

**GUIDELINE ON THE IMPLEMENTATION OF THE PHILIPPINE ADULT PULMONARY MEDICINE FELLOWSHIP
TRAINING CORE CURRICULUM FOR TRAINING INSTITUTIONS**

1. The Competency-based Core Curriculum for Philippine Adult Pulmonary Medicine Fellowship Training was formulated as a guide to standardize and elevate the quality of training in Adult Pulmonary Medicine provided by the training institutions in the Philippines. The training institution is still an independent body which will provide its own specific instructional design for its trainees based on the unique qualities of the institution.
2. It is of utmost importance that the institution is able to ensure that each and individual fellow-in-training (FIT), at the end of two years of training, already demonstrates the competencies of a professional, ethical and compassionate “Pulmonologist” who:
 - a. Given an actual patient, is able to proficiently
 - i. diagnose pulmonary conditions and diseases in the following settings: ambulatory, emergency & inpatient, intensive or critical care.
 - ii. institute preventive and therapeutic interventions for pulmonary conditions & diseases in the following settings: ambulatory, emergency & in-patient, intensive or critical care.
 - b. regularly demonstrates professionalism and compassion.
 - c. regularly participates in advocacies in lung health with enthusiasm
 - d. has completed and written his/her research study in pulmonary medicine
 - e. regularly utilizes evidence-based medicine approaches in his/her medical activities
 - f. has successfully led, managed or assisted in academic or health system based activities

For the institution to ensure that each FIT has indeed accomplished the professional competencies written above, at the end of each year in training, the performance portfolio (page 51 in the Core Curriculum) of each FIT should be reviewed by the trainers and deemed satisfactory so that the FIT can be promoted or be evaluated as having successfully completed the fellowship training.

With the series of meetings in Year 2014-2015, the content of the Performance Portfolio for each FIT has been revised as follows:

Revised Performance Portfolio Content:

Evaluation Parameter or Category	% total Grade	Competency being Assessed (please refer to pp. 3-5 in Core Curriculum manuscript)	Items Included
1. Clinical Performance	35%	1,2,3,4,5	Clinical Performance evaluation form accomplished by Faculty & Peer Patient Census For YL2: Electives learning contracts with or without grades
2. Written exam	20%	1,2,3,4	Written exam answer sheets or scores in written exams

3. Conference performance	20%	1,2,3,4	Conference performance evaluation forms
4. Skills performance	25%	1,2,3	Procedure log Procedure performance evaluation forms
5. Oral or practical examination (year-end, summative)	Pass or fail	1,2,3,4	Oral/practical exam or Mini-CEX results
6. Research	Pass or fail for research output	4 Research utilization embedded in Evaluation tools for Competencies 1-4	Research output: <ul style="list-style-type: none"> - YL 1: protocol with IRB/ERB approval & budget proposal - YL 2: completed research manuscript of an analytical study - Awards/certificates of participation in research fora, if present
7. Workshops/conferences attended	Pass or fail	1,2,3,4,5	Certificates of attendance
8. Administrative assignments	Pass or fail	3,5	Description of administrative assignments
9. Advocacy work	Pass or fail	3,5	Description of advocacy work Attendance in PCCP advocacy activities (if there are only a few FITs in the training institution, the FIT need not attend all advocacy activities of the PCCP – the Training Officer will be the one to decide on which the FIT should attend)
TOTAL GRADE	100%		* since this is mastery, the FIT should at least have a total grade of 75% to be considered passing, aside from passing each of the other Categories (#5-9), to be promoted to the next year level or to be able to graduate. This supersedes the Evaluation Scheme written in pp. 34-35 in the Core Curriculum manuscript.

As indicated in page 33 of the Core Curriculum, the institution can conduct a year-end summative practical or oral examination for each FIT to assess the first professional competency written above.

The above evaluation system is a mere guide and the institution may have its own evaluation system based on their unique requirements – as long as it is written formally as an evaluation system in their own instructional design and is followed.

A portfolio should still be provided per FIT.

