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# I. INTRODUCTION

## 1. UEMS Preamble

The UEMS (Union Européenne des Médecins Spécialistes, or European Union of Medical Specialists) is a non-governmental organisation representing national associations of medical specialists at the European level. With its current membership of 40 national associations and operating through 43 Specialist Sections and their European Boards, 17 Multidisciplinary Joint Committees and 4 Thematic Federations the UEMS is committed to promote the free movement of medical specialists across Europe while ensuring the professional consensus on the framework for the highest possible level of their training which will pave the way to the improvement of quality of care for the benefit of all European citizens and beyond.

**UEMS and its Postgraduate Medical Specialists Training programmes.** In 1994, the UEMS adopted its Charter on Postgraduate Training aiming at providing the recommendations at the European level for high quality training. This Charter set the basis for the European approach in the field of harmonisation of Postgraduate Specialist Medical Training, most importantly with the ongoing dissemination of its periodically updated Chapter 6’s, specific to each specialty. After the most recent version of the EU Directive on the recognition of Professional Qualifications was introduced in 2011, the UEMS Specialist Sections and other UEMS Bodies have continued working on developing the documents on European Training Requirement(s) (ETRs). They reflect modern medical practice and current scientific findings in each of the specialty fields and particular competencies covered and being represented within the UEMS. In 2012 the UEMS Council adopted the document Template Structure for ETR.

**The linkage between the quality of medical care and quality of training of medical professionals.** It is the UEMS’ conviction that the quality of medical care and expertise are directly linked to the quality of training, achieved competencies and their continuous update and development provided to the medical professionals. No matter where doctors are trained, they should have the same core competencies. The UEMS ETRs reflect many years (or even decades) of experience on the ground of the UEMS Sections/ Multidisciplinary Joint Committees (MJCs) and Boards developing in close collaboration with the relevant European Scientific Societies training requirements coupled with European Medical Assessments. It is one among the clear aims of the UEMS ETRs to raise standards of training to make sure that European patients find high quality standards of safe specialist care. While professional activity is regulated by national laws in EU Member States, it is the UEMS understanding that it has basically to comply with international treaties and UN declarations on Human Rights as well as the WMA International Code of Medical Ethics.

**UEMS and European legislation facilitating the mobility of medical professionals.** The UEMS Council and its Specialist Sections, first created in 1962, have regularly provided advice and expert opinion to the European Commission. This helped create the framework that informed the drawing up of the Doctors Directives in 1975, which provided for the mutual recognition of medical diplomas and the free movement of doctors throughout the EU. The revised EU Directive on the recognition of Professional Qualifications (2013/55/EU) allows member states to decide on a common set of minimum knowledge, skills and competencies that are needed to pursue a given profession through a Common Training Framework (CTF) which represents the third mechanism that could be used to ensure mobility within the EU. This directive states that “professional qualifications obtained under common training frameworks should automatically be recognised by Member States. Professional organisations which are representative at Union level and, under certain circumstances, national professional organisations or competent authorities should be able to submit suggestions for common training principles to the Commission, in order to allow for an assessment with the national coordinators of the possible consequences of such principles for the national education and training systems, as well as for the national rules governing access to regulated professions”. The UEMS supported CTFs since they encompass the key elements developed in modern educational and training models, i.e. knowledge, skills, professionalism. In addition, the Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients’ rights in cross-border healthcare introduced a strong incentive for harmonisation of medical training and achieved competencies among EU/EEA Countries through the requirements to assure good and comparable quality of care to increasingly mobile European citizens.

The UEMS ETR documents aim to provide for each specialty the basic training requirements as well as optional elements and should be regularly updated by UEMS Specialist Sections and European Boards to reflect scientific and medical progress. The three-part structure of these documents reflects the UEMS approach to have a coherent pragmatic document for each individual specialty, not only for medical specialists but also for decision-makers at the national and European level interested in knowing more about medical specialist training. To foster harmonisation of the ETR by adopting more specific guidelines, the CanMEDS competency framework is recommended which defines the entire set of roles of the professionals which are common across both medicine and surgery. UEMS has an agreement to use an abbreviated version of the competencies within those roles.

Importance of making a distinction between Knowledge and Competency in ETR documents. Competency-based education is not oriented towards the period of clinical rotations, but towards trainee, and trainee’s progress in the acquisition of competencies. Having a clear distinction within an ETR’s contents between competencies and knowledge helps define both how that training should be delivered and how it should be assessed. The UEMS considers that the appropriate use of different methods of assessment of knowledge and acquired skills, emphasising the workplace-based assessment, is an essential component of quality postgraduate training, focused on high standards of specialist medical practice. To improve the methods of assessment it is also recommended to use the so-called Entrustable Professional Activities (EPAs) in all specialties ETRs. In order to recognise common and harmonised standards on the quality assurance in specialist training and specialist practice at a European level some UEMS Specialist Sections and Boards also have, for a long time, organised European examinations (supported and appraised by the UEMS CESMA - Council of European Specialist Medical Assessments).

**Overlapping of learning outcomes and competencies**. Each of the UEMS ETRs defines a syllabus or knowledge base and describes learning outcomes defined for given competencies. Some of these curricula encompass a whole specialty, other focus on areas within or across specialties and define content of the training requirements for specific areas of expertise. By recognising the potential overlapping it creates the opportunity for those writing ETRs to draft overlapping or common goals for learning outcomes. Similar measurement does not necessarily equate to the same targets. Rather, across different specialties the final goal may differ, i.e. there may be clearly defined individual goals for trainees with different expectations.

**UEMS ETRs and national curricula**. The UEMS strongly encourages the National Medical Competent Authorities (NMCAs) to adopt such requirements and believes that this is the most efficient way of implementation of good standards in postgraduate training. We clearly respect and support the vital role of the NMCAs in setting high standards of training and care in their respective Coun- tries and checking through robust quality control mechanisms the qualifications of medical specialists moving across Europe. The UEMS ETRs are developed by professionals for professionals and this adds unique value to them. UEMS aim is to indicate the knowledge and competencies that should be achieved by trainees in EU/EEA countries and also competencies and organisation of the training centres. The training environment and results described in UEMS ETRs may be achieved in adapted ways, depending on local traditions, organisation of healthcare system and of medical specialist train- ing. Adaptation of UEMS ETRs to local conditions assures the highest quality of specialist training and each state may include additional requirements, depending on local needs.

**Importance of collaboration with other representative European medical bodies.** The UEMS always wishes to work with all Colleagues, NMAs, professional and scientific organisations across Europe. In the process of ETRs development, the UEMS recognises the importance of meaningful collaboration with the other European medical representative bodies, the European Junior Doctors (EJD representing doctors in training), the European Union of General Practitioners (UEMO – Union Européenne des Médecins Omnipraticiens), the Standing Committee of European Doctors (CPME - Comité Permanent des Médecins Européens), the Federation of European Salaried Doctors (FEMS) and the European Association of Senior Hospital Doctors (AEMH - Association Européenne des Médecins Hospitaliers). In addition, UEMS continues to develop closer links with the many European specialist societies. UEMS, in collaboration with its fellow European representative bodies, has constantly been highlighting the importance of coordinated postgraduate specialist medical training programmes always accepting the differing needs of different specialties. In this way quality medical care is delivered by highly qualified medical specialists - essential to ensuring consumer confidence and protection all over Europe.

**Conclusions.** UEMS is very proud for all the hard work that has been done until now in developing the UEMS ETRs as well as that they are increasingly implemented as national curricula. However, we also recognise the need for constant improvement, and we are always open to further suggestions. The UEMS insists that the medical profession remains the driver in defining its own specialist training and continuous professional development needs. On this basis, we sincerely look forward to working

with the key European Union responsible bodies, as well as the national stakeholders in implementing the basic common strategies and requirements outlined with this initiative. We are confident that the priorities detailed in UEMS ETR documents developed for individual specialties (and/or competencies) will become evident in national strategies and programmes, as well as action plans for postgraduate medical education and training.

## 2. Specialty of Reproductive Medicine

Reproductive Medicine is a key subspecialty within the field of Obstetrics and Gynaecology, dedicated to the comprehensive care of individuals and couples facing disorders of human reproduction. It encompasses the understanding, assessment, and management of both normal and abnormal reproductive function, including pubertal disorders, infertility, early pregnancy complications, contraception, and menopause. The management of people seeking fertility treatment, and the use of medically assisted reproduction (MAR) requires a multidisciplinary approach and specialist training in diverse areas such as endocrinology, andrology, reproductive surgery, genetics, embryology, early pregnancy care, ultrasound imaging, fertility preservation, and psychology. Therefore, the expertise in reproductive medicine is essential for providing holistic, evidence-based, and patient-centered care throughout the reproductive lifespan. This subspecialty builds upon the competencies acquired through the EBCOG PACT programme, which provides foundational training in Obstetrics and Gynaecology. Reproductive Medicine offers advanced knowledge and clinical skills in areas not fully covered by the core specialty curriculum, addressing increasingly complex diagnostic and therapeutic needs in modern reproductive health care.

