UNION EUROPÉENNE DES MÉDECINS SPÉCIALISTES
EUROPEAN UNION OF MEDICAL SPECIALISTS

Association internationale sans but lucratif
International non profit organisation

RUE DE L'INDUSTRIE, 24 T
BE- 1040 BRUSSELS
www.uems.eu

+32 2 649 51 64
+32 2 640 37 30
info@uems.eu

Requirements for the Competences of Upper GI surgery

European Standards of Postgraduate Medical Specialist Training

Based on the UEMS- Template-structure-for-European-Training-Requirements

Authors: Prof. Toni Lerut, Prof. Lars Bo Svendsen, Prof. Philippe Nafteux

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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 to provide recommendations at the European level for high-quality training. This Charter sets the basis for the European approach in the field of harmonization of Postgraduate Specialist Medical Training, most importantly with the ongoing dissemination of its periodically updated Chapter 6s, 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 specialty fields, and particular competencies are covered and 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 the quality of training of medical professionals. The UEMS's conviction is that the quality of medical care and expertise is 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 of 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 to basically comply with international treaties and UN declarations on Human Rights, as well as the WMA International Code of Medical Ethics.

UEMS and European legislation facilitate 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 provided the base for the framework that informed the drawing up of the Doctors' Directives in 1975, which made up 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 standard 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 recognized by Member States. Professional organizations which are representative at Union level and, under certain circumstances, national professional organizations 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 harmonization 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 harmonization of the ETR by adopting more specific guidelines, the CanMEDS competency framework is recommended, which defines the entire set of roles of the professionals that 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 the trainee and the 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, emphasizing 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 for ETRs. In order to recognize common and harmonized standards on the quality assurance in specialist training and specialist practice at a European level, some UEMS Specialist Sections and Boards have, for a long time, organized 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, others focus on areas within or across specialties, and define the content of the training requirements for specific areas of expertise. Recognizing the potential overlap allows those writing ETRs to draft overlapping or common goals for learning outcomes. Similar measurements do 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 implementing good standards in postgraduate training. We respect and support the vital role of the NMCAs in setting high standards of training and care in their respective Countries 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 trainees in EU/EEA countries should achieve, as well as the competencies and organization of the training centers. The training environment and results described in UEMS ETRs may be achieved in adapted ways, depending on local traditions, healthcare system, and medical specialist training. 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 organizations across Europe. In the process of ETRs development, the UEMS recognizes 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, which is essential to ensuring consumer confidence and protection all over Europe.

Conclusions. UEMS is very proud of all the hard work that has been done until now in developing the UEMS ETRs, and the fact that they are increasingly implemented as national curricula. However, we also recognize the need for constant improvement and are always open to further suggestions. The UEMS insists that the medical profession remains the driver in defining its specialist training and continuous professional development needs. On this basis, we sincerely look forward to working with the key European Union responsible bodies and 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, and action plans for postgraduate medical education and training.

The UEMS Multidisciplinary Joint Committee of Upper GI Surgery

The Multidisciplinary Joint committee (MJC) had its first origin in a working group of "Upper Gastrointestinal Surgery – Esophagus, Cardia & Stomach Surgery" within the UEMS Section of Surgery as of 2012. The name was changed to OG (Esophagogastric) surgery in 2016 and again to Upper Gastrointestinal (Upper GI) Surgery in 2018, to reflect the work being done in collaboration with a part of the UEMS Section of Thoracic Surgery.
Indeed Upper GI surgery is overlapping both Sections to become now a joint venture between esophagogastric surgeons and thoracic surgeons.

In October 2021 the UEMS council, approved the creation of a MJC (Multidisciplinary Joint Committee) confirming the joint venture.

The Upper GI Surgical activity covers the pre-, peri- and postoperative period and follow-up of patients. The specialty also includes individual and general preventive activities, awareness of the need for rehabilitation, palliation and management of pain, especially in oncologic patients. The specialty particularly focuses on managing diseases and injuries of the esophagus, GI junction and stomach, diaphragm and conditions related to morbid obesity.

I. TRAINING REQUIREMENTS FOR TRAINEES

Through a clear definition of the contents of training, the professional skills and attitudes requested to become an Upper GI Surgeon,(UGI) the characteristics and requirements of trainers, training institutions and trainees, this document is designed to:

1) harmonize training programs in Upper GI Surgery between and within different European countries;

2) establish defined standards of knowledge, skills and attitude required to practice UGI Surgery at secondary and tertiary care level;

3) improve the level of surgical care for patients with chest and upper GI diseases, and to thereby further enhance the European contribution to clinical and academic UGI Surgery in Europe (and worldwide.)

This document is reflecting the general criteria laid down in the charter on training of medical specialists in the EU, to be read in conjunction with the existing national programs. Emphasis has been placed on topic characteristic of the discipline, entrusting to the UEMS documents the presentation of the general principles of ethics and professionalism common to the medical profession as such.

This document is intended as a work in progress, in a continuous process of updating to keep up with the continuous development of the discipline. Updating is planned to be done at least every 5 years.

1. Content of training and learning outcome

Competencies required of the trainee

Definition of competency: knowledge, skills and professionalism

A medical trainee is a doctor who has completed their general professional training as a physician and is in an accredited training program to become a recognized medical specialist. Variably known in different countries as an intern, fellow or registrar.

'Learning Outcomes' means statements of what a learner knows, understands and is able to do on completion of a learning process, which are defined in terms of knowledge, skills and competence.

DEFINITION OF THE COMPETENCE UGI (UPPER GI) SURGERY

UGI Surgery is a substantial "transferable competency" which requires the acquisition of "**Knowledges**" in basic sciences required in the development of clinical, operative and endoscopic skills as well as specialized "**Knowledges and Skills**" in managing congenital and acquired diseases and injuries of the upper part of the gastrointestinal tract, which are treated by operative and other interventions.

The "transferable competency" of UGI Surgery covers acute and nonacute diseases and injuries and acute and elective procedures in patients of all ages.

It provides for the operative and non-operative management, i.e. prevention, diagnosis, evaluation, decision making, treatment, intensive care and need for rehabilitation of patients with pathological processes that affect these organs including the management of pain.

It also involves the necessary knowledge and expertise leading to referral to specialized centers when this is indicated and possible, and where this is not possible because of time or geographical considerations, to possess the multi-specialty skills to carry out these interventions safely.

UGI Surgery (upper GI surgeons/thoracic surgeons) cooperates with other specialties, e.g, anesthesia, intensive care, gastroenterology, emergency medicine, radiology, pediatrics, internal medicine, geriatrics, rehabilitation medicine and pharmacy in the management of patients.

The UGI surgeon must have acquired and must maintain specialized "**Knowledges**" and "**Knowledges and Skills**" (precisely defined in an additional catalogue) relating to the diagnosis, preoperative, operative and postoperative management in the following areas of primary responsibility:

- Abdominal wall and abdominal organs,
- Upper alimentary tract, e.g.
- Thoracic wall and organs, including vascular, congenital and oncological disorders, particularly tumors and functional disorders of the upper GI alimentary tract.
- Minimal invasive surgery, especially laparoscopic, robot assisted -, and thoracoscopic procedures
- Diaphragmatic surgery, including diagnosis and surgery for congenital hiatal hernia and reflux disorders.
- Bariatric surgery, including diagnosis, indications and procedures.
- Surgical oncology, including coordinated multidisciplinary management of the cancer patient,
- Comprehensive management of trauma to the upper alimentary tract,
- Care of critically ill patients with underlying conditions including coordinated multidisciplinary management,
- Flexible endoscopy of upper alimentary tract, diagnostic and therapeutic, as well as advanced therapeutic procedures
- Methods for gastrointestinal function diagnosis, e.g. manometry and pH-metry
- Point of care (POC) diagnostic and interventional radiology including sonography.

The focus is on diagnosis and treatment. Diagnosis and treatment comprises all non-instrumental and instrumental techniques including flexible endoscopy, POC radiology, POC sonography, knowledge of computer tomography and magnetic resonance imaging.

The UGI Surgeon must be capable of interpreting or employing endoscopic techniques both for diagnostic and therapeutic purposes and must have the opportunity to gain knowledge and experience of evolving technological methods in relation to national practices.

The UGI Surgeon must be also capable of interpreting POC surgery-related radiological examinations involving the upper gastrointestinal tract.

The UGI Surgical activity covers the pre-, peri- and postoperative period and follow-up of patients. The specialty also includes individual and general preventive activities, awareness of rehabilitation, palliation and management of pain, especially in oncologic patients.

The specialty particularly focuses on managing diseases and injuries of the esophagus, GI junction and stomach, diaphragm and conditions related to morbid obesity.

