Modelli Formativi Europei

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Gemelli 60 1964 2024

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1° OSPEDALE IN ITALIA
POLICLINICO UNIVERSITARIO A. GEMELLI

Organization Accredited by Joint Commission International

ITEMS
Italian Emergency Medicine Schools

XIII congresso nazionale
simeu
GENOVA 30 MAG - 1 GIU 2024

I.MEU
Ruolo.Talento.Passione.Idee

Come possiamo definire la Medicina D'Emergenza-Urgenza?

Emergency Medicine is a medical specialty based on the knowledge and skills required for the prevention, diagnosis and management of the acute and urgent aspects of illness and injury affecting patients of all age groups with a full spectrum of undifferentiated physical and behavioural disorders. It is a specialty in which time is critical. The Practice of Emergency Medicine encompasses the pre-hospital and in-hospital reception, resuscitation and management of undifferentiated urgent and emergency cases until discharge from the Emergency Department or transfer to the care of other physicians. It also includes involvement in the development of pre-hospital and in-hospital emergency medical systems.

Emergency Physicians have a fundamental role in modern healthcare systems. The emergency physician must address the comprehensive medical needs of all patients in the emergency setting and prioritise interventions, coordinating and directing care for multiple patients at any one time. Emergency Physicians must possess not only the essential knowledge and skills necessary for patients requiring acute care but also the organisational insights and capabilities needed to work efficiently in the pre-hospital environment, the emergency department (ED) and short stay wards and ambulatory care.

In quali Paesi Europei esiste la Scuola MEU?

Country	Full UEMS member	EUSEM member	Title	Current status	Established (year)	Training period (years)
Albania	no	yes		Primary specialty	2011	4
Andorra	no	no		No specialty		
Armenia	no	no		na.		
Austria	yes	yes	Notfallmedizin	No specialty		
Azerbaijan	no	no		na.		
Belarus	no	no		na.		
Belgium	yes	yes	Medecine d'Urgence; Urgentiegeneeskune	Primary specialty	2005	6
Bosnia and Herzegovina	no	no		na.		
Bulgaria	yes	yes	Спешна медицина	Primary specialty	1996	5
Croatia	yes	yes	Hitna medicina	Primary specialty	2009	5
Cyprus	yes	no	Επείγουσα Ιατρική	No specialty		
Czech Republic	yes	yes	Urgentni medicina	Primary specialty	2013	5
Denmark	yes	yes	Akutmedicin	Primary specialty	2018	6
Estonia	yes	yes	Erakorraline meditsiin	Primary specialty	2015	5
Finland	yes	yes	Akuuttilääketiede(Finnish)	Primary specialty	2012	6
France	yes	yes	Médecine d'urgence	Primary specialty	2015	4
Georgia	no	no		Primary specialty	2015	
Germany	yes	yes	Notfallmedizin	Supra-specialty	2018	2,5
Greece	yes	yes	Επείγουσα Ιατρική	Supra-specialty	2017	3
Hungary	yes	yes	Oxyológia és sürgősségi orvostan	Primary specialty	2003	5
Iceland	yes	yes	Bráðalækningar	Primary specialty	1992	5
Ireland	yes	yes	Emergency Medicine	Primary specialty	1997	7
Israel	no	no		Primary specialty	2009	4,5
Italy	yes	yes	Medicina d'emergenza urgenza	Primary specialty	2008	5
Kazakhstan	no	no		na.		