## 3. Aims and Objectives of Training in Reproductive Medicine

### 3.a. Aims of Training in Reproductive Medicine

The aim of the Reproductive Medicine subspecialty training program is to prepare obstetricians and gynecologists to become highly competent, reflective, and ethically grounded subspecialists capable of delivering evidence-based, patient-centred care in the field of human reproduction.

This training is structured in accordance with the standards and recommendations of the European Board and College of Obstetrics and Gynaecology (EBCOG) and the UEMS Section of Obstetrics and Gynaecology, ensuring that graduates are equipped to meet the complex clinical, scientific, and psychosocial demands of reproductive medicine in a multidisciplinary context.

**The programme specifically aims to:**

* Develop advanced clinical competence in the diagnosis, investigation, and management of male and female infertility, reproductive endocrinopathies (including pubertal physiology and disorders), early pregnancy disorders, and disorders of sexual development.
* Train specialists in the safe, effective, and ethical use of medically assisted reproduction (MAR) including ovulation induction, intrauterine insemination, in vitro fertilisation, intracytoplasmic sperm injection, embryo transfer, cryopreservation techniques, and fertility preservation.
* Foster a deep understanding of reproductive physiology, endocrinology, and embryology, enabling the subspecialist to collaborate effectively with laboratory professionals and critically evaluate laboratory processes and outcomes.
* Develop advanced competence in menopause care, including evaluation of perimenopausal symptoms and POI; risk-stratified use of hormone therapy; evidence-based non-hormonal options; midlife contraception; and long-term health optimisation (bone, cardiometabolic, urogenital) through shared decision-making and structured monitoring.
* Build expertise in reproductive genetics, covering indications and interpretation of carrier screening, cytogenetics and molecular diagnostics; integration of PGT-A/M/SR into care pathways; counselling on residual risk, variants of uncertain significance, mosaicism and polygenic risk; and ethical–legal considerations with robust data governance.
* Develop proficiency in reproductive immunology, including mechanisms of implantation tolerance; diagnostic evaluation for RIF/RPL with appropriate immune/thrombotic workups; critical appraisal and judicious use of immunomodulatory therapies; interdisciplinary collaboration with immunology/rheumatology; and stewardship against unproven “add-ons.”
* Strengthen competencies in andrology, encompassing comprehensive male infertility assessment (endocrine, genetic, anatomical and functional); interpretation of semen analysis and advanced sperm testing; lifestyle and pharmacologic management; surgical sperm retrieval (PESA, TESA, TESE, micro-TESE) and cryopreservation; management of ejaculatory/sexual dysfunction; and coordinated care with urology and the MAR laboratory for ART.
* Provide structured surgical training in reproductive surgery, including laparoscopy, hysteroscopy, and procedures addressing congenital uterine anomalies and tubal pathology, relevant to infertility care.
* Promote academic development, including critical appraisal of scientific literature, engagement in original research, contribution to peer-reviewed publications, and participation in the education and training of junior colleagues and allied professionals.
* Ensure awareness of ethical, legal, and psychosocial considerations, including third-party reproduction, fertility preservation for medical and non-medical indications, and cross-border reproductive care, with emphasis on communication and counselling skills.
* Cultivate leadership and service development skills, encouraging active participation in clinical governance, quality improvement, and the organisation and delivery of reproductive medicine services in line with European best practices.

### 3b. Objectives of the Training in Reproductive Medicine

The objective of the subspecialty training in Reproductive Medicine is to prepare specialists who can practice independently, safely, and at the highest standards of clinical and academic excellence. Specifically, the training aims to ensure that the subspecialist acquires:

**Clinical Competence**

* Expertise in the diagnosis and treatment of reproductive endocrinology and infertility, including both female and male reproductive disorders.
* Ability to conduct independent and safe clinical practice, applying evidence-based guidelines and ensuring patient safety.
* Advanced clinical knowledge and specific procedural skills, with competence in auditing and continuously improving clinical practice.

**Academic and Research Competence**

* Experience in medical education, including teaching of junior colleagues and allied health professionals.
* Active participation in research, with skills in critical appraisal of the scientific literature.
* Ability to contribute to the advancement of reproductive medicine through publications in peer-reviewed journals and presentations at scientific meetings.
* Leadership in fostering innovation and research within the subspecialty.

**Professional and Organisational Competence**

* Ability to coordinate and lead multidisciplinary team working, fostering effective collaboration with colleagues in laboratory medicine, genetics, psychology, nursing, and other allied fields.
* Competence in the organization and management of reproductive medicine services, including clinical governance, audit, and quality improvement.
* Knowledge of health system structures, certification requirements, quality assurance frameworks, and patient safety protocols relevant to reproductive medicine.

Through these objectives, the training aims to produce subspecialists capable of practicing independently, safely, and ethically, while contributing to clinical excellence, education, and the advancement of reproductive medicine in Europe.

## 4. Procedure of ETR Development/Revision

The development and revision of the European Training Requirements (ETR) in Reproductive Medicine follow the standards established by the European Board and College of Obstetrics and Gynaecology (EBCOG), in alignment with the principles of the European Union of Medical Specialists (UEMS).

The process is led by a dedicated Working Group within the Committee for Accreditation of Subspecialist Training Programme in Reproductive Medicine (ATCRM), a permanent body of the European Society of Human Reproduction and Embryology (ESHRE). ATCRM is responsible for developing and maintaining European standards for subspecialist training centres in Reproductive Medicine. This Working Group, as part of ESHRE ATCRM is composed of recognised experts in Reproductive Medicine from various European countries and UK who are educational specialists and representatives from relevant subspecialty society (ESHRE), as well as trained and accredited assessors for Reproductive Medicine subspecialist training certification.

The Working Group consisted of:

1. **Antonios Makrigiannakis** (Working group president) - Professor of Obstetrics and Gynaecology at the University of Crete; Head of the Department of Obstetrics and Gynaecology at PAGNI Hospital, Crete, Greece; Subspecialist in Reproductive Medicine; Past ESHRE/EBCOG Coordinator for Reproductive Medicine Subspecialist Training Accreditation.
2. **Barış Ata** - Dean of the Koç University School of Medicine and Professor of Obstetrics and Gynaecology, Istanbul, Turkey; Subspecialist in Reproductive Medicine; ESHRE/EBCOG Coordinator for Reproductive Medicine Subspecialist Training Accreditation.
3. **Roy G. Farquharson** - Consultant Gynaecologist at Liverpool Women’s Hospital UK; Former chair of ESHRE (2017-2019), Accredited Assessor for Reproductive Medicine Subspecialist Training Accreditation.
4. **Abha Maheshwari** - Honorary Professor at the University of Aberdeen; Lead Consultant for Reproductive Medicine and Surgery, Aberdeen Fertility Centre, UK.
5. **Tatjana Motrenko Simić** - Director of the Human Reproduction Centre, Budva, Montenegro; Subspecialist in Reproductive Medicine; ESHRE Certification Coordinator; Past Coordinator for Reproductive Medicine Subspecialist Training Accreditation.
6. **Dinka Pavičić Baldani** - Full Professor at the University of Zagreb School of Medicine and Head of the Unit for Medically Assisted Reproduction, Clinical Hospital Centre Zagreb, Croatia; Subspecialist in Reproductive Medicine and Gynaecological Endocrinology; Coordinator elected for the ATCRM. and Representative of the ESHRE Executive Committee in the Working Group.
7. **Kenny A. Rodriguez-Wallberg** Associate Professor and Senior Consultant in Reproductive Medicine and Oncology, Karolinska Institutet and Karolinska University Hospital, Stockholm, Sweden, accredited assessor for Reproductive Medicine training certification.

**The steps taken:**

* 1. Initial draft preparation based on current scientific evidence, clinical practice needs, and existing national curricula.
  2. Review and feedback integration through iterative rounds of discussion within the Working Group.
  3. Approval by ESHRE Executive Board and submission to the UEMS Council for formal adoption.
  4. Publication and dissemination of the final ETR document.
  5. Periodic review, usually every 5 years or as needed, to ensure the curriculum remains relevant and aligned with advances in medical science and education.

This transparent and collaborative process ensures that the ETR reflects a European consensus on the standards of training and promotes harmonization of subspecialty education across member countries.

# II. TRAINING REQUIREMENTS FOR TRAINEES

## 1. Trainee Profile and Competence Framework

### 1.a. Trainee in Reproductive Medicine

A trainee in Reproductive Medicine must be a fully qualified medical doctor who has successfully completed specialist training in Obstetrics and Gynaecology, and who holds official recognition as a specialist by the relevant national medical authority.

The training is intended to build upon the foundational competencies acquired during core specialty training (PACT program) and to provide in-depth expertise in the diagnosis, management, and research of reproductive disorders.

This structured subspecialty programme is developed under the auspices of ESHRE and is aligned with the standards set by the European Board and College of Obstetrics and Gynaecology (EBCOG) and the European Union of Medical Specialists (UEMS).

