CIRUGÍA ESPAÑOLA

www.elsevier.es/cirugia

Special article

General Surgery Training in Spain: Core Curriculum and Specific Areas of Training☆

José Mª Miguelena Bobadilla, Dieter Morales-García, Ignacio Iturburu Belmonte, José Antonio Alcázar Montero, Xabier Serra Aracil, Fernando Docobo Durantez, Ignacio López de Cenarruzabeitia, Mercedes Sanz Sánchez, Juan Ramón Hernández Hernández*

Members of the Sección de Formación Posgraduada and D.P.C. de la Asociación Española de Cirujanos, Spain

ARTICLE INFO

Article history:
Received 4 September 2014
Accepted 6 October 2014
Available online 14 February 2015

Keywords:
Surgical training
Specific training areas in surgery
General and digestive surgery

ABSTRACT

The Royal Decree RD 639/2014 has been published, regulating among others, the core curriculum, and specific areas of training (SAT). It is of great interest for the specialty of General and Digestive Surgery (GS and DS).

The aim is to expose and clarify the main provisions and reflect on their implications for the practical application of the core curriculum and SAT in the specialty of General and Digestive Surgery, to promote initiatives and regulations.

This RD will be a milestone in our specialty that will test the strength of the specialty, if it does not finally culminate in its degradation against the emergence of new surgical specialties.

A new stage begins in which the Spanish Association of Surgeons should be involved to define the conceptual basis of GS and DS in the XXI century, and the creation of new SAT to continue to maintain the ''essence of our specialty''.

Formación en cirugía general en España: troncalidad y áreas de capacitación específica

Palabras clave:
Formación quirúrgica
Áreas de capacitación específica en cirugía
Cirugía general y digestiva

RESUMEN

Se ha publicado el R.D. 639/2014 que regula la troncalidad y las áreas de capacitación específica (A.C.E.) que constituyen una norma de gran interés en la especialidad de Cirugía General y del Aparato Digestivo (C.G. y del A.D.)

Se pretende exponer y concretar las principales disposiciones y reflexionar sobre sus implicaciones en la especialidad de C.G. y del A.D., para promover iniciativas y regulaciones.

☆ Please cite this article as: Miguelena Bobadilla JM, Morales-García D, Iturburu Belmonte I, Alcázar Montero JA, Serra Aracil X, Docobo Durantez F, et al. Formación en cirugía general en España: troncalidad y áreas de capacitación específica. Cir Esp. 2015;93:147–151.

* *Corresponding author.*
E-mail address: jmmibo@unizar.es (J.M. Miguelena Bobadilla).

Después de una gestación compleja, este R.D. supondrá un hito en nuestra especialidad, que pondrá a prueba su fortaleza, si no es que culmina finalmente con su degradación frente a la emergencia de nuevas especialidades quirúrgicas, como ya sucedió en el pasado.

Se inicia una etapa en la que la Asociación Española de Cirujanos deberá implicarse, para definir las bases conceptuales de la C.G. y del A.D. en el siglo XXI, y la creación de las nuevas A.C.E., para seguir manteniendo la «esencia de nuestra especialidad».

Introduction

The Royal Decree (R.D.) 639/2014[1] has just been published regulating the core curriculum, the core curriculum re-specialisation and the so-called specific areas of training and establishing the regulations applicable to state testing of access to health training places with specialisation in Health Sciences and creating and modifying certain specialty degrees.

Overall, this R.D. has the following purposes: (1) to incorporate core curriculum criteria into the training of certain medical specialties; (2) to regulate the procedure for obtaining a new degree in a specialty which belongs to the same core block; (3) to establish and regulate the specific areas of training (SAT); and (4) to suggest the creation and, if applicable, the modification of certain specialty degrees in Health Sciences. All of this will entail a development of the training system which will require an important adaptation of the involved teaching structures.

It seems that it would be a current theme of great interest to expose and implement, firstly, the main provisions which will affect the core of a particularly complex and important specialty such as General and Digestive Surgery (GS and DS) which constitute the basis of the core curriculum training of the rest of the surgical specialties[2]; and, secondly, to raise some considerations about the near future, which permit and promote initiatives and regulations within the practical application environment of the core curriculum and SAT in the specialties of GS and DS.

The Core Curriculum

The incorporation of core curriculum criteria into the training of Health Science specialists is promoted as a development of Section 19 of the Law for the Organisation of the Health Professions.[3] It implies the acquisition of skills which are common to several specialties by means of a uniform training period and in line with the specialised training structure of other European Union countries.[4,5]

The purpose is to enable future specialists to acquire specific professional skills in the official training programme related to their specialty and, in addition, with an interdisciplinary and pluridisciplinary approach of the other specialties associated with the same core block, which favours team work and the patient's comprehensive medical care.

