Characteristics of Emergency Medicine Residency Programs in Colombia

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Introduction: Emergency medicine (EM) is in different stages of development around the world. Colombia has made significant strides in EM development in the last two decades and recognized it as a medical specialty in 2005. The country now has seven EM residency programs: three in the capital city of Bogotá, two in Medellín, one in Manizales, and one in Cali. The seven residency programs are in different stages of maturity, with the oldest founded 20 years ago and two founded in the last two years. The objective of this study was to characterize these seven residency programs.

Methods: We conducted semi-structured interviews with faculty and residents from all the existing programs in 2013-2016. Topics included program characteristics and curricula.

Results: Colombian EM residencies are three-year programs, with the exception of one four-year program. Programs accept 3-10 applicants yearly. Only one program has free tuition and the rest charge tuition. The number of EM faculty ranges from 2-15. EM rotation requirements range from 11-33% of total clinical time. One program does not have a pediatric rotation. The other programs require 1-2 months of pediatrics or pediatric EM. Critical care requirements range from 4-7 months. Other common rotations include anesthesia, general surgery, internal medicine, obstetrics, gynecology, orthopedics, ophthalmology, radiology, toxicology, psychiatry, neurology, cardiology, pulmonology, and trauma. All programs offer 4-6 hours of protected didactic time each week. Some programs require Advanced Cardiac Life Support, Pediatric Advanced Life Support and Advanced Trauma Life Support, with some programs providing these trainings in-house or subsidizing the cost. Most programs require one research project for graduation. Resident evaluations consist of written tests and oral exams several times per year. Point-of-care ultrasound training is provided in four of the seven programs.

Conclusion: As emergency medicine continues to develop in Colombia, more residency programs are expected to emerge. Faculty development and sustainability of academic pursuits will be critically important. In the long term, the specialty will need to move toward certifying board exams and professional development through a national EM organization to promote standardization across programs. [West J Emerg Med. 2017;18(6)1120-1127.]
INTRODUCTION

Colombia is a country of 47 million people located in the northwest corner of South America. The largest cities are Bogotá (pop 8.7 million), Medellín (pop 3.5 million), and Cali (pop 2.4 million) (Figure). Despite a history of continuous internal armed conflict, Colombia has well-established democratic institutions and has made significant economic progress. In the last decade poverty has been reduced from 50% to 32.7%, extreme poverty has fallen from 17.7% to 10.4%, the capacity for basic education has been increased by almost 1.5 million, and unemployment has fallen from 15.6% to 9.6%.

A new constitution in 1991 established healthcare as a fundamental right, and Ley 100 [Law 100] of 1993 aimed to provide universal health insurance coverage. Although the level of health insurance coverage is high, access to healthcare varies greatly across geography, from small clinics with limited supplies and often staffed only by recent medical school graduates to tertiary hospitals in large cities, some with technology and resources like those of hospitals in developed nations.

In Colombia students apply to medical school immediately after high school. There are currently 58 medical schools, of which 69% are private and 31% are public. Medical school lasts 6-7 years, of which the last year, or internado, is similar in structure and responsibility to that of the first year of residency in the United States. After completing a year of service in an underserved area, graduates may apply to a residency, work independently as general practitioners in primary care, or work under the supervision of a specialist. Colombia has residencies in all specialties but spots are limited, admissions are very competitive, the positions are often unsalaried, and almost all charge tuition.

There is increasing demand for emergency medicine (EM)-trained providers in Colombia. Colombia has only about 200 trained EM specialists. In major urban areas most large hospitals have emergency physicians staffing higher acuity areas of the emergency department during part of the day. However, the great majority of emergency care is still provided by non-residency-trained general practitioners and physicians from other specialties. The first EM residency in Colombia was founded in 1996. There are currently seven EM residency programs in the country (Table 1). The goal of this study was to characterize the current state of the seven EM residencies in Colombia.

METHODS

Christian Arbelaez conducted site visits and semi-structured interviews with representatives from each of the seven EM residencies in Colombia between July 2013 and July 2016. Respondents included program directors, faculty, and residents. Phone calls and email communications were also used for follow-up questions. Topics covered in the interviews included the history of each program, number of residents, curricula, clinical...
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sites, faculty, and challenges faced. Interviews were performed in Spanish, recorded, transcribed, and translated to English. We analyzed responses to create descriptions of each program and identify common themes. We also reviewed program websites and documents detailing curricula provided by the programs. This survey was granted exemption through the Partners Healthcare Institutional Review Board.

