European Training Requirements for Paediatric Allergology

This document was developed by the European Training Committee on Paediatric Allergology (ETC-PA), a working group of the Section on Paediatrics of the European Academy of Allergy and Clinical Immunology (SP-EAACI), in collaboration with the European Academy of Paediatrics (EAP), which serves as the Paediatric Section and Board of the European Union of Medical Specialists (UEMS).

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I-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 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 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 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 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.

II- THE SUBSPECIALITY OF PAEDIATRIC ALLERGOLOGY

1. Description of the subspeciality

Paediatrics is a distinct and comprehensive medical specialty focused on the prevention, diagnosis, and management of illness and injury in children from birth through adolescence, up to 18 years of age. It goes beyond the treatment of diseases in infants, children, and adolescents to encompass the broader domain of overall health. This includes all aspects of physical, emotional, and developmental growth, as well as disease prevention and health promotion.

In this document, the terms **Child** and **Children** should be understood in a broad sense (0–18 years), encompassing newborns, infants, preschool children, school-aged children, and adolescents, as each of these age groups presents its own specific allergological characteristics.

The role of the family and other environmental influences is central to a child's development, and many paediatric conditions require ongoing management and long-term follow-up. A key aspect of paediatric care is ensuring a smooth and effective transition to adult healthcare services when appropriate.

The prevalence of allergic diseases in children and adolescents has been steadily increasing over recent decades, particularly in industrialized societies. Today, allergic conditions represent a significant cause of morbidity in the paediatric population.
In response to this growing health burden and in parallel with advances in medical science, Paediatric Allergology (PA) has emerged as a dedicated medical subspecialty within Paediatrics. PA focuses specifically on the diagnosis, treatment, and prevention of allergic and immunologic diseases in children and adolescents and has developed as a recognized discipline across Europe and worldwide.

This document describes the **European Training Requirements (ETR) for Paediatric Allergology**. It is one of the subspecialist training programs in Tertiary Care Pediatrics, defined by the Secondary / Tertiary Council of the European Academy of Paediatrics, itself

the Paediatric section of the European Union of Medical Specialists (Union Européenne des Médecins Spécialistes - UEMS) The product of this training program is the **European Paediatric Allergist (EPAL)**. It is expected that European Paediatric Allergists will practice their skills and apply their expertise within the framework of a specialized Tertiary Care Unit. Furthermore, such specialists will have commitment to train general paediatricians and paediatricians with an interest in Paediatric Allergology.

In **Paediatric Allergology**, interdisciplinary cooperation is a central element of clinical practice. Paediatrics is a specialty with its own distinct characteristics, which differentiate it in this as in other areas—not with the intention of replacing or excluding other specialties, but rather to promote collaboration, optimize patient outcomes, ensure an appropriate transition to adult care, and affirm the need for differentiation in line with the natural evolution of paediatric disciplines.

We believe that all doctors practising Paediatric Allergology (PA) require a solid basic training in General Paediatrics, as set out by many National Training Authorities (NTAs), and in the recommended European Common Trunk Syllabus, approved by the EAP-UEMS. This training, which should be of 3-year minimum duration provides the core knowledge and clinical experience that support the competencies and principles outlined in this Paediatric Allergology training program.

2. Metholology for generating this ETR

The first version of the Syllabus was written by several members of the former European Paediatric Allergy and Clinical Immunology Society (ESPACI) in 1999 and revised in 2003 and 2011 by the European Training Committee on Paediatric Allergology (ETC-PA), a working group of the Section on Paediatrics of the European Academy of Allergology and Clinical Immunology (SP-EAACI). ETC-PA has also produced two further documents, defining the requirements for European Training Centres (2007) and the European Training Curriculum for PA (2013)
The Training Program finalized in 2017, and approved by UEMS in 2019 was a comprehensive new text issued by ETC-PA, combining and updating the Syllabus, Curriculum and Training Centre Requirements for PA using the format for training programs then suggested by UEMS and EAP
All these documents were patiently produced over the years, discussed by E-Mail, in telephone conferences, in small group meetings and in ETC-PA plenary meetings held during annual EAACI congresses
The present version is an updating of the 2019 UEMS document, mostly constructed by E-mail contacts between ETC-PA national representatives and discussed in the ETC-PA Plenary Meeting. It is based on the new format proposed by UEMS for ETR documents.