The "**Knowledges**" and "**Knowledges and Skills**" required by UGI Surgery are closely related to other specialities and UGI surgeons (upper GI surgeons/thoracic surgeons) collaborate with all other surgical specialities and a variety of non-surgical specialties like e.g., anaesthesia, intensive care medicine, gastroenterology, emergency medicine, radiology, paediatrics, internal medicine, geriatrics, rehabilitation medicine.

Additionally, UGI surgeons are expected to have significant knowledge of anatomy, physiology and biochemistry which enable them to understand the effects of common surgical disease and injuries upon the normal structure and function of the various systems of the body.

They are expected to have knowledge of cell biology which enable them to understand normal and disordered function of tissues and organs.

They should have an understanding of the pathogenesis of the common correctable congenital abnormalities.

They are expected to know the actions and toxic effects of drugs commonly used in perioperative and intraoperative care and in the management of critically ill surgical patients.

They must also have an understanding of general pathology including the principles of immunology and microbiology in relation to surgical practice.

The Upper GI surgeon must be trained in the economics of health care, in the assessment of research methods and scientific publications and be given the option of research in a clinical and relevant field of further training in another related specialty.

Training Portfolio and Logbook

The trainee must keep a Training Portfolio, which should include an up-to-date curriculum vitae incorporating:

- details of previous training positions, dates, duration, and trainers
-list of publications with copies of published first page or abstract
-list of research presentations at local, national, and international meeting
-list of courses attended
-Logbook

The trainee will have to demonstrate that he/she has assisted a wide range of cases which should include a balance of trainer assisted and personal cases under supervision. Logbook entries must be monitored by regular inspection and signed off by the appropriate trainer. The logbook must be available when applying for the Board Examination and presented in the file uploaded through the application link on the dedicated website page.

The logbook is evaluated in two phases:

1. For eligibility for the Board Examination (operations assisted and performed, summation) and
2. Procedures and operations evaluated by appropriate trainer and signed.

a. Theoretical knowledge

Should include the main domains covered by the specialty with a short description of domains that trainee should master in the specialty

UPPER GI SURGERY – SYLLABUS

This syllabus is a congregate of the knowledge and skills of a visceral upper gastrointestinal surgeon and a thoracic surgeon, since the two working groups under each UEMS section has decided to join.

The Upper Gi Surg syllabus comprehensively describes "**Knowledges** " and "**Knowledges and Skills**" (= basis for an individual "LUGI-book") mandatory for the qualification as **F.E.B.S./F.E.B.T.S. UGI Surg**.

The syllabus is at that time is not a complete curriculum that gives a structured educational plan but provides a crude orientation and a framework around which preparation for the qualification as **F.E.B.S./F.E.B.T.S. UGI Surg** can be structured and within the syllabus some parts can be exchanged as transferable skills for each division as long as a core curriculum is maintained.

The syllabus should not be viewed as static but will be continuously revised and updated by the members of the committee. It is noted, that research and changes in medicine may lead to significant changes in theory and clinical practice and by that will influence the content of the syllabus. New topics will be introduced and obsolete topics may be deleted. The candidates are expected to update their level according to the recent surgical practice and scientific literature.

To achieve the qualification as **F.E.B.S./F.E.B.T.S. UGI Surg.** "**Knowledges**" have to be documented and provided for **Eligibility** and are assessed by **Examination**.

"**Knowledges and Skills**" have to be documented and proved in the LUGI-book for Eligibility and may be additionally assessed by examination. For pragmatical reasons the individual LUGI-books are scrutinized in the Eligibility process taking into consideration the various national requirements and local situations.

By that provisional arrangements are provided: if e.g. "flexible endoscopy" is not part of UGI Surgery in a distinct country, the candidate may omit this section in "**Knowledges and Skills**" without consequences for the Eligibility process, but approval of "Knowledge" in e.g. "flexible endoscopy" will be mandatory for the Examination. This procedure is also valid for e.g. "bariatric surgery" or "diaphragmatic surgery" and others.

The UGI surgeon is the expert from the highly specialized centres within gastric, cardia and oesophageal surgery. Thus knowledge includes benign surgical diseases, elective as acute, traumas and cancer diseases. Due to considerable diversity of the diseases encompassed within the subspeciality it is important the UGI specialist has sufficient knowledge of newest developments in the field, concerning diagnostic work-up, indications for surgery, surgical technique, including early endoscopic treatment of premalignant diseases, minimal invasive techniques and he/she must be proficient in open procedures. Some procedures require documented training in specific parts of other specialities, such as bedside sonography (POCUS).

Within the acute surgery the UGI surgeon must be capable of receiving, resuscitating, diagnose and treat the acute upper gastrointestinal diseases in an evidence based manner.

Within treatment of benign diseases (in highly specialized centres) the UGI surgeon must be able to diagnose, work up and treat benign illnesses in oesophagus, transition zone and stomach in an evidence based manner.

Within treatment of malignant diseases (in highly specialized centres the UGI surgeon must cooperate with the Multi-Disciplinary Team (MDT) to be able to diagnose, work up and treat malignant and pre malignant illnesses in the oesophagus, transition zone, and stomach in an evidence based manner.

It is expected that the UGI surgeon has a thorough knowledge concerning the different radiological diagnostic modalities and invasive radiological treatment methods, ultrasonography and endoscopic methods.

Endoscopy on an advanced level is relevant for the UGI surgical field and knowledge in diagnostics and treatment in the continuation of competences attained during the board certification must be secured.

Furthermore the UGI surgeon is supposed to have a high degree of knowledge in advanced endoscopic surgery in the upper gastrointestinal tract (oesophagus, transition zone and stomach).

The competence for these procedures (could be e.g., knowledge of ablative procedures, stent treatments, EMR etc.) should be attained by education in departments with a large volume and high expertise in the field. It should furthermore be documented that the competence is being maintained by exposure to a sufficient number of procedures per year.

Assessment of skills should be done in a summative fashion and by mentor/rater judgement as

- Knowledge of (KO)

- Direct Observation of Practical /procedural Skills (DOPS): performance in different situations, ex. Surgical team leader, MDT conference team leader and by
- Visual observation of Operative Technique (VOT).
- In the end the competence level is judged as "unsupervised, independently competent (p)" and "can be trusted to perform (EPA Entrustable Professional Activity))", particularly scrutinized by mentor, and signed off.
- In the following black text is mandatory skills for both divisions, red text is supplementary knowledge for thoracic surgeons as green is for the visceral upper GI surgeon.

Knowledges

UGI Surgery requires documented knowledge in (DOPS):

Preoperative Management (KO)

- Embryological, anatomical and physiological knowledge of thoracic and abdominal organs
- Surgical, endoscopical and radiological anatomy of chest and abdomen
- Relevant pharmacology
- Relevant symptoms and physical signs of upper GI disease
- Relevant non-invasive diagnostic tools; as ex. CTA / PET –CT, isotop scintigraphical investigations, upper GI contrast studies aso
- Relevant invasive tools and their place in staging work-up, ex. bronchoscopy, endoscopy, laparoscopy, thoracoscopy, oesophageal functional assessment, FNA, EBUS, EUS, EMR, ESD aso.
- Tests of respiratory, cardiac, renal and endocrine function. Patient information and documentation of informed consent
- Assessment of fitness for anaesthesia and surgery
- Premedication and sedation

Intraoperative Care (KO)

- Patient positioning
- Prevention of nerve and other injuries in the anaesthetised patient

Postoperative Management (DOPS)

- Pain control
- Post-operative monitoring
- Post-operative complications
- Prevention, recognition and management of complications
- Respiratory failure-recognition and treatment
- Nutritional support-indications, techniques, total parenteral nutrition

Pancreas

Conditions (KO)

- Pancreatic cysts
- Splenic vein trombosis
- Pancreatitis, acute as chronic

Procedures (VOT)

- Open and MIS pancreatectomy (distal)

Spleen

Conditions (KO)

- Postsplenectomy sepsis
- Hemolytic anemias
- Idiopathic thrombocytopenic purpura
- Secondary hypersplenism and splenomegaly
- Neoplasms of spleen
- Splenic cysts

Procedures (VOT)

- Open and MIS splenectomy
- Partial splenectomy/splenorrhaphy

Oesophagus

Conditions (KO)

- Zenker's diverticulum
- Esophageal diverticulum

- Oesophagitis
- Eosinophilic Oesophagitis
- Inlet patch
- Hiatal hernia
- Gastroesophageal reflux and Barrett's oesophagus
- Dysphagia
- Schatzki's ring
- Achalasia
- Nutcracker oesophagus
- Foreign bodies
- Mallory-Weiss syndrome
- Diffuse oesophageal spasm
- Spontaneous oesophageal perforation
- Iatrogenic oesophageal perforation
- Chemical burns
- Scleroderma connective tissue disorders
- Benign neoplasms
- Malignant neoplasms

Procedures (DOPS, VOT)