Kosovo	no	yes		Primary specialty	2000	5
Latvia	yes	yes	Neatliekamās medicīniskās	Primary specialty		
Liechtenstein	no	no		na.		
Lithuania	yes	yes	Skubioji Medicina	Primary specialty	2013	5
Luxembourg	yes	no	Medecine d'urgence	Primary specialty	2010	
Macedonia (FYROM)	no	no		na.		
Malta	yes	yes	Mediċina tal -Emerġenzi	Primary specialty	2004	6
Moldova	no	yes		No specialty		
Monaco	no	no		na.		
Montenegro	no	no		na.		
Netherlands	yes	yes	Spoedeisende Geneeskunde	Profile	1999	3
Norway	yes	yes		Primary specialty	2017	5,5
Poland	yes	yes	Medycyna ratunkowa	Primary specialty	1999	5
Portugal	yes	yes	Medicina de Emergência	No specialty		
Romania	yes	yes	Medicină de urgenţă	Primary specialty	1999	5
Russia	no	no		na.		
San Marino	no	no		na.		
Serbia	no	yes		Primary specialty	1992	5
Slovakia	yes	yes	Urazova chirurgia=traumatology	Primary specialty	2003	5
Slovenia	yes	yes	Urgentna medicina	Primary specialty	2006	5
Spain	yes	yes	Medicina de urgencias	No specialty		
Sweden	yes	yes	Akutsjukvård	Primary specialty	2015	5
Switzerland	yes	yes		Supra-specialty		1,5
Turkey	no	yes	Acil Tip	Primary specialty	1993	4
Ukraine	no	no		na.		
United Kingdom (UK)	yes	yes	Emergency Medicine	Primary specialty	1972	6
Vatican City (Holy See)	no	no		na.		

SECTION FOR
EMERGENCY MEDICINE

EUSEM
EUROPEAN SOCIETY FOR EMERGENCY MEDICINE

EUROPEAN CORE CURRICULUM FOR EMERGENCY MEDICINE

VERSION 2.0

This is the revised document of the ECCEM (European Core Curriculum for Emergency Medicine) revision group which consists of members of the **Educational Committee of EUSEM (**European Society for Emergency Medicine**)** and **EMERGE** (Emergency Medicine Examination Reference Group in Europe) on behalf of the **UEMS Section of Emergency Medicine**.

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This revision is endorsed by the president of EUSEM and the president of UEMS section of Emergency Medicine in March 2019.

Luis Garcia-Castrillo
President of EUSEM

Lisa Kurland
President of UEMS section of Emergency Medicine

SECTION 1 INTRODUCTION

The European Core Curriculum for Emergency Medicine

Section 2 of the Core Curriculum lists the core competences in Emergency Medicine, namely:

- the ability to triage and resuscitate patients (Section 2.1)
- the symptoms, signs and situations Emergency Physicians (EPs) should be able to address (Section 2.2)
- the conditions EPs should be able to recognise and initially manage (Section 2.3)
- the procedures EPs should be able to carry out and investigations they should be able to interpret (Section 2.4)
- the ability to make judicious decisions regarding further investigations and treatments (Section 2.5)
- professional competences EPs should master (Section 2.6).

Most subsections feature introductory paragraphs that describe the inclusion criteria the lists are based on and the level of competence expected of Emergency Physicians.

Competences of EMp

- Triage
- Resuscitation
- Symptoms, Signs and Situations
- Diagnosis and Syndromes
- Procedures and Diagnostic tests
- Clinical reasoning and Decision-making
- Specific professional competences (i.e. disaster medicine, violence management and prevention, home support, pre-hospital)
- Professionalism, Ethics and Medico-Legal issues
- Communication
- Many other…

3 Education and Research

Reflective practice & self-education

EPs must continuously reflect upon their own clinical practice, identify gaps in knowledge and competence, and fills these gaps through self-education. EPs should be aware of the value and limitations of various educational modalities.

Teaching & mentoring

EPs must be able to teach Emergency Medicine to undergraduate, graduate and post-graduate health care personnel, within the classroom as well as within the clinical setting. In particular, EPs must be able to supervise more junior staff and promote competence development through questions, guidance, feedback and reference to educational material. EPs must be able to provide longitudinal supervision of and mentorship for trainees and complete an annual appraisal to confirm a trainee's progression. EPs must continually reflect upon the teaching process and develop their pedagogical skills.

