



UNION EUROPÉENNE DES MÉDECINS SPÉCIALISTES EUROPEAN UNION OF MEDICAL SPECIALISTS

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European Training Requirements for the Specialty of Plastic, Reconstructive and Aesthetic Surgery

European Standards of Postgraduate Medical Specialist Training

Preamble

The UEMS is a non-governmental organisation representing national associations of medical specialists at the European Level. With a current membership of 37 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 pave the way to the improvement of quality of care for the benefit of all European citizens. The UEMS areas of expertise notably encompass Continuing Medical Education, Post Graduate Training and Quality Assurance.

It is the UEMS' conviction that the quality of medical care and expertise is directly linked to the quality of training provided to the medical professionals. Therefore the UEMS committed itself to contribute to the improvement of medical training at the European level through the development of European Standards in the different medical disciplines. No matter where doctors are trained, they should have at least the same core competencies.

In 1994, the UEMS adopted its Charter on Post Graduate Training aiming at providing the recommendations at the European level for good 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. More than a decade after the introduction of this Charter, the UEMS Specialist Sections and European Boards have continued working on developing these European Standards in Medical training that reflects modern medical practise and current scientific findings. In doing so, the UEMS Specialist Sections and European Boards did not aim to supersede the National Authorities' competence in defining the content of postgraduate training in their own State but rather to complement these and ensure that high quality training is provided across Europe.

At the European level, the legal mechanism ensuring the free movement of doctors through the recognition of their qualifications was established back in the 1970s by the European Union. Sectorial Directives were adopted and one Directive addressed specifically the issue of medical Training at the European level. However, 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 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

UNION EUROPÉENNE DES MÉDECINS SPÉCIALISTES EUROPEAN UNION OF MEDICAL SPECIALISTS

Association internationale sans but lucratif – International non-profit organisation

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

Given the long-standing 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 practise for the benefit of the individual and community being served”*¹. While professional activity is regulated by national law in EU Member States, it is the UEMS understanding that it has to comply with International treaties and UN declarations on Human Rights as well as the WMA International Code of Medical Ethics.

This document derives from the previous Chapter 6 of the Training Charter and provides definitions of specialist competencies and procedures as well as how to document and assess them. For the sake of transparency and coherence, it has been renamed as “Training Requirements for the Specialty of X”. This document aims to provide the basic Training Requirements for each specialty and should be regularly updated by UEMS Specialist Sections and European Boards to reflect scientific and medical progress. The three-part structure of this documents reflects the UEMS approach to have a coherent pragmatic document not only for medical specialists but also for decision-makers at the National and European level interested in knowing more about medical specialist training.

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

UNION EUROPÉENNE DES MÉDECINS SPÉCIALISTES EUROPEAN UNION OF MEDICAL SPECIALISTS

Association internationale sans but lucratif – International non-profit organisation

DEFINITION OF THE SPECIALTY

Plastic, Reconstructive and Aesthetic Surgery is a specialty concerned with acute and non-acute conditions which may be congenital or acquired as a result of trauma, disease, degeneration or ageing in patients of both sexes and all ages. Its aim is the restoration or improvement of function and the normalization of appearance and well-being.

The content of the specialty may vary by country. However, UEMS strongly supports harmonization and incorporation of all topics relevant to Plastic, Reconstructive and Aesthetic Surgery outlined within this charter on a European, supra-national level. Thus, the following training requirements for trainees have been outlined.

I. TRAINING REQUIREMENTS FOR TRAINEES

1. Content of training and learning outcome

Competencies required of the trainee

In order to be eligible for specialty training, the medical trainee has to be accredited as a medical doctor which is the case upon successful graduation from an internationally recognized medical school and/or medical training programme such as listed under the International Medical Education Directory (IMED). Specialty training should be carried out within a specialized training programme in Plastic Surgery.

After entering a specialty training program in Plastic, Reconstructive and Aesthetic Surgery, the trainee should acquire a sufficient set of theoretical knowledge, practical skills and general core competencies to allow safe independent practise.

The underlying principle as regards this document is that it promotes high standards of care for patients with plastic, reconstructive and aesthetic surgical conditions throughout the European Union and sets the basic requirements in the domains listed above to enable specialists/consultants to move across European country borders for professional purposes. The data that would be provided to a receiving country/employer about a doctor is shown in Appendix 1 at the end of this document.

a. **Theoretical and clinical knowledge**

The required knowledge base is determined by the cognition of basic sciences and clinical conditions which a specialist/consultant would be expected to recognise and have knowledge of.