- Diagnosis of gastroesophageal reflux (e.g. pH-metry)
- Diagnosis of oesophageal and gastric motility disorders (e.g. manometry)
- Open and laparoscopic antireflux procedure
- Open and laparoscopic repair of paraoesophageal hernia
- Repair/resection of perforated oesophagus / anastomotic breakdown
- Total oesophagectomy
- Oesophagogastrectomy: Open and MIS,
- Achalasia operations
- Endoscopical procedures, see later
- Revisional procedures for complications after hiatal hernia surgery (redo)

Stomach

Conditions (KO)

- Upside down stomach
- Upper gastrointestinal bleeding

- Gastric carcinoma
- Duodenal ulcer with bleeding, perforation or obstruction
- Gastric ulcer with bleeding, perforation or obstruction
- Gastric polyps
- Gastric lymphoma
- Gastric carcinoid tumor
- Stress gastritis
- Morbid obesity
- Bezoars and foreign bodies
- Gastroparesis
- Postgastrectomy syndromes
- GIST
- MALT

Procedures (VOT)

- Percutaneous endoscopic gastrostomy
- Repair/resection of perforated stomach / anastomotic breakdown
- Jejunostomy
- Duodenostomy
- Open gastrostomy
- Partial/total gastrectomy
- Open and MIS gastric resection (No 20, EPA)
- Repair of duodenal perforation
- Haemostatic operations for bleeding ulcer
- Pyloroplasty
- Open and laparoscopic operation for morbid obesity
- Revisional procedures for postgastrectomy syndromes

Flexible Endoscopy

- Handling of endoscopes and hygienic measures (KO)

Procedures (VOT)

- Flexible diagnostic esophago-gastroduodenoscopy with
- Interventional endoscopy (e.g. stenting, polypectomy, mucosectomy (EMR ESD), RF treatment, bleeding, banding, dilatations, aso)

- Endoscopical ultrasonography with advanced procedures, including biopsies
- Therapeutic endoscopic interventions (e.g. polypectomy, dilatation) (
- Sclerotherapy and banding of esophageal varices (No 50, p)
- Treatment of gastrointestinal bleeding sites (injection, clipping. electrofulgeration)
- Endoscopic mucosectomy specified

Minimal Invasive Surgery (DOPS, VOT)

- Techniques of establishing access for MIS (e.g. laparoscopy, SILS, NOTES, robotic assisted)
- Detection and treatment of MIS complications
- Instruments and technical devices (e.g. stapling)
- Patient selection and indication for MIS (KO)
- Operative techniques in MIS

Metabolic and Bariatric Surgery (DOPS, VOT)

- Principles of metabolic and bariatric surgery (KO)
- Pathophysiogy and epidemiology of morbid obesity (KO)
- Patient selection and indication for bariatric surgery (KO)
- Surgical techniques in bariatric surgery (KO)
- Detection and treatment of complications

Thorax

The surgical anatomy and pathology of the heart, great vessels, air passages, chest wall, diaphragm and thoracic viscera and the applied cardio-respiratory physiology relevant to clinical examination, interpretation of special investigations and understanding of disorders of cardio-respiratory function caused by disease, injury and surgical intervention.

Conditions (KO)

- Pneumothorax/tension pneumothorax
- Anastomotic insufficiency
- Gastric conduit necrosis
- Cardiac tamponade
- Hemothorax
- Pleural effusion/empyema

- Mediastinitis
- Chylothorax
- Superior vena cava syndrome
- Oesophageal foreign bodies
- Oesophageal disruption
- Complications of thoracic operations
- Empyema thoracis
- Tracheo- and bronchoesophageal fistula
- Malignant disease of the lungs and bronchi

Procedures (DOPS, VOT)

- Chest tube placement
- Techniques of thoracotomy (muscle-sparing lateral and standard postero-lateral)
- Techniques for resection of oesophagus and reconstruction
- Cervicotomies
- Bronchoscopy, thoracoscopy, endoscopy transferable
- Exploratory thoracotomy
- Thoracoscopy with or without biopsy
- Transthoracic repair diaphragmatic hernia
- Drainage of empyema
- Ligation of thoracic duct
- Sternotomy
- Clam-shell incision
- Cervical oesophagostomy

Paediatric (KO)

Conditions (KO)

- Correctable life-threatening congenital abnormalities
- Hypertrophic pyloric stenosis
- Oesophageal atresia
- Tracheooesophageal fistula
- Foreign bodies of the trachea/oesophagus
- Congenital diaphragmatic hernia

Procedures (KO)

- Pyloromyotomy
- Open and laparoscopic antireflux procedure
- Repair diaphragmatic hernia

Oncology

The applied basic sciences relevant to the understanding of the clinical behaviour, diagnosis and treatment of neoplastic disease (KO)

- Clinico-pathological staging of cancer and premalignant states (DOPS)
- Principles of cancer treatment by: surgery, radiotherapy, chemotherapy, immunotherapy, hormone therapy (DOPS)
- Pain therapy management (DOPS)
- Terminal care of cancer patients and palliation (DOPS)

Radiology (DOPS,VOT)

- Diagnostic and therapeutic interventional radiological methods (KO)
- POC interventional radiological assisted implantation of prostheses and stents into organs and other structures
- X-ray guided detection of foreign bodies
- POC sonographically guided identification and treatment of pleural effusions and pneumothorax

Evaluation & Quality (DOPS)

- Decision-making in surgery
- ERAS
- MDT chair experience
- Clinical audit
- Statistics and computing in surgery
- Documentation

- Principles of research and design and analysis of clinical trials
- Critical evaluation of innovations-technical and pharmaceutical
- Health Service management and economic aspects of surgical care
- Medical/legal ethics and medico-legal aspects of surgery
- Psychological effects of surgery and bereavement
- Rehabilitation
- Screening programs
- Quality control and quality management
- CIRS (Critical Incident Reporting System), Dindo Clavien index, CCI score
- Implementation of clinical studies
- Legal aspects
- Communication with patients, relatives and colleagues

Level of knowledge (DOPS and VOT)

Assessment of skills should be done by rater judgment as Direct Observation of Practical / procedural Skills (DOPS) and by observation of Operative Technique (VOT) and on a summative score.

In the end the competence level is judged as “unsupervised, independently competent (p)” (EBSQ) and “can be trusted to perform (EPA)”, particularly scrutinized by mentor and signed off.

Oesophagus – Cardia (GE junction)

- Optimization of patients to oesophagus- GE resection including selection and diagnostic work-up of the patient (DOPS)
- Evaluation and decision making concerning surgical resectability (DOPS)
- Strategies in order to increase the resectability (KO)
- Techniques and the extent of endoscopic treatment of acute, premalignant and malignant diseases in the oesophagus
- Techniques and the extent of R0 resection of malignant tumours in oesophagus, GEJ and stomach (DOPS;VOT)
- Techniques used for bariatric surgery (by-pass, gastric sleeve) (KO)
- Techniques used in reflux surgery (KO)

- Techniques used in surgery for para oesophageal hernias (DOPS)
- Techniques used at surgery/endoscopy of achalasia (lap Heller myotomy, POEM) (DOPS)
- Treatment of complications; abscesses, bleeding, anastomosis insufficiency and infections (DOPS)
- Perioperative care (DOPS)

Stomach

- Optimization of patients for ooesophagus- cardia resection including selection and diagnostic work up of the patient (DOPS)
- Evaluation and decision making concerning surgical resectability. (DOPS)
- Strategies in order to increase the resectability. (KO)
- Techniques and the proportion of endoscopic treatment for acute, premalignant and malignant diseases in the stomach (DOPS)
- Techniques and the extent of R0 resection of malignant tumours in the stomach (DOPS;VOT)
- Techniques used for bariatric surgery (by-pass, gastric sleeve) (KO)
- Techniques used for reflux surgery (KO, DOPS)
- Techniques used for surgery for para oesophageal hernias (DOPS)
- Techniques in MIS resection of above mentioned illnesses
- Treatment of complications: abscesses, bleeding, anastomotic leakage, leakage of the duodenal stump and infections (DOPS)
- Perioperative care (DOPS)

b. **Practical and clinical skills**. Key skills to possess in the speciality. Number in headings is procedures and number in tables are points to aquire

c.

The "transferable competency" of UGI Surgery requires assessed and documented numbers for "**Knowledge and Skills**". Candidates for the qualification must demonstrate skills / documented training in each of the above areas of responsibility and be able to present a complete and signed log-book.

The candidates' individual LOG-books have to fulfill the UEMS criteria . In the LOG-book for each item patient's initials (or hospital admission number), type of procedure, date of procedure and approval with signature by independent expert must be provided.

The individual LOG-books for the categories A, B and C are scrutinized in the Eligibility process.

The minimal Eligibility requirement for a UEMS UGI Surg qualification is a proved number of 800 credit points for interventions and / or procedures, endoscopies and operations (categories A + B + C).