Critical appraisal

EPs must be able to systematically search the medical literature to answer specific clinical questions, critically appraise studies, and determine whether these studies ought to impact on local practice according to the principles of Evidenced-Based Medicine.

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UEMS Section & Board of Emergency Medicine

European Training Requirements for the Specialty of Emergency Medicine

European Standards of Postgraduate Medical Specialist Training

(old chapter 6)

2. Level of competence expected:

The Emergency Physician will progress in competence from a novice to expert and in being able to recognise a clinical condition or problem to being able to independently provide definitive treatment. There will also be progression in skills in managing time, multi-tasking, supervision, leadership and other core professional skills. In this regard 5 levels of competence are recognised:

Level 1: The physician is able to recognise that the patient potentially suffers from the condition or diagnosis. The physician manages single patients and requires supervision

Level 2: The physician is able to estimate the likelihood that the patient suffers from a specific condition on the basis of bedside information (history, physical examination, bedside tests e.g. ultrasound, ECG, initial blood tests, urinalysis) and using clinical decision tools. The physician may manage simple conditions independently.

Level 3: The physician knows how and acts to further evaluate the patient to rule-in or rule-out the diagnosis and may manage more than one patient at a time.

Level 4: The physician knows how to initially manage the majority of patients in the ED and is able to undertake much of the initial work independently. The physician will manage more than one patient at a time and provide limited supervision and support to others.

Level 5: The physician knows how to arrange further care either in-hospital or out-of-hospital and can coordinate the care as required or completes the care themselves where appropriate. The physician can provide leadership to others and supervise a department during a shift.

3. Organisation of training

3.1. Schedule of training

According to the EU-directive 2005/36 /EC the minimum requirement of training to be recognised as an Emergency Physician as a primary specialty is 5 years of full time training. A minimum of three of these years should be in an Emergency Department supervised by trained emergency physicians or approved trainers (see below), where the workload is between 30-35,000 attendances a year and where the full range of emergency cases is received and which includes the care of adults and children (see below).

Within the programme, a trainee must be evaluated **at the end of each year** and a personal learning programme devised that allows the trainee to acquire skills and competences not yet achieved.

3.3.2 Assessment

Formative assessment

Formative assessment is used as part of an ongoing learning or developmental process in giving feedback and advice. It **must** provide benchmarks to orientate the trainee. These benchmarks must include evaluation of the non-technical skills defined in the curriculum as much as technical expertise.

It **must** evaluate the trainee's progress and identify the strengths and weaknesses of that individual. The evaluation and any recommendations **must** be fully shared with the trainee.

The following **should** be part of formative assessment:
Formal Documentation of trainee's development and progress after review of evidence collected.
Workplace based Assessments

- Observed clinical care of unselected patients during working time including team behaviours, communication, and non-technical skills.
- Video or observed behaviour of the trainee within a team.
- Mini Clinical Examination (or Direct Observation of Procedural Skills), to assess the knowledge, procedural and practical skills and attitudes of the trainee's interaction with a patient
- Case-Based Discussion, to explore clinical reasoning on a recent case.

Non-workplace based Assessment

- Record of participation in simulation
- Record of courses
- Personal reflection of cases and development
- Record of e-learning completed
- Record of teaching received
- Record of teaching delivered with feedback
- Multi-source feedback from multi-professional team members
- Patient experience feedback
- Academic activity including critical appraisal, original research, editorial activity
- Quality improvement activity including audit
- Serious incident review and other governance activity

Summative assessment

Summative assessment is usually a formal assessment that takes place after a specified training period with the purpose of deciding whether the trainee has reached a standard to proceed to the next level of training or to be awarded a certificate of Completion of Training. The methods of summative assessment **should** include:

- Written examinations (multiple choice questions, short answered questions, essays).
- Oral and practical examinations (clinical vivas and objective structured clinical examinations or OSCEs i.e. stations to assess medical knowledge, clinical, communication and ethical skills in short predetermined scenarios).
- Evaluation of trainee's Portfolio and confirmation of appropriate progression
- The Section and Board recommend that the European Board Examination in Emergency Medicine is adopted by all European countries as the final assessment of competence to promote freedom of movement of specialists in Europe.