RESULTS

History of Emergency Medicine Residencies

Of the seven EM residency programs, three are in Bogotá, two in Medellín, one in Manizales, and one in Calí. The first EM residency program in Colombia was created in 1996 in Medellín by Universidad CES. In 2001 Universidad del Rosario in Bogotá, opened the second and only four-year program. In 2004 Universidad de Antioquia in Medellín started the only public, tuition-free program to date. In 2008, two programs opened in Bogotá: Pontificia Universidad Javeriana and Fundacion Universitaria de Ciencias de la Salud (FUCS). The Universidad de Caldas program started in Manizales in 2013, Universidad ICESI Fundación Valle del Lili in Cali was started in 2016 (Table 1). There are currently two Colombian EM peer-reviewed journals. They include Perspectiva en Urgencias, from the Asociación Colombiana de Especialistas de Emergencias, and Urgentia from Javeriana. The Asociación Colombiana de Especialistas de Emergencias (ACEM) is the largest EM organization in the country, representing over 200 emergency physicians and EM residents.

Applicant Selection

Applicants come mostly from the cities where the programs are located, but also from many other regions of the country. Similar to the application process for residencies in other specialties, EM residency applications are not centralized. The first step for all physicians applying to an EM residency consists of a general medicine written exam created by each residency program. Then each program has different processes to select candidates. CES conducts interviews with emphasis on clinical knowledge and leadership skills. Rosario has applicants shadow in the ED for half a day and discuss patient management with preceptors and also interview with psychiatry, EM faculty, the chief EM resident, the chief of EM, and an invited professor. Antioquia requires an English-language test and does not require interviews. Javeriana invites applicants with the best scores for a clinical simulation test, an oral exam and interviews with faculty.

Table 1. General program characteristics of the seven emergency medicine residency programs in Colombia, which differ in tuition, length, number of faculty, number of residents and fellowships offered.

<table>
<thead>
<tr>
<th>Program</th>
<th>CES</th>
<th>Rosario</th>
<th>Antioquia</th>
<th>Javeriana</th>
<th>FUCS</th>
<th>Caldas</th>
<th>ICESI</th>
</tr>
</thead>
<tbody>
<tr>
<td>City</td>
<td>Medellín</td>
<td>Bogotá</td>
<td>Medellín</td>
<td>Bogotá</td>
<td>Bogotá</td>
<td>Manizales</td>
<td>Cali</td>
</tr>
<tr>
<td>Length</td>
<td>3 years</td>
<td>4 years</td>
<td>3 years</td>
<td>3 years</td>
<td>3 years</td>
<td>3 years</td>
<td>3 years</td>
</tr>
<tr>
<td>Tuition A</td>
<td>10,661,000</td>
<td>13,000,000</td>
<td>No tuition</td>
<td>13,228,000</td>
<td>13,050,000</td>
<td>10,300,000</td>
<td>11,840,000</td>
</tr>
<tr>
<td>Class size B</td>
<td>6</td>
<td>10</td>
<td>4</td>
<td>8</td>
<td>6</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Residents total C</td>
<td>17</td>
<td>40</td>
<td>9</td>
<td>17</td>
<td>21</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>Emergency medicine faculty</td>
<td>15</td>
<td>10</td>
<td>1 plus 2 part-time</td>
<td>9</td>
<td>2</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Application requirements D</td>
<td>Interviews</td>
<td>Interviews</td>
<td>English test</td>
<td>Simulation, oral exam, interviews</td>
<td>Interviews</td>
<td>Interviews</td>
<td>Interviews</td>
</tr>
<tr>
<td>Fellowships</td>
<td>Critical care</td>
<td>None</td>
<td>Critical care</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>Critical care</td>
</tr>
<tr>
<td>Special features</td>
<td>Oldest EM program in the country</td>
<td>Only four-year program in the country</td>
<td>Only program with free tuition</td>
<td>Program has its own academic journal</td>
<td>Hospital San José was first hospital to train medical specialists in Colombia, starting 120 years ago</td>
<td>None</td>
<td>First residency program in a mid-size city</td>
</tr>
<tr>
<td></td>
<td>All EM rotations done with EM faculty</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Newest program in the country</td>
</tr>
</tbody>
</table>

FUCS, Fundacion Universitaria de Ciencias de la Salud.