Knowledge of basic sciences includes:

- The anatomy, vascular and neural supply of the skin and musculoskeletal tissues
- The biology of wound healing and its pathological disturbance

UNION EUROPÉENNE DES MÉDECINS SPÉCIALISTES EUROPEAN UNION OF MEDICAL SPECIALISTS

Association internationale sans but lucratif – International non-profit organisation

- Other relevant sciences such as pharmacology, histopathology, physiology, biomechanics

The list of items which provides the basis of the European Plastic, Reconstructive and Aesthetic Surgery Curriculum is shown below. Trainees may well have seen patients with conditions not listed and this would be reflected in their portfolio of training or equivalent documentation.

These items define the basis of the core curriculum. By the time an individual is appointed as a specialist/consultant, he/she would be expected to have the following attributes:

- Knowledge and understanding of the relevant and topical underpinning 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 Plastic Reconstructive and Aesthetic Surgery, so that their clinical practise is, as far as possible, based upon evidence.
- The ability to provide evidence that they are maintaining their general medical as well as their plastic surgical knowledge sufficiently to ensure a high standard of clinical practise.
- An understanding of the healthcare system(s) within their country of training.
- Be prepared for their role as future clinical leaders.
- The ability to be an effective member and a leader of a multidisciplinary team.

b. Items of the specialty training in Plastic Surgery in all UEMS countries:

I. General Principles and Procedures

- a. History of Plastic, Reconstructive and Aesthetic Surgery
- b. Basic science related to plastic surgery
- c. Relevant anatomy and vascular and neural territories of the body
- d. Basic principles and techniques in Plastic, Reconstructive and Aesthetic Surgery
 - i. Transplantation of autologous grafts
 - ii. Flap surgery
 - iii. Lipoplastic procedures (liposuction and fat grafting)
 - iv. Microsurgery
 - v. Tumour management
 - vi. Management of congenital malformations
 - vii. Principles of endoscopic procedures
 - viii. Use of implants and expanders
 - ix. Principles of local, regional and basic general anaesthesia
 - x. Principles of diagnostic procedures such as imaging (i.e.

UNION EUROPÉENNE DES MÉDECINS SPÉCIALISTES EUROPEAN UNION OF MEDICAL SPECIALISTS

Association internationale sans but lucratif – International non-profit organisation

- ultrasound, core needle biopsy, CT, MRI and scintigraphy) and lab tests
 - xi. Principles of osteosynthesis
 - xii. Principles of composite tissue allotransplantation
 - e. Principles of wound management
 - i. Wound healing
 - ii. Debridement
 - iii. Methods for wound closure
 - iv. Management of chronic wounds including pressure sores
 - v. Management of severe soft tissue infections including necrotizing fasciitis and gas gangrene
 - vi. Management of complications (haematoma, seroma, infection)
 - f. Principles of trauma management
 - i. Acute trauma life support (ATLS)
 - g. Principles of burn management
 - i. Advanced burn life support (ABLS) and burn ICU treatment
 - ii. Thermal, chemical, electrical and radiation injury
 - iii. Burn surgery
 - iv. Use of biomaterials and tissue culture in burn management
 - v. Treatment of postburn scars and contractures
 - h. Principles of Laser treatment
 - I. Principles of tissue engineering
 - m. Principles of lymphoedema management
- II. Head and Neck
- a. Congenital
 - i. Cleft lip/palate
 - ii. Ear deformities including prominent, cup and Stahl ears
 - iii. Microtia
 - iv. Craniofacial anomalies and syndromes
 - b. Traumatic
 - i. Soft tissue injuries
 - ii. Bony injuries
 - c. Neoplastic
 - i. Tumour and lymph node management;
 - ii. Reconstruction
 - d. Other
 - i. Facial palsy
 - ii. Orthognatic surgery
 - iii. Eyelid ptosis (congenital/acquired)
- III. Chest and Breast
- a. Congenital
 - i. Asymmetry of the breast including Poland syndrome
 - ii. Tuberos breast
 - iii. Pectus excavatum /carinatum

UNION EUROPÉENNE DES MÉDECINS SPÉCIALISTES EUROPEAN UNION OF MEDICAL SPECIALISTS

Association internationale sans but lucratif – International non-profit organisation