3.3.3 Assessment of progress

Specialist education and training **must** include continuous assessment which tests whether the trainee has acquired the requisite knowledge, skills, attitudes and professional qualities to practise in the specialty of Emergency Medicine. This must include formal annual and final evaluations. The annual evaluation **must** formalise the assessment of a trainee's competence to promote the trainee's improvement.

Final completion of a training programme should be dependent upon review of the trainee's portfolio as well as success in the final examination. The Training programme director must provide an overall judgment about the trainee's competence and fitness to practice as an independent specialist in Emergency Medicine.

II. TRAINING REQUIREMENTS FOR TRAINERS

1. Definitions of trainers

The faculty is defined as all senior physicians and healthcare professionals who contribute to the training of the trainee. Faculty are made up of:

Training programme directors (TPD) who supervise a training programme, ensure quality of trainers and training placements and coordinate placements to ensure trainees achieve the correct experience

Educational supervisors who provide ongoing individual professional development advice, monitor progression, provide placement reports on an annual basis and who are responsible for a limited number of trainees. Educational supervision activity usually occurs outside of clinical time in the emergency department and the majority of educational supervision does not include patient contact. Each trainee should have a named educational supervisor who provides advice and support over an extended period in one or more placements

Clinical supervisors who provide support in patient contact activity – giving clinical advice and maintaining standards of care for patients. Clinical supervisor supervise multiple trainees at one time, and the activity is usually within their clinical time. Clinical supervisors may undertake workplace based assessment as part of the clinical supervision.

All physicians **should** participate in practice-based training as emphasised. Trainers should receive training for their educational activity and demonstrate ongoing regular professional development in educational matters.

3. Evaluation of trainers

The Training Program Director **must** evaluate trainer performance at least annually. This appraisal **should** include evaluation of clinical teaching ability, clinical knowledge, professional attitude and academic activities. Trainers should be supported in developing their supervisory skills.

2.3 Evaluation of training programmes

Regular internal and external evaluation of the Training Programme **must** be assured in a systematic manner both as regards adherence to the curriculum and the attainment of educational goals. Both trainees and trainers **must** have the opportunity to evaluate the programme confidentially and in writing at least annually. External evaluation may be requested to the Section and Board (at the expense of the local organisation).

III. TRAINING REQUIREMENTS FOR TRAINING INSTITUTIONS

(if not covered by EU Directive on Professional Qualifications)

1. Criteria for recognition as training centre/programme

a. Requirement for staff and clinical activities in a centre

There must be a minimum number of undifferentiated new attendances of between 30,000-35,000 per annum for a training department. This number should include a minimum of 25% children under 16 years of age in order to provide experience to maintain skills. A significant number of these patients must be ambulance conveyed.
The case mix in a training department should reflect the presentations and conditions in the syllabus. If a centre does not see an appropriate case mix, a programme of rotational posts between relevant centres or an alternative method for gaining practical experience must be in place.

The ratio of trainers to the number of trainees **must** be sufficient to allow training to proceed without difficulty and to ensure close personal interaction and monitoring of the trainee during their training . The recommended optimal trainer/ Emergency Medicine trainee ratio is **1 to 2 within a department.**

2. Quality Management within Training programmes

2.1 Criteria for training centre

Training should generally be carried out in university hospitals or affiliated teaching hospitals although some training can take place on rotations in general hospitals or the community/pre-hospital environment providing case-mix and supervision is adequate (as above).

Each training institution should have an internal system of medical audit or quality assurance, including a mortality review process for reporting adverse events.

The curriculum should be delivered through a variety of learning experiences. The foundation of postgraduate education in Emergency Medicine is predominately experiential training in conjunction with formal teaching sessions with the aim of integrating theory and clinical activities.
The trainees should be given opportunities for self-directed learning and professional development with agreed learning objectives and goals for the learning period.

