EUROPEAN TRAINING REQUIREMENTS IN OTORHINOLARYNGOLOGY

This European Training Requirements document in Otorhinolaryngology (ORL) Surgery was approved by the delegates of the UEMS-ORL Board and Section in Dublin on 4 October 2019. It was endorsed by wider consultation and feedback with the European Specialist societies by July 2020. This ETR was co-ordinated by UEMS-ORL General Secretary Mr Adrian M Agius. The valuable contribution of these Boards and individuals is acknowledged below.

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Introduction

The UEMS is a non-governmental organisation representing national associations of medical specialists at the European Level. With a current membership of 39 national associations and operating through 43 Specialist Sections and European Boards, the UEMS is committed to promote the free movement of medical specialists across Europe while ensuring the highest level of training which will lead to the improvement of quality of care for the benefit of all European citizens. The UEMS areas of expertise covers Continuing Medical Education, Post Graduate Training and Quality Assurance.

Quality of medical care and expertise is directly linked to the quality of training provided to the medical professionals. The UEMS commits itself to improve medical training at European level through the development of European Standards in the different medical disciplines. EU doctors should have the same core competencies irrespective of where they trained.

In 1994, the UEMS adopted its Charter on Post Graduate Training aiming at providing the recommendations at the European level for medical training. Made up of six chapters, this Charter set the basis for the European approach in the field of Post Graduate Training. With five chapters being common to all specialties, this Charter provided a sixth chapter, known as “Chapter 6”, that each Specialist Section was to complete according to the specific needs of their discipline.

The UEMS Specialist Section and European Board has continued working on developing these European Standards in Medical Training that reflect modern medical practice and current scientific findings. Their aim is not to supersede the National Authorities' competence in defining the content of postgraduate training in their own State but to complement these and ensure that high quality training is provided across Europe.

At European level, legal mechanisms ensuring the free movement of doctors through the recognition of their qualifications was established in the 1970s by the European Union. In 2005, the European Commission proposed to the European Parliament and Council to have a unique legal framework for the recognition of the Professional Qualifications so as to facilitate and improve the mobility of all workers throughout Europe. This Directive 2005/36/EC established the mechanism of automatic mutual recognition of qualifications for

medical doctors according to training requirements within all Member States and is based on the length of training in the Specialty and the title of qualification.

Given the experience of UEMS Specialist Sections and European Boards on the one hand and the European legal framework enabling Medical Specialists and Trainees to move from one country to another on the other hand, the UEMS is uniquely in position to provide specialty-based recommendations. The UEMS values professional competence as "*the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served*"[1]. While professional activity is regulated by national law in EU Member States, the UEMS understands that it should also comply with International treaties and UN declarations on Human Rights as well as the World Medical Association International Code of Medical Ethics [1].

This document derives from and expands on **Chapter 6** of the UEMS Training Charter. It provides definitions of specialist competencies and procedures as well as how to document and assess them. It aims to provide the basic European Training Requirements for Otorhinolaryngology and should be regularly updated to reflect scientific and medical progress.

([1] Defining and Assessing Professional Competence, Dr Ronald M. Epstein and Dr Edward M. Houndert, Journal of American Medical Association, January 9, 2002, Vol 287 No 2)

Table of Contents:

This ETR document is divided into the following sections:

Definition of the ORL Specialty

Otorhinolaryngology (ORL)[2] is the specialty which deals with functions and diseases of the Ear, Nose, Throat, skull base, and Head and Neck. Disorders include trauma, malformations, tumours and other disorders in childhood and in adults; of the ear, temporal bone and lateral skull base, nose, paranasal sinuses and anterior skull base, oral cavity, pharynx, larynx, trachea, oesophagus, head, neck, thyroid, salivary and lacrimal glands and adjacent structures. It also includes investigation and treatment of conditions affecting the auditory, vestibular, olfactory and gustatory senses and disorders of the cranial nerves as well as human communication in respect of speech, language and voice disorders. Some of the conditions diagnosed by otorhinolaryngologists but located in adjacent areas will be treated with close cooperation with these related specialists.

([2] Although defined as ORL in most European countries according to Annexe V of Directive 2005/36/EC, this specialty is also described in certain countries as Otorhinolaryngology and Head and Neck Surgery in accordance with the practice in Europe where competencies related to Head and Neck Surgery are part of the training curriculum and clinical practice of ORL surgeons)

I. TRAINING REQUIREMENTS FOR TRAINEES

(1). Trainee Requirements-Content of training and learning outcomes

Knowledge and Competence required by trainee

(a) Theoretical knowledge

(b) Practical and clinical skills

(c) Levels of competence attained

Eligibility for selection as ORL trainee

To be eligible for specialty training, the medical trainee should be in possession of a medical degree recognised by the European Union.

It is recommended that this be followed by at least one year of practical training as an intern, house officer or whatever training is demanded by that country to be qualified as a physician. This practical training should at least comprise training in general surgery and internal medicine. Adequate documentation of the qualification should be provided.

Specialty training should be carried out within a specialised accredited ORL training centres in the EU, under supervision of a trainer for a recommended duration of at least five (5) years. During this period, training may take place in different institutions if they are recognised nationally as a training institution with confirmation by the European Board. For those training in several centres the responsibility of completion of training will be borne by the head of training of the last period before certification. Part of this training may include experience in related specialties and further guidance is found in section 5 on Training Institutions below.

The following are general guidelines for training institutions, however there may be additional requirements for access to particular recognized training programmes.

Knowledge and competence required by trainee

The trainee should demonstrate commitment to practice in an ethical and professional manner. Trainees should be dedicated to patient care of the highest professional standard and should obtain experience in the breadth of the specialty. This includes care of disadvantaged, disabled or syndromic patients, and those with rare diseases.

To enter the training programme, trainees should have demonstrated competence in working as a team member, assessing emergency patients and initiating investigations and treatment. Competitive selection for a training programme is recommended.

An interview should be an integral part of the entry process. The ORL trainee must be physically and mentally fit to practice medicine and surgery. A probationary period is recommended, although some countries may opt for an examination to secure a place on a training programme.

The trainee should be able to communicate sufficiently with patients and relatives in a sensitive and caring manner in the language of the country of practice. The trainee should be able to record and present the patients' medical information and clinical findings.

The trainee should be able to obtain informed consent from patients having explained in detail the operative procedure, its benefits and risks.

Trainees should abide by the rules and regulations of the training programme. Some training centres may require a training agreement to be signed by the trainee and the Training Programme Director to define their respective duties and obligations.

(a) Theoretical knowledge

The main domains covered by the specialty that a trainee should master in the specialty are covered in the core curriculum (section 2e below)

This includes prevention, diagnostics (including imaging techniques), non-operative, pharmacological and surgical treatments and rehabilitation of degenerative, traumatic, inflammatory, infectious, metabolic and neoplastic pathologies. It also includes contributions to the multi-disciplinary management of congenital and neoplastic disorders and of rare diseases.