- iv. Aplasia of breast
 - b. Traumatic / Acquired
 - i. Reconstruction of chest wall defects
 - ii. Reconstruction of spinal area defects
 - c. Neoplastic
 - i. Surgical treatment of benign breast changes
 - ii. Breast cancer treatment, including surgery, sentinel lymph node procedure / axillary dissection and pre- or postsurgical medical and radiation therapy
 - iii. Oncoplastic procedures
 - iv. Breast reconstruction, including reconstruction of NAC
 - v. Chest wall reconstruction
 - d. Other
 - i. Hypertrophic breasts
 - ii. Gynaecomastia
- IV. Trunk and Abdomen, Genitalia
- a. Congenital
 - i. Hypospadias and epispadias
 - ii. External female genital anomalies
 - iii. Spina bifida
 - b. Traumatic / Acquired
 - i. Reconstruction of abdominal wall defects
 - ii. Reconstruction of lumbar, sacral and buttock defects
 - iii. Reconstruction of genital defects
 - c. Neoplastic
 - i. Principles of management of vulvar and vaginal tumours
 - ii. Principles of management of penile tumours
 - iii. Principles of management of other soft tissue tumors
 - iv. Penile reconstruction
 - d. Other e.g.
 - i. Gender reassignment
 - ii. Peyronie disease
- V. Upper Extremity (including Hand)
- a. Congenital
 - i. Syndactyly
 - ii. Polydactyly
 - iii. Macrodactyly
 - iv. Other
 - b. Traumatic
 - i. Tendon repair, reconstruction and transfer
 - ii. Fracture management
 - iii. Joints and ligaments repair/reconstruction
 - iv. Soft tissue repair/reconstruction
 - v. Peripheral nerves including brachial plexus

UNION EUROPÉENNE DES MÉDECINS SPÉCIALISTES EUROPEAN UNION OF MEDICAL SPECIALISTS

Association internationale sans but lucratif – International non-profit organisation

- vi. Functional muscle and tendon transfers
 - vii. Amputation and replantation
 - viii. Thumb and finger reconstruction
 - ix. Compartment syndrome
 - c. Neoplastic
 - i. Management of bone tumours
 - ii. Management of soft tissue tumours
 - d. Acquired/Degenerative.
 - i. Dupuytren Disease
 - ii. Rheumatoid arthritis
 - iii. Osteoarthritis
 - iv. Wrist instability
 - v. Arthroscopy
 - e. Other
 - i. Infection
- VI. Lower Extremity
- a. Congenital
 - i. Syndactyly
 - ii. Constriction bands
 - iii. Other
 - b. Traumatic / Acquired
 - i. Soft tissue repair/reconstruction
 - ii. Bone reconstruction
 - iii. Nerve repair/reconstruction
 - c. Neoplastic
 - i. Management of bone tumours
 - ii. Management of soft tissue tumours
- VII. Skin and Adnexa
- a. Congenital
 - i. Vascular anomalies
 - 1. Vascular malformations
 - 2. Haemangiomas
 - ii. Congenital melanocytic naevi
 - iii. Aplasia cutis
 - b. Traumatic / Acquired
 - i. Acute and chronic wounds
 - ii. Correction of hypertrophic scars and keloids
 - c. Neoplastic
 - i. Benign skin tumors
 - ii. Malignant skin tumours
 - iii. Sentinel lymph node procedure and lymphadenectomy
- VIII. Aesthetic surgery
- a. Head and neck

UNION EUROPÉENNE DES MÉDECINS SPÉCIALISTES EUROPEAN UNION OF MEDICAL SPECIALISTS

Association internationale sans but lucratif – International non-profit organisation

- i. Nonsurgical facial rejuvenation e.g. fillers, botulinum toxin
- ii. Laser treatment
- iii. Blepharoplasty
- iv. Facelift / Necklift
- v. Browlift / Foreheadlift
- vi. Rhinoplasty
- vii. Otoplasty
- viii. Treatment of alopecia e.g. hair transplantation
- ix. Facial contouring
 - 1. Implants
 - 2. Lipoplasty including autologous fat grafting
 - 3. Genioplasty
- b. Upper limbs
 - i. Liposuction
 - ii. Brachioplasty
- c. Breast
 - i. Augmentation mammoplasty
 - ii. Breast ptosis correction
 - iii. Inverted nipple management
- d. Abdomen
 - i. Liposuction
 - ii. Abdominoplasty
 - iii. Bodylift
- e. Lower limbs
 - i. Liposuction
 - ii. Thigh lift
 - iii. Buttock lift
 - iv. Implants
- f. Postbariatric surgery
- g. Hyperhidrosis management

In order to guarantee common standards of medical specialty training, the trainee's curriculum should cover the majority of the listed items. Proof of exposure should be documented in the trainee's portfolio.

a. Theoretical knowledge

Every institutional training program should include dedicated teaching rounds or meetings on a regular (weekly) basis dedicated to specific topics relating to Plastic, Reconstructive, and Aesthetic Surgery. Exceptions may exist for countries where hand and maxillofacial surgery are not included in the national medical board specifications.