The core block is defined as the set of central skills that are common to several Health Science specialties and which will be acquired through a first period of common scheduled, structured, and specialised training, called core training, lasting two years, without implying professional effects ''per se'' and which will be completed with a second period of specific training in each specialty for the following three years.

GS and DS specialties and the rest of the surgical specialties are included in core block No. 2 or surgical core block, where Obstetrics and Gynaecology, Ophthalmology and Otorhinolaryngology (the three ''non-core'' specialties), and Anaesthesiology (medical core block) are not included.

Therefore, it will be compulsory to suggest new official training programmes of each of the specialties which will define the skills to be acquired in the two periods of core and specific training. The core programme, with skills that are common to all specialties integrated within the same core block, will be created by a national delegate commission, specific to each core block, and the specific programme, once the objectives and skills of the core training period have been determined, by a national commission for each specialty.

The R.D.[1] specifically regulates the process of access to and allocation of places both in core training and specialty training (Sections 27 and 35).

The core specialised training period will be offered in core teaching units legally accredited for such purpose and not necessarily matching the specific training teaching units as far as location is concerned, although they will be assigned by the corresponding autonomous community to an already set-up teaching commission or to a new one specially created for one or more core blocks, when required by the number of residents, the degree of dispersion or the multiple nature of the training devices.

The core last-year assessment or core final assessment shall be made by the corresponding assessment committee and may be positive, negative with possibility of makeup or negative with no possibility of makeup. Once core training has been completed, students will access specialty training by means of a state selective process where the (surgical) specialty and the accredited teaching site/service/unit will be chosen, where it will be performed, but always depending on the reference teaching commission selected in the previous core period, in the order of priority established by the score obtained in the initial access test.

Specific Areas of Training

The R.D.[1] in chapter IV categorises the SAT as those covering a set of knowledge, skills, and attitudes added deeply or in extension to those required by the official programme of one or several specialties, provided that this set of skills has a

relevant healthcare, scientific, social, and organisational interest. Some specialists will be allowed to go deeper in those facets required by the scientific progress within the specialty field, thus enabling the ''high specialisation''. Access and accreditation shall be governed by a specific, tutored, and assessed training programme, with reservation of the source place and the consideration of training specialists under a residency regimen. This will thus make it possible to get a SAT diploma, to be exclusively used by the professional who obtains it and without the possibility that, due to the denomination thereof, it may be confused with other university degrees.

The application for SAT creation, out of which none has been currently approved in GS and DS, may be filed by the health departments of the autonomous communities or by one or several national specialty commissions. For such purpose, they must meet the following requirements: (1) to represent a significant increase in the professional skills required by the official programmes of the specialties involved; (2) to prove there exists a relevant healthcare, scientific, social, and organisational interest which requires the involvement of a significant number of professionals; and (3) the impossibility of meeting such skills by means of training of other specialties, other specific training or advanced qualification and accreditation diplomas.

When a SAT is passed, a first area committee will be set up which will become part of the National Council of Specialties. It will be made up of six members chosen by the National Commission of Specialties, from among specialists who have a SAT diploma (?), a renowned prestige and professional experience in the SAT of at least five years, in the seven years prior to the date this R.D. comes into force. Two shall be members of national scientific societies within the SAT field and a maximum of three may be members of the National Commission of the Specialty. This area committee shall perform the following functions: to propose an official training programme, to establish the assessment criteria, to collaborate with the tutors and those in charge of the autonomous communities in terms of health training with specialisation in the organisation of teaching activities.

Access to the training process for getting a SAT diploma will be performed through the established state annual exams and it will be necessary to have the corresponding specialist degree and prove a minimum of two years of effective professional practice in the specialty as of the date the SAT was established. Finally, the SAT diploma will be obtained by means of a positive assessment showing the fulfilment of the objectives and the acquisition of the skills planned in the training programme.

As a unique exception, specialists who at the date of the SAT creation have a specialist degree enabling them to have access to the first ordinary call where training places for such area are offered may opt for obtaining the diploma, if they show professional expertise related to the area field, of at least four years prior to the publication in the Official State Journal. The corresponding area committee shall examine the applications and issue a report about the adjustment between the research teaching healthcare activity developed by the applicant and its equivalence with the skills derived from what is planned in the training programme. If the report is favourable, the applicant shall be admitted to sitting, at a single call, for a theoretical–practical test on the official training programme. By means of this exceptional procedure, only one area diploma shall be granted.

Re-specialisation

Chapter III ''briefly'' refers to the concept and criteria for obtaining a new specialist degree regarding the same core block through the re-specialisation system.

