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Curricular changes in pediatric residency: Gains, losses, and the need for balance

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Graduate medical education, structured through residency programs, constitutes one of the cornerstones of healthcare quality. Within this framework, curricular design invariably entails a delicate balance: determining which knowledge, skills, and attitudes should be prioritized within an inherently limited timeframe. Pediatrics, given its breadth and heterogeneity, illustrates this tension particularly well. Training pediatricians capable of practicing across diverse settings—from ambulatory care to critical care—requires allocating training time across multiple domains.

Over time, pediatric residency programs, like those in other disciplines, have undergone substantial transformations. The expansion of medical knowledge, increasing subspecialization, the incorporation of new technologies, the consolidation of competency-based education, and greater regulation of residents' working conditions have, over more than a century,[1] reshaped training structures. In parallel, shifts in epidemiological profiles—including a growing burden of chronic diseases and mental health conditions—have further influenced these changes. In this context, curricula are periodically revised, with content and time redistributed in an effort to adapt to an evolving environment.

These changes are not without consequences. Training may become better aligned with population needs, with greater emphasis on transversal competencies and interdisciplinary collaboration. However, reducing time allocated to certain areas may lead to decreased clinical exposure, erosion of specific skills, and reduced professional confidence. Ultimately, every curricular decision involves prioritization—but also trade-offs.

Within this context, recent changes introduced in the United States by the Accreditation Council for Graduate Medical Education (ACGME), through its Review Committee for Pediatrics, have reduced the required duration of neonatology rotations within pediatric residency training. This measure aims to shift training toward ambulatory care, individualized learning pathways, and other prioritized experiences.

Nevertheless, this decision has raised concerns. For residents, reduced exposure to neonatal intensive care units may result in insufficient training in the recognition and initial management of critical conditions, potentially affecting core competencies in newborn care—particularly in settings where general pediatricians continue to play a central role in neonatal care.[2] For neonatology services, shorter rotation periods may translate into reduced availability of trainees, with potential impacts on care delivery and educational processes within highly specialized teams.[3]

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These debates are not unique to the United States. In Argentina, changes implemented as early as 2015 in pediatric residency programs reduced the relative weight of neonatology, in an effort to align training with emerging healthcare and educational demands.

The tensions between breadth and depth, generalism and specialization, and tradition and innovation have long shaped medical education. Rather than being definitively resolved, these tensions are continually reconfigured in response to changes in healthcare and educational contexts. The challenge is not to eliminate them, but to manage them thoughtfully, avoiding both inertia and the uncritical adoption of trends. Maintaining this dynamic balance is not merely a pedagogical concern; it is ultimately essential for training pediatricians prepared to respond effectively and judiciously to the evolving needs of the population.

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