Trainees should attend conferences on a national or supranational basis, and if available should attend the national teaching program.

UNION EUROPÉENNE DES MÉDECINS SPÉCIALISTES EUROPEAN UNION OF MEDICAL SPECIALISTS

Association internationale sans but lucratif – International non-profit organisation

b. Practical and clinical skills

Clinical training should include rotations of full-time (usually 5 days a week) practise under supervisory guidance. If less than full-time training programs are considered, appropriate documentation is required to demonstrate equivalent time-periods of training.

Trainers should assure that the trainee is able to independently perform each documented procedure.

c. Competences

Also documented should be additional core competences acquired by the trainee such as autonomous on-call duty, ward-duty, activity as medical appraiser, skills training in microsurgery and/or presentations at (inter-)national meetings. Established national or supranational programs leading to academic certification/qualification are encouraged. However, competences which have been acquired outside an accredited medical training program cannot be considered for medical board certification in plastic surgery.

To be appointed as a specialist/consultant in Plastic, Reconstructive, and Aesthetic Surgery an individual should show a level of competence sufficient to allow independent clinical practise and be able to care for patients both in acute and chronic situations. Such a level of performance may vary from country to country and from post to post but the above lists and competencies describe the basic requirements one would expect of a 'European Plastic, Reconstructive and Aesthetic Surgeon'.

A European specialist/consultant in Plastic, Reconstructive and Aesthetic Surgery should be well informed about research principles: principles and methods of epidemiological research, principles of clinical research, evidence-based medicine, data analysis and medical informatics, laboratory techniques, ethics of clinical and basic research, critical review.

A 'European Plastic, Reconstructive and Aesthetic Surgeon' would be expected to demonstrate ethical behaviour, in keeping with the requirements of their country's medical registry/statutory body, to provide evidence to this effect and to be in good standing with their relevant National Registration Body.

2. Organisation of training

a. Schedule of training

Required duration of training periods remains a core competency of respective national medical specialty boards. Candidates should have completed two years common trunk training in the generality of surgery, after which the trainee should have acquired appropriate knowledge, training and experience in the care of general and acute surgical conditions. Specialty training in Plastic, Reconstructive and Aesthetic Surgery should be a minimum of four years. Further training may be undertaken thus allowing the development of sub-specialists. Details of this are not part of the training requirements for the core Plastic, Reconstructive and Aesthetic Surgery training.

UNION EUROPÉENNE DES MÉDECINS SPÉCIALISTES EUROPEAN UNION OF MEDICAL SPECIALISTS

Association internationale sans but lucratif – International non-profit organisation

The training period in Plastic, Reconstructive and Aesthetic Surgery will be in keeping with EU requirements and in any case sufficient to ensure that a trainee has met all the required educational and training needs and has demonstrated the acquisition of all the required educational and training competencies necessary for the awarding of the certificate of specialisation. Specific arrangements for the overall training for any individual trainee will be decided locally and be influenced by relevant national requirements. The list of items shown above is a guide to the knowledge and skills base required of a specialist/consultant. The clinical experience should encompass all common Plastic, Reconstructive and Aesthetic Surgical conditions.

For a trainee to be able to apply for a post in another EU country it would be necessary for there to be a published curriculum which has been followed by the trainees with details as to how it is known that the curriculum has been followed by both trainees and their trainers. The curriculum should contain details about the required nature and extent of clinical experiences, the methods by which a trainee is supported in their development and how assessments are made about their progress in the development of their knowledge and understanding, the progression of their clinical work and their development as a professional.

b. Curriculum of training

The curriculum is outcomes focused but with sufficient flexibility to allow personal development distinguished by the needs of the individual, the centre in which they are training and the country where this is occurring. Training should include teaching skills for generic competences and Plastic, Reconstructive and Aesthetic Surgery specific competences.