Trainees should be proficient in the fundamentals of basic sciences, including relevant anatomy, physiology, biochemistry, genetics, public health and statistics.

The trainee should have an updated knowledge of the mainstream international literature and the principles of evidence-based medicine. The following four step-wise achievements of competency are recommended:

- Knows of
- Knows basic concepts
- Knows generally
- Knows specifically and broadly

(b) Practical and clinical skills

Training for ORL surgeons is recommended to include one to two years of basic education (or 'core training'), depending on the structure of the medical training programme in that particular country where training is taking place. For example this may be the 6th year of medical degree together with one year training or 5 years of medical degree with two years training. Core training will teach the trainee to cope with routine tasks in the healthcare system including the management of medical emergencies, first aid, the basics of peri-operative and post-traumatic care. Following core training, a general ORL training duration of

at least 5 years is recommended to achieve general ORL competency, which may include attachments in allied specialties.

Training should be guided and controlled by national authorities responsible for health care provision. The educational process in the curriculum should lead to a progressive increase in knowledge and skills in the specialty. Due to the different structures and facilities of clinical departments this process can be flexible. There should be established rotation periods covering all main area of the specialty.

The trainee should also be sufficiently exposed to inpatient, day stay and outpatient management. There should be a contingency for fast track progression through the training programme if trainees have achieved competencies early to the satisfaction of the Training Programme Director as well as the National Authority. Similarly there should be provision for trainees working on reduced hours, who may require a longer training programme.

Protected time must be given to the trainee for study and research. The training programme should include protected time for study, lectures by staff and visiting speakers, clinical presentations and multidisciplinary case conferences, journal clubs, morbidity and mortality meetings. Teaching in ethics, audit, management, communication and business administration is essential together with a knowledge of the implications of handling sensitive data and relevant legal requirements.

The trainee should have acquired research skills by the end of training. A publication should be produced during the programme that may be presented at a national or international meeting.

(c) Level of Competence attained

The content of the curriculum should cover the whole spectrum of ORL and comprises knowledge, experience, clinical skills and attitudes, and professional behaviour.

As the field is so wide, it is felt that a rigid “number” of procedures required is debatable, the accent being more on quality rather than actual numbers.

Minimum numbers may however be introduced in the future. Procedures performed by the trainee will become progressively more complex. They would be first observers, then later supervised by a senior surgeon, and finally shall carry out procedures unaided. Trainees should keep a portfolio of their competency outcomes and at the end of training should be clinically independent.

The levels of competence to be attained in theoretical and practical skills are listed in the UEMS-ORL general logbook and summarised in section 2 (e) Core Curriculum below.

For European training programmes the required levels of skills are more recently defined as Entrustable Professional Activity or EPA which encompasses 5 levels (see below clinical and technical skills).

An EPA is 'a critical part of professional work that can be identified as a unit to be entrusted to a trainee once sufficient competence has been reached'. An EPA goes a level higher than the traditional 4th level of competence which is the 'independence competency'. The key factor is *Entrustment.* The trainee is not only capable of tackling the particular procedures or units independently, but he can be *trusted* to do this by his tutors. Training is aimed at this level 5 for all relevant skills, with the exception of some very specialised areas which may warrant for obtaining level 4 (competent to handle without assistance, including complications). The assessments to evaluate the level of skills should be done in the last 3 years. Thus, the EPA is an integral part of the Logbook and is a comprehensive and holistic tool for Competence Based Assessment. It constitutes the 5th Grade of Competence and serves as a bridge between the Syllabus/Curriculum and the Eligibility Assessment. The Head of the Training Programme or Tutor officially certifies this level of Competence when signing the various items in the Syllabus and Curriculum. The Examination Board Website should be known to the trainee and contain a clear explanation of the criteria required to sit the assessment with a concise outline of the curriculum to be covered in the test. The EPA is a unit which allows an exact computation of ability and is the key to examination eligibility when presented as the fifth and highest achievable grade of competence in combination with a certified logbook and validated Portfolio. As the emphasis and attitudes regarding the spectrum of competences and education within any Medical discipline vary

significantly in the individual states, one cannot expect applicants to have attained EPA 5th level competency in each and every item listed in the Syllabus/Curriculum. The Eligibility Committee can apply the correct degree of flexibility annually allowing for equivalence of some procedures at a minimum level based arbitrarily by evaluating the data from previous candidates.

A Specialty Examination Board is already in existence for the past decade as EBEORL - an independent body to UEMS-ORL, allowing the test to be undertaken by candidates in their final year of training in their base countries. It is the current decision of the UEMS-ORL Board that this examination is of sufficiently high standard for all required aspects that it is endorsed and recommended by the specialty rather than attempting to replicate or reproduce a test that has an input by reputable pan-European academics in our discipline. It is proposed that members of the UEMS-ORL Board serve as ex-officio members of the EBEORL-HNS Board for the purposes of quality control and assessment. The threshold has already been set as per the EBEORL website while EPAs have helped assessment of eligibility to sit the Examination.

A Knowledge acquisition can therefore be subdivided into 1-4 (see Page):

- Knows of
- Knows basic concepts
- Knows generally
- Knows specifically and broadly

B & C Clinical & Technical Skills acquisition can be subdivided into 1-5:

1.Has observed.

The trainee acts as an 'Assistant and progresses from complete novice through to being a competent assistant.
At end of level 1 the trainee

(a) has adequate knowledge of the steps of through direct observation
(b) demonstrates that he/she can handle the instruments relevant to the procedure safely
(c) can perform parts of the procedure with reasonably fluency

2. Can do with assistance.

The trainee is able to carry out the procedure 'directly supervised'.
At end of level 2 the trainee
(a) knows all the steps and the reasons lying behind methodology
(b) can carry out a straightforward procedure fluently from start to finish and knows when to call for assistance or advice

3. *Can do the whole procedure but may need assistance*

A trainee is able to do the procedure 'indirectly supervised', ie without direct supervision.
The trainee
(a) can adapt to well-known variations encountered in the procedure
(b) Recognises and makes a correct assessment of common problems encountered
(c) is able to deal with most of the common problems
(d) knows and demonstrates when help is needed
(e) requires advice rather than help from the trainer

4. Competent to do the procedure without assistance including complications

The trainee can deal with the majority of procedures, problems and complications, but may need occasional help or advice.

In this scenario, the trainee is now capable of instructing and supervising other trainees.

5. *Can be trusted to carry out the procedure, independently, without assistance or need for advice*

The highest level of clinical skills should be covered by the concept of the Entrustable Professional Activity (EPA) which means that a trainee can be trusted to perform the job (carry out a procedure or manage the disease) and not whether he is just competent to do it.