It specifies that the quota of re-specialisation places offered for all the State at the annual call of selective tests will refer to ''deficit specialties'' and shall not be higher than 2% of the places offered at the annual call, of the core specialties. The maximum percentage of these re-specialisation places which may be offered in each autonomous community shall not exceed 10% of the total number offered by the corresponding community.

It indicates that during applicant selection, an objective eliminatory test will be included, on the training programme of the corresponding core block, as well as the assessment of academic and professional merits of applicant specialists who may have passed such test, with the specific weight of the academic and professional merits being established between 50% and 60% of the total.

Once access is gained, the specialty-specific official training programme will be exclusively implemented in accredited teaching units and a source place reservation system will be established pursuant to the provisions set forth in the applicable regulations.

Considerations

After more than six years of speculations,[2,5,6] the core curriculum has finally arrived and is here to stay; however, in our opinion, the core curriculum is aimed at radically regulating some specialties in general and the surgical ones in particular. It is based on the proposal of some fundamental conceptual bases, common to (surgical) specialties of a same core block and which could be developed in any surgical specialty and even in any hospital accredited for core training.

But if the analysis of the contents of the R.D. goes deeper, the core curriculum could represent a mere speculative artifice which may enhance the training spectrum of the so-called surgical specialties ''a priori'', but obviously, in our opinion, not specifically of ours, which is solidly established in the current training programme. Apparently, it is set up as a ''tool'' that may somehow obtain, regulate, and boost the general surgical assistance by core residents, mainly at the level of the emergency room and also, allegedly, justify a utopian, specific surgical training of the future specialists in a record time of three years.[2,6–8]

Therefore, in our opinion, its implementation will not get an effective operational development ''a priori'' due to several circumstances:

1. It will entail not only a substantial change in the specific programme of the specialty[2,6] but also a potential deterioration of the specialised surgical training, of both General Surgery and the rest of the specialties, if the specific training programme duration is not temporarily increased.
   In a previous article,[5] it has already been commented that GS and DS could be seriously compromised in their concept and training programme, since only one core discipline position is known in the surgical field, which is why the phrase ''General Surgery and Digestive Surgery in particular'' could gain more relevance. In our opinion, the implementation of the core curriculum, taking into account the consideration of General Surgery as a core discipline of the rest of the surgical specialties (L.O.P.S [*Ley de Ordenación de las Profesiones Sanitarias* (Law for the Organisation of the Health Professions)])[3] and the very definition of our specialty ''GS and DS'' may be a milestone and an important recognition for it or, on the contrary, it could be another link in its conceptual deterioration by reducing the level of the specialisation scale. Could a general level be allegedly achieved at the end of core training, despite being only of name and not of skill, and could training for the second part of the degree be obtained in the following years?[2]
   In addition, it would have negative implications on the skill field in the training of our residents. It is not difficult to deduce that by increasing the resident turnover time of other specialties in surgical services and taking into account the implementation of European criteria related to the distribution of medical time, the density of residents therein will be significantly increased. And, if it is as expected, there is no boosting of (hospital and staff) healthcare resources, the attendance index of residents of GS and DS regarding the performance and involvement in several ''specific'' elective and urgent surgical and healthcare activities could be significantly reduced.
2. It will entail a restricted and temporary geographical mobility of some residents, possibly of those who have obtained a lower score in the selective process, to perform their core training in hospitals (for example, regional) or sites where some surgical services have obtained accreditation for core training, but with no accreditation to complete the specialty-specific training.
3. It could also be interpreted that one of the objectives and indirect consequences of the core curriculum would be the incorporation of new (and unprecedented up to then) professional healthcare resources (core residents) into new surgical services (accredited for core training) and emergency rooms of such hospitals, thus boosting their staff and operation, which up to that moment and on many occasions were seriously compromised or restricted.
4. What is the sense of (after a potential surrender to collective Resident Medical Interns [RMIs] and students) maintaining some criteria of access to the training system, and therefore to the core curriculum, and of further access to the specialty itself by means of a single objective test (since the positive assessment of the core phase does not modify the initially obtained priority, according to the score of the initial access selective process). Finally, there also does not appear to be, at the end of the training process, any proposal of a final, objective and universal assessment procedure that provides accreditation, categorises the level and degree of training achieved and guarantees transparency and effectiveness of the training system.

