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EDITORIAL

Urology and the core curriculum: The current status and controversies of the urology residency in Europe and Spain☆

Urología y troncalidad: actualidad y controversias sobre la residencia en urología en Europa y España

Long history of the core model and its variants

The core model for specialized medical training (SMT) has been implemented in some countries for over 70 years.[1] The extensive basic training in the common core of general surgery is at the origin of the surgical specialties; in fact, all were initially subspecialties of general surgery, with its forced hierarchical and operational dependency.[2] Urology was the first specialty that achieved a certain autonomy and independence in the department of surgery of the university hospital.[3]

The official residency programs for the SMT start in the United States, with that name, ''residencies'', in the 40s. The proposed itinerary is known accurately and even the first urology resident who extended the period of 5 years to one more, devoted to research: W. Goodwin, later founder and first Chief of the Urology Department at the University of California, Los Angeles (UCLA).[4]

The countries of northern Europe, especially represented by the United Kingdom, have traditionally required an extensive basic training in surgery before starting the SMT.[5] This increased emphasis on surgical training, 5 years, has involved certain disdain for the medical aspect of Urology, which is evident in the title of the British Association of Urology; British Association of Urological Surgeons (BAUS). In Germany, where there are 2 types of urological professionals, office and hospital, it is also the dominant core training, and exactly the same for everyone, then opting for either of the 2 career options.[6] France has taken an intermediate position with internship and 2 years of core subjects, but entirely assuming the medical commitment of the specialty.[7] Scandinavian countries follow the English model. Other European countries have followed the old system of personalized tutorials in vocational schools, with the possibility of obtaining a specialist degree in 2 years, a definitely insufficient period to meet the training required for urology, which already in the 50s had amplitude and variety in outstanding medical and surgical commitments. Increasingly, these countries were joining the urology residency program, with a minimum requirement of 5 years' duration.[8]

The European Union (EU Treaty of Rome 1958) has attempted to standardize the residential itinerary of surgical specialties. For that, the European Union of Medical Specialists (UEMS) was created, a subcommittee of the EU that devoted considerable efforts to this issue, without success, since 3 founding countries, England, Germany and France were self-excluded of the project. The urology section of the UEMS convened regular meetings, always attended by the Spanish Association of Urology, which achieved uniformity progress in several areas. Depending on the UEMS, the European Board of Urology was created, with similar and broader objectives, which has made great efforts to standardize the training of European urologists, but without getting to change the length and peculiarities of national programs.[7,8] Ultimately, the aim of getting a Bologna Process to standardize the Residency in Urology, as it has been achieved for medical education in European medical schools, has failed.[9]

In Spain, the formalization of the urology residency -MIR system- began in the mid 60s.[10] Detailed reports can

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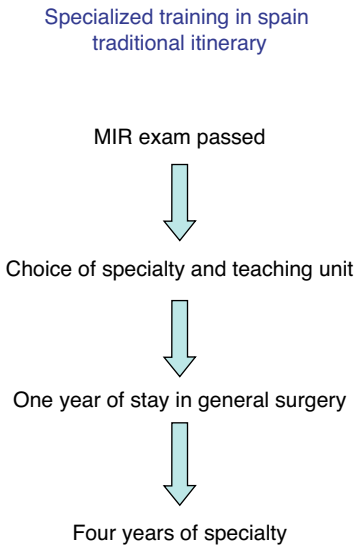

Figure 1 Specialized training in Spain. Traditional route.

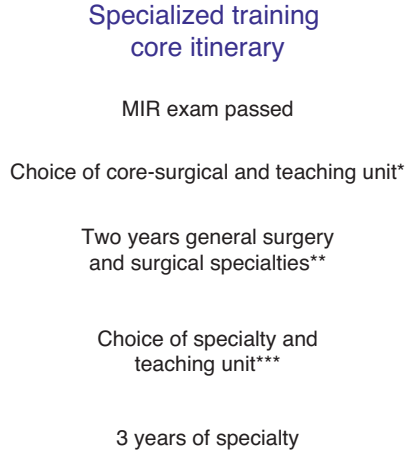

Figure 2 Specialized training. Core route.

be found on the structure and regulation of MIR system in various publications,[11,12] with precise references to the royal decrees and laws issued for final implementation. It is interesting to emphasize that all currently active Spanish urologists were trained in the MIR system, whose access and itinerary are shown in Fig. 1 to compare with the proposal of the Royal Decree 639/2014 (Fig. 2). Reducing the core period to a year, compared to the American residency program, taken as a model, was, in our opinion, an act of modernity and updating, not of weakness and professional lack of solidarity.

Core subjects and professional aspects in urology

Urology is a medical–surgical specialty. Other specialties included in the surgical core (Table 1) have complementary medical specialties. Nephrology is not the medical specialty of urology. These 2 specialties only coincide in some of their professional objectives, such as surgical treatment of renal failure.

Table 1 Specialties that are accessed through the surgical core.

Angiology and vascular surgery	Pediatric surgery
Cardiovascular surgery	Plastic, esthetic, and reconstructive surgery
General and digestive surgery	Thoracic surgery
Oral and maxillofacial surgery	Neurosurgery
Orthopedic surgery and traumatology	Urology

The various models of urology residencies of the European Union allow for accurate comparisons on their professional consequences. Especially interesting is the comparison between countries with a maximum and a minimum core training: UK (5 years) and Spain (one year).

The extraordinary difference in the *number of urologists per inhabitants* is, from the start, surprising; one urologist per 34,000 inhabitants in Spain versus one per 130,000 in the UK. Certainly, these are not the most extreme figures across the EU, which would be Ireland and Greece, but the most convenient for the comments that follow. In none of the 2 countries is there urological unemployment.[13]

The *care commitment of the urologist* in Spain (service portfolio/*manpower*) is extraordinarily wide. For example, the kidney transplant program with its huge surgical action. It is not the case in the UK, with only marginal collaboration in living and dead programs.

Spanish urology has not delegated any of its *diagnostic activities*. It must be remembered that the definition of specialty includes self-sufficiency in diagnostic procedures. Our urologists personally conduct prostate biopsy, urodynamic studies, invasive radiographic procedures of the urinary tract, all urethrovesical endoscopy studies and other procedures. On the contrary, it is clear that the UK has incorporated urological nursing in a specialized and skilled way in its professional activity.[14]

Urology medical activity has strengthened in recent years with the extraordinary progress of functional pharmacology and the chronicity and complexity of some urological procedures such as prostatism, erectile dysfunction, incontinence, etc., which require extensive dedication. English urology has progressively delegated this care commitment. For example, to transpose prostatism care to the general practitioner, new terminology was invented: lower urinary tract symptoms, which was implemented simultaneously with the forced strategy of *shared care* with the general practitioner, a rejected strategy in other countries.

Perhaps for the same reasons of numerical scarcity, and legitimately, polyvalent surgeons trained in the English system of core subjects, up to 5 years, continue to make a significant number of interventions considered inexcusably urological in other countries. Consequently, the *surgical activity* of British urologists is *reduced*.

The numerical scarcity also transcends to the *university world*. In the study carried out by Strategy and Planning Office of the European Association of Urology on the future of European Urology,[15,16] the important relationship between urology as a university discipline and its teaching by