Evaluation forms that may be used from the Core Curriculum manuscript:

1. Clinical Performance Evaluation Form (Appendix 1)
 2. Pulmonary Fellows’ Peer Evaluation Rating Scale Form (Appendix 2)
 3. Conference Evaluation Form (Appendix 3 – revised version attached)
 4. Morbidity , Mortality & Improvement Conference Evaluation Form (Appendix 4 – revised form attached)
 5. Rating Scale for Performance of Flexible Bronchoscopy (Appendix 5)
 6. Checklist for Performance of Pleural Biopsy (Appendix 6): if performed
 7. Checklist for the Performance of Pleurodesis (Appendix 7)
 8. Checklist for Performance of Spirometry (Appendix 8)
 9. Learning Contract Form
3. For the training institution to ably carry out its training function, it has to have its own instructional design or training curriculum based on the Core Curriculum agreed upon. The template for the instructional design is in page 6 of the Core Curriculum manuscript. The instructional design and structure of clinical rotation exposure of the institution (p. 28) need not exactly follow the template written. It should be adapted to the needs and goals of the individual institution.

The other basic components that have to be present in the institution are the (1) in-patient & out-patient population, (2) ward and ICU units, (3) basic pulmonary medicine equipment, and the (4) consultant staff or trainors as stipulated in the “Standards and Requirements for Training Institutions” in the Accreditation Guidelines of the Philippine College of Chest Physicians.

4. Teaching-Learning Activities: Conferences

The conferences are meant to benefit the whole Pulmonary Medicine department of the institution and not just the FITs. The conferences can have as presentors, not only the FITs, but consultants and resident rotators as well. Hence, if there are only a few FITs, some of the conferences may have other staff members as presentors.

As agreed upon, the following sit-down conferences are to be regularly conducted by the institutions with the objectives & suggested method of conduct of these conferences already contained in the Core Curriculum manuscript:

Conference Name	Frequency	Presence of Faculty	Evaluation Form
1. Pulmonary didactic conference	2x/ month	At least 1 consultant present; A consultant may be the presenter	In Appendix 3 or equivalent. At least 1 evaluator for the presenter. May not have an accomplished evaluation form

			should there be no FIT presenter;
2. Pulmonary Case Conference	2x/month	At least 2 consultants present	In Appendix 3 or equivalent; at least 2 evaluators for each presenter
3. Pulmonary Grand Rounds	1x/month	At least 3 consultants present	In Appendix 3 or equivalent; at least 3 evaluators for each presenter
4. Morbidity, Mortality & Improvement (MMI) Conference	1x/ month * the suggested fishbone analysis is optional and other system-based analysis may be utilized.	At least 3 consultants (not necessarily all from the pulmonary medicine department staff)	In Appendix 4 or equivalent; at least 1 evaluator for each presenter

Institutions may be using another name for the Conferences above but they should indicate which conference is the equivalent to the ones mentioned above. The learning objectives should also be aligned to the equivalent conference. The schedule of the conferences will be set according to the discretion of the training committee or officer.

The institutions can add other sit-down conferences to the above conferences.

5. Teaching-Learning Activities: Procedures

Performance of diagnostic and therapeutic procedures is a crucial skill to be mastered by the FITs. Mastery can be best assessed when the FIT is observed while actually performing the procedure on a real patient. There has to be a global assessment by the trainors, even if it is just a qualitative assessment, at the end of the year, whether the FIT has gained the appropriate mastery in the minimum procedures listed below. This is an additional assessment on top of the evaluation forms accomplished by the faculty on the performance of the FIT of the procedures throughout the year.

Mastery in the performance of these procedures can also be best achieved by assisted and repetitive performance of these procedures, whether on a real patient or a simulated environment, with proper feedback and correction from the faculty until expertise is achieved.

The minimum procedures that are required are as follows:

Procedures	YL1	YL2	Evaluation forms to be included in FIT Portfolio
Bronchoscopy	10 assisted or performed per year	10 performed with washings or biopsy or therapeutic per year	At least 10 per year (if the FIT performed more than 10, there is no need to include more than 10 evaluation forms in the portfolio. All procedures though

			have to be placed in the performance or procedure log of the FIT). It is strongly recommended that comments on the quality of performance by the FIT be placed in the evaluation forms by the faculty supervising the FIT.
Thoracentesis	20 per year	20 supervised or assisted per year	20 minimum – indicate whether assisted or performed
Pleural biopsy or equivalent such as pleural biopsy in a simulated environment, tube thoracostomy, chest catheter insertion or assist in medical pleuroscopy, or observation during surgical exploration of the pleura or VATS procedure	2 assisted per year	2 performed or assisted/year	2 forms – indicate whether assisted or performed; if simultaneously performed with another procedure on the same patient, the FIT can ask the supervising faculty to rate him/her with separate evaluation forms for the 2 procedures. If just observed, to indicate only as part of procedure log with no evaluation form
Medical pleurodesis	5 per year	5 per year	5 forms per year per FIT
ABG	30 interpreted per quarter	30 interpreted per quarter	The FIT can just indicate the # of ABG's interpreted in his/her procedure log with no need to write the name of the patient & interpretation.
PFT	3 performed/year 20 interpreted/quarter	6 performed/year 20 interpreted/quarter	At least 3 evaluation forms per year for YL1 FIT and 6 evaluation forms per year for YL 2 FIT on PFT performance required in FIT portfolio. For PFT interpretation, the FIT just needs to indicate the number of PFT interpretations done in his/her procedure log with no patient names nor interpretation needed.