A Tuition in Colombian pesos (2,900 Colombian pesos ~ 1 USD).

B Number of residents accepted per year.

C Total number of residents in the program.

D Application requirements listed are in addition to a written test, which all programs require.
and the program director. FUCS invites the applicants with the
top five test scores for interviews with the program director, the
assistant coordinator, a psychologist and human resources staff.
Caldas and ICESI require interviews. Programs receive between
30 and 60 applications every year. Some programs accept new
residents on a yearly basis; CES accepts six, Antioquia four,
Caldas three, and ICESI four. The remaining programs accept
new residents every six months: Rosario accepts five, Javeriana
four, and FUCS three (Table 1). The graduation rate is 90-100%
cross programs.

Tuition
Most residency programs in Colombia charge tuition.
Antioquia is affiliated with a public university that does not
charge tuition. Further, it provides a stipend of approximately
$650 USD (COS1,300,000) per semester. The rest of the
programs do not provide a stipend and charge approximately
$3,400 - $4,500 USD (COS 10,300,000 to 13,200,000) per
semester (Table 1). Crédito Ley 100 is a “forgivable” loan
awarded to a limited number of residents through ICETEX, a
government financial institution that provides financial aid for
post-secondary education.  

Residency Program Characteristics
The curricula of the different programs are loosely based
on those of U.S. EM residencies but with significant variations
(Table 2 and Table 3).  

Emergency Medicine Faculty
At the time of this survey, the older programs, CES and
Rosario, had the most EM faculty. CES had 15, and all EM
rotations were done with EM faculty supervision. Rosario had
25 EM faculty, Javeriana nine EM faculty, FUCS two EM-
trained faculty, and Antioquia had one full time and two part-time
EM-trained faculty (Table 1). All program directors were EM-
trained except for one who was surgery trained. EM is its own
department at Rosario. At Javeriana and Antioquia EM is under
the department of internal medicine.

Point-of-Care Ultrasound Training
All Colombian programs cited point-of-care ultrasound
(POCUS) as one of the weaknesses in their curricula in a 2014
study. The most commonly cited barriers to POCUS use were
lack of instructors, lack of machines, and lack of time. Other
barriers included turf battles with other specialties, billing issues
and equipment cost. However, since 2014 POCUS has become
more available and now Rosario, Javeriana, Caldas and ICESI
offer ultrasound training.

Residency Program Assessment and National Quality
Assurance
The Ministry of Education plays an active role in ensuring
the quality of postgraduate programs, including EM residencies,
through the Consejo Nacional de Acreditación de Colombia
(CNA), or National Accreditation Council. The accreditation
system begins with a self-assessment, with the purpose of
formulating actions to improve the quality of the program. This
self-assessment is followed by an external evaluation by peer
review, referred to as Evaluación por Pares, which evaluates the
accuracy of the self-assessment and results in a submitted report
to the CNA. Accreditation is granted after a final review based on
the self-evaluation and peer review. This is valid for a period of
4-10 years depending on the quality of the program. 

Post-Residency
Most EM-residency graduates are finding jobs in community
hospitals or in academic centers, usually in critical care areas
within the ED. Since the specialty of EM is relatively young,
these graduates are often the first EM-trained physicians and are
often in charge of establishing the specialty in those institutions.
Fellowship training in critical care is available in some programs.
Fellowships such as ultrasound, EMS, pediatric EM or disaster
medicine are not currently available. Many EM residency
graduates go on to work in intensive care units rather than EDs,
given better financial incentives.

Strengths and Challenges

CES
As the oldest program in the country with more than 20
years of experience, all EM rotations at CES are done with EM-
trained faculty. The EM specialty and residency program are well
established. Nonetheless, the program feels it needs to continue
promoting itself within the university and hospitals to achieve the
same level of recognition as older specialties.

Rosario
Rosario is the only four-year residency in the country and has
40 residents, the largest number in the country. Its seven clinical
sites add expertise in trauma, toxicology, prehospital care, disaster
preparedness, and cardiology. The program is working towards
establishing a stronger academic connection with the university,
since residents and faculty have felt disconnected from the larger
university community.

