Sr. Editor:

Currently, there are in Argentina 26 medical schools, 10 are public and 16 are private\(^1\). Public education is free and public universities are autonomous although entirely dependent on the government for income. Students enter to a six-year medical curriculum right after high school (average age = 17 ± 1 years old; mean ± standard deviation) since no intermediate stages (college or similar) exist between secondary education and university. Furthermore, there exists a wide variety of admission policies resulting in a wide range of medical school admission numbers (from about 150 ± 70 to 1.500 ± 500 matriculates/year)\(^2\).

When our public medical school at Rosario, Argentina, engaged in implementing a pure problem-based learning (PBL) curriculum, the basic requirements for successful implementation of that format, the difficulties that such curriculum could face, and the need for an unbiased and continuous monitoring and adjustment were made public, proposing simultaneously an alternative hybrid format in view of some arisen problems shortly after its first-year implementation\(^2,3\). However, the curriculum planners' decision was to go on with the program assuming that potential impediments for PBL curriculum implementation could be overcome.

After six years of implementation, this letter refers to the fulfillment of the aforesaid basic requirements and to some teachers' working experiences dealing with the first three years of the curriculum design intending to be helpful for curriculum planners, particularly in developing countries, in terms of being aware of potential drawbacks and ways for solving them.

Earlier reports on this subject\(^4-5\), university database\(^6\) and National Commission for the Evaluation and Accreditation of Universities (CONEAU) recommendations\(^7\) were considered for comparing the aforesaid basic requirements with our present scenario. In parallel, a personal interview was carried out during 2007 to a representative and reliable group of 20 medical teachers of both sexes (48 ± 12 years old, mean ± standard deviation) selected from a population of approximately 200 teachers.

The obtained results revealed that the referred basic requirements and the improvements recommended during 2005 by CONEAU could not be fulfilled at all by internal and external reasons\(^8-10\), despite some efforts made in this regard.

In turn, interviewed teachers identified a set of problems likely to be solved:

- (a) a predominance of triggering enunciates instead of real medical problems,
- (b) a reduced background for understanding physiopathology, pharmacology and its related clinical and therapeutic contents resulting from a weak morphophysiological core,
Exceeding the bibliographic pros and cons and whatever the underlying reasons for the adopted and sustained decision, an action to be faced is a quick, up-to-date and reality-grounded adjustment of the current curriculum, compatible with the CONEAU recommendations. Summing up, the best of former curricula must be retrieved, and the best of the new trends in medical education must be added, for achieving a reliable curricular hybridization.

To conclude, the lessons to take home were: (a) the greater the curriculum change the better the outcomes to be required, (b) the best ideas and purposes and the most promising formats may become problematic when the contextual and operational factors are not fully considered for its implementation, and (c) an advisable flexibility must prevail whatever the curricular design being proposed.

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