Endotracheal intubations are no longer required as a procedure to be evaluated for a FIT.

6. Teaching-Learning Activity Source: Patient Exposure

The number of patients to which a FIT should be exposed to for proficiency in the skill of making a proper diagnosis and management plan is difficult to determine. The patient case to trainee ratio will be studied in the local scenario. With the present suggested rotations, for YL1 FIT, a minimum of 200 outpatient cases per year and 300 in-patients per year is recommended. For YL2 FIT, a minimum of 120 outpatient cases per year is recommended and this may include patients seen during their elective rotations. For YL2 FIT, a minimum of 150 in-patients per year is recommended and these will include their ICU patients and non-ICU patients they supervise with the YL1 FIT.

The sources of patients and other clinical materials for the FITs to handle may be outside the institution but these should be continuous and sustainable sources that are regularly supervised and handled by the institution's faculty members as well (eg. adopted community clinic, home care, PCCP-sponsored community clinic, & DOTS clinics). These sources should not overlap with those being used by other PCCP-accredited institutions, except for those pertaining to elective rotations.

Intensive Care Unit (ICU) rotations may also be included in YL 1. The institution, though, should be cognizant in differentiating the competencies aimed to be developed in Year Level 1 from that of Year Level 2. The Year Level 2 cannot be a mere duplication of Year Level 1 in the instructional design of the institution.

A variety of cases should be aimed for by the institution and, if this is not possible, effort should be exerted to either have the FITs see these cases in other settings or discuss these clinical cases in didactic conferences.

CLINICAL CONDITIONS & ILLNESSES A FIT MUST BE ABLE TO PROFICIENTLY DIAGNOSE AND MANAGE AT THE END OF HIS/HER YEAR LEVEL OF TRAINING (pp. 35-50 in Core Curriculum manuscript)	
YL 1	YL 2
Must know conditions/illnesses (case exposure should be present in the census of the FIT)	
<p>Respiratory failure</p> <ul style="list-style-type: none"> • Hypoxemic respiratory failure including acute respiratory distress syndrome • Acute and chronic hypercapnic respiratory failure <p>Respiratory medical and surgical conditions</p> <ul style="list-style-type: none"> • Obstructive lung diseases: <ul style="list-style-type: none"> - Asthma, including status asthmaticus - Bronchitis - COPD - Bronchiectasis • Respiratory failure due to obstructive lung disease • Pulmonary vascular diseases (any) including primary & secondary pulmonary hypertension, Pulmonary hypertension and cor pulmonale, vasculitides and pulmonary hemorrhage syndromes, venous thromboembolism • Disorders of the pleura and mediastinum • Empyema , Pleural effusion, Pneumothorax, Haemothorax, Chylothorax • Iatrogenic respiratory disease, including drug induced disease • Pulmonary manifestations of systemic diseases, including collagen vascular disease and diseases which are primary in other organs • Bronchopulmonary infections including aspiration • Diseases of the upper airway (any: <ul style="list-style-type: none"> - Structural defect of the airway including stenosis, malacia, tracheal tear, and fistula - Upper airway obstruction - Vocal cord dysfunction - GERD • Perioperative non-thoracic & thoracic surgical cases with pulmonary problems <p>Infectious diseases</p> <ul style="list-style-type: none"> • Suppurative lung diseases, including bronchiectasis, lung abscess, empyema • Pulmonary infections, Community-acquired and health-care associated pneumonias • Tuberculosis, Complicated tuberculosis infections (disseminated, MDRTB, XDRTB, 	<p>All conditions listed under YL1</p> <p>Respiratory medical and surgical conditions</p> <ul style="list-style-type: none"> • Diffuse parenchymal lung disorders: <ul style="list-style-type: none"> - Infiltrative & Interstitial lung diseases: - Idiopathic fibrotic disorders (eg. IPF) - Secondary Interstitial Lung Diseases: CTD, occupational/environmental, treatment-related/drug-induced • Chest trauma (e.g. flail chest, pulmonary contusion, rib fractures, etc.) & inhalational injury • Sleep disordered breathing, obstructive sleep apnea, central & obesity-related hypoventilation • Complicated Perioperative thoracotomy conditions • Congenital & developmental lung diseases • Critically ill patients on advanced mode of ventilator and life support • Care at the end of life for patients with respiratory failure <p>Infectious diseases</p> <ul style="list-style-type: none"> • Hospital-acquired and opportunistic infections in the critically ill • ICU support of the immunosuppressed patient <p>Cardiovascular disorders</p> <ul style="list-style-type: none"> • Shock syndromes and hypoperfusion (obstructive shock, sepsis and sepsis shock, other distributive shock, multi-organ dysfunction cardiogenic shock) syndrome, hypovolemic shock • Cardiac patients on thrombolytic and anticoagulant therapy • Pulmonary complications in post CABG conditions <p>Central nervous system disorders</p> <ul style="list-style-type: none"> • Neuromuscular disease causing respiratory failure

