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EUROPEAN UNION OF MEDICAL SPECIALISTS

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UEMS Policy Proposals for Classification and Training Durations of Specialties registered in Doctors Directives 1996

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INTRODUCTION

Founded in 1958, less than one year after the treaty of Rome, the European Union of Medical Specialists (UEMS) groups together specialist doctors regardless of their field or mode of practice, or their legal status. Its object is the advancement and harmonisation of the quality of specialist medical practice in Europe and the defence, at international level, of the status of the medical specialist and of his/her professional role in society.

The UEMS, in cooperation with the Standing Committee of European Doctors (CP), participated in the drafting of the European Directives governing the free movement of doctors and mutual recognition of medical credentials throughout the European Community which were adopted by the Council of the European Community in 1975 and came into effect in 1976.

UEMS played a major role in the elaboration of the reports and recommendations issued by the Advisory Committee on Medical Training (ACMT) on 5 April 1979, 11 March 1981, 9 March 1983 and 20 June 1985. These various reports to a very large extent reflect UEMS views on the training of specialist doctors and the practice of specialised medicine.

THE POLICY OF UEMS

1. The Definition of Specialist Medicine

The specialist doctor has chosen to confine his or her practice essentially to one field of medicine. This implies that he or she shall be, and must remain, at a high level of competence in the chosen specialty by mastering advances and innovations both in data and technique.

For some specialties the expansion of knowledge threatens to lead to super-specialties concentrating on particular techniques or a narrowly defined field of pathology. National authorities often grant official recognition to these competences, which should however remain within the broad framework of the main specialty. These developments should not lead to the proliferation of new specialties, as the number of specialties must be kept under control. The development of techniques should not prevent awareness that specialised medicine is a clinical discipline which must remain focused upon the patient.

Clearly the practice of the general practitioner and the medical specialist are complementary. Their precise roles and arrangements for access to specialist treatment vary from country to country. Patients should be able to exercise freedom of choice, and should have prompt access to the treatment which they need, within the framework of the health care system of the country in which they live. Good practice in both disciplines depends on effective cooperation and exchange of information.

2. Medical Specialist Training

a) The Competent Body

At national level, the training of medical specialists is regulated by a National Authority, which may be a combination of competent professional or University bodies, a National Board or a national governmental authority receiving advice from professional organisations. It sets standards in accordance with national rules and EU legislation as well as considering UEMS recommendations for recognition of training programmes, of trainers and training centres, the quality assurance of training, the qualifications of the medical specialist and manpower planning.

b) Guarantee of the Quality of training

- Basic medical training should be authenticated before the course of specialist training is started. The specialist training must be comprehensive and should omit no important field.
- In the training centres, adequate numbers of teaching staff and appropriate training facilities must be available and in balance with the number of trainees in order to guarantee high quality training.
- Other methods of ensuring the quality of training could include, for example, the audit, logbook, the possibility of part of the training period being spent abroad, and a national examination at the end of the postgraduate training.
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c) Particular Aspects of Specialist Training

The content and practice of the specialty inevitably determine the training that is required. A system of centralised classification which takes into account the real content of each specialty and its historical development shows that training in medical and surgical specialties follows different pathways. However, apart from these main groupings, there exist organ-related disciplines which include both medical and surgical elements. This type of classification allows one to define a specialist training programme based on a common trunk, which broadens out to include the divisions and subdivisions of both medical and surgical specialties.

A regrouping of specialties such as was proposed in 1983 by the Advisory Committee on Medical Training (ACMT) should be adopted in place of the classification in Articles 26 and 27 of the existing Medical Directives, which take no account of the relationship of the specialties to one another (see Appendix 1). As regards the content of training and the relation of the Common Trunk to specialist training, the work of the UEMS Sections and European Boards has resulted in the publication, in October 1995, of a more accurate definition. At the same time, a precise definition of the content of training should not be taken to imply that specialist practice is a system of watertight compartments. Because disciplines frequently overlap, there must be scope for flexibility, although quite clearly no specialist should carry out a procedure for which he or she is not appropriately trained.

3. Continuing Medical Education (CME)

Continuing medical education is both a necessity and an obligation, which applies as much to the medical profession as to any other. The process of education lasts throughout the doctor's entire career, beginning with basic undergraduate training, carrying on through specialist training and extending for the remainder of professional life as

Continuing Medical Education. As it is a professional, ethical and moral obligation, CME must be managed and supervised independently by the profession.