3. Aims of the ETR

This program aims to achieve the following key objectives:

a. Harmonise training in Paediatric Allergology (PA) across European countries to ensure consistency and high standards in education and clinical practice.

b. Define clear, standardised competencies in knowledge and clinical skills required for practising PA at the tertiary care level.

c. Promote the development of a robust European network of accredited Tertiary Care Centres specialising in PA.

d. Improve the quality of care for children with allergic diseases throughout Europe by advancing training and collaboration.

e. Strengthen Europe's contribution to global scientific progress in the field of Paediatric Allergology through high-level education and research initiatives.

III-TRAINING REQUIREMENTS FOR TRAINEES

1. Content of training and learning outcome

a Competencies required of the trainee

The aim of tertiary care training in PA is to provide training to allow competent practice to be undertaken as a Tertiary Care Specialist in PA whose practice would be expected to deal with complex problems in this area including:

Atopic diseases
Bronchial asthma
Allergic Rhinitis, othe ENT Allergy and Ocular allergy
Skin Diseases
Food Allergy
Insect venom allergy
Drug Allergy
Anaphylaxis

Specialist competence in Paediatric Allergology (PA) requires comprehensive knowledge and advanced clinical skills to care for children and adolescents affected by, or at risk of, allergic diseases and non-allergic hypersensitivity reactions. This expertise must extend across all levels of care, from outpatient clinics to hospital-based services.

Beyond diagnosis, treatment, and ongoing management, the sub-specialty also encompasses the full spectrum of allergy prevention—both at the individual and population level. A thorough understanding of environmental factors is now essential for effective primary and secondary prevention strategies.

Delivering optimal care in PA necessitates close collaboration not only with the child and their family, but also with the various institutions and public bodies that shape the child's

daily environment. These include nurseries, kindergartens, schools, social services, environmental and building authorities, and other relevant agencies.

To gain the necessary depth of experience each trainee should be actively involved in the management care of a range of patients during the whole period of his/her speciality training. This should include the care of outpatients, inpatients (including emergency admissions) and community care where appropriate.

Evaluation of trainees should incorporate competency-based assessment, alongside traditional knowledge assessments and portfolio review. An excellent model to structure this process is the **CanMEDS Framework**, developed by the Royal College of Physicians and Surgeons of Canada https://canmedsproject.ca/en/Framework outlining the following competencies:

- **Medical expert**: applies clinical skills and biomedical knowledge within the defined scope of PA, establishes partnership with patients and families in providing patient-centred care and promotes healthcare quality and patient centred care
- **Communicator:** effectively facilitates doctor-patient relationship and dynamic exchanges before, during and after medical encounter
- **Collaborator:** effectively works within healthcare system to achieve optimal patient care
- **Leader:** contributes to the continuous improvement of the healthcare system, manages clinical and administrative responsibilities effectively and uses resources efficiently and ethically.
- **Health advocate**: advocates for improved care systems and public health policy, promotes health education and disease prevention.
- **Scholar:** demonstrates lifelong commitment to reflective learning and to creation, dissemination, translation of medical knowledge
- **Professional:** committed to the health and wellbeing of individuals and society through ethical practice, professional led regulation and high personal standards of behaviour.

Log-book and Portfolio

Trainees are required to maintain a comprehensive log-book documenting all relevant clinical activities. This should include patients seen, procedures performed, diagnoses established, therapeutic interventions undertaken, and follow-up outcomes. The log-book should also incorporate knowledge and skills checklists outlining core competencies, with space provided for supervisor verification and sign-off. This documentation will form an integral part of the trainee's professional portfolio.

Trainees must ensure that their personal log-book, or equivalent record, is kept up to date in accordance with national guidelines and European Union directives. The log-book should follow the Training Syllabus described below and must be reviewed and endorsed regularly by the trainee's tutor or an authorised deputy.