At the time of entry into subspecialty training in Reproductive Medicine, the trainee must already:

* Hold a recognised specialist qualification in Obstetrics and Gynaecology, with full registration as a medical specialist according to national regulations.
* Possess core competencies in general obstetrics and gynaecology as defined by the European PACT training programme, including:
* Basic knowledge of female and male reproductive anatomy and physiology.
* Competence in taking a comprehensive medical, gynaecological, and reproductive history, and performing relevant clinical examinations.
* Ability to perform and interpret baseline diagnostic investigations such as pelvic ultrasound, hormonal assays, and semen analysis in collaboration with laboratory specialists.
* Experience in the management of common gynaecological disorders (e.g., menstrual cycle disturbances, endometriosis, fibroids, contraception).
* Familiarity with early pregnancy management and complications.
* Demonstrate professionalism, ethical awareness, and communication skills appropriate for patient-centred care.
* Be able to work effectively within a multidisciplinary team.
* Show basic knowledge of research methodology and evidence-based clinical practice.

### 1.b. Competencies Required of the Trainee (as per CanMEDs framework)

* **Medical Expert.**Applying medical knowledge, clinical skills, and professional values in their provision of high-quality and safe patient-centred care.

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| **Key competencies** | **Enabling competencies** |
| **Physicians are able to:** | |
| **1. Practise reproductive medicine within their defined scope of practice and expertise** | 1.1 Demonstrate a commitment to high-quality care of their patients  1.2 Apply knowledge of the clinical and biomedical sciences relevant to their discipline  1.3 Perform appropriately timed clinical assessments with recommendations that are presented in an organized manner  1.4 Carry out professional duties in the face of multiple, competing demands  1.5 Recognize and respond to the complexity, uncertainty, and ambiguity inherent in medical practice |
| **2. Perform a patient-centred clinical assessment**  **and establish a management plan** | 2.1 Prioritize issues to be addressed in a patient encounter  2.2 Elicit a history, perform a physical exam, select appropriate investigations, and interpret their results for the purpose of diagnosis and management, disease prevention, and health promotion  2.3 Establish goals of care in collaboration with patients and their families, which may include slowing disease progression, treating symptoms, achieving cure, improving function, and palliation  2.4 Establish a patient-centred management plan |
| **3. Plan and perform procedures and therapies for the purpose of assessment and/or management** | 3.1 Determine the most appropriate procedures or therapies  3.2 Obtain and document informed consent, explaining the risks and benefits of, and the rationale for, a proposed procedure or therapy  3.3 Prioritize a procedure or therapy, taking into account clinical urgency and available resources  3.4 Perform a procedure in a skilful and safe manner, adapting to unanticipated findings or changing clinical circumstances |
| **4. Establish plans for ongoing care and, when appropriate, timely consultation** | 4.1 Implement a patient-centred care plan that supports ongoing care, follow-up on investigations, response to treatment, and further consultation |
| **5. Actively contribute, as an individual and as a member of a team providing care, to the continuous improvement of health care quality and patient safety** | 5.1 Recognize and respond to harm from health care delivery, including patient safety incidents  5.2 Adopt strategies that promote patient safety and address human and system factors |

* **Communicator.** As Communicators, physicians form relationships with patients and their families that facilitate the gathering and sharing of essential information for effective health care.

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| **Key competencies** | **Enabling competencies** |
| **Physicians are able to:** | |
| **1. Establish professional therapeutic relationships with patients and their families** | 1.1 Communicate using a patient-centred approach that encourages patient trust and autonomy and is characterized by empathy, respect, and compassion  1.2 Optimize the physical environment for patient comfort, dignity, privacy, engagement, and safety  1.3 Recognize when the values, biases, or perspectives of patients, physicians, or other health care professionals may have an impact on the quality of care, and modify the approach to the patient accordingly  1.4 Respond to a patient’s non-verbal behaviours to enhance communication  1.5 Manage disagreements and emotionally charged conversations  1.6 Adapt to the unique needs and preferences of each patient and to his or her clinical condition and circumstances |
| **2. Elicit and synthesize accurate and relevant information, incorporating the perspectives of patients and their families** | 2.1 Use patient-centred interviewing skills to effectively gather relevant biomedical and psychosocial information  2.2 Provide a clear structure for and manage the flow of an entire patient encounter  2.3 Seek and synthesize relevant information from other sources, including the patient’s family, with the patient’s consent |
| **3. Share health care information and plans with patients and their families** | 3.1 Share information and explanations that are clear, accurate, and timely, while checking for patient and family understanding  3.2 Disclose harmful patient safety incidents to patients and their families accurately and appropriately |
| **4. Engage patients and their families in developing plans that reflect the patient’s health care needs and goals** | 4.1 Facilitate discussions with patients and their families in a way that is respectful, non-judgmental, and culturally safe  4.2 Assist patients and their families to identify, access, and make use of information and communication technologies to support their care and manage their health  4.3 Use communication skills and strategies that help patients and their families make informed decisions regarding their health |
| **5. Document and share written and electronic information about the medical encounter to optimize clinical decision-making, patient safety, confidentiality, and privacy** | 5.1 Document clinical encounters in an accurate, complete, timely, and accessible manner, in compliance with regulatory and legal requirements  5.2 Communicate effectively using a written health record, electronic medical record, or other digital technology  5.3 Share information with patients and others in a manner that respects patient privacy and confidentiality and enhances understanding |

* **Leader**. As Leaders, physicians engage with others to contribute to a vision of a high quality health care system and take responsibility for the delivery of excellent patient care through their activities as clinicians, administrators, scholars, or teachers.

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| **Key competencies** | **Enabling competencies** |
| **Physicians are able to:** | |
| **1. Contribute to the improvement of health care delivery in teams, organizations, and systems** | 1.1 Apply the science of quality improvement to contribute to improving systems of patient care  1.2 Contribute to a culture that promotes patient safety  1.3 Analyze patient safety incidents to enhance systems of care  1.4 Use health informatics to improve the quality of patient care and optimize patient safety |
| **2. Engage in the stewardship of health care resources** | 2.1 Allocate health care resources for optimal patient care  2.2 Apply evidence and management processes to achieve cost-appropriate care |
| **3. Demonstrate leadership in professional practice** | 3.1 Demonstrate leadership skills to enhance health care  3.2 Facilitate change in health care to enhance services and outcomes |
| **4. Manage career planning, finances, and health human resources in a practice** | 4.1 Set priorities and manage time to integrate practice and personal life  4.2 Manage a career and a practice  4.3 Implement processes to ensure personal practice improvement |

* **Health Advocate.** As Health Advocates, physicians contribute their expertise and influence as they work with communities or patient populations to improve health. They work with those they serve to determine and understand needs, speak on behalf of others when required, and support the mobilization of resources to effect change.

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| **Key competencies** | **Enabling competencies** |
| **Physicians are able to:** | |
| **1. Respond to an individual patient’s health needs by advocating with the patient within and beyond the clinical environment** | 1.1 Work with patients to address determinants of health that affect them and their access to needed health services or resources  1.2 Work with patients and their families to increase opportunities to adopt healthy behaviours  1.3 Incorporate disease prevention, health promotion, and health surveillance into interactions with individual patients |
| **2. Respond to the needs of the communities or populations they serve by advocating with them for system-level change in a socially accountable manner** | 2.1 Work with a community or population to identify the determinants of health that affect them  2.2 Improve clinical practice by applying a process of continuous quality improvement to disease prevention, health promotion, and health surveillance activities  2.3 Contribute to a process to improve health in the community or population they serve |

* **Scholar**

As Scholars, physicians demonstrate a lifelong commitment to excellence in practice through continuous learning and by teaching others, evaluating evidence, and contributing to scholarship.

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| **Key competencies** | **Enabling competencies** |
| **Physicians are able to:** | |
| **1. Engage in the continuous enhancement of their professional activities through ongoing learning** | 1.1 Develop, implement, monitor, and revise a personal learning plan to enhance professional practice  1.2 Identify opportunities for learning and improvement by regularly reflecting on and assessing their performance using various internal and external data sources  1.3 Engage in collaborative learning to continuously improve personal practice and contribute to collective improvements in practice |
| **2. Teach students, residents, the public, and other health care professionals** | 2.1 Recognize the influence of role-modelling and the impact of the formal, informal, and hidden curriculum on learners  2.2 Promote a safe learning environment  2.3 Ensure patient safety is maintained when learners are involved  2.4 Plan and deliver a learning activity  2.5 Provide feedback to enhance learning and performance  2.6 Assess and evaluate learners, teachers, and programs in an educationally appropriate manner |
| **3. Integrate best available evidence into practice** | 3.1 Recognize practice uncertainty and knowledge gaps in clinical and other professional encounters and generate focused questions that address them  3.2 Identify, select, and navigate pre-appraised resources  3.3 Critically evaluate the integrity, reliability, and applicability of health-related research and literature  3.4 Integrate evidence into decision-making in their practice |
| **4. Contribute to the creation and dissemination of knowledge and practices applicable to health** | 4.1 Demonstrate an understanding of the scientific principles of research and scholarly inquiry and the role of research evidence in health care  4.2 Identify ethical principles for research and incorporate them into obtaining informed consent, considering potential harms and benefits, and considering vulnerable populations  4.3 Contribute to the work of a research program  4.4 Pose questions amenable to scholarly inquiry and select appropriate methods to address them  4.5 Summarize and communicate to professional and lay audiences, including patients and their families, the findings of relevant research and scholarly inquiry |

## 2. Content of Training and Learning Outcome

### 2.a. Content of Reproductive Medicine Training

**Fertility Preservation**

Training includes techniques and procedures for fertility preservation in both male and female patients, including gamete and embryo cryopreservation, ovarian and testicular tissue preservation, and counselling regarding oncological and non-oncological indications.