On the other hand, with the proposal, recognition and regulation of the SATs, a new ''paradigm'' is incorporated to the near future and fate of the medical specialties, since it will entail an authentic ''revolution'' both in the conceptual definition of the GS and DS and in the curricular positioning of Spanish surgeons and, as a consequence, in the structure, spectrum and categorisation of hospitals in relation to surgical services, functional or reference units and SAT.[2,5]

The result, despite being ''not urgent'' in our opinion, will be the substantiation by the Spanish Association of Surgeons and the National Commission of the Specialty, of those SAT which really entail an authentic approximation to specific scientific, surgical, and healthcare needs within the General Surgery field and in accordance with those accepted in Europe. In this sense, it would be necessary to choose, for example, general areas (laparoscopic surgery, oncologic surgery, transplants), clinicopathologic areas (hepatobiliopancreatic, coloproctological, endocrinological, of abdominal wall)[8] or other interdisciplinary ones (breast surgery, etc.).[7]

Moreover, it seems obvious to deduce that after the implementation of this R.D. there will be an intense positioning campaign both for the application for SAT by scientific societies or by its specific sections, and for obtaining and getting the individual recognition of such SAT ''original'' diplomas and, concomitantly, of the services/teaching units, currently active functional sections or units, that may include the training programme.

However, if, as it is expected, this first generation of specialists were to turn out to be very limited, the bases have been solidly established so that, as a unique exception, those specialists who at the date of the SAT creation have a specialist degree in GS and DS, showing professional expertise related to the area field of at least four years, prior to the publication in the Official State Journal, may have access to obtain the diploma in the first ordinary call where training places for such area are offered (3rd transitional provision).

Despite being already known that ''this regulation shall be applied the day after the publication in the Official State Journal'', it is clear that core training, at least structurally, would start to be effective, in the best of cases, within two years of the organisation and approval of the core delegate commissions and the publication in the Official State Journal of the official training programmes of specialties assigned to the core training system in which the skills to be acquired by residents within the core and specific periods will be determined. Thus, as of the RMI state call of year 2016, this is predicted to be implemented in first-year residents of 2017.

Likewise, the creation of SAT in our specialty, as well as the actual start of the training programme in accredited units,

could be logically implemented, in our opinion, only as of 2016 or 2017.

Therefore, a period of hard work, consideration and responsibility starts for the Spanish Association of Surgeons and its Training Section, which should not remain passive and away from these changes, to define conceptual and operative bases of GS and DS in the XXI century, the selection of SAT and the proposal of objectives, training programmes and skills of core training and the new specific programme of the specialty as well as of the SAT.

However, this will be done always boosting and defending the spectrum, importance and ''essence'' of our specialty, possibly suggesting, moreover, a change in its name to be more comprehensive and specific.

The SAT established will constitute an incentive and a training goal for general surgeons, which will also strengthen the progress and adjustment of GS and DS to new facts, technological developments and challenges. All of this will have a positive impact on the healthcare level of our health system with the definition, accreditation and distribution of reference and specific units.

Finally, we should trust in that, after such a difficult, long, apparently complex and, in our opinion, ''self-interest'' creation, this R.D. will be a meaningful milestone in our specialty, which will test its strength. The underlying risk is that the ''core basis'' on the one hand, and the generalised super-specialisation on the other hand, may finally culminate in its degradation against the emergence of new surgical specialties, as it already happened in the past.

Conflicts of Interest

The authors declare that they do not have any conflicts of interest.

REFERENCES

1. Real Decreto 639/2014, de 25 de julio. B.O.E. núm. 190. Miércoles 6 agosto; 2014. p. 63130–67.
2. Miguelena JM, Landa JI, Jover JM, Docobo F, Morales D, Serra X, et al. Formación en cirugía general y del aparato digestivo: nuevo programa, mismos retos. Cir Esp. 2008;84:67–70.
3. Ley 44/2003, de 21 de noviembre, de Ordenación de las profesiones sanitarias. B.O.E. núm. 280; Sábado 22 noviembre 2003. p. 41442–58.
4. Kristoffel R, Traynor O, Broos P, Gruwez J, Darzy AW, Williams N. Educación quirúrgica en el nuevo milenio. Perspectiva europea. Clin Quir N Am. 2004;6:1400–20.
5. Miguelena JM. Cirugía general y del aparato digestivo: ¿quo vadis? Cir Esp. 2010;88:209–10.
6. Miguelena JM, Landa JI, Docobo F, García J, Iturburu I, Jover JM, et al. Formación quirúrgica en España: resultados de una encuesta nacional. Cir Esp. 2010;88:110–7.
7. Miguelena Bobadilla JM. Formación del residente de Cirugía en Cirugía de la mama. Cir Esp. 2010;88:432.
8. Miguelena JM, Morales D, Serra X, Sanz M, Iturburu I, Docobo F, et al. Consideraciones en torno a la formación del residente en Cirugía de pared abdominal en España. Cir Esp. 2013;91:72–7.