I. TRAINING REQUIREMENTS FOR TRAINEES (cont)

(2). Organisation of Training

(a) Schedule of training

(b) Assessment and evaluation of trainee

(c) Support

(d) Governance

(e) Emergency Safe curriculum

(a) Schedule of training

The institutions providing training must provide the infrastructure (including the financial and administrative elements) to allow the trainee access to inpatient, outpatient and theatre settings. It should comply with relevant quality assurance and surveillance mechanisms designed to maintain the quality of training. Particular attention should be applied to the trainee in difficulty including those who do not or who are deemed unlikely to ever gain basic competence requirements. A probationary period with regular review is therefore advocated. Innovative systems of training including the use of surgical simulation, are encouraged. It is acknowledged that trainees would be integrated into the Healthcare system of that particular country, with the need to adapt to particular staffing situations.

A minimum training duration of five years is recommended to acquire competency in general otorhinolaryngology some of which may be spent gaining experience in allied specialties such as community-based ORL, Plastic and reconstructive surgery, Neurosurgery or Oral & Maxillofacial surgery.

Sub-specialisation following completion of general training should be achieved by a Fellowship process in a recognised centre of excellence in that area of practice. The content and structure of these programmes is beyond the scope of this document but has been formally developed by the Specialist Societies in

conjunction with the UEMS-ORL Section. Fellowship level training should be therefore be related to the requirements of each specific sub-specialty with its own reference points in terms of quantity, quality and structure. Sub-specialisation fellowships are not part of these ETR and will not be discussed further.

The ORL curriculum should allow the resident to manage patients holistically, providing diagnostic and first line treatment, and to fulfil general on-call requirements in an ORL setting. The trainee should be deemed emergency-safe at the completion of training. It is advisable that there should be an interchangeable or rotational aspect involving at least two departments during the period of training. The onus should be on the trainee to prove that the respective institutions chosen are of good enough standing to provide adequate training.

In summary, the concept of training in general ORL leading to certification and followed by specialist training at Fellowship level in a field of the trainee's choice establishes a European standard of ORL competence.

(b) Assessment and evaluation

Regular assessment by the Training Programme Director or designated members of staff should be performed on a regular basis, see section 4 below.

Each trainee should keep an official national trainee logbook/portfolio, or if a national logbook is not available in some EU countries the UEMS-ORL logbook may be used instead. In this logbook the trainee should demonstrate that he or she has been sufficiently exposed to a wide range of cases as an assistant or supervised operator. Logbooks should be monitored regularly and signed off by the trainer and the Training Programme Director. At the end of the training, the Training Programme Director would certify the attainment of an adequate competency level based on the individual's performance.

An individual Portfolio is required to include:

- a logbook with record of surgeries performed
- details of previous training post, dates, duration and responsible trainers
- a record of emergencies looked after by the trainee throughout their training programme
- success in relevant examinations
- evidence of completed audits
- list of articles published and clinical presentations at a local, national and international meetings
- courses attended with the CME/CPD accredited points
- copies of assessment forms for each training period, completed and signed by trainers for that period.
- evidence of teaching of medical students and junior trainees which is encouraged as a means of learning for the trainee

Assessment of trainees may include formative and summative elements.

Formative assessments

Trainees shall be supported at a number of levels. A trainee's clinical work shall be supervised by a trainer. Such an individual already exists in all countries and is known by a variety of titles. The trainer shall be responsible for providing the trainee with regular feedback as regards their performance and guidance in matters related to the clinical care that they are delivering. In addition, all training programmes in ORL Surgery shall be led in an institution (or in a group or network of allied institutions) by a Programme Director. A trainee will meet with their Programme Director on a regular basis, which typically would be every six to twelve months, to discuss their work and progress. Such discussions will take the format of an appraisal with the trainee providing information about how they are progressing, accompanied by documented evidence of clinical engagement and achievement of their learning and training outcomes. The purpose of the appraisal is to enable a constructive discussion about how the learning needs of the trainee should be met. An annual MCQ examination is also suggested.

Subsequent appraisals will revisit earlier appraisals to determine progress in achieving these needs. The appraisals are not part of any summative assessment process but are designed entirely to support the trainees.

Assessment of skills in practical procedures will be in the training establishment. Such assessments may include, where appropriate, the use of simulation prior to an assessment in clinical practice using skills lab facilities.

Training Programme Directors should be able to assess the overall progress of their residents and should have the opportunity of comparing their institutional performance with the other hospitals in the country or elsewhere in Europe.

Feedback by the trainees is essential with exit questionnaires recommended. Within Europe there is a broad diversity of educational progression. Each training institution should have an internal system of medical audit or quality assurance, including a morbidity and mortality review process for reporting adverse events, together with a process for auditing clinical quality improvement. Some countries hold examinations at the end of training, which is a summative part of trainee assessment.

Summative Assessments

Most European countries have National Boards that assess and certify ORL trainees. The past ten years has also seen the creation and development of the European Board examination (EBEORL) with widespread input from European ORL academia. The aim of this examination is not to replace the National Boards but to provide a European standard of certification for ORL specialists. This examination may be taken by trainees from Europe in their last year of training or shortly after completion of training. It can also be taken by specialists who completed their training outside Europe. The EBEORL has found favour with smaller European countries who do not have the resources to undertake the difficult and costly process of running an examination of a high standard.

At present the EBEORL examination comprises two parts, taken separately, with the written section sat in centres throughout Europe, and the oral examination taken in November in Vienna. The examination is currently in English only, but Spanish version of the Oral assessment took place in 2016 and French and German versions are being prepared. It is planned to introduce simultaneous

online examinations in various centres for the written part over the next few years.

A clinical examination in local languages in the candidates' own country is also planned for the future. Attitude, clinical skills and professional behaviour of candidates is tested. Fellows of the European Board should be skilled clinicians who can make a therapeutic decision based on the relevance of the clinical findings and of the investigations performed.

It is important to recognise that successful completion of the EBEORL examination is not the sole determinant of clinical competence and must be associated with a rigorous appraisal system before a trainee is recognised as a Specialist. It should be emphasised that successful completion of a final examination would not confer Specialist status on its own but will have to be the last step in a residency program where all other steps have been fulfilled successfully during training.

(c) Support

There is a progressive move to a common approach determining whether an individual is suitable to be recognised as a specialist in General ORL.

A comprehensive assessment plan should be established with different types of assessments to be performed at various times and at different levels throughout the training. The methods aim to promote learning and have to be compatible with the general objectives of the learning outcomes and the content of training. They should be adapted to the different skill levels of the trainees. The assessment plan should consider a balance between formative and summative assessment and different types of examinations, the use of a logbook documenting competence, and should make use of specified types of medical examination formats e.g. direct observation of procedural skills (DOPS), MiniCex – mini clinical examination, OSCE – Objective Structured Clinical Examinations, Global Rating Scales (GRS), Objective Structured Assessment of Technical Skills (OSATS).