For each intervention (A) as principle surgeon /endoscopy (B) as principle surgeon or operation (C) performed by the candidate as assistant 1 credit point is given.

For each operation (C) performed by the candidate as principle surgeon (the principle surgeon is the person who performs the majority of the essential steps of the procedure) 2 credit points are given.

At least 50% of the total number of 800 credit points have to achieved as principle surgeon.

For the procedures labelled as EPA the procedure in the log book summation has to be signed by the mentor.

This means, that a total of 400 interventions/procedures/endoscopies/operations (categories A + B + C) are the minimum requirement, when they are all performed as principle surgeon.

	Upper GI	**Thorax**
A.Interventions, Procedures	**n=100**	**n=100**

B.Endoscopies	**n=365**	**n=365**

C.Operations (total)	**n=335**	**n=335**
Thorax	n=80	n=210
Abdomen (major resections)	n=210	n=80
Minimal invasive intraluminal advanced	n=45	n=45

For pragmatic reasons provisional arrangements are provided (see below: "Provisional arrangements") to enhance the qualification until complete European harmonization of surgical training is achieved.

These provisional arrangements allow a range of different compensations to consider various national and/or individual situations.

As to the abdominal pathology exposure the non-surgical CCST board certified trainee should be exposed to a minimum number of abdominal non esophageal procedures.

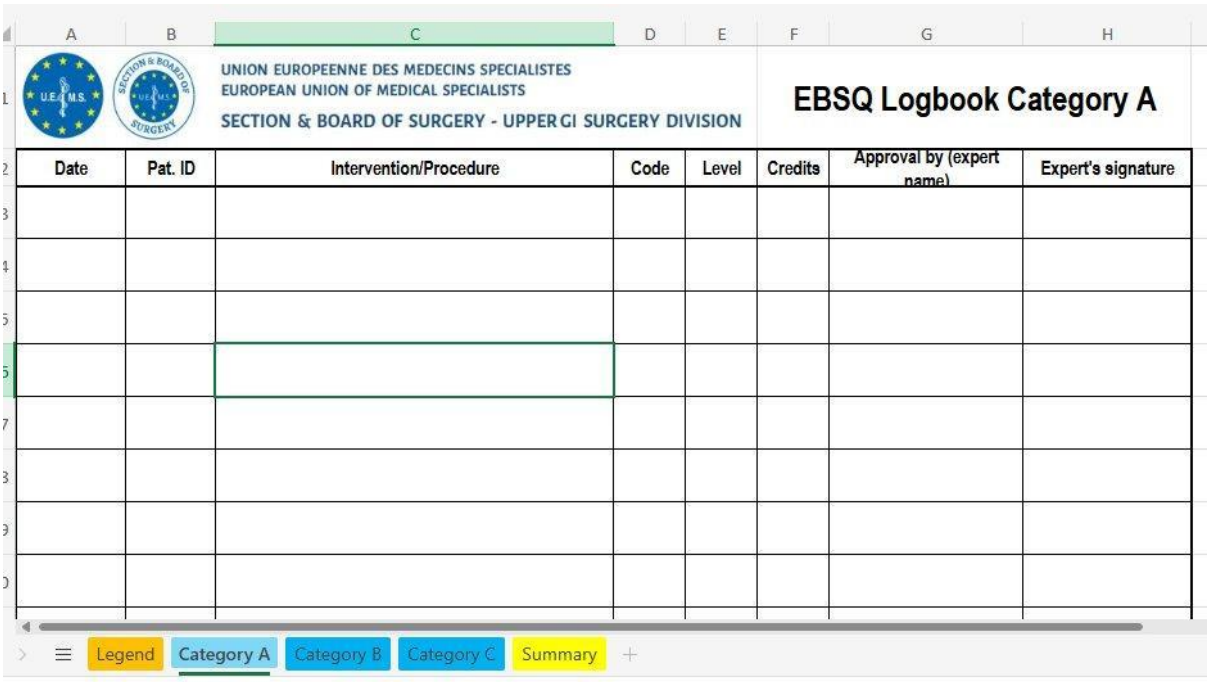
As to the thoracic pathology exposure the non EBTS board certified trainee should be exposed to a minimum number of thoracic non esophageal procedures.

Trainees should have been directly involved in the pre- and post- operative management of these patients and should have a understanding of the preoperative diagnostic investigations.

The Thoracic and Abdominal experience Record accepts the cumulative operative totals actually done by a trainee.

At the end of the training, both the trainer and the national training authority certify that the information provided by the applicant concerning his/her training experience is correct.

Logbook example



UNION EUROPEENNE DES MEDECINS SPECIALISTES
EUROPEAN UNION OF MEDICAL SPECIALISTS
SECTION & BOARD OF SURGERY - UPPER GI SURGERY DIVISION

EBSQ Logbook Category A

Date	Pat. ID	Intervention/Procedure	Code	Level	Credits	Approval by (expert name)	Expert's signature

Legend | Category A | Category B | Category C | Summary

Candidate's name: EXample

Category	Principal No	Assistant No	For eligibility Total (P=2,A=1)	For EPA EPA
Interventions, procedures				
A 1 e *FAST, pleural drainage UL* ect.				
A 2 *specialist teaching*				
A 3 *specialist courses (3 credits)*				
A4 *Chair MDT*				
P credits=1				
Total A	**0**	**0**	**0**	
Endoscopy (				
B 1 OGD endoscopy				
B 2 EUS / EBUS a=1				
B 3 b-scopy/ ERCP/medi.-scopy a=1				
B 4 endoscopy interventions				
P credits = 1				
Total B	**0**	**0**	**0**	
C 1 A thoracotomy				
C 1 B oesophageal resect, conduit				
C 1 C VATS, diaphragmatic repair				
C 1 D hiatal repair thorax				
C 1 E cervico-oesophagostomy				
C 1 F empyema treatment				
P credits=2, A credits =1				
Total C 1	0	0	0	
C 2 A gastric resections				
C 2 B gastrectomy				
C 2 C small and large bowel				
C 2 D Pancreas, liver				
C 2 E hiatal operations				
C 2 F abdominal wall				
P credits=2 A credits=1				
Total C 2	0	0	0	
C 3 A endoscopical proc.				
P credits=2 A credits =1				
Total C 3	0	0	0	
Total C	**0**	**0**	**0**	
Total A + B + C	**0**	**0**	**0**	

APPROVAL P EPA

Expert's name:

Expert's signature:

a. Competences

Description of levels of competencies
The European Specialist Curriculum must cover not only knowledge and skills, but also domains of professionalism, as detailed by the UEMS Section.

The European Board of Upper GI surgery (EB UGIS) believes that their certificates carry an obligation for ethical behavior and professionalism in all conduct. The exhibition of unethical behavior or lack of professionalism by a candidate may therefore prevent the certification of the applicant or may result in the suspension or revocation of certification. All such determinations shall be at the sole discretion of the EB UGIS. Unethical and unprofessional behavior is denoted by any dishonest behavior, including: cheating, lying, falsifying information, misrepresenting one's educational background, certification status and/or professional experience and failure to report misconduct.

The EB UGIS has adopted a "zero tolerance" policy toward these behaviors, and individuals exhibiting such behaviors may be permanently banned from certification, reported to state medical boards, and/or legally prosecuted for copyright or other violations if identified.
This also extends to sharing examination information or discussing an examination while still in progress.

With regard to Upper GI surgery, the trainee must demonstrate the ability to record and convey patient details of history, examination and investigation findings to senior staff. The trainee must clearly consent patients for operative procedures detailing the reasons for performing the procedure and the risks involved. The trainee must communicate with patients and relatives and must be able to pass on distressing information (e.g., malignancy or bereavement) in a sensitive and caring manner.

Moreover, medical professionalism includes knowledge of aspects of health care management, hospital management, and safeguarding vulnerable patients.

The EB UGIS encourages attitudes such as:

-Respect towards colleagues and junior staff

-Abiding by the values of honesty, confidentiality, and altruism

-Maintenance of competence throughout our careers

-Improving care by evaluating its processes and outcomes

-Providing care irrespective of age, gender, race, disability, religion, social or financial status

- Delivering best quality care in a compassionate, caring, and respectful environment.

2. Organisation of training

Schedule of training *Minimum duration of training Include required timing*

Training must cover the full range of the specialty and lead to the ability for independent practice on completion of training

Overall minimum length of training is a minimum of at least 2 year and training should be spent in 2 high specialized Upper GI Surgery surgical units. Training should be terminated within 5 years of start of fellowship.

Besides, exposure to thoracic surgery (for non EBTS board certified trainees) , intensive care, gastroenterology, advanced interventional endoscopy and/or - documented training in specific areas of radiology (POCUS) and Upper GI motility lab should be encouraged

a. Curriculum of training

A Training Curriculum should be designed to provide a diversified and balanced quality (theoretical and practical) of Upper GI Surgery education describing the contents and aims in each year of training. Emphasis should be placed on adequate time allocation for study and tuition independent of clinical duties. It should be encouraged in some departments to formally organize specific training periods in associated other Upper GI Surgery units.