<p>in special situations)</p> <ul style="list-style-type: none"> • Nontuberculous mycobacterial disease, bacterial, viral, fungal, and those in the immunocompromised host • Epidemic lung infections (any) (e.g., influenza, SARS, avian influenza, Ebola, MERSCov) • Sepsis syndrome & Systemic inflammatory response syndrome <p>Pulmonary malignancies, primary and metastatic</p> <ul style="list-style-type: none"> • Lung cancer • Mediastinal and chest wall tumors • Paraneoplastic syndromes • Metastatic cancer to the respiratory system • Mesothelioma • Benign respiratory tumors <p>Cardiovascular disorders</p> <ul style="list-style-type: none"> • Myocardial infarction and its complications • Pulmonary oedema — cardiogenic, noncardiogenic <p>Renal disorders</p> <ul style="list-style-type: none"> • Acid–base disorders and their management • Dialysis-related pulmonary complications • KT-related pulmonary complications <p>Central nervous system disorders</p> <ul style="list-style-type: none"> • Neuromuscular disease causing respiratory failure/ respiratory disorders related to neuromuscular diseases • Guillain-Barré syndrome • Myasthenia gravis 	
<p>Good to know conditions/illnesses (if no actual cases, may explore sources of cases outside the institution or included in didactic activities)</p>	
<ul style="list-style-type: none"> • Obstetric & gynaecologic cases with pulmonary problems 	<ul style="list-style-type: none"> • Occupational and environmental lung disease • Bronchiolitis • Pulmonary embolism — air, fat, amniotic • Primary Unclassified Interstitial Lung diseases (eg. Sarcoidosis, LAM) • Patients exposed to environmental hazards, drugs, poisons, radiation and narcotics with pulmonary manifestations • Near drowning, diving and the lung

7. Teaching-Learning Activity: Elective Rotation in YL2

- a. The training institution will utilize its institutional template for Memoranda of Agreement or Understanding (MOA or MOU) to formally allow its FIT to rotate in electives outside the institution or to accept FITs from other institutions to rotate in their institution. Should the institution not have a MOA or MOU template, the PCCP will assist the institution in developing a MOA or MOU and in the placement of these FITs in other institutions.
- b. The elective rotations of the YL2 FITs are meant to be flexible and can be experienced concurrently with other basic clinical rotations. As mentioned in the Core Curriculum manuscript pages 14-15, half of the whole year maybe devoted to the different electives. A minimum of 3 electives is recommended for a YL 2 FIT. There is no fixed duration of the YL2 elective and clinical rotations and these may be done in short periods of time or non-continuously throughout the year.
- c. Elective rotations can be performed outside the FIT's institution. It is recommended though that elective rotations outside the institution should comprise less than half of the total number of electives of the FIT. The external institution may be a PCCP-accredited institution or, in special situations, it may not be a PCCP-accredited institution. In this scenario, there has to be an extra effort on the Faculty of the FIT to ensure that the FIT, when rotating in this non-PCCP accredited institution, be trained under a PCCP Fellow or a non-PCCP related Trainor who will ensure that the learning objectives of the rotation are met by the FIT. The Faculty of the FIT will be held responsible for the conduct and outcome of this special situation for an elective rotation.
- d. It is emphasized that the performance of an elective rotation will not qualify a FIT to being a subspecialist in this specific pulmonary subspecialty.

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