**Infertility Diagnosis and Treatment**  
Covers comprehensive evaluation of infertility in men and women (history, physical examination, hormonal and genetic testing, imaging, semen analysis), and management through ovulation induction, intrauterine insemination (IUI), in vitro fertilization (IVF), intracytoplasmic sperm injection (ICSI), surgical treatments, and use of donor gametes.

**Reproductive Health Issues**  
Involves diagnosis and management of conditions impacting fertility and reproductive health, including puberty disorders, Mullerian abnormalities, disorders of sexual development, prepubertal labial adhesions, vulvovaginitis and vaginal discharge, menstrual cycle disorders, contraception, endometriosis, recurrent pregnancy loss, polycystic ovary syndrome (PCOS), sexual dysfunction, sexually transmitted infections (STIs) and menopause Also includes preconception counselling and genetic counselling.

**Assisted Reproductive Technologies (ART)**  
Competence in all aspects of ART, including ovarian stimulation protocols, oocyte retrieval, embryo transfer, laboratory techniques, cryopreservation, use of donor gametes and embryos, surrogacy, and monitoring outcomes.

**Andrology and Male Reproductive Health**  
Training includes evaluation and treatment of male infertility, sperm retrieval techniques, testicular biopsy, and management of endocrine and genetic male reproductive disorders.

**Endocrinology of Reproduction**  
Understanding the hormonal regulation of the menstrual cycle, gametogenesis, implantation, pregnancy, and related disorders.

**Ethical and Legal Issues**  
Covers ethical principles and legal frameworks relevant to reproductive medicine, including consent, confidentiality, use of donor gametes and embryos, embryo research, preimplantation genetic testing (PGT), cross-border reproductive care, and equitable access to treatment.

**Psychological Support, Education and Counselling**  
Training in providing counselling and support to individuals and couples undergoing fertility treatments, addressing psychological impact, stress management, sexual health, and implications of treatment outcomes.

**Research and Evidence-Based Practice**  
Understanding clinical research methodology, interpretation of scientific literature, critical appraisal of evidence, and contribution to the advancement of reproductive medicine.

**Public Health and Preventive Aspects**  
Awareness of reproductive epidemiology, prevention of infertility (e.g., lifestyle factors, infection prevention), fertility awareness, and health policy considerations.

### 2.b. Learning outcomes

The intended learning outcomes (ILOs) are specified at the level of subspecialty training and correspond to the independent practice expected of a subspecialist in Reproductive Medicine, unless otherwise indicated in the logbook (Levels 1–5).

At the end of subspecialty training in Reproductive Medicine, the trainee must demonstrate the following learning outcomes:

#### Theoretical Knowledge

Trainees must gain comprehensive theoretical knowledge across the following domains:

**Reproductive Endocrinology**

* Hypothalamic-pituitary-ovarian axis and endocrine disorders (e.g., PCOS, POI, hyperprolactinemia).
* Embryology, development and physiology of ovary, uterus and endometrium.
* Menstrual cycle physiology, ovarian aging, and reproductive hormone function.
* Follicular recruitment, follicle selection, ovulation cascade, corpus luteum formation and luteolysis.
* Hormonal contraceptive methods and menopause management.
* The relevance of adrenal functions in relation to reproductive physiology and disorders.
* The relevance of thyroid for reproduction and pregnancy.
* The relevance of lifestyle and environmental factors, including obesity, for reproductive functions.
* Normal and abnormal sexual development.
* Normal and abnormal growth and pubertal development.
* Endocrine disrupting compounds (EDC) and effect on reproduction.
* Gender identity and gender transition.
* Impact of non-pharmacological and pharmacological management of obesity on MAR
* Obesity impact on MAR and pharmacological and non- pharmacological management of obesity

**Medical Assisted Reproduction (MAR)**

* Indications for MAR and associated legal, ethical, and psychological aspects.
* Pretreatment evaluation, including preconception assessment, to optimise MAR outcomes.
* Clinical relevance of serum levels of sex steroids and gonadotropins during ovarian stimulation.
* Etiology of semen analysis abnormalities and counsel patient appropriately.
* Comprehensive assessment of male partner including endocrine, genetic and physical evaluation
* Principles and protocols of ovulation induction, ovulation triggering and oocyte retrieval
* Understanding of what is cumulus oocyte complexes (COCs) in follicular fluid, COC denudation methods, different methods of oocyte in vitro fertilisation, assessment of fertilisation and in vitro embryo development, including cleavage and blastocyst stage morphologic grading systems.
* Embryo scoring, selection and embryo transfer,
* Preimplantation Genetic Testing (PGT) and outcomes of MAR pregnancies.
* Medical and legal requirements by the competent authority for a MAR practice.
* The medical and legal requirements for cryopreservation of gametes, embryos and reproductive tissues.
* Surgical and non-surgical methods of sperm retrieval for MAR, i.e., PESA, TESA, (micro) TESE, sperm retrieval from post ejaculate urine, transrectal electro stimulation.
* Principles of cryobiology relevant for MAR and expected cryosurvival rates for gametes, embryos and reproductive tissues.
* Embryo biopsy procedures for preimplantation genetic testing and their potential impact on embryo development and potential.
* Available technologies for preimplantation genetic testing for aneuploidy with relative advantages and limitations.
* Indications for in vitro fertilisation vs intracytoplasmic sperm injection.
* Relative advantage and disadvantages of fertilisation methods, IVF vs ICSI.
* Counselling of patients regarding indications, risks and benefits of preimplantation genetic testing for aneuploidy.
* Indications for preimplantation genetic testing for monogenic and/or structural rearrangement disease.
* Obstetric and perinatal outcomes of pregnancies and children conceived with MAR.
* Psychological aspects of the diagnosis of infertility, undergoing MAR, and coping with treatment failure
* Pharmacokinetics and pharmacodynamics of prescribed drugs in MAR procedures

**Laboratory and Genetics**

**Laboratory**

* Gametogenesis, fertilization, embryology, and chromosomal/genetic abnormalities.
* Laboratory.
* MAR laboratory set up, safety and quality control.
* Role of MAR laboratory equipment.
* Laboratory preparation of gametes for fertilisation and different artificial insemination.
* Role of different embryo culture systems.
* Role of MAR laboratory processes (semen preparation, IVF, ICSI, embryo scoring, embryo selection criteria, and cryobiology.
* Advantages and risks of short versus prolonged embryo culture.
* Cryopreservation of gametes, tissues, and embryos and cryobanking.
* Distinguish between evidence based and non-evidence based laboratory methods of MAR.
* Quality assurance according to the EU Directives / Regulation / on setting standards of quality and safety for the donation, procurement, testing, processing, preservation, storage and distribution (including import and export in/out of the EU) of human tissues and cells intended for human application.
* Different sperm collection methods (ejaculation, split ejaculation, retrograde ejaculation, PESA, TESA, TESE).
* Oocyte collection methods (oocyte pick-up, ovarian tissue biopsy).
* In vitro gamete transport.
* In vitro oocyte maturation.
* Donor oocytes and sperm in relation to serological tests (different handling and storage).
* Laboratory treatment options in cases of total fertilisation failure after IVF and ICSI or embryo developmental arrest.
* Recommendations upon transferring embryos after PGT.
* Number of embryos to be transferred. According to the recent document on the number of embryos to be transferred.
* Preimplantation genetic testing of embryos for aneuploidies (PGT-A), chromosomal structural rearrangements (PGT-SR) and monogenic diseases (PGT-M).
* Application of novel non-evidence-based laboratory methods by considering all safety and quality standards and by using Euro DTP II, practical tools for assessment and verification of the quality, safety and efficacy of novel therapies with human tissues and cells.

**Genetics**

* Gametogenesis from embryonic stage to adult, including various pathologic situations deriving from developmental, genetic or environmental factors.
* Physiology and pathophysiology of fertilisation process and types of abnormal fertilisation.
* Preimplantation embryo development and developmental disorders.
* Meiotic and mitotic irregularities in gametes and early embryos.
* Normal genetics (e.g. genotype and phenotype, basic Mendelian inheritance patterns, the structure and identification of chromosomes).
* Abnormal genetics including chromosomal abnormalities (numerical, structural), monogenic diseases, mutations, copy number variations, genetic disorders of sexual development (e.g, hermaphroditism, Turner’s syndrome.
* Inherited, non-reproductive disorders referrable to reproduction (e.g., congenital adrenal hyperplasia, diabetes mellitus).
* Genetic analyses including pedigree, karyotype analysis, antenatal diagnosis of genetic disease, use of gene probes, fluorescent in-situ hybridisation, array comparative genomic hybridisation, next generation sequencing and associated techniques, indications and arrangements for specialised genetic diagnosis and counselling.
* Genetic causes of infertility and early pregnancy loss.
* Genetic aspects of artificial insemination and assisted fertilisation.
* Genetic counselling techniques.
* Embryo biopsy and preimplantation genetic testing for aneuploidies (PGT-A), chromosomal structural rearrangements (PGT-SR) and genetic mutations (PGT-M).