There should be established rotation periods covering all main areas of Upper GI Surgery. These rotations should be organized in such a way as to give trainees increasing responsibility as they progress through their training with regard to patient care and surgical experience. Rotations may include other clinical disciplines and research in Upper GI Surgery depending on requirements, local availability, and the department's emphasis. Some institutions may wish to use a structured Upper GI Surgery Training Plan. The main idea of this is a continuous and systemic escalation of surgical responsibilities and competence through subsequent training year(s).

Part of the rotation period should include training on either a thoacosurgical department or a specialized abdominal department for surgeons in training from each section. Furthermore, at least one month of stay in another highly specialized department should be encouraged. If departments are further subspecialized in care of benign and malignant diseases stay in each sector is recommended.

The program of training should be planned to maintain an ongoing scholarly activity including:

- Weekly clinical discussions and rounds
- Regular program of teaching
- Regular journal clubs
- Regular clinical and experimental research conferences
- Discussions of morbidity and mortality

There must be protected time for study and tuition. Trainees should be encouraged and are expected to develop an understanding of research methodology. All trainees are expected to be able to assess published work. In academic programs, the opportunity for clinical and/or basic research should be available to the trainee with appropriate faculty supervision. There should be a protected period of time within a minimum 1-year-program where a trainee can participate in a specific research project.

It is recommended that trainees attend at least the meetings of the national Upper GI Surgical or related society (or an equivalent meeting). If possible, trainees should participate in the meetings organized by the European Society of Disease of the Esophagus (ESDE the International Society of Disease of the Esophagus (ISDE) . During their training, they should also attend scientific meetings and hands-on-courses and preparatory courses for the UEMS MJC Upper GI Surgery Board exams.

b. Assessment and evaluation

Definition of assessment, description of formative and summative assessments,

Assessment: Process by which information is obtained relative to some known objective or goal. (a broad term that includes testing)
Evaluation: Inherent in the idea of evaluation is "value." Process designed to provide information that will help us make a judgment about a given situation

UPPER GI SURGERY - KNOWLEDGE AND SKILLS ASSESSMENT

The "transferable competency" of UGI Surgery requires assessed and documented numbers for "**Knowledge and Skills**". Candidates for the qualification must demonstrate skills in each of the above areas of responsibility and be able to present a complete and signed log-book.

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The individual LOG-books for the categories A, B and C are scrutinized in the Eligibility process.

The minimal Eligibility requirement for a UEMS UGI Surg qualification is a proved number of 800 credit points for interventions and / or procedures, endoscopies, and operations (categories A + B + C).

For each intervention (A) as principal surgeon /endoscopy (B) as principal surgeon or operation (C) performed by the candidate as assistant 1 credit point is given.

For each operation (C) performed by the candidate as principal surgeon (the principle surgeon is the person who performs the majority of the essential steps of the procedure) 2 credit points are given.

At least 50% of the total number of 800 credit points have to achieved as principal surgeon.

This means, that a total of 400 interventions/procedures/endoscopies/operations (categories A + B + C) are the minimum requirement, when they are all performed as principle surgeon.

	Upper GI	**Thorax**
A.Interventions, Procedures	**N=100**	**N=100**

B.Endoscopies	**N=365**	**N=365**

C. Operations (total)	**N=335**	**n=335**
Thorax	N=80	n=210
Abdomen (major resections)	n=210	n=80
MIS intraluminal endoscopic procedures	n=45	n=45

For pragmatic reasons provisional arrangements are provided (see below: "Provisional arrangements") to enhance the qualification until complete European harmonization of surgical training is achieved.

These provisional arrangements allow a range of different compensations to consider various national and/or individual situations.

SOP: Provisional arrangements

Category A and B: The 60% rule

The total number of 280 credit points for the Categories A and B resp. is mandatory. Within the Categories A and B at least 60% (e.g. ex. 36 MDT and 190 gastroduodenoscopies) have to be reached.

Category C: The 60% Rule

The total number of 380 credit points (category C) is mandatory. At least 200 points in cat. 1A, 1B, 1C, 1 D, 2 A and 2 B as principal surgeon. Within each of the 5 subcategories stated under C the particular total number has to be reached at least to 75%. Numeric deficits in one or more subcategories have to be compensated by higher numbers in other groups.

Category A: Interventions & Procedures

If the candidate is not able to present a detailed LOG-book on category A or B "Interventions, Procedures and Endoscopy" a formal confirmation signed by 2 independent experts about the candidates experience in this category may be accepted. In this case the minimum number (n=280 credit points) for category A/B has to be supplemented in category C.

Category B: Flexible Endoscopy

If flexible endoscopy is not performed by the UGI in a specific country, category B may be omitted for the individual candidate. In this case the minimum number (n=220 credit points) for category B must be supplemented in category C

Catalogue of Interventions, Procedures, Endoscopies & Operations

	Thorax / Upper GI
Category A: Interventions, Procedures (principal surgeon=1)	**N=100**
1. Thoracal and abdominal sonographies, inclusive of eFAST, pleural drainage ultrasonography guided aso	N=15
2. Teaching experience on specialist level in UGI approved Environment, specialist level (1 hour = 1 credit)	N=15
3. Approved theoretical and practical courses (one whole course = 3 credits)	N=10
4. Upper GI MDT presence as chair	N=60

Category B: Endoscopy (principal surgeon=1)	**n=365**
1. Flexible esophagogastroduodenoscopy	n=315
2. EUL / EBUS (attended as assistant)	n=50
3. Bronchoscopy / ERCP / mediastinal endoscopic procedures (attended as assistant)	n=20
4. Endoscopic interventions (e.g. polypectomy, sclerotherapy, foreign body removals, dilatation, thermal ablation, PEG, aso)	n=120

	Upper GI	**Thorax**
Category C: No operations	**n=335**	**N=335**
1. Thorax Credit points (Surgeon =2, assistant=1)		
A. Thoracotomy (at ex. Oesophageal surgery, re-operations)	N=20	N=30
B. Oesophagus resections (e.g. oesophagus resection; conduit preparations). At least 40 in patients with malignancies as principal surgeon and 40 transthoracic procedures	N=80	N=80
C. VATS, diaphragmatic repair, sternotomies, oesophageal disruptions, lung resections aso	N=10	N=60
D. Diaphragmal hiatal operations (Hiatal hernia, fundoplications, redo etc) transthoracic	N= 10	N= 30
E / F. Cervico- oesophagostomy/ Empyema treatment	N= 10	N=30
2. Abdomen (Surgeon =2, assistant=1)		
A. Gastric resections, GEA, pyloroplasty Roux en Y, BII anastomoses, bleeding ulcer, perforated ulcer	n=40	N=20
B. Gastrectomies, re-do operations	n=50	N=10
C. Small and large bowel	n=40	N=20
D. Liver, spleen, pancreas (e.g. dissection, organ injury, distal resection)	n=10	N=10
E. Hiatal operation, transabdominally	n=55	N=45
F. Abdominal wall (e.g. incisional hernia	n=10	N=10
3. **Endoscopical procedures (not included in summation)**		
A. Minimal invasive intraluminal surgery (gastric GIST, EMR, RFA,), POEM, stents)	N=45	N=45

Procedures done during CCST education in surgery or Thoracic Surgery may account when done in the last year of CCST

The catalogue may be revised anytime according to UEMS decisions.

For the thoracic surgery interventions catalogue cfr supra

Regulations of the UEMS Board of Upper GI Surgery

Purposes and Objectives

EBQ UPPER GI-SURGERY – ELIGIBILITY CRITERIA 2018

To apply for certification as **F.E.B-UGI** (Fellow of the European Board – Upper GI Surgery) a candidate has to undergo a two-step quality validation process: **Eligibility** and **Examination**. Eligibility is a prerequisite for the Examination.

The UEMS European Board of Upper GI Surgery consists in a 2-part examination certifying that the successful applicant has reached a satisfactory level of knowledge and judgement for safe clinical practice in Europe.

This certification is not designed to bypass national examinations where they exist.

The European Board examination is a prestigious quality label, but cannot be considered as an equivalent to a national specialist fellowship, and cannot be utilized as a working permit, or to obtain a working permit, in European Union.

UEMS EB UGIS certification recognizes knowledge, skills and competence responding to European standards. For doctors certified by a European Union member state, EB UGIS should favor mobility within European Union countries. For applicants graduated outside of European Union, EB UGIS (int) serves as a recognition of competence matching with European quality requirements.

Admistrative documents/

Application is subjected to a fee. Candidates are encouraged to carefully watch for eligibility criteria. If the application is rejected after peer review, the application fee will only partly be refunded, after a 50% deduction for cost of administrative handling.