Basically, it should be a voluntary responsibility for the individual specialist. The representative national professional organisation is free to decide in a democratic manner to impose a formal obligation to fulfil CME requirements. However, someone who does not fulfil these requirements cannot lose his/her status as a doctor or specialist, but must understand that he/she may be disadvantaged in other ways. The content of CME must take into account the specific situation of the specialist and in consequence is of an individual nature. Systems of assessment which award credit points are preferable to those which involve re-evaluation or recertification of the specialist's knowledge. Control of such systems must remain in the hands of organisations which represent the medical community. These systems could also include models of self-assessment.

4. The organisation of Specialist Medicine

The activity of the specialist doctor may be practised not only in a hospital or private office, but also in health centres, companies, schools and other places where the specialist's presence is required. In all cases the specialist doctor shall be free to treat his/her patient without external constraint. The medical specialist must have adequate medical equipment at his/her disposal. The quality of care should remain independent from the system of remuneration, and compliance with professional quality standards should be assured by Peer Review assessment.

Contracts with and the remuneration of specialists, whether salaried or in private practice, must provide for the expenses involved for the doctor in meeting his/her CME obligations. Independence from outside pressure in the choice of management and treatment of the individual patient remains the cornerstone of medical care. The physician and the patient must remain free to exercise a responsible choice.

Conclusions

The UEMS, through its 34 Specialist Sections, is in a position to know the conditions which each specialty needs to meet in order to reach harmonisation, both as regards the duration and the content of training and the practice of the various disciplines registered in the Medical Directives. It can inform each EU member state of these conditions, in all countries and all specialties. Thanks to the European Boards, which are the working groups of the Specialist Sections, and include delegates appointed by scientific and academic bodies as well as representatives of the Sections, the UEMS is in a position to define for each discipline the conditions which will ensure high quality training and the necessary criteria for a training centre. It can put forward suggestions regarding methods of assessment to which individuals can submit if they so desire.

COMPOSITION AND FUNCTIONING OF U.E.M.S.

The UEMS was founded in 1958 with the aim of defending, at international level, the status of the medical specialist and his professional role in society. Its membership is composed of the national medical association representing medical specialists in each of its member countries, at the rate of one per country. At present it includes 18 full members (1997):

Germany	Gemeinschaft Fachärztlicher Berufsverbände
Austria:	Österreichische Ärztekammer
Belgium ;	Groupement des Unions Prof. Belges de Médecins Spécialistes
Denmark:	Danish Medical Association
Spain:	Consejo General de Colegios Oficiales de Médicos
Finland:	Finnish Medical Association
France :	Union Nationale des Médecins Spécialistes Confédérés
Greece:	Panhellenic Medical Association

Iceland:	Icelandic Medical Association
Ireland:	The Irish Medical Organisation
Italy :	Federazione Nazionale degli Ordini dei Medici
Luxembourg:	Association des Médecins et Médecins-Dentistes du Grand-Duché de Luxembourg
Norway:	Norwegian Medical Association
The Netherlands:	Orde van Medische Specialisten
Portugal:	Ordem dos Medicos
United Kingdom:	British Medical Association
Sweden:	Swedish Medical Association
Switzerland:	Fédération des Médecins Suisses

i.e. the countries of the European Union and Norway and Switzerland.

Associate members are Hungary (Federation of Hungarian Medical Societies (Motesz), Malta (The Medical Association of Malta), Slovenia (Zdravniska Zbornica Sloveije), Croatia (Croatian Medical Association), Poland (Polish Chamber of Physicians and Dentists) and Turkey (Turkish Medical Association).

The **UEMS Executive Committee** is responsible for assisting the Secretary-General and meets regularly. It is comprised of the President, the Secretary-General, the Treasurer and the Liaison Officer with the C.P. It can be augmented by the Vice-Presidents if necessary, but, always formally meets them on the day before each meeting of the Management Council.

The **Management Council** is composed of two delegates from each country, who represent their country rather than their specialty. Since its foundation, the principle of one vote per country has been observed. Each delegation may be strengthened by one or more experts. Associate members sit in an advisory capacity. At least two plenary assemblies are held each year.