**Andrology**

* Physiology of spermatogenesis and evaluation of male infertility.
* Sperm retrieval methods, genetic evaluation, and treatment of male infertility. The cycle of spermatogenesis, including endocrinological control mechanisms, its abnormalities, and the effects of drugs.
* The physiology and pathophysiology of sexual function; disorders of sperm deposition including ejaculation disorders.
* The results of sperm and seminal fluid examination.
* Causes of azoospermia, aspermia, oligozoospermia, asthenozoospermia and teratozoospermia.

**Reproductive Surgery**

* Diagnostic and operative hysteroscopy and laparoscopy.
* Surgical treatment of endometriosis, uterine fibroids, and mullerian anomalies.
* Surgical treatment of benign ovarian and tubal disease, myoma, endometrial pathology and uterine abnormalities and tubal ligation.
* Surgical management of miscarriage.
* Surgical management of ectopic pregnancy.
* Management of imperforate hymen and vaginal septa.

**Early Pregnancy and Implantation**

* Diagnosis and management of pregnancy of unknown location, ectopic pregnancy, and miscarriage.
* Understanding repeated implantation failure (RIF) and recurrent pregnancy loss (RPL).
* Endocrinology of pregnancy and Human Chorionic Gonadotrophin (HCG) levels and fluctuations in relation to the spectrum of early pregnancy outcomes.
* Immunology of reproduction and implantation.
* The feto-placental unit as relates to the physiology and pathophysiology of steroid hormones (e.g., oestrogen, progestogen, corticosteroids).
* The physiology of decidua-chorionic-placental peptide hormones (e.g. gonadotrophins, thyrotrophin, ACTH/opioid peptides and prolactin).
* The physiology and pathophysiology of fetal hypothalamic-pituitary-gonadal function.
* The pathophysiology of altered maternal thyroid, adrenal and pancreatic status during early pregnancy.
* Endocrine and cell signalling mechanisms contributing to implantation.
* Immunological adaptation to implantation (immunotolerance) and early pregnancy.
* Repeated implantation failure (RIF) and recurrent pregnancy loss (RPL).

**Fertility Preservation**

* Techniques of oocyte, embryo, sperm and ovarian tissue cryopreservation.
* Impact of cancer and benign conditions on fertility.
* Counselling for fertility preservation in cancer patients and transgender care.
* Genetic conditions requiring fertility preservation.
* Fundamentals of fertility preservation.
* Frequent indications for fertility preservation including benign conditions.
* Impact of cancer treatment on male fertility.
* Impact of cancer treatment on female fertility.
* Gonad toxicity related to any treatment (targeted therapy, chemotherapy).
* Downstream use of cryopreserved reproductive material.
* Embryo, tissue and germ cells banking.

#### Practical and Clinical Skills

Trainees must achieve practical competence in the following areas:

**1. Reproductive endocrinology**

*The Trainee should be able to manage at least 100 patients over the two years (they must consist of a wide variety of clinical conditions as listed below):*

* Assess ovulatory function, to perform differential diagnosis and provide management for different etiologies of oligo-anovulation.
* Perform diagnostic work up and management of polycystic ovarian syndrome including infertility as well as endocrinologic, metabolic, psychological, dermatologic and oncologic concerns.
* Perform a differential diagnosis and manage androgen excess.
* Independently manage ovulation induction.
* Assess ovarian reserve and interpret the results.
* Perform diagnostic work up of amenorrhea and manage amenorrhea due to different etiologies.
* Diagnosis and management of thyroid diseases related to infertility.
* Organise and interpret tests results including endocrine assessment, DEXA, immunological investigations and genetic testing in POI.
* Counselling on the treatment options for young women with POI, including advantages and disadvantages, risks and benefits of hormone replacement therapy (HRT).
* Provide counselling, management and psychologic support for women with premature ovarian insufficiency.
* Perform medical management of endometriosis.
* Manage medical disorders that affect reproduction.
* Explain menopausal transition, provide comprehensive counselling to perimenopausal and menopausal women including screening services, lifestyle and nutrition recommendations, risks and benefits of hormone treatment and non-hormonal alternatives. (10 patients required)
* Counsel the patients regarding all types of contraception. (10 patients required)

**2. Infertility diagnosis and therapy including Medically Assisted Reproduction (MAR) procedure**

*The Trainee should be able to manage at least 100 cases of infertility over the two years (they must consist of a wide variety of clinical conditions as listed below):*

* Genetics of female and male infertility.
* Counselling of infertile couples to all other possible treatment except ART/MAR.
* Diagnosis and treatment for recurrent pregnancy loss.
* Counselling for ART/MAR.
* Knowledge of the legal situation mainly nationally and optional in Europe.

*The Trainee should be competent to perform independent clinical practice (30 cases):*

* Investigation of tubal patency and / or uterine cavity with HSG, or hydrosonography, or hysterosalpingo-sonography with contrast medium.

*The Trainee should be competent to perform independent clinical practice:*

* Construct an ovulation induction protocol for ovulatory dysfunction without MAR. (50 cases)
* Construct an ovulation stimulation protocol tailored to the individualized care leading to a MAR procedure, i.e., oocyte or embryo cryopreservation, fresh embryo transfer, planned freeze all cycle, etc. (50 cases)
* Monitor response to ovarian stimulation by ultrasound. (100 cases)
* Identify patient at risk of ovarian hyperstimulation syndrome before and/or during ovarian stimulation.
* Know/apply methods to decrease the risk of ovarian hyperstimulation syndrome.
* Perform oocyte retrieval through transvaginal route for the patient. (75 cases)
* Perform transcervical embryo transfer procedure under ultrasound guidance. (75 cases)
* Endometrial preparation protocols for frozen thawed embryo transfer or embryos produced in non-stimulated cycles, fresh embryo transfer with donor oocytes/ with priorly frozen thawed own oocytes. (25 cases)
* Identify luteal support requirements and apply protocols based on ovarian stimulation and endometrial preparation protocol in fresh and frozen embryo transfer cycles, respectively. (25 cases)
* Know, identify, and manage complications of ovarian stimulation, ovarian hyperstimulation syndrome, bleeding, infection, ovarian torsion. (50 cases)
* Counsel patients regarding risks of multiple pregnancy and multiple embryo transfers. (50 cases)
* Refer patients for psychological assessment/support where indicated. (50 cases)

**Competence in transvaginal ultrasound**

* Follicular tracking. (250 cases)
* Normal and abnormal pelvis. (250 cases)
* Antral follicle count. (250 cases)
* Follicular tracking IVF. (250 cases)
* Endometrial development. (250 cases)
* Uterine fibroids. (250 cases)
* Uterine cavity abnormalities. (250 cases)
* Congenital uterine anomaly. (250 cases)
* Ovarian pathology. (250 cases)
* Adnexal pathology. (250 cases)

**3. Laboratory (Embryology and Genetics)**

*The Trainee should understand and be able to discuss the genetic testing and the appropriate referral for reproductive disorders:*

* Normal genetics (e.g. genotype and phenotype, basic Mendelian inheritance patterns, the structure and identification of chromosomes).
* Abnormal genetics including chromosomal abnormalities (numerical, structural), monogenic diseases, mutations, copy number variations, genetically transmitted abnormalities of sexual development (e.g, hermaphroditism, Turner’s syndrome.
* Inherited, non-reproductive disorders with implications for reproduction (e.g., congenital adrenal hyperplasia, diabetes mellitus).
* Genetic analyses including pedigree, karyotype analysis, antenatal diagnosis of genetic disease, use of gene probes, fluorescent in-situ hybridization, array comparative genomic hybridisation, next generation sequencing and associated techniques; indications and arrangements for specialized genetic diagnosis and counselling.
* Inherited causes of infertility and early pregnancy loss.
* Genetic aspects of artificial insemination and assisted fertilization.

*A Trainee should be able to apply correct criteria for:*

* Different sperm collection methods (ejaculation, split ejaculation, retrograde ejaculation, PESA, TESA, TESE).
* Oocyte collection methods (oocyte pick-up, ovarian tissue biopsy).
* Various fertilization procedures (IUI, IVF or ICSI).
* Donor oocytes and sperm in relation to serological tests (different handling and storage).
* Laboratory treatment options in cases of total fertilization failure after IVF and ICSI or embryo developmental arrest.
* Preimplantation genetic testing of embryos for aneuploidies (PGT-A), chromosomal structural rearrangements (PGT-SR) and monogenic diseases (PGT-M).
* Recommendations upon transferring embryos after PGT.
* Application of novel non-evidence based laboratory methods by considering all safety and quality standards and by using Euro GTP II, practical tools for the assessment and verification of the quality, safety and efficacy of novel therapies with human tissues and cells.
* In vitro gamete transport.

**4. Andrology**

**The interpretation of sperm analysis. (100 cases)**

*The Trainee should be able to consult infertile male cases:*

* To take an appropriate history and examine the man, if appropriate. (30 cases)
* To perform classification of andrological disorders: pretesticular, testicular and post testicular origin and arrange/perform appropriate investigations. (30 cases)
* To select appropriate methods of male investigation and treatment. (30 cases)
* To organise appropriate sperm retrieval techniques where indicated. (20 cases)
* To perform counselling of genetic disorders related to male infertility.