Clinical experience will also be assessed by a review of the patients seen by the trainee and for whom the trainee has had a personal responsibility as regards care. Evidence of such engagement will be maintained in the clinical logbook or

portfolio. The logbook will be reviewed by the trainee's trainer together with the trainee in a formative manner (see section b above). This will enable the trainee to see and be involved with the care of an appropriate number and range of patients. The logbook will be reviewed in a summative manner, separately, by the local Programme Director together with relevant trainers with whom the trainee has worked.

Professional behaviour would be part of the assessment strategy too and typically a 360-degree multi-source feedback (MSF) would occur at the end of each year of training and at the start of the final year of training. Such assessments may occur more frequently in some countries. The Programme Director would be central to the discussion and reflection undertaken after each MSF and provide guidance and support in response to comments made by those providing the MSF to a trainee. Additional MSFs would occur if the initial MSF demonstrated an inadequate performance by the trainee. Local national standards as regards an individual's suitability for clinical practice would determine whether or not a trainee is employable as a consultant/specialist.

In order to be eligible to apply for a post in a country other than the country in which one has trained or to be recognised as a 'European specialist in ORL', all aspects of the above assessment approaches will need to be completed satisfactorily.

Following a specified training period, trainees will usually become eligible to take nationally implemented board exams to assess the acquired theoretical knowledge. This can be at a supranational level through a written and oral examination, such as the EBEORL, and acts as a further means of EU-wide standardisation in specialty training. This examination samples from the list of core clinical conditions shown above and tests knowledge in the areas of relevant science and clinical practice (diagnosis, investigation and treatment). Trainees would able to retake the summative assessment should they fail it initially.

(d) Governance

The governance of an individual's training programme will be the responsibility of the Programme Director and the institution(s) in which the training

programme is being delivered. A trainer will be responsible to the Programme Director for delivering the required training in their area of practice. Governance of training competencies and contents for now remains a core competency of respective national medical specialty boards. However, UEMS strongly encourages the implementation of structures on a national level that allow for continued reassessment of specialty training programs in close cooperation with all participants.

(e) EMERGENCY-SAFE GENERAL OTORHINOLARYNGOLOGY CORE CURRICULUM

UEMS-ORL has had an approved general logbook since 2006 detailing the areas of this specialty with competence-based learning. The logbook was updated and re-approved by all national delegates and European Specialist Societies in 2018, 2019 and 2020.

The logbook is a key part of the training portfolio.

It is recognised that some departments for organisational or geographical reasons may not provide exposure to all aspects of curriculum.

Each country should have a national oversight board of training which would oversee the achievement of competencies and consider trainee rotation to cover all aspects of the curriculum.

Small countries having a population of less than 5 million may wish to consider amalgamation of their training board with that of a larger country.

At present the UEMS board is considering producing “minimal numbers” for individual surgical procedures.

Core competencies

In addition to knowledge and understanding of Basic Sciences (1), the trainee should have an understanding of diagnostic procedures, conservative medical

management and surgical management of (2) Otology and Neuro-otology), (3) Rhinology (Nose and paranasal sinuses), (4) Laryngology, Head and Neck and Phoniatrics, (5) Facial Plastic and aesthetic/reconstructive surgery and (6) Paediatric Otorhinolaryngology.

A summary of the competencies required in the principal sections of the logbook are presented below.

ORL Portfolio/General Logbook

Introduction

The following items define the basis of the core curriculum in Otorhinolaryngology and includes a section on Head and Neck Surgery. By the time an individual is appointed as a specialist, he or she would be expected to have the following attributes:

- Knowledge and understanding of the relevant and topical medical sciences, population health sciences, pathophysiology and principles of management and care of patients with any of the core clinical conditions.
- The ability to indicate and interpret diagnostic testing: laboratory tests, diagnostic imaging techniques, test performance characteristics.
- An understanding of the modes of action and potential adverse effects of therapies and experience in advising patients about the risks and benefits of such therapies.
- An understanding of the benefits and risks of surgical procedures, their chances of success and failure, their complications and time needed to achieve a stable result.
- The ability to analyse and utilise research findings in Otorhinolaryngology, so that their clinical practice is evidence-based.
- The ability to provide evidence that they are maintaining their general medical as well as their ORL knowledge sufficiently to ensure a high standard of clinical practice.
- An understanding of the healthcare systems within their country of training.

- Be prepared for their role as future clinical leaders.
- The ability to function as an effective member and a leader of a multi-disciplinary team.

The following six sections in the General logbook briefly lay out the basic knowledge required in the principal areas of ORL and the surgical procedures in which it is necessary to attain competence. There may be some overlap between the various sections. There may also be overlap with other specialties to which the trainee may have had some exposure during their basic surgical rotations. For the General ORL specialist it is necessary to attain proficiency in most procedures at a general basic level; certain procedures are included with this list for completeness and may be carried out by colleagues attending specialised fellowships or following particular training and career paths. Advanced procedures are marked as (A) in the logbook. Full details are available in the UEMS-ORL general logbook at (http://www.orluems.com/index.asp?seccion=12&apartado=11)

I Otorhinolaryngology General Objectives -General Basic Knowledge

- Principles of emergency medicine and resuscitation
- basic laboratory procedures and investigations, correct taking and handling of samples and interpretation of results, tumour markers, immunology and allergology investigations
- basic nutritional medicine: oral and parenteral nutrition
- principles of endocrinology as applied to the ORL regions
- Principles of infection control, bacteriology, mycology and antimicrobial medication
- principles of blood transfusion
- General surgical principles of management, operative techniques, haemostasis
- Principles of wound healing and plastic surgery
- Principles of oncology, reconstructive surgery and where necessary, transplantation medicine
- Soft tissue and bone traumatology
- Medical quality control, audit and management within multidisciplinary teams
- Ethical principles and informed consent

- Social welfare legislation with respect to disability (such as hearing and balance) and conditions of an aging population
- Radiation protection
- Management of psychosomatic disorders

II Otology/Neurotology-Knowledge of, Medical and Surgical management of the following conditions:

1. History and clinical examination, imaging of hearing pathway, relevant laboratory investigations
2. Vestibular assessment and physical rehabilitation
3. Ear infections and their treatment
4. Assessment of conductive and sensorineural hearing loss in adults and children (including screening) with hearing rehabilitation
5. Tinnitus
6. Facial nerve palsy assessment and treatment

Auricle
Congenital malformations
Infections
Inflammatory
Benign & malignant tumours
Otological trauma

Ear Canal
Congenital malformations
Infections
Inflammatory
Benign and malignant tumours
Exostoses
Necrotizing otitis externa
Keratosis obturans and external canal cholesteatoma
Trauma