Trainees are expected to attend local, regional, and national scientific meetings and provide documented evidence of participation.

Attendance at international meetings is considered essential, particularly for tertiary care training. Trainees are encouraged to present their work at such meetings, with a recommendation of delivering at least two to three presentations during the training period. Participation in summer schools and winter schools is also strongly encouraged.

b Learning outcomes

The European Paediatric Allergist (EPAL) at the end of training, should be able to:

- Provide competent clinical care within the framework of a specialised Tertiary Care Unit in the inpatient/outpatient setting using various specialised diagnostic and therapeutic modalities.
- Provide competent clinical care as an autonomous paediatric subspecialist in a public or private community-based outpatient setting.
- Liaise with the appropriate laboratories and similar departments
- Liaise with colleagues in Primary and Secondary Care Paediatrics in the provision of high-quality local care.
- Provide technical assistance and consult with other Tertiary Care Specialists, namely, specialists in Paediatric Pulmonology, Paediatric Gastroenterology, Oto-Rhino-Laryngology, Dermatology, Clinical Physiology, Clinical Immunology ,Genetics
- Coordinate with Adult Allergology and Pulmonology teams for smooth transitional care.
- Design and implement a relevant research program in PA.
- Lead and maintain a quality assurance program.
- Contribute to educational activities at undergraduate and postgraduate levels.
- Actively participate in relevant administrative and professional bodies.

c Theoretical knowledge, practical and clinical skills and competences

Training Syllabus

The present Syllabus is addressed to the training of Tertiary Care Specialists in Paediatric Allergology. It is structured in modules. Each module contains training requirements in a specific area, expertise, or skill.

Each item will be classified under the categories of Knowledge (K), Skill (S) or both

Recommended minimum degree of expertise to be acquired for each knowledge item or skill:

H – High (updated scientific knowledge)
I – Intermediate (Paediatric allergology textbook knowledge)
B – Basic (general Paediatric Textbook)

K – Knowledge
S – Sk

Modules A to S mandatory Modules T to V optional

European Syllabus in Paediatric Allergology for Tertiary Care Specialists (European Training Committee Paediatric Allergology)			
A Basic Knowledge on Immunology and Allergic Diseases (mandatory)		**K**	**S**
1	Immune response and Immunoregulatory mechanisms	H	
2	Pathogenesis of hypersensitivity and allergic diseases	H	
3	Epidemiology of allergic diseases, locally and worldwide	H	
4	Influence of genetic and environmental factors on development of allergic disease	H	
5	Clinical course of allergic disease, from infancy to adulthood	H	
6	Primary and secondary prevention of allergy	H	
B Allergens (mandatory)		**K**	**S**
1.	Allergens and allergenic composition of the source materials	H	
2.	In vivo allergen standardization, principles and differences between methods	I	
3.	In vitro characterisation of allergen extracts, components and total allergenic activity	I	
4.	Allergens, aerobiology and distribution of inhalant allergens in the environment	H	
5.	Allergens, latex and drug allergens	H	
6.	Allergens, food allergens (including additives) and cross-reactivity of food allergens	H	
7.	Allergens/modified allergens/hypoallergenic allergens	H	
8.	Polyclonal and monoclonal antibodies against IgE and IgG epitopes	I	
9.	Methods for determination of indoor allergens, moulds etc. in dust and air	I	
10.	Methods for determination of mould spores and pollens in the air outdoors	I	
11.	Distribution of allergens in the environment	H	
12.	Hidden allergens in foods	H	
13.	Molecular Allergy diagnosis in clinical practice	H	
14.	Cross-reactive molecules and their clinical relevance	H	
15.	Allergen families and databases	H	