**5. Reproductive Surgery**

* **Diagnostic hysteroscopy. 25 cases**
* **Operative hysteroscopy: 25 cases for each section**
  + Hysteroscopic surgery – resection of fibroid.
  + Hysteroscopic surgery – resection of polyp.
  + Hysteroscopic surgery – division of septum. ­­
  + Hysteroscopic surgery – division of adhesions.
* **Diagnostic laparoscopy: 25 cases for each section**
  + Dye test for tubal patency.
  + Proficiency in: Veress, needle entry, Hasson & Palmer’s point entry techniques.
  + Safe tissue handling with laparoscopic instruments, sharp and blunt dissection.
* **Operative laparoscopy: 15 cases for each section**
  + Laparoscopic destruction of superficial endometriosis.
  + Laparoscopic excision of deep endometriosis.
  + Laparoscopic excision/ablation of ovarian endometriomas.
  + Laparoscopic surgery – treatment of ovarian dermoid.
  + Laparoscopic surgery – division of adhesions.
  + Laparoscopic surgery – salpingectomy for hydrosalpinx.
  + Laparoscopic surgery – myomectomy.
  + Excision of ovarian cystectomy.
  + Laparoscopic salpingostomy for distal tubal blockages (cuff salpingostomy).
  + Laparoscopic ovarian diathermy for anovulatory polycystic ovary syndrome.
  + Surgical treatment of benign ovarian and tubal disease with laparotomy.
  + Surgical Management of uterine abnormalities.
  + Myomectomy via laparotomy.
  + Male surgery – percutaneous epididymal sperm aspiration.
  + Male surgery – testicular sperm aspiration.
  + Male surgery – open testicular biopsy.
  + Male Surgery – Microscopic epididymal sperm aspiration.
  + Male surgery – Micro – TESE.

**6. Early Pregnancy and Implantation**

*The Trainee should be able to discuss:*

* Endocrinology of pregnancy especially Human Chorionic Gonadotrphin (HCG) levels and fluctuations in relation to the spectrum of early pregnancy outcomes.
* The feto-placental unit as relates to the physiology and pathophysiology of steroid hormones (e.g., oestrogen, progestogen, corticosteroids).
* The physiology of decidua-chorionic-placental peptide hormones (e.g. gonadotrophins, thyrotrophin, ACTH/opioid peptides and prolactin).
* The physiology and pathophysiology of fetal hypothalamic-pituitary-gonadal function.
* The pathophysiology of altered maternal thyroid, adrenal and pancreatic status during early pregnancy.
* Endocrine and cell signaling mechanisms contributing to implantation.
* Immunological adaptation to implantation (immunotolerance) and early pregnancy.

*The Trainee should:*

* Be competent at early pregnancy ultrasound evaluation including those with maternal uterine anomalies. (50 cases)
* Manage and evaluate pregnancy of unknown location (PUL). (10 cases)
* Make medical, surgical and conservative management of miscarriage. 10 cases
* Diagnose and manage ectopic pregnancy. (10 cases)
* Evaluate and refer to a specialist for gestational trophoblastic disease (GTD). (10 cases)
* Manage recurrent pregnancy loss. (10 cases)
* Manage repeated implantation failure. (10 cases)
* Make Early pregnancy assessment.

**7. Fertility Preservation**

**Male Fertility**

**Cancer treatment:**

* The effects of cancer treatment on spermatogenesis.
* Correct assessment of male fertility (semen analysis and endocrine profile).
* Sperm banking.
* Relevant local consent procedures pertaining to sperm storage and usage long term (late effects) of cancer treatment on male gonadal function.
* The later use of cryopreserved sperm.

**Benign conditions:**

* Genetic conditions: Klinefelter syndrome. (15 cases)
* Chronic inflammatory diseases, haematological, neurological diseases requiring treatments that may affect fertility. (15 cases)

**Female Fertility**

**Cancer treatment:**

* + The effects of cancer treatment on the ovarian reserve. (20 cases)
  + Assessment of ovarian reserve. (20 cases)
  + Oocyte vs. embryo cryopreservation. (20 cases)
  + Ovarian tissue banking. (20 cases)
  + Current place of uterine transplantation. (20 cases)
  + Methods to protect the ovary from the effects of chemo and radiotherapy. (20 cases)
  + Relevant local consent procedures pertaining to oocyte and embryo cryopreservation and usage. (20 cases)
  + Discuss the later use of cryopreserved oocytes and embryos long term (late effects) of cancer treatment on female gonadal function. (20 cases)

**Benign conditions:**

* + Turner syndrome. (10 cases)
  + Endometriosis. (10 cases)
  + Chronic inflammatory diseases, hematological, neurological diseases requiring treatments that may affect fertility. (10 cases)
  + Cancer risk reduction surgery for BRCA mutation carriers. (10 cases)
  + Transgender patients. (10 cases)

**Assisted Reproductive Techniques for Fertility Preservation:**

* + Discuss controlled ovarian stimulation regimens for fertility preservation. (10 cases)
  + Counsel patients regarding the process of controlled ovarian stimulation. (10 cases)
  + Organise in a timely manner a cycle of controlled ovarian stimulation including the use of random cycle start. (10 cases)
  + Discuss the use of adjuvant drugs during the stimulation cycle (e.g. Letrozole, GnRH analogues and Tamoxifen. (10 cases)
  + Psychological Aspects of Fertility Preservation treatment. (10 cases)

#### Competences

Competence is assessed according to the following grading - Level of Competence:

*1. Passive attendance, assistance*

*2. Needs close supervision*

*3. Able to carry out procedure under some supervision*

*4. Able to carry out procedure without supervision*

*5. Able to supervise and teach the procedure.*

The numbers indicated represent recommended targets to ensure sufficient exposure; flexibility is allowed depending on the case-mix and structure of training centres.

At end of training all Trainees must demonstrate the ability to achieve **Level 4 competency** (independent practice) in all key areas of Reproductive Medicine and Level 5 (teaching/supervising) in core competencies (see Logbook):

1. Diagnostic and therapeutic management of reproductive endocrinology disorders.
2. Independent practice of MAR procedures, including oocyte retrieval and embryo transfer.
3. Surgical procedures: hysteroscopy, laparoscopy, and fertility-preserving surgeries.
4. Laboratory competencies: understanding PGT, cryopreservation, and MAR laboratory techniques, safety and quality control.
5. Psychosocial and ethical counselling in reproductive health, infertility, and fertility preservation.
6. Apart from clinical skills and competencies, the subspecialty training involves*:*
7. *Administration*.The fellow should be given some administrative experience and responsibility, which will allow him/her to acquire skills relevant to the future provision and organisation of clinical services in this area including follow up of patients who have had fertility preservation.
8. *Research***.** The research component of the subspecialty training aims to verify that fellows are able to conduct a research study, in the field of Reproductive Medicine, that will be scientifically of good quality and according to the internationally recognized standards (i.e. standards published in the Medical Research Council’s Good research practice: principles and guidelines <http://www.mrc.ac.uk/research/research-policy-ethics/good-research-practice/>). Research skills involve the search for information that can be used effectively in order to investigate and discover new insights in the mechanisms of pathological conditions and possible markers for diagnosis or drugs to be used in therapies.
9. *Epidemiology, Data collection and Audit.*The Fellow should be able to: a) understand epidemiological techniques and inferential statistics, b) understand population parameters and sampling techniques, c) validate the data and evaluate the quality control, d) understand disease surveillance systems and disease registries, design, scoping, construction, and implementation of clinical guidelines and e) use of robust evidence assessment such as GRADE analysis. The Fellow should be familiar with a) Data acquisition, storage, interpretation, and statistical analysis and b) Conducting clinical audit and feedback and be able to utilise data collection systems.
10. *Teaching*The Fellow should gain experience in teaching which will include a) some responsibility for teaching junior staff in their subspecialty area, b) full participation in the unit's postgraduate programme with some administrative responsibility for the organisation of teaching in the subspecialty and c) Participation in the undergraduate teaching programme (where possible).
11. *Ethical and Legal Aspects.*The Fellow should be able to discuss the ethical and legal aspects of the clinical practice of the subspecialty and should have knowledge of the relevant areas (Legislation, particularly recent, relevant to the subspecialty practice - Ethics of health care provision and resource allocation - Medical confidentiality - Informed consent - Medical negligence - Handling of complaints and relevant procedures - Role and relevance of ethics committees.

#### ENTRUSTABLE PROFESSIONAL ACTIVITIES (EPAs)

**Entrustment level at completion:** Trainees must demonstrate the ability to achieve **Level 4 competency** (independent practice) in all key areas of Reproductive Medicine and Level 5 (teaching/supervising) in core competencies:

**1. Comprehensive Infertility and Reproductive Endocrinology Work-up**

Take full couple and individual history (female and male), perform targeted physical exams, order and interpret endocrine, ovarian reserve, genetic, imaging, and semen analyses; synthesise findings into a diagnosis and present an evidence-based management plan.