Surgical Procedures:
Management of oto-haematoma
Excision of lesions of the auricle
Wax removal

Foreign body removal
Removal of external auditory canal lesions
Meatoplasty (Soft tissue & bony)
Removal of osteomas/exostoses

Tympanic Membrane and Middle Ear conditions
Congenital malformations
Acute & chronic otitis media
Benign & malignant tumours
Trauma
Barotrauma
Eustachian tube dysfunction-Conductive hearing loss in adults & children (congenital & acquired)
Surgical Procedures:
Myringotomy
Ventilation tube insertion
Myringoplasty (Type1 Tympanoplasty)
Tympanotomy
Mastoidectomy-
- Cortical
- Modified radical / radical (Back to front approach)
- Atticotomy / Attico-antrostomy (Front to back approach)
- Combined approach tympanoplasty
- Mastoid obliteration

Bone anchored hearing aid implantation
Ossiculoplasty
Implantation of prostheses
Middle ear prosthesis (ossicular prosthesis/implantable hearing aids)
Cochlear implants
Stapes Surgery

Inner Ear and Lateral Skull Base conditions
Congenital malformations
Sensorineural hearing loss in adults & children (congenital & acquired) and its management
Peripheral and central vestibular disorders
Non-vestibular balance disorders
Management of tinnitus (including pulsatile tinnitus) & hyperacusis
Benign & malignant tumours
Trauma

Infective disorders

Surgical Procedures:

Facial nerve surgery, Decompression and Grafting; Anastomotic nerve surgery
Endolymphatic sac decompression
Vestibular schwannoma surgery
Translabyrinthine approach
Retrosigmoid approach
Middle cranial fossa approach
Vestibular neurectomy
Glomus tumour surgery
Petrosectomy
Correction of malformations
Peri-auricular fistulas
Repair of injuries: auricle, external auditory canal, middle ear, middle and posterior cranial fossa
Surgery of tumours: auricle, external auditory canal, middle and inner ear including management of nerves, vessels; temporal, middle cranial fossa and posterior cranial fossa approaches; management of dura
Management of postoperative complications

III Nose and Paranasal sinuses- Medical and Surgical management of the following conditions:

Nose

congenital malformations of nose, mid-face (cleft lip, palate), including genetic anomalies
infections of nose
Neoplastic conditions: benign and malignant
nasal and facial trauma
Epistaxis
Inflammatory conditions
Allergic conditions (rhino-allergology)

Diagnostic tests and Surgical Procedures

Assessment of function, investigations (airway, allergic tests, rhinoscopy, endoscopy and visual assessment including photography and facial measurements)
Pharmacological therapy of nasal conditions
Specific immunotherapy (hyposensitisation), sublingual immunotherapy
Management of anaphylaxis

Application of local and regional anaesthesia, rigid and flexible nasal endoscopy
Management of epistaxis-nasal packing, nasal cautery and other endoscopic management, Management of medical conditions in epistaxis patients
Foreign body removal
Nasal Polypectomy
Turbinate procedures (including coblation, radiofrequency etc)
Septal surgery
Revision septoplasty
Septorhinoplasty (open and closed, reduction, augmentation, grafting techniques, cleft lip septorhinoplasty)
Rhinophyma management and operative techniques
Correction of congenital malformations (choanal atresia, fistulas, dermoids)

Paranasal Sinuses
congenital malformations
rhinosinusitis: acute and chronic
atopic, non-atopic, bacterial, fungal, allergic fungal
Inflammatory and granulomatous systemic conditions including sarcoid, tuberculosis
Benign and malignant tumours
Surgical Procedures of paranasal sinuses
Sinus endoscopy
Antral lavage
Endoscopic antrostomy and sinus endoscopy
Radical antrostomy
Frontal sinus trephination
External frontal sinus surgery
External ethmoidectomy
Endoscopic Sinus Surgery and its possible acute complications: a) anterior ethmoidectomy; b) posterior ethmoidectomy; c) frontal recess procedures; d) sphenoid sinus procedures
Surgery of floor of maxillary sinus
Ligation of maxillary, ethmoidal or sphenopalatine artery including endoscopic
Orbital decompression procedures
Endoscopic dacry-cysto-rhinostomy (DCR)
Management of CSF leak
Tumour Surgery; a) maxillectomy (partial, total); b) lateral rhinotomy; c) midfacial degloving
Combined approach to anterior skull base

e) orbitotomy; f) exenteration of orbit; g) surgery of anterior skull base (incl osteoplastic flap, duraplasty and endoscopic)
Trauma: a) soft tissue injuries; b) management of fractures of nasal bones/septum and septal haematoma under local or general anaesthesia; c) paranasal sinus fractures; d) fractures of orbit including blowout fractures; e) zygomatic fractures; f) optic nerve decompression; g) reconstruction of anterior skull base

IV Laryngology, Head and Neck, Phoniatrics: knowledge of, assessment, medical and surgical management of the following:

Basic Knowledge
1.Carcinogenesis, molecular biology and immunobiology in Head and Neck oncology
2. Epidemiology and biostatistics of cancer management
3. TNM staging
4. Basics of cancer management
4a. Indications and limitations of surgery
4b. Biophysics of radiotherapy - indications and side effects
4c. Chemotherapeutic agents - indications and side effects
4d. Biologic and Immuno-therapy - indications and side effects
5. Clinical trials in Head and Neck oncology
6. Prevention in Head and Neck oncology
7. Clinical databases in Head and Neck oncology

Benign diseases Head and Neck
Oral Cavity
Larynx
Pharynx
Sinonasal
Vascular malformations
Trauma

Malignant Disease of Head and Neck
Oral Cavity
Pharynx
Larynx
Nose and Paranasal Sinuses
Neck and Unknown primary

Salivary glands
Thyroid gland
Skin of Head and Neck

Multi-disciplinary management of Head and Neck cancer patients
Treatment planning – single versus multimodal Treatment
Principles and safety of lasers in Head and Neck management
Reconstruction options for Head and Neck defects
Flap physiology and wound healing
Single or multiple non-surgical therapies:
a. Radiotherapy
b. Chemotherapy
c. Immunological therapy
d. Combination of the above with surgery
Curative versus Palliative

Oral Cavity Surgical Procedures
Local surgery (including laser and robotic)
Open neck surgery – pull through procedure
Marginal mandibulectomy
Segmental mandibulectomy

Nasopharynx surgical procedures
Local surgery
Maxillary swing
Neck nodes (see paragraph on 'neck')

Oropharynx surgical procedures
Tonsillectomy
Transoral surgery (including robotic surgery)
Pharyngotomy
Mandibulotomy (mandibular split, mandibular swing)