Candidates must submit an application file containing the documents listed below. All documents that are not in English should be doubled with an officially stamped and signed translation made by a sworn-in translator. Files will be submitted to a peer review to decide whether the candidate fulfils criteria to be eligible for EBTS membership examination.

The following documents should be submitted:

- A completed UEMS/EBTS application form.
- Identity
    - Copy of passport.
    - A recent photograph.
- Professional qualification
    - Copy of national medical diploma.
    - Copy of license to practice medicine.
- Copy of national specialist fellowshipor CCST (certificate of completion of training) that allows practicing thoracic surgery or general surgery, (least the country recognize EBTS, EBSQ examination as the exit examination). Short curriculum vitae
- Training curriculum
    - Detailed list of rotations with precise start– and end-dates and location during the whole training, and the resume year by year, signed by the Director/coordinator of the Training program.
    - Precise and exhaustive logbook of operations performed during the training period, indicating separately which have been performed as first surgeon or as assistant, validated by the referees (as first or assisting surgeon).
    - List of courses and meetings attended.
- *Scientific credential (optional)*
    - List of publications and presentations.

- Certificate of Master's degree in Science or PhD when existing, but optional.

- 2 recommendation letters of their mentors.
- Proof of payment of the registration fee by wire transfer.

To apply for **Eligibility** the candidate must fulfill the following requirements:

1. Eligibility for all exams run by the divisions of the European Board of Surgery and European Board Thoracic Surgery is open for candidates trained in one of the 27 European Union countries, a UEMS country (Iceland, Norway, Liechtenstein and Switzerland) or an associated UEMS country (Armenia, Croatia, Israel and Turkey) or a country with UEMS observer status (Georgia).

2. Eligibility for all exams run by the divisions of the European Board of Surgery and by the European Board Thoracic Surgery is also open to those candidates trained outside the UEMS-area.

Candidates, having trained outside of European member states (and Switzerland, Norway, Liechtenstein, Iceland, and countries with observer status), should meet requirements for certification and practice in Upper GI surgery in their country of training, and should be ready to start independent practice.
Applicants should have obtained the certificate of completion of specialist training (CCST) in thoracic surgery or general surgery (there are countries where general surgery no longer exists !) by the national body responsible for issuing such certificate. Applicants should have obtained a working permit in thoracic surgery / general surgery (visceral) in their country of training or practice.

The successful applicant will be certified as *international member of the European Board of Upper GI Surgery* **FEBS UGI S (Int) or FEBTS UGI S (Int)**

3. The candidate must be able to communicate in the English language. Examinations in the local national language(s) may be additionally provided at the discretion of the executive. A national CCT/CCST or a UEMS EBSQ Specialty Exam from another specialty / division is a prerequisite.
4. The candidate must provide a defined **Logbook** countersigned by an independent expert on every page.

The Logbook must include general information (surgeon, hospital) and for any item

the type of procedure and patient initials or hospital admission number (no information that allows identification of the patients' names). The content of the mandatory Logbook (minimum: 800 credit points) is published in "**Upper GI Surgery – Knowledge and Skills**".

4. A candidate must have been working for at least two years in a senior position at a highly specialized center with main responsibility in the Upper GI surgery as stated in Upper GI syllabus. The application should be within 5 years after taking up this position. Decision at the discretion of the executive.

5. A candidate's individual Logbook with comparable layout and structure may be accepted for the Eligibility process on the decision of the committee.
6. In any case the "**Logbook Summary**" in the EBSQ form is mandatory (the corresponding ECXEL file can be downloaded; in the table "Summary" the formulas for the automatic calculation are already provided).

7. The candidate must have a total of **25 credit points** based on the following criteria:
    - Co-Authorship in a UGIS related publication is mandatory
    - Participation at recognized UGIS international congress (4 points) is mandatory
    - Participation at recognized international congress and first authorship of presented paper/ poster? (8 points)
    - Participation national congress (2 points)
    - Participation at national congress and first authorship of presented paper / poster (4 points).
    - Participation at relevant International Postgraduate Course (6 points)
    - Publication (first authorship) in peer reviewed national surgical journal (8 points)
    - Publication (first authorship) in peer reviewed international surgical journal (12 points)

8. Candidates have to be recommended by **2 independent experts**. One of the experts must work in another region/country than the candidate.

9. Candidates are required to pay the fees for Eligibility (Euro 350) and - if accepted - a further Euro 650 to cover the Examination to the EB-Upper GI Surg

Administration Office. The Eligibility sum is to cover the costs associated with the processing of returned application forms by the central EB office and are nonrefundable. All payments must be effected by the required deadlines and there are no refunds for (Eligibility) candidates who are deemed ineligible to sit for the EBQ Upper GI-Surg examination or do not succeed in passing the Examination. In the event that a candidate has paid for the Examination and does not attend the examination there will be no refund.

10. Reapplication is possible for Eligibility and/or Examination.

11. Candidates accepted after peer review of their files are invited to participate at the fellowship examination. Part 1 is a Multiple Choice Question based written examination. Part 2 This is a 6- 7-part oral examination with multiple scenario-based clinical questions marked by examiners working in teams. For each of the 4-7 teams, each examiner discusses 1 scenarios with 10 questions; both examiners of each team mark independently.

The official language is English.

12. Successful EB Upper GI-Surg Eligibility and Examination candidates are awarded the title "**Fellow of the European Board Upper GI Surgery– F.E.B.S.- UGIS or F.E.B.T.S. -UGI Surg**".

The European Board of Surgery

U.E.M.S.

The European Board of Surgery confers the title of:

Fellow of the European Board of Surgery (FEBS) in Upper Gastrointestinal Surgery

upon .....

as its European Board of Surgery Qualification (EBSQ),

on the recommendation of ***the Upper GI Surgery Examination Board****, having passed the required Examination on the 23rd of April 2021*

President of the UEMS Section of Surgery | *President of the European Board of Surgery* | *Co-Chairperson of the UEMS EBSQ Upper GI Surgery* | *Co-Chairperson of the UEMS EBSQ Upper GI Surgery*

13. Appeals may be addressed to the chairman of EBTS after the examination. The Board, whose decision is final, will consider all appeals.

The UEMS fellowship (F.E.B.S UGIS /F.E.B.T.S - UGIS) represents a high-level validated quality control process and reflects certain knowledges and skills of a candidate.

The title F.E.B.-Upper GI Surgery determines, that the person successfully proved to have validated knowledge and skills, that in most cases by far exceed the requirements for the national CCSTs and allow him/her to successfully cover the field of Upper GI Surg. in respective to the actual demanding according to the judging of the commission.

In the moment the qualification F.E.B.-Upper GI Surgery has no automatic legal recognition in the E.U. or in any other country. Individual recognition of qualifications by the national authorities is supported by the EBSQ committee and the number of countries officially adopting the Board exam is continuously rising.

The fellowship does not implicate automatic allowance to work at own responsibility and does not automatically enhance participation in national social security systems of the E.U.

The future perspective of this European diploma is to be seen in unanimous legalization within the ongoing project of the European harmonization process of medical education.

How to prepare for the EBQ-Upper GI surgery exams?

To prepare for Part 1 exam assessing knowledge in general and thoracic surgery with MCQ's, standard textbooks would suffice). Preparatory courses for future applicants may be organized in close collaboration with the European Scientific Societies (ESTS ,ESDE,ISDE…..) offering regular knowledge courses in person or online through webinars. Questions mainly focus onto the mandatory items as described in the syllabus.

To prepare for assessing knowledge, clinical reasoning, non-technical skills, and decision making based on clinical case vignettes, regular attendance to specific teaching sessions at the

annual meetings ,webinars ,teaching courses organized by the international ,in particular the European societies as well as reading the main journals of our specialty on a monthly basis, is advised.

This is for purpose of example what ESTS is doing *to stimulate discussion*

ESTS has made great efforts in organizing the preparatory courses, which are held to familiarize applicants with the clinical formats that are raised during UEMS Thoracic Surgery board examinations, and to benchmark their knowledge against that from peers from different centers in different European countries. The courses have a structure based on the different modules, with interactive presentations, complex cases, audiovisual sessions or in the form of webinars

The theoretical sessions of the ESTS educational platform are held in Antalya, Turkey

Lab courses on the pig model are taking place in Elancourt, France

Both courses are very well attended with around 30-40 participants per course.

These courses as well as the webinars are UEMS EACCME approved.

c. Governance

The UEMS MJC Upper GI Surgery through its Board is the 'Governing Body' is responsible for all aspects of the examination. This Governing Body, including the Chairmen of the MJC Upper GI Surgery and the Chairman of the Board, is responsible for the oversight of Governance of the examination. The examination is organized by the Chairman of the Board with the help of a local organizer. Examiners are chosen by the Chairman of the Board after consulting with the Chairmen of the MJC Upper GI Surgery . Examiners must be board certified themselves.