**Evidence:** 3 Mini-CEX, case-based discussion, logbook ≥ 30 workups, ≥ 10 male-factor cases.

**2. Contraception, Menopause, and Non-MAR Counselling**

Provide personalised counselling on all hormonal/non-hormonal contraceptive methods, menopausal transition management (HRT and non-hormonal), and full spectrum of fertility options beyond ART/MAR (expectant management, timed intercourse, medical/surgical approaches, adoption, child-free living).

**Evidence:** observed consultations ≥ 5 contraception, ≥ 5 menopause, ≥ 5 non-MAR; patient feedback.

**3. Design and Supervise Controlled Ovarian Stimulation / Ovulation-Induction Cycles**

Select protocol, prescribe and adjust drugs, monitor with ultrasound/biochemistry, mitigate OHSS, and document outcomes.

**Evidence:** DOPS of 3 cycles, logbook ≥ 50 stimulations & ≥ 50 inductions, OHSS-prevention audit.

**4. Plan and Implement Endometrial Preparation Protocols**

Select and manage protocols for:

* Frozen-thawed ET
* Non-stimulated cycle embryos
* Donor oocyte cycles
* Autologous cryopreserved oocytes

Identify contraindications for fresh and frozen ET and act accordingly.  
**Evidence:** logbook ≥ 20 cycles, 2 case-based discussions.

**5. Perform Transvaginal Ultrasound-Guided Oocyte Retrieval**

Obtain informed consent, prepare theatre, execute retrieval a traumatically, recognise and manage complications (including OPU-specific injuries), complete operative note.

**Evidence:** direct observation ≥ 10, complication log.

**6. Perform Atraumatic Ultrasound-Guided Embryo Transfer**

Verify identity, position catheter, ensure optimal placement, counsel on post-transfer care.

**Evidence:** direct observation ≥ 10, patient MSF, placement audit.

**7. Manage MAR Laboratory Interface**

Collaborate with embryology to ensure optimal gamete handling, culture, embryo scoring, cryobiology, and PGT processes in compliance with Euro-GTP II.

**Evidence:** 2 observed lab debriefings, 3 PGT reflective cases, embryology MSF.

**8. Interpret PGT Results and Counsel on MAR Pregnancy Outcomes**

Interpret PGT reports, explain clinical implications, discuss MAR pregnancy risks and perinatal/long-term outcomes.

**Evidence:** 3 observed consultations, 2 reflective write-ups, patient feedback.

**9. Diagnose and Manage Repeated Implantation Failure (RIF) and Recurrent Pregnancy Loss (RPL)**

Conduct complete endocrine, anatomical, genetic, and immunological investigations; apply evidence-based management.

**Evidence:** case-based discussions ≥ 3 RPL and ≥ 3 RIF, logbook ≥ 10 combined cases.

**10. Integrate Immunology of Reproduction into Care**

Recognise immune-mediated reproductive failure, select and interpret relevant tests, counsel on benefits/risks of immunomodulatory therapies.

**Evidence:** 2 case-based discussions, literature review presentation.

**11. Evaluate and Manage Male Infertility**

Take focused history, interpret semen and hormonal profiles, counsel on surgical and medical options, coordinate sperm retrieval.

**Evidence**: logbook ≥ 20 male-factor cases, urology MSF.

**12. Perform Diagnostic and Operative Hysteroscopy / Laparoscopy**

Indicate, consent, perform and document fertility-enhancing hysteroscopic (polyp, fibroid, septum, adhesions) and laparoscopic procedures (endometriosis, cystectomy, tuboplasty).

**Evidence**: DOPS ≥ 5 each, complication review.

**13. Manage Early Pregnancy Complications in Fertility Patients**

Perform and interpret early pregnancy ultrasound, correlate with hCG dynamics, manage PUL, miscarriage, ectopic pregnancy, gestational trophoblastic disease.  
**Evidence**: 3 Mini-CEX for PUL/miscarriage, logbook ≥ 20 cases, M&M review.

**14. Deliver Fertility Preservation Across Contexts**

Provide urgent counselling, coordinate stimulation/tissue banking for oncology, benign disease, chronic illness, and transgender patients; ensure legal compliance.

**Evidence**: observed counselling ≥ 2 oncology patients, logbook ≥ 10 preservation cycles.

**15. Address Obesity in MAR and Pregnancy**

Assess BMI, counsel on lifestyle modification, pharmacotherapy, and bariatric surgery implications for fertility and pregnancy.

**Evidence**: observed counselling ≥ 5, reflective entry on 3 obesity-MAR cases.

**16. Lead Multidisciplinary MAR Team and Ensure Quality & Safety**

Organise ART list, allocate resources, supervise juniors, oversee safety checks, lead root-cause analyses, and implement QI projects.

**Evidence**: MSF, observation, QI project presentation.

**17. Navigate MAR Legal, Ethical, and Cultural Frameworks**

Apply national/EU laws on MAR, gamete donation, surrogacy, embryo disposition; manage culturally sensitive cases ethically.

**Evidence**: 2 observed complex cases, ethics case presentation.

**18. Maintain Scholarship, CPD, and Teaching**

Critically appraise literature, integrate evidence into protocols, teach juniors in theory and hands-on skills, engage in CPD.

**Evidence**: teaching evaluations, journal club presentations, CPD log.

###### Curriculum-to-EPA Mapping Table

|  |  |
| --- | --- |
| Curriculum Competency | Mapped EPA(s) |
| Endocrine physiology across reproductive lifespan | EPA 1 |
| Hormonal contraceptive methods & menopause management | EPA 2 |
| Clinical pharmacology of hormonal drugs | EPA 2, EPA 3 |
| Endocrine disorders affecting reproduction  (PCOS, POI, hyperprolactinemia) | EPA 1, EPA 3 |
| Ovulation induction, ovarian stimulation protocols | EPA 3 |
| Contraindications for fresh & frozen embryo transfer | EPA 4 |
| Embryology principles, embryo scoring, cryobiology | EPA 7 |
| PGT principles, interpretation, outcomes of MAR pregnancies | EPA 8 |
| Impact of obesity management on MAR & pregnancy outcomes | EPA 15 |
| Physiology of spermatogenesis, male-factor infertility | EPA 1, EPA 11 |
| Sperm retrieval methods & genetic evaluation | EPA 11 |
| Hysteroscopy/laparoscopy for fertility | EPA 12 |
| Repeated implantation failure (RIF) | EPA 9 |
| Recurrent pregnancy loss (RPL) | EPA 9 |
| Immunology of reproduction | EPA 10 |
| Fertility preservation modalities  (Oocyte / Sperm, Embryo, Ovarian / Testicular tissue) | EPA 14 |
| Early pregnancy complications & hCG dynamics | EPA 13 |
| OPU complications prevention & management | EPA 5 |
| Comprehensive counselling  (Fertility, MAR, Contraception, Menopause) | EPA 2 |
| Counselling on non-MAR treatment options | EPA 2 |
| Endometrial preparation protocols  (FET, Donor cycles, Autologous oocytes) | EPA 4 |
| Ovarian reserve testing & interpretation | EPA 1 |
| Communication of difficult news | EPA 2, EPA 8 |
| Multidisciplinary team roles & collaboration | EPA 16 |
| Clinic governance, resource stewardship | EPA 16 |
| National/EU MAR legislation | EPA 17 |
| Social determinants of reproductive health | EPA 15, EPA 17 |
| Public health messaging for fertility, obesity, STI prevention | EPA 15 |
| Critical appraisal of MAR literature | EPA 18 |
| Teaching juniors & CPD | EPA 18 |
| Ethical frameworks  (Embryo disposition, Donor anonymity) | EPA 17 |
| GDPR compliance, confidentiality | EPA 17 |
| Surgical asepsis & procedural professionalism | EPA 5, EPA 6, EPA 12 |
| Root-cause analysis & QI projects | EPA 16 |
| Patient equity & cultural competence | EPA 2, EPA 15, EPA 17 |

# III. ORGANISATION OF TRAINING

## Schedule of Training

* The duration of training is a **minimum of 2 years** in an approved program.
* Training is structured into clinical and research components with clear milestones and periodic assessments.

## Curriculum of Training

* Training is divided into seven modules:
  + 1. Reproductive Endocrinology
    2. Medical Assisted Reproduction (MAR)
    3. Laboratory (Embryology and Genetics)
    4. Andrology
    5. Reproductive Surgery
    6. Early Pregnancy and Implantation
    7. Fertility Preservation
  + A structured educational plan is developed between the tutor and the trainee at the start of the program.
  + The trainee must be actively involved in research and conduct a research study, in the field of Reproductive Medicine, that will be scientifically of good quality and according to the internationally recognized standards (i.e. standards published in the Medical Research Council’s Good research practice: principles and guidelines <http://www.mrc.ac.uk/research/research-policy-ethics/good-research-practice/>
  + The trainee must develop essential non-technical skills: administration, teaching, adherence to ethics and knowledge of relevant legislation.
  + A logbook must be maintained and validated by the supervising tutor every 6 months.

## Assessment and Evaluation

### Formative Assessment:

Formative and summative assessments will be explicitly linked to the intended learning outcomes (ILOs) and levels of competence defined in this curriculum, ensuring coherence between training objectives and evaluation.” In training mini-CEXs and DOPS as well as reflective writing should be employed.

a. Regular reviews of progress with the tutor considering:

1. Completion of the Log book of clinical experience in Reproductive Medicine. (evaluation each 6 months)
2. Participation in reproductive medicine courses particularly those organised by EBCOG and ESHRE.
3. Peer review publications in Pubmed indexed journals.