Introdurre il “teaching hospital” nell’ambito della formazione specialistica

di Direttivo Nazionale Settore Anaao Giovani

- Nel 59% (13/22) dei paesi esaminati, gli specializzandi sono obbligati a ruotare in diverse sedi extrauniversitarie, mentre nel 18% (4/22) questo non accade.

- Nella maggior parte dei paesi, gli specializzandi sono sottoposti a valutazioni annuali, o al termine di ogni modulo praticato, mentre solo 4 paesi non effettuano alcuna valutazione durante la specializzazione.

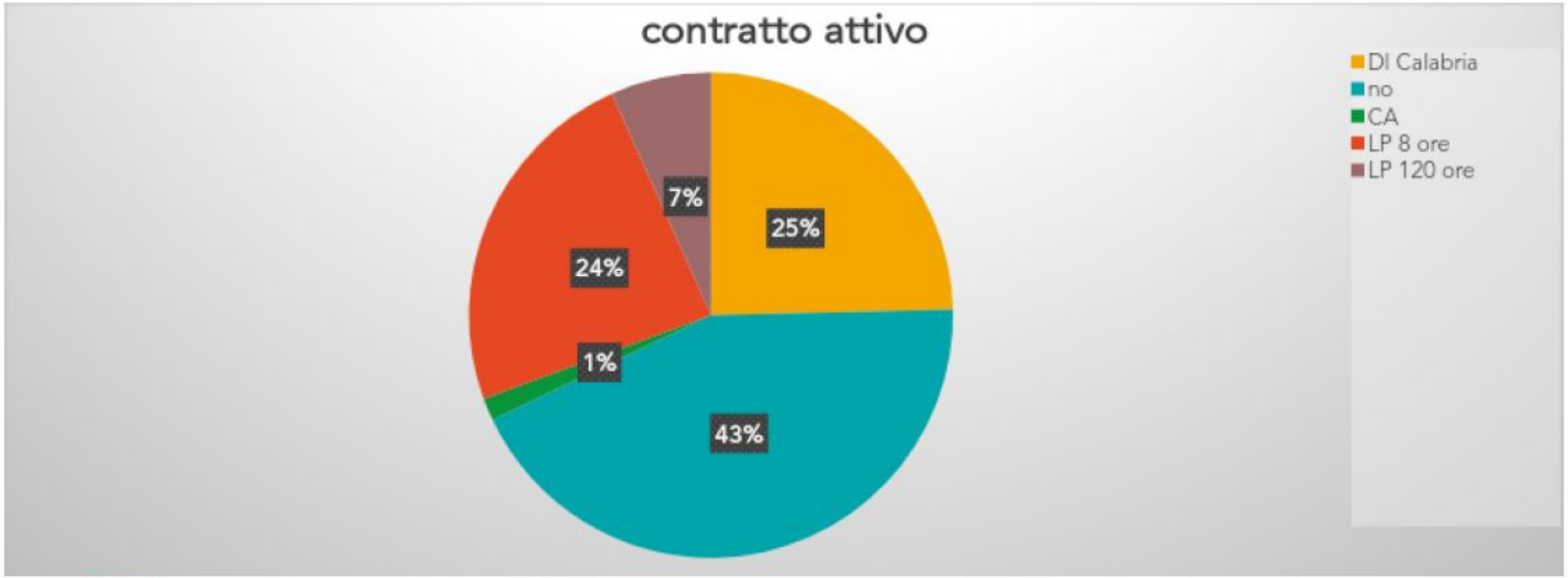
- Nel 32% dei paesi (7/22) è possibile poter cambiare facilmente specializzazione; in un altro 32% (7/22) è possibile poter cambiare solo in determinate condizioni, ad esempio per motivi di salute; nel 27% (6/22) sono presenti limitazioni (ad esempio in Slovenia è concesso cambiare specialità solo una volta); solo in Italia non è possibile cambiare specialità durante il percorso formativo.