Hypopharynx surgical procedures
Endoscopic surgery (TORS, TOUSS, laser surgery), management of pharyngeal pouch
Pharyngectomy with/ without laryngectomy
Partial pharyngectomy with near total laryngectomy
Partial pharyngectomy with total laryngectomy
Total pharyngectomy with total laryngectomy

Total pharyngo-laryngo-esophagectomy with reconstruction

Larynx surgical procedures
Endoscopic surgery
Partial or total laryngectomy
Primary or secondary placement of vocal prosthesis
Maintenance and change of speech prosthesis

Nose and paranasal sinuses surgical procedures (overlap with Rhinology above)
Endonasal surgical procedures (including use of navigation systems)
Maxillectomy (partial, total)
Lateral rhinotomy
Midfacial degloving
Orbitotomy and Exenteration of orbit
Surgery of anterior skull base (incl osteoplastic flap, duraplasty and endoscopic)
Endoscopic surgery

Neck surgical procedures
Management of congenital neck masses (eg thyroglossal and branchial cysts)
Benign neck tumours (including paraganglioma, haemangioma, schwannoma)
Management of infective and inflammatory lymph node pathology
Management of deep neck space abscesses
Trauma of the neck and neck exploration
Single node resection
Sentinel node procedures
Neck dissection procedures (local, selective, radical, conservative)

Salivary glands surgical procedures
Salivary gland inflammatory and auto immune conditions, stones, gland biopsy and duct surgery
Sialadenoscopy
Submandibular gland surgery
Parotid surgery (partial or total) surgery (Neck dissection Levels I to V according to the ESGS classification)
Reconstruction (local flaps, SCM and SMAS, Fat)

Thyroid surgical procedures
Goitre and management of thyroid nodule, thyroiditis, parathyroid disorders
Hemithyroidectomy

Total thyroidectomy
Parathyroidectomy
Neck nodes (see paragraph neck)

Skin of Head and Neck-knowledge and surgical procedures

UV-light, excessive sun exposure
Skin types and classifications
Pigmented lesions
Management of Precancerous lesions
Sentinel node technique in Melanoma
Limited surgical excision (including local reconstruction)
Extended surgical excision
Reconstruction of the Skin

Airway Disorders and swallowing
History and clinical examination, evaluation of hoarseness and dysphagia, neck pain, achalasia and gastro-oesophageal reflux, management of foreign bodies and mediastinal infections
Endoscopy (including bronchoscopy, oesophagoscopy), imaging, airway and lung function tests, tests of swallowing (FEES, swallow CT, chest CT)
Inhalational trauma
Ingestion of caustic substances
Vocal cord palsy, evaluation and diagnosis

Snoring and sleep related disorders
History, examination, physiological investigation and endoscopic assessment of snoring
Non-surgical (including cPAP) and surgical management of snoring (multi-level surgery)

Vascular malformations of head and neck and airway
Non-surgical, laser treatment, surgical treatment, treatment of airway obstruction

Phoniatrics
Assessment of vocal function, FEES, videofluoroscopy
Pharmacologic treatment and rehabilitation of dysphonia and acquired language disorders

Developmental language disorders, fluency disorders
Assessment and treatment of dysphagia following surgery or association with neurodegenerative disease

V Facial plastic and Aesthetic surgery

Knowledge, medical and surgical management of :
Congenital malformations
Infections
Inflammatory
Benign & malignant tumours
Trauma

Assessment
assessment of the face and ethnic variation
facial analysis
effects of aging process
assessment of skin
psychological assessment / screening
photography
investigation of the cranial nerves and facial paralysis grading
anterior rhinoscopy
endoscopy and microscopy
computer imaging

Non-surgical management
pharmacological therapy
topical drug application
chemical peels
laser therapy
intense light therapy
noninvasive tissue therapy
intense ultrasound and related methods
percutaneous cryotherapy
percutaneous, minimally invasive tissue ablation
management of wounds
application of botulinum toxins and neuromodulators
a. for reconstructive purposes
b. for the treatment of facial paralysis, neural deficits and facial pain

c. for cosmetic purposes including wrinkle treatment
d. for wound healing and improved scarring
application of fillers (temporary and permanent)
wrinkle treatment, other methods
management of scar tissue, wound dressings
lipolysis
prosthetic options for ear, nose, etc.

Surgical treatment
topical, local and regional anaesthesia
suture techniques
turbinate surgery
excision techniques for cutaneous malignancies

Trauma
Repair Soft Tissue Injury/Lacerations
Facial Nerve Repair
Lacrimal Duct Repair
Nasal Fracture
Frontal Sinus Fracture
Naso-ethmoid Fracture
Skull and Cranial Fracture
Midface Fracture
Malar (Zygoma), orbital, mandibular and other fractures

Congenital
Hemangioma and Lymphangioma Resection
Choanal Atresia Repair
Cleft Lip, unilateral and bilateral
Alveolar Cleft Repair
Cleft Palate Repair
Craniofacial Procedure
Microtia Reconstruction
Otoplasty and Other Auricular

Reconstructive
Mandible Reconstruction
Facial Bone Grafting and Reconstruction
Orthognathic Procedures
Grafts-Split Thickness, Full Thickness, Composite, Dermal/Dermal-Fat, Cartilage

Auricular grafts
Rib grafts
Septal
Flaps-Local, Regional, Distal, Free
Lip
Detachment of Pedicle Flap
Facial Nerve Reconstruction
Nerve Graft
Gold Weight
Lower Lid Tightening
Microneurovascular Flap
Muscle Sling
Static Sling
Other
Scar Revision Surgery
Z-Plasty, W-Plasty and Geometric Broken Line Closure
Complex Other closures
Full Face Dermabrasion
Tissue Expanders and other

Cosmetic and Reconstructive
Rhinoplasty
Septorhinoplasty
Septoplasty
Blepharoplasty
Upper Cosmetic
Upper Functional
Lower with fat repositioning
Lower
Skin Pinch
Rhytidectomy:
Extended SMAS
W/Smart Lipo Laser
Deep Plane
Mini-Lift
Plication Lift
W/ Smart Lipo Laser
Midface Lift
Mentoplasty (Chin)-Augmentation, Reduction
Facial Implants (e.g. malar)

Coronal/Frontal Lift
Browlift
Endoscopic Forehead Lift
Transtemporal
Tricophytic
Cervicofacial Liposuction
Skin Resurfacing
Dermabrasion (major-not scars)
Chemical Peel (medium & deep only)
Face, Eyelid, and/or Perioral Laser Resurfacing.
Laser Treatment of Vascular Lesions
Fat Transfer

Treatment of complications of the above group V

VI Paediatric Otorhinolaryngology

Otology
Foreign body removal
Myringotomy
Ventilation tube insertion
Tympanoplasty
Antrotomy
Mastoidectomy - simple
Cochlear implants, BAHA