Thus, the curriculum would be based on the following principles. A 'European Plastic, Reconstructive and Aesthetic Surgeon' would:

- Be a pluripotent specialist
- Be competent in history taking, physical examination, management and continuing care of patients with common and specific Plastic, Reconstructive and Aesthetic Surgical conditions
- Communicate effectively with patients, their families and with professional collaborators
- Practise evidence-based care
- Practise cost-effective care
- Understand the nature of and degree of risk taken in their clinical practise
- Maintain the quality of their practise by being aware of developments in the subject
- Undertake multi-disciplinary team (MDT) work
- Provide clinical leadership and also possess the ability to be led and to work as part of a multi-disciplinary team
- Demonstrate a lifelong commitment to reflective learning
- Promote the health and well-being of individual patients, communities, and populations
- Have an understanding of specialty-based Public Health
- Teach and support trainees

UNION EUROPÉENNE DES MÉDECINS SPÉCIALISTES EUROPEAN UNION OF MEDICAL SPECIALISTS

Association internationale sans but lucratif – International non-profit organisation

- Be committed to the health and well-being of individuals and society through ethical practise, profession-led regulations and high standards of personal behaviour and clinical practise
- Have a portfolio of evidence that they have achieved the above goals; especially should they wish to seek employment in a country different from the country in which they trained.

Different countries will have different approaches to achieve these outcomes but the evidence that they have been achieved should be increasingly of a homogeneous nature that facilitates the learning and experiences of trainees, the engagement of clinical supervisors and ease of recognition of progress and achievements across EU member countries. In addition, such an approach will help provide surety to the public and to individual countries that the training has been of an appropriate standard and that the performance of doctors is likewise of a satisfactory standard.

c. Support, assessment and evaluation

Countries will use assessment strategies appropriate to their needs. Progressively, there will be a move to a common approach determining whether an individual is suitable to be recognised as a 'European Plastic, Reconstructive and Aesthetic Surgeon'

Trainees will be supported at a number of levels. A trainee's clinical work will be supervised by a trainer. (Such an individual already exists in all countries and is known by a variety of titles.) The trainer will 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 Plastic, Reconstructive and Aesthetic Surgery will 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 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. 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 practise using skills lab facilities.

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 in Plastic, Reconstructive and Aesthetic Surgery. The methods have to promote learning and have to be compatible with the general objectives of the learning outcomes and the content of training. They have to 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 portfolio and

UNION EUROPÉENNE DES MÉDECINS SPÉCIALISTES EUROPEAN UNION OF MEDICAL SPECIALISTS

Association internationale sans but lucratif – International non-profit organisation

should make use of specified types of medical examination formats (e.g. DOPS – direct observation of procedural skills, MiniCex – mini clinical examination, OSCE – Objective Structured Clinical Examinations, GRS – Global Rating Scales, OSATS – Objective Structured Assessment of Technical Skills).

Clinical experience will also be assessed by a review of the patients seen by a trainee and for whom the trainee has had a personal responsibility as regards care. Evidence of such engagement will be maintained in a clinical log-book or equivalent. The log-book will be reviewed by the trainee's trainer together with the trainee in a formative manner. This will enable the trainee to see and be involved with the care of an appropriate number and range of patients. The log-book 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 the first or second 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 a less than adequate performance by the trainee. Local national standards as regards an individual's suitability for clinical practise 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 Plastic, Reconstructive and Aesthetic Surgeon', 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 is organized by the European Board of Plastic, Reconstructive and Aesthetic Surgery (EBOPRAS), which acts as a working body of the UEMS Section of Plastic, Reconstructive and Aesthetic Surgery, and acts as a further means of EU-wide standardization 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 practise (diagnosis, investigation and treatment). Trainees are 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 practise. 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.

II. TRAINING REQUIREMENTS FOR TRAINERS

UNION EUROPÉENNE DES MÉDECINS SPÉCIALISTES EUROPEAN UNION OF MEDICAL SPECIALISTS

Association internationale sans but lucratif – International non-profit organisation

1. Process for recognition as trainer

a. Required qualification and experience

A trainer would be a registered medical practitioner and registered too as a Plastic, Reconstructive and Aesthetic Surgery specialist/consultant, which should be an independent specialty recognized by the respective national medical boards. In order to promote harmonization 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 the European Board of Plastic Reconstructive and Aesthetic Surgery (EBOPRAS).

They will have satisfied any relevant national requirements as regards accreditation / appraisal / training to be a trainer. A Programme Director would be someone who has been/is a trainer and who has considerable knowledge and experience of training doctors.

Trainers and Programme Directors must be in active clinical practise 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 continued for a further five years and so on.