- Riguardo la responsabilità legale per le decisioni cliniche prese durante la specializzazione: lo specializzando condivide tale responsabilità con il suo tutor nel 60% dei paesi (13/22); nel 18% (4/22) il supervisore ha piena responsabilità legale per le decisioni dello specializzando; nel 9% (2/22), lo specializzando è pienamente responsabile delle sue decisioni cliniche; in un altro 9% (2/22), la responsabilità dipende dalla specifica situazione; solo nel il Regno Unito lo specializzando è pienamente responsabile per le sue decisioni, manche nel periodo precedente la formazione specialistica.

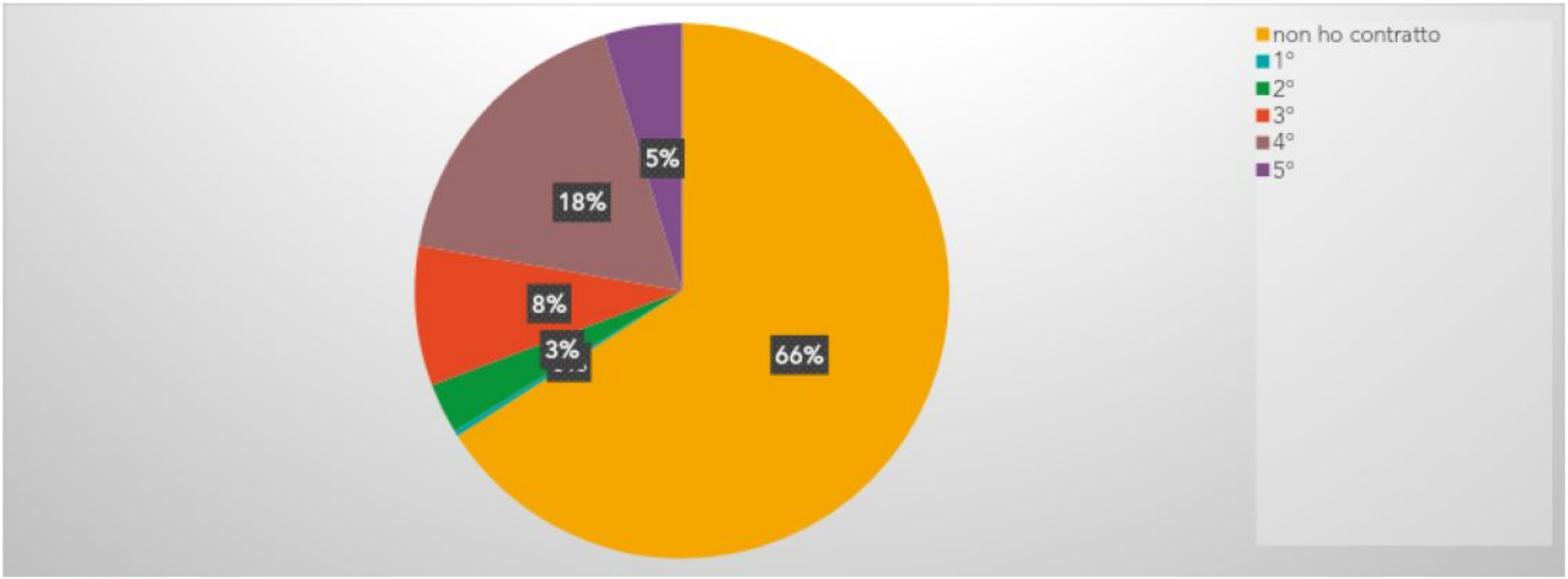
DI Calabria

Cosa pensano gli specializzandi

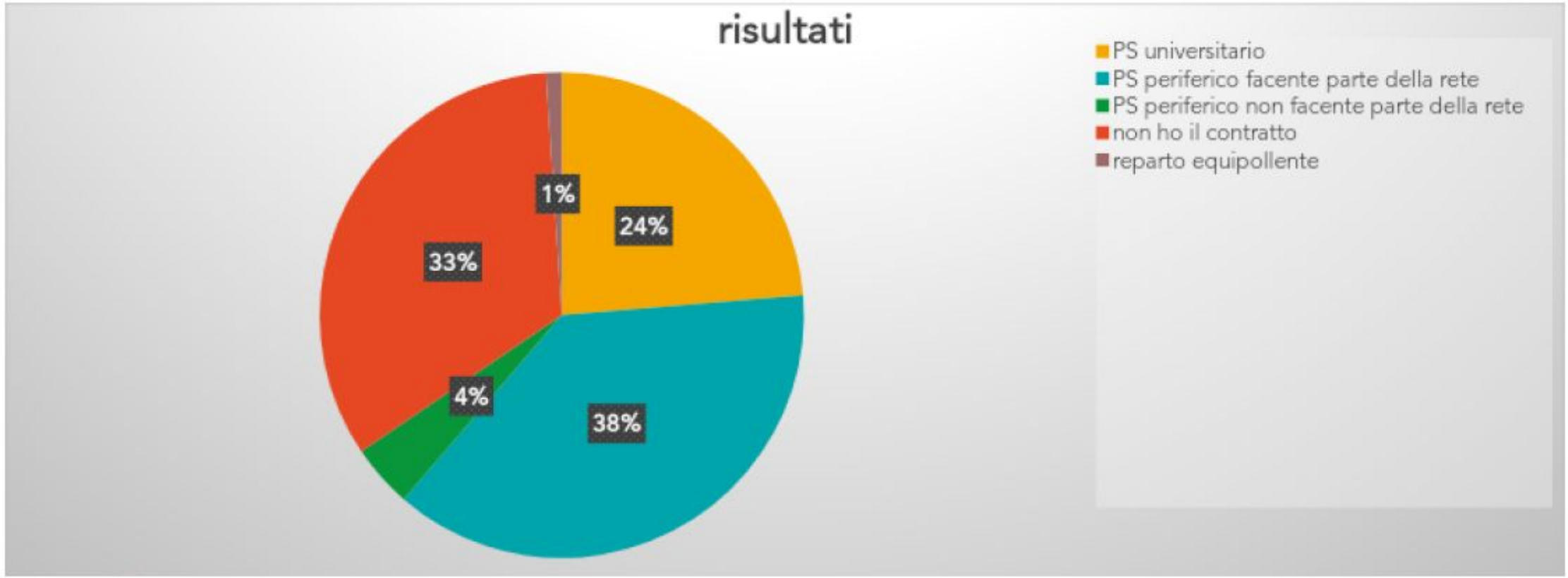
Hai un contratto attivo?



A che anno hai sottoscritto il contratto a tempo pieno?



Dove hai sottoscritto il contratto?



Perché? Motiva brevemente la risposta precedente

sì

- [ ] Motivazioni economiche
- [ ] Autonomia lavorativa
- [ ] Aumentare confidenza e opportunità di crescita
- [ ] Essere assunti nel luogo di lavoro futuro / agevolare ingresso nel mondo del lavoro
- [ ] Sopperire carenze formative della scuola

no

- [ ] Mancanza di tutoraggio e poca tutela
- [ ] Mancanza di momenti formativi / Inficia la qualità della formazione fino a mortificarla
- [ ] Carico di lavoro eccessivo
- [ ] Terminare il percorso di specializzazione

Take Home Messages

- L'UE ha diramato precise direttive riguardanti l'organizzazione delle Scuole

- Nonostante questo persiste ancora una certa eterogeneità tra i vari Paesi europei

- Mentre la definizione di Academic Hospital è molto chiara, mancano in molti Paesi, inclusa l'Italia, criteri standardizzati con i quali definire esattamente il Teaching Hospital

- Queste considerazioni sono di fondamentale importanza per il miglioramento continuo della qualità delle nostre Scuole

Grazie!