Laryngology
Removal of foreign bodies from the larynx, trachea, bronchi and oesophagus
Endotracheal intubation
Tracheotomy - tracheostomy
Endolaryngeal surgery of tumours
Endolaryngeal laser surgery of tumours in the upper aerodigestive tract
Management of laryngo-tracheal stenosis

Rhinology
Control of epistaxis, nasal packing/cautery
Foreign body removal
Reposition of nasal fractures
Incising abscess

Septal hematoma
Soft tissue injuries
Otoplasty
Septal surgery
Pediatric endoscopic surgery
Dacryocystorhinostomy in children
Cleft patient rhinoplasty
Corrections of malformations (e.g. choanal atresia, fistulae, dermoids, etc)
Juvenile angiofibroma endoscopic and open surgery

Head and Neck
Adenoidectomy
Tonsillectomy and tonsillotomy
Abscess tonsillectomy (hot tonsillectomy)
Arrest of postadenotonsillectomy haemorrhage
Foreign body removal
Transoral removal of salivary calculi
Drainage of abscess
Peri- and retrotonsillar abscesses
Para- and retropharyngeal abscesses
Correction of malformations
Lingual and labial frenulum
Ranula and inclusion Cysts
Macroglossia
Surgery of simple neck injuries
Surgery of tumours:
a) thyroglossal duct/cyst
b) branchial cyst
c) neck fistulae
d) single lymph node excision
e) benign tumours including salivary glands
f) Incision and drainage of neck abscess
g) Surgery of benign skin tumours
h) Surgery of vascular tumours
i) Surgery of malignant tumours
Surgery of the thyroid gland
Hemithyroidectomy
Total thyroidectomy

Management of postoperative complications of the above group VI

CORE CURRICULUM (continued)

The core curriculum has been adopted from the updated intercollegiate fellowship diploma of the UK and may be viewed at:

https://www.gmc-uk.org/-/media/documents/otolaryngology-master-2018-admin-change_pdf-73494259.pdf

II. REQUIREMENTS FOR TRAINERS

Training Director and Trainers: qualifications, experience and support

Training Program Director (TPD)

The TPD should be a certified specialist for a minimum of 5 years.

The substantial working contract must be within the training institution.

Should demonstrate a proven track record in teaching and training

The TPD should provide evidence of continuing professional development (CPD) in the field of ORL.

The TPD must have full secretarial and administrative support together with sufficient protected time

The TPD should be a member of the national ORL Society

Responsibilities of the Training Programme Director

To establish a transparent and fair selection and appointment process for trainees.

To define the curriculum, learning objectives and levels of competence of the training program.

To provide a platform to discuss content, quality and implementation of the training program together with the trainers and trainees.

To supervise training within the department.

To train the trainers.

To arrange a balanced training programme with established rotations ensuring that the trainee will have complete exposure to the aspects of ORL

To ensure that the individual trainees´ documentation and training portfolios are up to standard.

To advise trainees about attending approved courses.

To oversee the types of operative procedures and clinical activities performed in the department and participating units connected with the training programme.

To provide opportunity for research, audit and other educational valid activities such as attending courses and scientific meetings.

To provide an annual and final report on each trainee.

To provide valid documentation at the satisfactory completion of training.

Process for recognition as trainer

a. Required qualification and experience

A trainer would be a registered medical practitioner and registered for at least five years as a specialist/consultant in ORL. Prospective trainers apply for their training position with the approved National institution and are approved by the Training Director. In order to promote harmonisation of European training standards, it is also strongly recommended that trainers and trainees should demonstrate additional accreditation on a European level such as provided by examinations offered by EBEORL.

They will have satisfied any relevant national requirements as regards accreditation, appraisal and training to be a trainer, including experience in training and teaching and evidence of continuing professional/academic development such as recent publications.

Trainers must be in active clinical practice at a UEMS affiliated country and engaged in training in the training centre or network. Their appointments would be for five years in the first instance. In some countries their work would be reviewed within the training centre or network on a regular basis at staff appraisals (or equivalent) but in any case it would be a requirement that their training activities are reviewed in the fifth year of their appointment. Subject to mutual agreement their position may be renewed for a further five years.

Recognition across the EU as regards competence to be a trainer despite coming from different countries and having different routes and extents of training is covered by Directive 2005/36/ EC (Paragraph C2/20).

Senior trainers should be within 3 years of retirement from active practice.

b. Core competencies for trainers

A trainer should be:

1. Familiar with all aspects of the overall ORL curriculum as it relates to practice within their country.

2. Experienced in teaching and in supporting trainees.

3. Skilled in identifying the learning needs of their trainees and in guiding the trainees to achieve their educational and clinical goals.

4. Able to recognise trainees whose professional behaviour is unsatisfactory and initiate supportive measures as needed.

5. Trainers should lecture to a peer-audience on a regular basis, attend national meetings and be able to demonstrate appropriate participation in continuing professional development.

Responsibilities of the Trainers

To attain the learning objectives and competences.

To provide a safe training environment in which the resident can develop into a medical specialist.

To supervise the day to day work of the trainee in the ward, clinic, the operating theatre and during on-call commitments.

To ensure that there is appropriate balance between service commitment and training.

To ensure that the regular assessments and reports are completed and agreed upon by both the trainer and the trainee (under the supervision of the Training Programme Director) and to keep the Training Programme Director informed of any problems at an early stage.

To manage with the other trainers under the guidance of the Training Programme Director any inadequacies demonstrated by a trainee. The institution and, if necessary the relevant national authority should become involved if the local conflict between the Training Programme Director and the trainee cannot be resolved

Trainers should provide evidence of academic activities (clinical and/or basic research, publications in peer reviewed journals and participation in ORL scientific meetings).

Requirements for trainers

Trainers will require secretarial and administrative support.

There should be sufficient number of trainers. The ratio between the number of trainers and the number of trainees should ideally be 1:1 and enable mentoring and provide exposure to different schools of thought.

2. Quality management for trainers

To assure the quality of the training programmes, the programme director and trainers may undergo regular auditing and external visitations of the department. This may include evaluation of their curriculum vitae, practice evaluation in clinical work, surgical work and scientific publications.

A cycle of five years is suggested as appropriate (see section **a** above).

Quality management for trainers remains a core competency of respective national medical specialty boards. It is hoped that trainers and Programme Directors will have their job description agreed with their employer which will allow them sufficient time each week for support of trainees and in the case of Programme Directors, sufficient time for their work with trainers.

It is recommended that a single trainer should have no more than two trainees. The number of trainees would determine the amount of time each week that would be allocated to their support.

Trainers will collaborate with trainees, the Programme Director and their Institution to ensure that the delivery of training is optimal. Feedback from trainees will assist in this regard.

The educational work of trainers and Programme Directors will be appraised typically on an an annual basis within their Department/Institution as local circumstances determine.