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

b. Core competencies for trainers

A trainer will be:

1. Familiar with all aspects of the overall Plastic, Reconstructive and Aesthetic Surgery curriculum as it relates to practise within their country.
2. Experienced in teaching and in supporting learners.
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. Trained in the principles and practise of medical education.
6. Trainers should also act as lecturers to a peer-audience on a regular basis, attend national meetings and be able to demonstrate appropriate participation in continuing professional development.

2. Quality management for trainers

UNION EUROPÉENNE DES MÉDECINS SPÉCIALISTES EUROPEAN UNION OF MEDICAL SPECIALISTS

Association internationale sans but lucratif – International non-profit organisation

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 no less than 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. TRAINING REQUIREMENTS FOR TRAINING INSTITUTIONS

Clinical institutions offering specialty training in plastic surgery should be affiliated as a whole or on a personal basis (trainer) with an internationally recognized medical school (<https://imed.faimer.org/>) and/or a competent national medical board.

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

1. Process for recognition as training center

a. Requirement on staff and clinical activities

A 'Training Centre' is a place or number of places where trainees are able to develop their Plastic Reconstructive and Aesthetic Surgical 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.

Thus, Plastic Reconstructive and Aesthetic Surgical training may take place in a single institution or in a network of institutions working together to provide training in the full spectrum of clinical conditions and skills detailed in the curriculum. This should include a hospital or institution that provides academic activity and is also recognised for training in other specialties with a minimum of internal medicine and surgery. Each participating institution in a network must be individually recognised as a provider of a defined section of the curriculum.

The training of a trainee will be led and managed by a specialist/consultant Plastic Reconstructive and Aesthetic Surgeon. This specialist will be active in the practise of clinical Plastic Reconstructive and Aesthetic Surgery with personal responsibility for the management of patients with a wide range of Plastic Reconstructive and Aesthetic Surgical conditions. Within a training centre there would be a

UNION EUROPÉENNE DES MÉDECINS SPÉCIALISTES EUROPEAN UNION OF MEDICAL SPECIALISTS

Association internationale sans but lucratif – International non-profit organisation

number of specialist/consultant Plastic Reconstructive and Aesthetic Surgeons (trainers) who would be able to supervise and personally train a trainee. Whilst the trainer will not manage patients with all the diagnoses listed above he/she will be able to ensure, by working with the Programme Director and other local trainers that the clinical experience of the trainee will prepare them for clinical work as a specialist. The preparation for being a specialist in one country may be different from that needed if the trainee wishes to practise in another country as a specialist.

It is essential that, as part of their training, trainees will be responsible for caring for patients on both an emergency and routine basis. This may need the involvement of multiple training sites that offer different 'opening hours'. The trainee should be involved in the management of new patients, follow up of patients and in-patients.

A trainee must have progressively increasing personal responsibility for the care of patients with Plastic Reconstructive and Aesthetic Surgical conditions and retain their general medical skills so as to be able to identify patients who present to a Plastic Reconstructive and Aesthetic Surgery service but whose underlying clinical problems are not related to Plastic Reconstructive and Aesthetic Surgery.

The staff of a training centre will engage collaboratively in regular reviews of the centre's clinical activity and performance. There will be regular multi-disciplinary meetings to determine optimal care for patients and such meetings will involve both medical and other healthcare staff. There will be clinical engagement outside of the centre with other clinical groups such as, but not limited to, rehabilitation medicine, orthopaedics, paediatrics, oral medicine in dental practise, surgery with all its subspecialties, ENT, gynaecology and obstetrics, urology, anaesthesiology, intensive care medicine and dermatology.

Within a Plastic Reconstructive and Aesthetic Surgery training centre there should be a wide range of clinical services available so that a trainee will be able to see and contribute to the care of all common Plastic Reconstructive and Aesthetic Surgical problems. In addition, the patient numbers and specialist numbers should be sufficient so that trainees will be able to be instructed and then supervised in the clinical procedures required of a specialist.

Specialist staff appointed to a training centre will have completed all training requirements themselves and will have been trained also in teaching and mentoring trainee staff. Specialists already in post will undertake training, if they have not already completed this, to enable them to support trainees optimally. Such training and maintenance of skills and knowledge in this area will be part of their job-plan and subject to appraisal (see above).

It would be unacceptable for a trainee to have only one trainer during their entire training period. It would be more usual for a trainee to have a number of named trainers with whom they work on a day-to-day basis. Each trainer would cover different aspects of a trainee's clinical training but this individual will not be the only person who will provide educational support for a trainee. (See above for comments about the Programme Director and his/her role). In addition to medical staff supporting a trainee's development it is likely that non-medical members of staff will also be engaged. It would be expected that the specialists in training centres represent a wide range of

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Plastic Reconstructive and Aesthetic Surgery expertise and that such individuals demonstrate that they remain up to date with their clinical practise, knowledge and educational skills.