Universidad de Antioquia
Antioquia is the only program in the country that offers free
tuition. It has a strong emphasis on local epidemiology. Being
part of the university faculty has significant financial benefits.
Over the years the program has had to overcome political and
administrative barriers within the hospitals and in relation to
other specialties.

Javeriana
Javeriana has a strong emphasis on academic production and
has its own academic journal. A weakness initially identified by
trainees was the lack of ultrasound training. However, ultrasound
training is now provided. Another weakness is relatively low
exposure to trauma patients locally. However, at the time of this
### Table 2. Clinical rotation curricula in Colombia.

Colombian emergency medicine (EM) residency curricula are loosely based on U.S. EM residency curricula with important differences in percent of time spent in EM and other rotations. Residencies in the U.S. are accredited by the Accreditation Council for Graduate Medical Education (ACGME). ACGME requirements for EM residencies are included in the table for comparison.

<table>
<thead>
<tr>
<th>Program</th>
<th>CES</th>
<th>Rosario</th>
<th>Antioquia</th>
<th>Javeriana</th>
<th>FUCS</th>
<th>Caldas</th>
<th>ICESI</th>
<th>U.S. ACGME</th>
</tr>
</thead>
<tbody>
<tr>
<td>EM time in months</td>
<td>11 (31%)</td>
<td>11 (23%)</td>
<td>4 (11%)</td>
<td>7 (19%)</td>
<td>12 (33%)</td>
<td>10 (28%)</td>
<td>7 (19%)</td>
<td>60% of all clinical time</td>
</tr>
<tr>
<td>Pediatric time in months</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>None</td>
<td>5 months (or 20% of all EM time)</td>
</tr>
<tr>
<td>Critical care time in months</td>
<td>4</td>
<td>7</td>
<td>4</td>
<td>2</td>
<td>6.5</td>
<td>6</td>
<td>6</td>
<td>4 (2 during PGY2 or higher)</td>
</tr>
<tr>
<td>Obstetrics time in months</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0.5 months or 10 low risk vaginal deliveries</td>
</tr>
</tbody>
</table>

**Other Rotations**

- Anesthesia
- Cardiology
- Surgery
- IM
- Neurology
- Orthopedics
- Psychiatry
- Radiology
- Toxicology
- Elective

**ACGME, Accreditation Council for Graduate Medical Education; EM, emergency medicine; ENT, otolaryngology; ID, infectious diseases; IM, internal medicine; Ophtho, ophthalmology.**
Table 3. Didactics, research, and resident evaluation. The seven EM residency programs in Colombia differ in didactics, research and resident evaluation requirements. The U.S. ACGME* requirements are included for comparison.

<table>
<thead>
<tr>
<th></th>
<th>CES</th>
<th>Rosario</th>
<th>Antioquia</th>
<th>Javeriana</th>
<th>FUCS</th>
<th>Caldas</th>
<th>ICESI</th>
<th>U.S. ACGME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Didactics (hours per week)</td>
<td>4 plus rotation-specific didactics</td>
<td>5 plus 4 hours of research</td>
<td>5</td>
<td>5</td>
<td>6</td>
<td>Varies</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Prehospital rotations</td>
<td>Educational sessions</td>
<td>None</td>
<td>4-week rotation</td>
<td>1-month rotation</td>
<td>No information available</td>
<td>Educational sessions</td>
<td>None</td>
<td>Ambulance rides, Direct medical command experience, Multi-casualty drills</td>
</tr>
<tr>
<td>Certifications (ACLS, ATLS, PALS)</td>
<td>Done in-house</td>
<td>Program covers 60% of cost</td>
<td>Not required but encouraged</td>
<td>ACLS and ATLS required</td>
<td>Required</td>
<td>ACLS required</td>
<td>Not required</td>
<td>Not required by ACGME but required by most hospitals</td>
</tr>
<tr>
<td>Research Requirement</td>
<td>1 project</td>
<td>1 project / semester 1 final thesis</td>
<td>1 project</td>
<td>1 project</td>
<td>1 project / year</td>
<td>1 project</td>
<td>None</td>
<td>1 project</td>
</tr>
<tr>
<td>Evaluation</td>
<td>Written test at random times Individual evaluation for each rotation according to competencies</td>
<td>Written tests every 3 months Evaluations after each rotation Evaluation for promotion to following year (meeting with PD)</td>
<td>Evaluation at the end of each rotation Semester evaluation “German seminar” i.e. seeing patients with faculty and getting feedback</td>
<td>Written exams every 3 months by subject Written and oral exam at the end of each rotation Test for promotion to the following year</td>
<td>Written and oral exams every 3 months administered by internists and surgeons</td>
<td>Clinical supervisors evaluate residents after every rotation block on their knowledge, clinical skills, teaching skills, and bedside manner.</td>
<td>Evaluation at the end of each rotation Continuous clinical evaluation Twice-yearly written feedback on clinical performance Yearly evaluation with program director</td>
<td></td>
</tr>
</tbody>
</table>