Educational support of trainers and Programme Directors will be provided by their Department and Institution.

III. REQUIREMENTS FOR TRAINING INSTITUTIONS

(1) Process and requirements for recognition as training centre

A 'Training Centre' is a place or number of places where trainees are able to develop their ORL competences. Such provision may include sites which are condition specific and which thus may not offer a wide clinical experience such as that provided by a large centre. Clinical institutions offering specialty training in ORL should be affiliated as a whole or on a personal basis (trainer) with an internationally recognised medical school and/or a competent national medical board.

Training institutions should have organised teaching programs, instruction in basic sciences, administration and management, and audit meetings. UEMS

institutions such as CESMA (appraisal of assessments), NASCE (certification of skills centres) and EACCME (accreditation of educational events) are acknowledged and may contribute in their own way to the training institution.

(a) Staff Requirements and clinical activities

The Training Programme Director shall assure that the trainee will receive appropriate exposure to the depth and breadth of the specialty.

Appropriate faculty covering the broad spectrum of ORL should be available in full at a "fully" accredited department. Some smaller departments may be able only to cover part of the curriculum and this should be acknowledged. This deficiency may be compensated by having part of training at other fully accredited departments.

There may be a reduced faculty in the "partially" accredited departments; nevertheless the programme of the trainee has to cover the curriculum with all aspects of the specialty, including otology, rhinology, head and neck surgery, laryngology, facial plastic surgery and paediatric otorhinolaryngology. Each participating institution in a network must be individually recognised as a provider of a defined section of the curriculum.

An appropriate ratio of two trainees/one trainer will be maintained in such a way that the trainee will have enough exposure to patient care in all its aspects but also time for scientific work and appropriate rest time. It was decided by the UEMS-ORL Board and Section that attainment of competency will be at the discretion of the trainer who signs off the trainee so numbers of patients and procedures are not mentioned in this document. The minimum duration of the training programme is recommended to be not less than 5 years. An annual departmental audit should be performed and a regional or national presentation expected. The trainee should produce at least one peer-reviewed publication and should have experienced presenting a paper or poster at an international congress.

(b) Equipment, processes and facilities

The training department should have the following facilities:

A fully equipped out-patient department for consultation with ORL patients including emergencies. Equipment should be available for microscopic and endoscopic examinations.

Facilities for audiologic examination including audiometry, speech audiometry and electro-physiology

Facilities for vestibular examination and investigation

Facilities for phoniatrics, including stroboscopy, photography and swallowing assessment

A clinical ward for in-patients and day-care facilities for diagnostic and surgical procedures.

At least one operating theatre at full time disposal with specialised equipment for common procedures in ORL training including an operating microscope, modern audiovisual facilities.

Facilities for anatomical dissection and/or simulation should be available

A conference room for discussion and tutorial sessions

Traditional library or computer with internet access to online medical journals will be made available to the trainee

instructional courses on database searches and use of online resources

Appropriate accommodation for scientific work and on-call accommodation facilities should be available.

It is recommended that an adequate number of patients are treated by the trainee to ensure proper assessment of his/her capabilities and that competency goals are achieved

Ethical support and Local Ethical Committee access

Administrative Audit assistance

Availability of Professional Leave for approved courses

An annual attendance at one simulation course is required so that all of the subspecialties are covered throughout the training period

(2) Quality Management within Training Institutions

Training institutions should receive official recognition by the National Authority responsible for training in ORL. The UEMS-ORL will receive a list of training institutions issued by the National Boards and their degree of recognition. If this meets the requirements set out by the UEMS-ORL, they will be confirmed as a European Institution for training in Otorhinolaryngology (or Otorhinolaryngology and Head & Neck Surgery depending on the country concerned). Training institutions should be sited within university hospitals or major general district hospitals with adequate supporting services in order to provide an optimal training climate and deliver safe, effective and patient-centred clinical care. Interdisciplinary experience with other specialties is encouraged.

Specified periods of training may be undertaken in approved institutions including community otorhinolaryngology. For specialist institutions or clinics, only limited periods of training will be recognised here and as formulated by the UEMS-ORL in discussion with EBEORL.

Accreditation

The following decisions must be taken by the National Authorities with regards to the accreditation status of the Training Institution and Programme. The National Authority is responsible for setting up at national level a programme for quality assurance of training and of trainers and training institutions in accordance with national rules, EU legislation and UEMS-ORL recommendations.

Full accreditation may be granted if the programme has demonstrated full compliance. The Department will receive a certificate indicating that the

Department and the Training Programme fulfils the standards and criteria. The accreditation should be reassessed regularly.

Partial accreditation may be granted if the programme has demonstrated training limitations. The Department will receive a certificate indicating that the Department and Training Programme fulfils the standards and criteria for a limited spectrum of accreditation or a limited period. The accreditation should be reassessed regularly. Missing criteria can be reassessed and full accreditation granted if they are fulfilled.

Accreditation may be withdrawn if the training institution does not substantially comply with the requirements. The administrative staff of the institution concerned should be fully informed and engaged in this process.

The training institution should possess an adequate infrastructure and offer qualitative and quantitative clinical exposure as defined in the scope of the curriculum.

The nationally accredited training programme fulfilling the criteria will obtain approval delivered by the European board.

A training programme should be reviewed after an interval such as every five (5) years.

External auditing – site visit

The site visit will be performed by the regulatory authority, medical society or medical chamber in accordance with the national regulations. The site visiting committee may be assisted by representatives from the UEMS-ORL. The site visit aims to explore the training programme in detail, the educational and scientific environment by holding discussions with the Training Programme Director, the trainers, the trainees and the administration of the institution. A report will be prepared by the site visitors and will be part of the final decision regarding the accreditation status of the programme. All information obtained during the interviews with trainers and trainees will remain confidential. The accreditation status as decided by the relevant National Authority will be reported to the Training Programme Director by a formal letter of notification. Together with the site visit report, additional advice and recommendations, if necessary, will

be given for the benefit of the Training Programme. Responsibility for the cost of the visit should be undertaken by the institution undergoing the assessment.

Clinical Governance and Manpower planning

The National Authority is the responsible body for recognition and certification of medical specialists in each member state of the UEMS member states. The standards for recognition of national training institutions and education networks are matters for National Authorities, in accordance with national rules and EU legislation.

Employee structure and workload methods in training institutions should be geared towards competency training. Clinical governance, that is, accountability and setting standards for service provision, is a shared responsibility of the Program Directors and the National Authority which at national level should incorporate manpower planning. UEMS has a role to play in clinical governance due to the important participation of CESMA (examination quality control), EACCME (continued professional development and CME points) and NASCE (accredited skills centres).

Manpower planning should be reviewed periodically by the National Authorities of individual states according to their needs.