The **Specialist Sections** were created in 1962 and are composed of experts in each discipline. At present, there are 34 specialist sections representing 43 of the 50 specialties registered in the EU Medical Directives. Consisting of two delegates per country, the sections lead an independent existence. They report to the Management Council, which co-ordinates their activities.
Since 1990, each section has been empowered to establish a European Board for its specialty with the appointment of delegates from the scientific and academic sectors. These are in reality working groups whose main objective is to guarantee the highest standards of care in the field of the specialty concerned in the countries of the EU by ensuring that the medical specialist training is raised to the highest possible level.

The UEMS collaborates actively with the Standing Committee of European Doctors where it is represented by a Liaison Officer. UEMS maintains continuing relations with other European medical organisations such as the European Union of General Practitioners (UEMO), the European Academy for Medical Training (EAMF), the Permanent Working Group of Junior Hospital Doctors (PWG), the European Association of Hospital Doctors (AEMH) and the European Association of Salaried Doctors (FEMS). It also maintains close contact with the authorities of the European Union and the Council of Europe.

PROPOSALS FOR CLASSIFICATION AND TRAINING DURATIONS OF THE SPECIALTIES REGISTERED IN THE DOCTOR'S DIRECTIVES

These proposals take into account the conclusions of the report published by the Advisory

Committee on Medical Training in 1983, and the evolution of the situation of the specialties in the different countries.

1. Group of the medical specialties:

a. **Adult internal medicine**: 6-year training experience in one or more medical specialties

Medical specialties requiring a strong experience in internal medicine: 6-year training

2-year common trunk in internal medicine, 3 years achieved in clinical practice in the specialty concerned, 1 year may be devoted to research or to training in a closely related discipline.

- cardiology (*)
- endocrinology (*)
- gastro-enterology (*)
- general haematology (*)
- renal diseases (*)
- respiratory medicine (*)
- rheumatology (*)

(*) a possible period of transition should be foreseen

b) **Child and Adolescent internal medicine (paediatrics):** 5-year training

Medical specialties requiring a strong experience in paediatrics: 5-year training

3-year common trunk in paediatrics, 2 years achieved in clinical practice in the specialty concerned

- cardiology (*)
- endocrinology (*)
- gastro-enterology (*)
- general haematology (*)
- renal diseases (*)
- respiratory medicine (*)
- rheumatology (*)

(*) a possible period of transition should be foreseen

Allergology: 5-year training with a common trunk in internal medicine

Neurology: 6-year training, including 4 years in neurology (*) (**)

(**) for paediatric neurology, a 3-year common trunk in paediatrics should be foreseen

Tropical medicine: 4-year training

Geriatrics: the same

Infectious diseases: same with common trunk in internal medicine

2. Group of surgical specialties

General surgery: 6-year training, common trunk with the other surgical specialties

Surgical specialties requiring a training of 6 years with common trunk in surgery

- orthopaedic surgery
- urology
- plastic surgery
- thoracic surgery
- paediatric surgery
- vascular surgery
- gastro-enterological surgery

Surgical specialties requiring an experience in parent specialties, and cephalic specialties:

- neurosurgery: **6-year training**, out of which two years in parent disciplines, including basic neurological sciences
- oto-rhino-laryngology: **6-year training** (*)
  (*) a possible transition period should be foreseen
- maxillo-facial surgery (basic medical training): **6-year** training including a trong training in stomatology
- oro-maxillo-facial surgery (basic medical training and of dental art practi - tioner):
  6-year training, out of which two may be dedicated to the award of the legal diploma in odontology
- ophthalmology: **4-year** training
- stomatology: **4-year** training

3. Mixed group

Anaesthesiology-reanimation: 5-year training
Physical and rehabilitation medicine: 5-year training
Radiations medicine: common trunk in radiological theory

- radiodiagnosis: **5-years**
- radiotherapy: **5-years**
- adiology (combined): **6-years**

Nuclear medicine: 4-year training
Dermato-Venereology: 4 year training
Dermatology: same
Venereology: same

4. Obstetrics-gynaecology

5-year training, with common trunk for the different sub-specialties.

5. Laboratory medicine

a) **5-year** training:

- pathological anatomy

b) **5-year** training with clinical experience (1 year of common trunk in internal medicine):

- medical biopathology (clinical biology)
- biological haematology
- microbiology
- biological chemistry
- immunology

6. Psychiatry

5-year including a common trunk in neurology

- psychiatry
- child and adolescent psychiatry

6-year training including a common trunk in neurology

- neuro-psychiatry

7. Miscellaneous

- Community medicine" (public health): **4-year** training
- pharmacology: **4-year** training
- occupational medicine: **4-year** training