The recommended trainee/trainer ratio is 1:1. There should normally be no less than three specialists in a training centre or clinical network. If a trainee moves between a number of centres for their training it is recommended that whenever possible, although their trainers may change, their Programme Director should remain the same. Programme Directors may also be trainers.

It is not a requirement that a training centre is also an academic centre for Plastic Reconstructive and Aesthetic Surgery but it is desirable that a training centre would have strong academic links and contribute to research and it is an aspiration that all training centres will become so involved in the future.

It would be expected that a training centre as described in this document will have been recognised/accredited by the relevant national authority as being suitable for training specialists/consultants in Plastic Reconstructive and Aesthetic Surgery. Confirmation of such status of training centres will be by National Representatives to the Section and Board. Revalidation of training centers at this national level should take place at 5 yearly intervals.

When a Plastic Reconstructive and Aesthetic Surgery department/centre wishes to be recognised as a training centre by UEMS, the section of PRAS they will submit a report to the UEMS, Section and Board of Plastic Reconstructive and Aesthetic Surgery through their National Representative(s). This will demonstrate that all the necessary educational and training provisions are available in a sustained manner. Subsequently, on a five yearly basis a training centre will provide a brief report on its activities, to the Section and Board, again through their National Representative(s). This will demonstrate the maintenance of the education and training provision and allow examples of good practise to be disseminated.

There should be appropriate quality assurance systems in place that involve regular objective assessment of the quality of medical care as well as evaluation of the programme and outcomes of training.

b. Requirement on equipment, accommodation

A training centre should have sufficient equipment and support to enable the clinical practise that would be expected of a training centre and thus provide the necessary educational opportunities for trainees. Trainees should have suitable accommodation for their work and if required to be resident suitable accommodation for this too. Computing and Information Technology and library resources must be available. All trainees must engage in clinical audit and have the opportunity to engage in research.

2. Quality Management within Training institutions

Participation of the training institution in a certified quality management programme with an external auditing process on a regular basis seems to be necessary. Criteria of quality management at specialty training institutions include the following:

UNION EUROPÉENNE DES MÉDECINS SPÉCIALISTES EUROPEAN UNION OF MEDICAL SPECIALISTS

Association internationale sans but lucratif – International non-profit organisation

Accreditation Training institutions need to be accredited with competent national medical boards. Additional accreditation on a supra-national level such as provided by the European Board of Plastic Reconstructive and Aesthetic Surgery (EBOPRAS) is strongly recommended.

Clinical Governance Employee-structure at training institutions needs to be designed in a way to accommodate for specialty training. Workload has to be managed with a priority on training.

Manpower planning Training institutions should appoint a coordinator responsible for the composition, implementation and supervision of a specialty training programme. Roles of trainer and trainee need to be clearly defined. Allotted time of at least one day per workweek should be implemented for specialty training interaction.

Regular report Annual reports on various aspects of an institution's specialty training programme should be made publically available.

External auditing Training institutions should appoint a coordinator who is also responsible for compliance of the training programme with current guidelines, directives or regulations of competent medical boards as well as the local medical school.

Transparency of training programmes Based on national and regional guidelines, UEMS strongly encourages training institutions to formulate defined training programmes and make them publicly available (e.g. on their website).

Framework of approval As part of training programmes it should also be made clear how and by whom key achievements of training will be ascertained leading to a higher level of clinical responsibility and new assignments.

Appendix 1

Record of clinical work and clinical skills

Many trainees already keep a record or have a record kept automatically of patients for whom they have provided care. It is not proposed as a requirement of becoming a European Plastic, Reconstructive and Aesthetic Surgeon that any additional record should be kept but when a doctor seeks to gain employment in an EU country other than their own (or the one in which they have been trained if different) they will be required to provide access to appropriate records (logbook) demonstrating the extent and nature of their clinical experience and skills to a future potential employer and any other relevant body (for example a statutory medical body that grants employment rights within a country).