The UEMS MJC Upper GI Surgery does not have indemnity arrangements in place within its examination structure and procedure. It is realized that this might constitute a risk, even though there have never been incidents in the past which could have called for the use of Indemnity Insurance. It is intended to join any a collective indemnity

arrangement when this is concluded by the UEMS **(to be verified)- to be discussed with UEMS central office**

II. TRAINING REQUIREMENTS FOR TRAINERS

1. Process for recognition as trainer

TRAINING AND EDUCATION OF UPPER GI SURGERY IN A EUROPEAN UNIT

The development of common recommendations for training in Europe is a difficult task. The curriculum, content, and duration of training in Upper GI Surgery differ considerably between European countries.
Indeed, the specific content and organization of the curriculum depends on the individual national regulations and is also de-pendent on the specific specialist recognition currently in place in each Country.

It will be the task of the EB UGIS to define a core curriculum, which should apply as a common denominator to the different UEMS-affiliated countries and to revise and update the curriculum criteria on a regular basis

- An EB UGIS approved surgeon will have had their specialized education in units recognized and authorized for training in Upper GI surgery according to the rules in each country.
- Special training in Upper GI surgery in order to qualify for independent positions needs a minimum duration of 2 year or more .
- Experience of general as well as thoracic is mandatory.
- During the training in Upper GI surgery a comprehensive knowledge of the entire field of Upper GI surgery must be offered to the trainee.

Which requirements for teachers?

All staff surgeons should be UEMS Upper GI board certified or holding an equivalent certification recognized by UEMS (i.e. National Diploma of Specialization, CCST) at the level of EPA.

At least the head of department should be university/academic affiliated, and the faculty should have documented experience in specialty training and in training of medical students.
The faculty should be actively involved in National/European teaching activities and teachers should be evaluated yearly.

Which type of cases?

During the training in Upper GI surgery a comprehensive knowledge of the entire field of Upper GI surgery must be offered to the trainee.
The caseload should cover all aspects of Upper GI diseases.
The spectrum of surgery should include diagnostic surgery, conventional open surgery, and minimally invasive procedures.
The trainer is responsible to offer the trainee sufficient exposure to perioperative care such as placement of central venous lines, tracheal intubation and tracheostomy, non-invasive and invasive ventilation and enteral and parenteral nutrition.
All trainees when applying for eligibility evaluation should have a signed, up dated logbook.
All residents should be able to perform basic minimally invasive procedures and should have exposure to and experience with advanced procedures. The trainers should initiate the trainees in basic procedures, followed by more difficult resections and leading to training in MIE .
In order to be trained to perform MIE the trainee should be exposed to a least **25**MIE.

Ideally the trainee should have opportunities to participate in both national and international training courses and should be exposed to other programs and other institutions to gain experience in highly specialized procedures and care.
Trainers should encourage trainees to follow the educational events offered by ESDE and EISDE or other EACCME recognized specialist courses on Upper GI. One of the objectives of these schools and dedicated courses is to ascertain teaching of the basic requirements for board certification.

The end-goal of training a European Upper GI surgeon is to successfully pass the examination of the UEMS EB UGIS.

Which commitment to teaching from the trainers ?

The following teaching activities should be guaranteed by the trainers:

- Daily rounds and/or staff meeting, discussion of perioperative problem situations.
- Complicated case discussion (either at staff meeting or at dedicated meeting).
- Institutional tumour board.
- Morbidity and mortality conferences.
- Multidisciplinary upper GI meetings.
- Journal club.
- Visiting professors/local conferences, etc.
- Risk-adjusted outcomes discussion.

There should be an on-site library and/or free Internet access to major journals and teaching material, a dedicated room for teaching activities and a dedicated office for trainees. All trainees should be encouraged to participate in clinical research. Access to basic or experimental research is a bonus

- Availability of a skills lab/simulation area is a big plus.
- Presence of other learners should not interfere with the trainees' curriculum (e.g. Fellows, PhD students and others).
- The training unit should prepare the trainee to meet the UEMS EBUGIS requirements successfully.
- Trainees should be encouraged to participate in Upper GI courses and other educational activities.

Institutional commitments to trainees

On-call schedules need to fit with the European Working Hours initiatives/law.

The training curriculum should involve partner specialties such as cardiovascular and visceral surgery.

a. Requested qualification and experience

Trainers must be certified Upper GI surgeons, preferably certified by the European Board of Upper GI Surgery. The trainers should follow the requirements of continuing

professional development. Trainers should possess the necessary clinical, teaching and administrative skills, and commitment to conduct the program. Trainers should have undertaken instruction in training (learning needs and teaching objectives) and in assessment of trainees. Trainers should provide evidence of scholarly activities (clinical and/or basic research, publications in peer reviewed journals and participation in neurosurgical scientific meetings).
Trainers will require secretarial and administrative support.

b. Core competencies for trainers

Special Qualifications of the trainers when required (if not covered by EU Directive on Professional Qualifications)

The main competence of an Upper GI surgeon lies in the pre-, intra- and postoperative care for patients with Upper GI surgical diseases. This includes the investigation of patients, decision-making process on the indication for surgery in each individual, maintaining a highly specialized operating team to perform the specific procedure on each individual patient and to see him through the postoperative period. In essence, the main competence of an Upper GI surgeon is the ability to perform various operations, including all kinds of open, endoscopic or video-assisted surgical procedures as enumerated in the catalogue

Trainers must set realistic aims and objectives for a rotation or training period. The trainer must supervise the day-to-day work of the trainee on the ward, in the outpatient clinic and in the operating theatre. The trainer must evaluate the trainees' surgical progress at the end of each rotation or training period and ensure that the assessments and reports are documented and signed both by the trainer and the trainee.

2. Quality management for trainers

Trainers should be committed to Upper GI surgical education. The Training Centre should provide appropriate time, space, facilities and funding to protect the needs of education from the demands of service. The members of the faculty should be experienced both as surgeons and as teachers / mentors, committing time, effort, and enthusiasm to the training programme. They should regularly attend interdisciplinary and even interprofessional meetings. The faculty should be large enough to supervise clinical, educational and research activities of the trainees.

III. TRAINING REQUIREMENTS FOR TRAINING INSTITUTIONS

(if not covered by EU Directive on Professional Qualifications)

1. Process for recognition as training centre

a. Requirement on staff and clinical activities

Minimal number of patients cared for as inpatients and as out patients
Range of clinical specialties
Composition and availability of faculty, training programme defined, guidelines applies Trainee / trainer ratio

Minimal scientific activity

Characteristics of high specialization and standard units are summarized in Table 1.

Characteristics high specialization Unit Upper GI surgery
Setting: within or in affiliation with a university setting Dedicated surgical ward (4–6 beds/100 major procedures) Access to dedicated T ICU Head of unit: UEMS Upper GI or UEMS-recognized equivalent certification, minimum of 5 years of practice in Upper GI Surgery Dedicated staff and institutional resources Team: qualified Upper GI surgeons performing a minimum of 100 major Upper GI procedures per year Surgeons expected to participate in research activities One fully equipped operating theatre In addition to on-site minimum facilities, access to esophageal pathophysiology laboratory; more advanced imaging techniques including MRI and on-site or collaboration with PET scanning facility; specialist laboratories relevant to subspeciality

Minimum Institutional case-load: 100± 50 major Upper GI procedures/year

Mandatory participation in regional / national databases based upon national guidelines

Upper GI Surgery units of high specialization should be within or in affiliation with a university or comprising a level of multidisciplinary care and specialization that is expected in a university. The unit should be headed by a surgeon preferably certified by the UEMS European Board of Upper GI Surgery (EB UGIS) or by an equivalent body recognized by the UEMS (national diploma of Upper GI surgeon). This is in accordance with the most recent evidence from the literature showing a positive association between specialization and short-term or long-term outcomes in Upper GI surgery.

This Head of unit should have educational and scientific responsibilities and should possess a minimum experience of 5 years of clinical practice as a qualified Upper GI surgeon. The unit should have dedicated staff and institutional resources and ideally a separate budget whenever feasible.

High specialization units able to offer a comprehensive and a full-length training program in Upper GI Surgery

This includes a sufficient amount and variety of cases on the one hand, and a sufficient amount of mentors on the other hand, the training unit should guarantee a minimum of 100+_50 major procedures/year, and, ideally, presence of 2+ full-time staff surgeons.

Cases should include a variety from the complete syllabus of upper GI Surgery

This Head of Department should be entrusted with educational and scientific responsibilities, and should possess a minimum experience of five years clinical practice as a qualified Thoracic surgeon / general surgeon. There should be a separate budget and clearly defined staff and institutional resources.

Educational and experimental facilities

Upper GI surgery units need to provide the logistic basis for ongoing education and research.