Each trainee will be assessed every 6 months and on a yearly basis according to the following table:

|  |  |  |  |
| --- | --- | --- | --- |
| Scoring system: A = Excellent, B = Sufficient, C = Weak, D = Unacceptable, E = Not applicable | | | |
| **Year** | **1** | **2** | **3** |
| INTEGRATED KNOWLEDGE |  |  |  |
| REACHING OF APPROPRIATE DECISIONS; COLLECTION AND INTERPRETATION OF DATA |  |  |  |
| MOTIVATION, SENSE OF DUTY, DISCIPLINE, PUNCTUALITY |  |  |  |
| TECHNICAL SKILLS |  |  |  |
| ORGANISATORY SKILLS |  |  |  |
| ADMINISTRATIVE TASKS (MEDICAL FILES, CORRESPONDENCE, ETC.) |  |  |  |
| ETHICS |  |  |  |
| RELATIONS WITH PATIENTS |  |  |  |
| RELATIONS WITH MEDICAL AND OTHER STAFF |  |  |  |
| ATTENDANCE AND ACTIVE PARTICIPATION IN STAFF MEETINGS |  |  |  |
| SCIENTIFIC INTEREST |  |  |  |
| SCIENTIFIC ACTIVITY |  |  |  |

* Periodic feedback meetings to monitor performance and identify learning needs.

### Summative Assessment

* Completion of minimum clinical and procedural requirements.
  + Research contribution: one publication in a peer-reviewed journal or two conference presentations.
  + Final evaluation by a national or federal committee.

## Governance

* The training programme must be delivered in an **ESHRE-accredited centre** under the supervision of a certified programme director.
* The programme director is responsible for ensuring:
* Alignment with ESHRE/EBCOG guidelines.
* Adequate clinical exposure to content of each module in sufficient way, research opportunities, and access to multidisciplinary teams.
* Regular monitoring and reporting to the Assessment Committee.
* One to one mentorship in each area
* Protected time for research and consultation
* Fulfilled legal requirement related to work and worker rights

# V. TRAINING REQUIREMENTS FOR TRAINERS

## Process for Recognition as Trainer

### Requested Qualification and Experience

* + Trainers must be certified specialists in Obstetrics and Gynaecology with recognised expertise in Reproductive Medicine.
  + Must have completed formal training in Reproductive Medicine and hold accreditation from relevant professional bodies (e.g., ESHRE/EBCOG).
  + A minimum of **5 years of experience** in clinical practice, research, and teaching within Re- productive Medicine.

### Core Competencies for Trainers

* + Proficiency in all clinical, surgical, and laboratory competencies defined in the training programme.
  + Demonstrated experience in supervising and assessing trainees.
  + Ability to deliver structured teaching, feedback, and mentorship.
  + Active participation in clinical research, audits, and scientific publications.
  + Understanding of ethical and legal aspects of Reproductive Medicine practice.

## Quality Management for Trainers

* + Trainers must participate in ongoing professional development programmes to maintain their clinical and educational skills.
  + Trainers are also encouraged to participate in ongoing programmes in the aim to improve their teaching skills.
  + Regular evaluation of trainers through trainee feedback, clinical outcomes, and research contributions.
  + Trainers must demonstrate adherence to ESHRE/EBCOG guidelines and participate in external audits where applicable.

# V. TRAINING REQUIREMENTS FOR TRAINING INSTITUTIONS

## Process for Recognition as Training Centre

### Requirements on Staff and Clinical Activities

* + Be ESHRE-accredited and recognised by national regulatory authorities.
  + Provide multidisciplinary services, including Reproductive Endocrinology, MAR, Andrology, Re- productive Surgery, and Fertility Preservation.
  + Manage a minimum of **1,000 outpatients per year** and **200 MAR cycles per trainee per year**.
  + Perform a minimum of **100 reproductive surgical procedures annually**.
  + Have a sufficient number of qualified trainers to ensure a **1:1 trainee-to-trainer ratio**.
  + Demonstrate active participation in research, clinical audits, and scientific publications.
  + In case of missing parts of curriculum, have provided training in another institution supported by signed

MOU about teaching and practicing collaboration, with tutorial system.

### Requirements on Equipment and Accommodation

* Fully equipped MAR laboratories adhering to EU quality standards.
* Access to advanced imaging, diagnostic, and surgical facilities.
* Adequate library resources, research infrastructure, and IT support for trainees.
* Facilities for patient counselling and multidisciplinary team meetings.

## Quality Management Within Training Institutions

* Implement a robust quality management system, including accreditation processes and regular external audits.
* Clinical governance structures to ensure patient safety and care quality.
* Transparent training programs with clearly defined curricula and assessment frameworks.
* Annual reporting on training outcomes, trainee progress, and institutional performance.

Institutions must ensure:

* Structured feedback mechanisms for trainees.
* Regular updates to the curriculum in line with scientific advancements and guidelines.
* Compliance with national and European regulations for specialist training in Reproductive Medicine.

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3. **Frank JR, Snell L, Sherbino J, editors.** CanMEDS 2015 Physician Competency Framework. Ottawa: Royal College of Physicians and Surgeons of Canada; 2015.
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5. **The ESHRE Guideline Group on fertility preservation,** Anderson RA, Amant F, Braat D, et al. ESHRE guideline: female fertility preservation. *Hum Reprod Open.* 2020;2020(4):hoaa052.
6. **UEMS Council.** Charter on Training of Medical Specialists (UEMS 93/40). Brussels: European Union of Medical Specialists; 1993.
7. **UEMS Council.** Template Structure for European Training Requirements. Brussels: European Union of Medical Specialists; 2012.

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# VI. GLOSSARY

**AFC** – Antral Follicle Count (USG marker of ovarian reserve).

**AEMH** – European Association of Senior Hospital Doctors (UEMS stakeholder).

**AMH** – Anti-Müllerian Hormone (biochemical ovarian reserve marker).

**ART** – Assisted Reproductive Technology (umbrella term incl. IVF/ICSI).

**AUC** – Area Under the Curve (used in assay/time-series analyses).

**CESMA** – Council of European Specialist Medical Assessments (UEMS).

**CPD** – Continuing Professional Development (lifelong learning).

**CPME** – Standing Committee of European Doctors (UEMS stakeholder).

**CTF** – Common Training Framework (EU mechanism for automatic recognition).

**DOPS** – Direct Observation of Procedural Skills (workplace assessment).

**EBCOG** – European Board & College of Obstetrics and Gynaecology.

**EJD** – European Junior Doctors (UEMS stakeholder).

**EPA** – Entrustable Professional Activity (unit of assessable clinical work).

**ESHRE** – European Society of Human Reproduction and Embryology (accreditation/governance partner).

**ET** – Embryo Transfer (fresh/frozen).

**EU-GDPR** – General Data Protection Regulation (EU 2016/679).

**Euro-GTP II** – European Good Tissue Practices II (quality/safety standards in tissues/cells).

**FET** – Frozen Embryo Transfer.

**FEMS** – Federation of European Salaried Doctors (UEMS stakeholder).

**FSH** – Follicle-Stimulating Hormone.

**HCG/hCG** – Human Chorionic Gonadotropin (early pregnancy dynamics).

**HRT** – Hormone Replacement Therapy (menopause).

**HyCoSy** – Hystero-contrast-sonography (tubal patency).

**ICSI** – Intracytoplasmic Sperm Injection.

**IVF** – In Vitro Fertilization.

**MAR** – Medically Assisted Reproduction (EU term used throughout).

**Mini-CEX** – Mini Clinical Evaluation Exercise (observed encounter).

**MSF** – Multi-Source Feedback (360° assessment).

**OHSS** – Ovarian Hyperstimulation Syndrome (risk/mitigation in COS).

**OPU** – Oocyte Pick-Up (transvaginal retrieval).

**PACT** – Pan-European Curriculum for Obstetrics & Gynaecology Training (EBCOG).

**PGT** – Preimplantation Genetic Testing; **PGT-A/M/SR** – for aneuploidy/monogenic/structural rearrangements.

**POI** – Premature Ovarian Insufficiency.

**PCOS** – Polycystic Ovary Syndrome.

**PUL** – Pregnancy of Unknown Location.

**QI** – Quality Improvement (audits, RCA, safety cycles).

**RCA** – Root-Cause Analysis (incident learning).

**RIF** – Repeated Implantation Failure.

**RPL** – Recurrent Pregnancy Loss.

**TESE / TESA / PESA / micro-TESE** – Sperm retrieval procedures (surgical/needle).

**UEMO / CPME / FEMS / AEMH** – European professional bodies collaborating with UEMS.

**UEMS** – European Union of Medical Specialists; sets the ETR framework.

Appendix: Training Objectives Pertaining to the Care of Adolescents and Young Adults: Fellows must be able to assess pubertal disorders, menstrual disturbances, congenital anomalies, disorders of sexual development, and reproductive health issues in adolescents and young adults. They must demonstrate competence in communication, confidentiality, involvement of carers when appropriate, safeguarding, and multidisciplinary referral.