Independent confirmation of progress of a trainee (or of work as a specialist)

Doctors seeking to gain employment in a country other than their own or the country in which they have been trained will be required to provide references that provide details about:

UNION EUROPÉENNE DES MÉDECINS SPÉCIALISTES EUROPEAN UNION OF MEDICAL SPECIALISTS

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1. The curriculum that the trainee has followed.
2. The nature of assessments completed by the trainee and the outcomes of any assessments undertaken by him/her.
3. The outcomes of assessments of a trainee's professional behaviour.
4. The good-standing of the trainee.
5. The nature of the quality assurance processes by which it is known locally that the quality of the curriculum and its delivery are satisfactory.
6. As regards a specialist seeking to work in another country, references will be required to contain confirmation regarding an individual's clinical experience and good-standing, including outcomes of any assessments of professional behaviour.

Appendix 2

Examination format and timing

The examination consists of two parts, and the dates and venues for the exam are published on the EBOPRAS website (<http://www.ebopras.org>) as soon as they are known.

Part 1 - Multiple choice question paper (MCQ)

Eligibility: Candidates must be

Either Registered specialists in Plastic Surgery from any country
Or Trainees in Plastic Surgery, training in a UEMS member country

Part 1 is a written examination, normally held twice a year. It consists of 120 multiple choice questions (MCQ) in English only, covering the EBOPRAS syllabus. It is a test of theoretical and clinical knowledge. Three hours are allowed to complete the exam. The questions are intended to avoid the use of national features or proper names as much as is possible, replacing these with concepts which should be widely understood. Invigilators will be present during the exam and will be able to help candidates understand any difficult words.

An exam booklet is given to each candidate, together with a special answer sheet. There are 4 or 5 possible answers to each question, and candidates must choose the one answer that they consider best. No marks are deducted for wrong answers. The written exam is marked using an optical mark reader and software to allow analysis of the questions and corrections for ambiguity or error, to make the exam as fair as possible. Questions which the examiners consider to be incorrect or ambiguous will be withdrawn from the exam. The pass mark is set using a modified Angoff procedure.

UNION EUROPÉENNE DES MÉDECINS SPÉCIALISTES EUROPEAN UNION OF MEDICAL SPECIALISTS

Association internationale sans but lucratif – International non-profit organisation

The results of the written examination will normally be available later on the day of the MCQ, but will be sent by email to all candidates. Candidates will be told whether or not they have passed, but the exact marks are not given out. Only candidates who have passed the MCQ are eligible for the Oral examination.

Candidates who fail the MCQ may resit at a later date, and pay the fee and must agree to the rules applicable at the time of the resit. There is no limit to the number of attempts at Part 1.

Part 2 - Oral examination

Eligibility: Candidates must

- I. Have passed the MCQ examination within the previous 3 years and
- II. Not have failed Part 2 four times since passing Part 1 and
- III. Be Either Registered specialists in Plastic Surgery from any country
Or Trainees who have completed 4 years of Specialist Plastic Surgery training in an approved programme in a member country of the UEMS.

The oral is intended to test clinical application of knowledge, and the questions are based on clinical pictures depicting problems that present to Plastic Surgeons. The pictures are divided into categories, and each candidate will normally be asked a question from each of the eight categories (congenital abnormalities, trauma, burns, hand surgery, tumours, reconstruction, aesthetic and breast) to make the exam as fair as possible to all.

There are two orals per candidate, each lasting about 25 minutes, and covering half the categories. The two orals are normally conducted by two separate pairs of examiners, in English. If the candidate has requested, when applying for the exam, some help with assistance in one of the other main EU languages, (French, German, Italian or Spanish) then one of the examiners will normally speak the chosen language fluently. There may be an additional examiner present, who will either be an examiner in training, observing the procedure, or a senior examiner who is assessing the examiners to ensure fairness. Each topic in each oral is marked independently by each of the examiners. The outcome of one oral does not affect the second. The marks for each oral are added at the end of the examination to determine whether or not a candidate has passed.

The result of the examination (Pass or Fail) will usually be available on the day. Candidates who are unable to receive their result in person may receive it by email. Those candidates who are registered specialists in plastic surgery will receive an EBOPRAS certificate, and be able to call themselves "Fellow of EBOPRAS." Their names will be posted on the EBOPRAS website (www.ebopras.eu) which is the official list of Fellows. Trainees who pass the exam will not receive their certificate, become a "Fellow of EBOPRAS" or be listed on the website, until they have sent a copy of their Specialist Diploma to EBOPRAS.

Candidates who fail the oral may resit at a later date, and pay the fee and agree the rules applicable at the time of the resit. However, candidates who fail Part 2 four times or who do not pass Part 2 within 3 years of passing Part 1 will need to resit and pass Part 1 again, before they can retake Part 2.

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