeit without making explicit mention of any

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* Corresponding author.
E-mail address: jjferrer@vhebron.net (J. Ferrer).

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improvement in the actual specialization phase. Quite the contrary, in pulmonology in particular, the specific training period was to be reduced even further, from 30 to 24 months.[11] While it is true that the act did consider the function of the National Pulmonology Council when redefining the training program, there was no guarantee that the total training time would eventually be extended: as we have pointed out, this period should be 5 years.

Of course, other questions have also fueled the debate. Indeed, while each national specialty council determined the competencies to be acquired in the specialist training phase, the national specialty council had to define the generic competencies, and the role of the pulmonology tutor was not defined by the core specialty committees. The assessment system of the core specialty phase was yet another bone of contention. For example, the introduction of a subjective assessment at the end of the core speciality phase is questionable in a system which has always based its impartiality on the objectivity of the MIR examination.

Considering the foregoing, we believe that the debate on the suitability of the core curriculum model as it affects pulmonology cannot be resolved unless we can be certain that specific pulmonology training will not be affected by the change. Improving the overall training of pulmonologists is clearly a reasonable objective. We believe that a model such as the UK system, which includes core training for at least 2 years and a minimum of 4 years in specialist pulmonology could be a good starting point. The Spanish proposal for the core curriculum, in our opinion, only affects the core training period, to the detriment of specialist training in pulmonology.

In view of all this, and without going into the economic reasons on which the repeal of the project was based, saying we are in favor of the core curriculum model provided the total time of training is increased, is the same as saying we are against it unless such an extension is guaranteed.

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