Upper GI surgery units should be the only recognized training centers for Upper GI Surgery

Upper GI surgery units of high specialization should provide the facilities and ambience for advanced postgraduate education for Upper GI surgeons.

Upper GI surgery units of high specialization must have, and units of standard care should have, access to experimental laboratories and to basic science laboratories.

Trainees are encouraged to follow the educational events offered by e.g. ESDE /ISDE EISDE or other EACCME recognized specialist courses on Upper GI. One of the objectives of these events is to ascertain teaching of the basic requirements for board certification.

STRUCTURAL ORGANIZATION AND REQUIREMENTS OF A CLINICAL RESEARCH PROGRAMME WITHIN AN Upper GI SURGERY UNIT IN EUROPE

The academic program of an Upper GI surgery unit should be led by surgeon(s) with experience and expertise in clinical research as evidenced by specialized training through the acquisition of a higher (research) degree, research grants and publication output.

Once identified, Upper GI surgery units should support academic surgeons with dedicated and protected (non-clinical) research time within the job framework.

Upper GI surgery units undertaking clinical research should support the development of academia for surgeons in training, either as part of their Upper GI surgery training or more formally for the award of a higher (research) degree.

Upper GI surgery units undertaking any health care outcome research, systematic reviews and meta-analyses should have access to the services of a professional medical librarian, epidemiologist, medical statistician and/or health economist as appropriate to the research focus.
Thoracic and visceral surgery units that are 'developing' randomized trials as part of their clinical research program should have access to a formal clinical trials unit and a research and development office for the administrative support of grant applications.

Upper GI surgery unit 'participating' in clinical trials should have access to dedicated supporting personnel such as research managers, database managers and research nurses.
Upper GI surgery units developing translational clinical research should have the access to basic science laboratories and supporting personnel (e.g. post-doctoral scientists and lab technicians).

b. Requirement on equipment, accommodation

Medical-technical equipment, library, opportunities for R&D .

Surgeons

Upper GI surgery units should have a dedicated staff equivalent to one EB Upper GI approved surgeon per 50 major Upper GI procedures per year. Adequate on-call arrangements should be in place to ensure that patient care is continuously provided. In units of higher specialization surgical staff are expected to participate in research activities.

Operating theatres

The number of fully equipped operating theatres within an Upper GI surgery unit may be calculated on the basis of 1 per 100 major upper GI thoracic / major upper GI procedures per year. A fully equipped operating theatre includes standard equipment for video-assisted surgery. One additional operating theatre should be available for minor procedures generated by this case load.

. *Advanced care facilities*

Upper GI surgery units of higher specialization should preferably have access to a dedicated Upper GI Intensive Care Unit (ICU). The average number of beds required is 1–2 per 100 major Upper GI procedures per year. In addition, High Dependency Unit beds are necessary at a rate of 1 per50 major Upper GI procedures.

. *Ward care*

Upper GI surgery patients should be cared for in a dedicated Upper GI c surgery surgical ward with full supporting paramedical staff, including dedicated physiotherapists. Optimally, there should be 2–4 beds per 100 major Upper GI procedures per year. One wound treatment room should be available on every ward. Segregated male and female areas and facilities should be provided and at a minimum one bed should be in a single room to allow provision for barrier nursing. Dedicated Upper GI nutritionists should attached to the ward.

. *Outpatient*

There should be sufficient facilities for outpatient visits with same visit access to radiology.

. *Inpatient diagnostic facilities*

Minimum facilities must include:

- hematological, biochemical and microbiological laboratories.
- respiratory pathophysiology laboratory.
- endoscopic examinations by bronchoscopy and esophagoscopy and advanced
- procedures
- radiological investigation by plain X-ray, contrast studies, ultrasound, vascular imaging and CT- scan.
- cytology, histopathology, and frozen section analysis.
- units of higher specialization should also have access to an esophageal pathophysiology laboratory;
- more advanced imaging techniques including MRI and, ideally, PET scanning.
- specialist laboratories such as Motility lab

2. Quality Management within Training institutions

Accreditation
Clinical Governance
Manpower planning
Regular report
External auditing
Transparency of training programmes
Structure for coordination of training
Framework of approval – how are they approved

In general manpower planning will have to take into consideration demographic changes in any population such as its growth and ageing, changing treatment modalities and actual workload, the effects of legislation on working hours .

A training institution must have an internal system of medical audit or quality assurance. There should be written general guidelines concerning patient care and patient information (patient's consent), referrals, medical records, documentation, on- call and back-up schedules. These should be available to staff and trainees.
There must be within the unit an internal system of medical audit, such as mortality and morbidity conferences, together with a structured procedure for the reporting of accidents.

The hospital should, under the responsibility of the Chief Medical Officer, have measures in place in relation to quality control such as infection control. A drugs and therapeutics committee should exist. A program and training in risk management should be in place. The hospital or the training institution should have an annual activities report.

Quality surveillance in a Upper GI *surgery unit*

-Quality surveillance has to be performed in every Upper GI unit. There must be a computerized documentation of all procedures performed together with a documentation of all major adverse events. Results should be analyzed on a regular basis.

All procedures should be registered in a regional / national database with possibility of identification of results per participating surgical unit. A yearly report should be published

-There should be a recognized and generally accepted system for risk stratification. Complications should be discussed regularly and feedback of risk stratified individual results should be given to every surgeon.

-Procedure specific mortality figures should be in the official range given by ECCG (Esophageal Complications Consensus Group)
-Thoracic surgery units should report to ECCG (Esophageal Complications Consensus Group) on a regular basis. Information from this registry should be analyzed and given to every surgeon and to the Upper GI surgery staff.

-Regular analysis of long term follow-up should be performed.

Recertification of Upper GI Surgeons and Upper GI Surgery Units

- Upper GI surgeons approved by the EB UGIS need to recertify after a period of every 8 years. Criteria for recertification should include evidence for their ongoing work in the field of Upper GI together with records of their operative practice within the period of time since their last certification.
- Upper GI surgery units officially acknowledged by the certification process need to undergo recertification according to the rules of the certification process.
-Minimal demands of activities should meet the range defined by this document.

Process for Accreditation of Upper GI Centres for Training in Upper GI Surgery (not yet available , see addendum example transplant surgery)

The accreditation is a quality label ,a process aimed at standardizing and improving practice
The UEMS Section and Board of Upper GI Surgery is planning to initiate in collaboration with ESDE a specific accreditation of Upper GI Centers for Training in Upper GI Surgery

EBSQ APPLICATION FORM

FAMILY NAME

……

FIRST NAMES ……..

NATIONALITY ……..

DATE/PLACE OF BIRTH ……..

ADDRESS FOR CORRESPONDENCE:

……

……...

……

……

TELEPHONE ……. FAX……..

Email address …….

PRESENT APPOINTMENT:

TITLE

……

DEPARTMENT

……

ADDRESS

……

……

……

DOCUMENTS ENCLOSED

Verified and signed documents following the UEMS Division of Upper GI criteria are enclosed.

- **25 credit points (based on Eligibility criteria)**
- **LogBook (based on Eligibility criteria)**
- **LogBook Summary**
- **2 recommendations**
- **Eligibility fee paid** ***+ proof of payment***

SIGNATURE …….

DATE…….

DECLARATION BY APPLICANT

I wish to apply for Eligibility of the European Board of Surgery / Thoracic Surgery Qualification based upon assessment of my training experience. I declare that all information provided in support of my application is correct.

SIGNATURE …….

DATE…….

DECLARATION BY TRAINER 1

I have scrutinised this application and declare that to the best of my knowledge the information provided by the candidate concerning his/her training experience is correct.

SIGNATURE ……..

PRINT NAME ……..……

DATE……..……

POST HELD …….…….

HOSPITAL ADDRESS

……

……

…….

DECLARATION BY TRAINER 2

I have scrutinised this application and declare that to the best of my knowledge the information provided by the candidate concerning his/her training experience is correct.

SIGNATURE ……..

PRINT NAME ……..……

DATE…….……

POST HELD …….…….

HOSPITAL ADDRESS

……

……

……

Please return this form to

Eligibility Office

European Board of Surgery Qualification (EBSQ)

Chairman: Professor Arthur Felice, M.D., M.A.S., F.A.C.S.

office@uemssurg.org

RUE DE L'INDUSTRIE, 24
BE- 1040 BRUSSELS
www.uems.eu

T +32 2 649 51 64
F +32 2 640 37 30
info@uems.eu

UNION EUROPÉENNE DES MÉDECINS SPÉCIALISTES

EUROPEAN UNION OF MEDICAL SPECIALISTS

Association internationale sans but lucratif – International non-profit organisation

RUE DE L'INDUSTRIE 24 61 T +32 2 649 51 64
BE-1040 BRUSSELS F +32 2 640 37 30
www.uems.eu info@uems.eu