ACLS, Advanced Cardiac Life Support; ATLS, Advanced Trauma Life Support; PALS, Pediatric Advanced Life Support, ACGME, Accreditation Council for Graduate Medical Education; PD, program Director.

In this study, there was a plan to have residents do a trauma rotation at Hospital Universitario del Valle in Cali, which has large numbers of trauma.

**FUCS**

FUCS has a strong emphasis on critical care and the larger university has a strong tradition of academic training with one of its hospitals having had the first residencies in any specialty in the country more than 120 years ago. Two weaknesses identified by the program are its lack of ultrasound training and absence of a formal university affiliation for program faculty.

**Caldas and ICESI**

These two programs are new with a small faculty but have dynamic leaders as program directors. They are both located in urban settings and are affiliated with strong medical schools that offer excellent clinical training.

**DISCUSSION**

Colombia is a land of contrasts. Its large cities have hospitals that rival those in the developed world, while healthcare in rural areas is more akin to that of a developing country with minimal infrastructure. EM professionals not only can improve the care Colombians receive in the ED but also bring expertise to strengthen prehospital and disaster care, both in urban and rural underserved areas. While Colombia’s Constitution of 1991 established healthcare as a right and Law 100 expanded health insurance coverage to cover greater than 90% of the population, access, quality and funding continue to be a challenge. Deficiencies in the system have led to ED crowding around...
the country. Most emergency care in Colombia is still being provided by non-residency trained providers. Emergency care requires expertise in the recognition and timely treatment of life-threatening conditions as well as the prioritization of resources for the flow of the ED. Now more than ever EM-trained physicians can help maximize ED resources to optimize throughput and clinical outcomes.

Colombia has made important strides in the development of EM with its seven residency programs and official recognition of EM as a specialty. Curricula are similar to those of residencies in the U.S., though with important variation. For example, ACGME requires 60% of clinical time to be spent in the ED under the supervision of EM-trained faculty. In contrast, EM residents in Colombia spend 11-39% of their time in the ED. This low ratio of EM clinical time is likely related to the youth of EM as specialty in Colombia and the relatively few EM faculty. Colombian EM residents receive strong training in critical care with programs requiring 4-7 months, compared to the 4-month ACGME requirement. All programs offer about 4-6 hours of protected didactic time each week and all programs require or encourage residents to obtain Advanced Cardiac Life Support (ACLS), Pediatric Advanced Life Support (PALS), and Advanced Trauma Life Support (ATLS) certifications. Ultrasound training has been expanding, with four of the seven residencies providing ultrasound training at this time. Ultrasound is Colombia is not only an important tool for every emergency physician, but it can also be crucial as EM-trained providers start working in hospitals in more rural areas with no other imaging resources.

Most EM residency graduates go on to work in community hospitals with most becoming the first EM specialist at their workplaces. Many go on to work in intensive care units given their extensive training in critical care and better compensation. As EM matures, the specialty must advocate for better compensation and working conditions in order to attract emergency physicians to EDs. As EM continues to develop in Colombia, more residency programs are expected to emerge along with a growing number of EM faculty. Standardization of training across programs, certifying board exams, strengthening of professional societies, and academic development will be important steps to further advance the specialty.

LIMITATIONS

A limitation for this study is its data collection over a three-year span, which with the rapid evolution of the residency programs may have resulted in some of the results not being up to date at the time of publication. Co-authors of the study are part of the different residency programs, which could have introduced bias. However, this is balanced by the fact that each residency is represented by a co-author in the study.

CONCLUSION

Colombia has made great strides in the development of EM. EM continues to gain traction as a specialty and the number of residencies will likely continue to grow. There are seven EM residencies at this time with different curricula that will serve as models for future programs.

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