C Diagnosis of allergy (mandatory)		K	S
1.	Definition of allergy and atopy.	H	
2.	Total IgE and eosinophil count – context and limitations	H	
3.	Understanding of hypersensitivity reactions : Antibody mediated (Type I, Type II, Type III) Cell mediated (Type IV a, Type IV b Type IV c) Tissue driven mechanisms (Type V, Type VI) Direct response to chemicals (Type VII)	H	
4.	Methods for routine *in vivo* immediate hypersensitivity: skin prick tests and intradermal tests and their interpretation	H	H
5.	*In vivo* test for delayed hypersensitivity (allergy patch test, intradermal tests)	H	H
6.	Basophil activation Test (BAT) protocols, flow cytometry, interpretation	I	
7.	Histamine Release Test (HRT): technique and comparison with BAT	I	
8.	Methods and interpretation of challenge tests in the conjunctiva, (nose), bronchi (allergen bronchial challenges) and single blind and double-blind oral food and drug challenges, See also Asthma, Food Allergy and Drug Allergy	H	H
9.	Specific IgE Testing: Singleplex (e.g., Immuno CAP), Multiplex/Component-resolved diagnostics (e.g., ISAC, ALEX)	H	
10.	Understand cross-reactivity based on molecular allergology insights	H	H
11.	Understand the mechanisms and clinical implications of polysensitization and polyallergy in children.	H	H
12.	IgG/IgG4 Testing: understanding misuse and appropriate research context	H	
13.	Methods for determination of mediators of allergic inflammation (MC mediators, Eosinophile cell derived mediators, interleukins and other cell markers).	H	
14.	Indications and interpretation for *in vivo* and *in vitro* allergy testing. Choosing tests based on age, condition, contraindications, and clinical scenario	H	H
15.	*In vitro* morphological and functional assessment of cells and molecules involved in the mechanisms of immune response, hypersensitivity and immunopathology, according to current state of the art (principle and interpretation; meaning and validity of test results)	H	
16.	Biomarkers and mediators: Mast cell mediators: serum and urinary tryptase, histamine, chymase Eosinophil mediators: eosinophil cationic protein (ECP), EDN, MBP Cytokines and interleukins: IL-4, IL-5, IL-13, IL-10, TNF-alpha, IFN-gamma (research or selected clinical settings)	H	

D Bronchial asthma and other wheezing disorders (mandatory)		K	S
1	Different recurrent wheezing and asthma clinical patterns, phenotypes and endotypes, their different pathology and natural history (including underlying pathophysiology and basic epidemiology)	H	
2	Differential diagnosis of asthma and clinically similar paediatric disorders	H	H
3	Interpret emerging biomarkers (FeNO, periostin, TARC) and understand their current and potential roles in paediatric allergy and asthma.	H	H
4	Epidemiology of viral infections, mechanisms of viral wheezing	H	
5	Treatment of acute asthma and wheezing illness at various ages	H	H
6	Long term management of asthma and recurrent wheezing at different ages including age related pharmacology and emerging therapeutic strategies, with special emphasis on side effects and those influencing *children's* growth	H	H
7	Available techniques for inhalation therapy and their age-related advantages and limitations	H	H

E Ocular and ENT Allergy (mandatory)		K	S
1	Diagnosis and management of allergic conjunctivitis and clinically similar paediatric disorders	H	H
2	Anatomy, physiology and pathology of the upper respiratory tract and ear of paediatric patients	H	
3	Anatomy of the upper respiratory and ear of paediatric patients as visualised using imaging techniques	I	I
4	Rhinitis: etiopathogenesis, classification, diagnosis and treatment. Sinusitis. Paediatric disorders mimicking rhinitis	H	H
5	Long term management of rhinitis, considering the impact of both the disease and the medication on the patient's quality of life and school performance.	H	H
6	Identify upper airway comorbidities—including tonsillar and adenoid hypertrophy and obstructive sleep apnoea—in children with allergic diseases	H	
7	Otitis media in allergic paediatric patients	H	
8	Indications of ENT surgery in patients with allergic rhinitis	H	

F Skin Diseases (mandatory)		K	S
1	Urticaria and angioedema (physiology, pathology, diagnosis, differential diagnosis with clinically similar paediatric disorders and treatment)	H	H
2	Chronic urticaria (diagnosis and long-term management with special emphasis, on quality of life and school performance)	H	H
3	Diagnosis and management of hereditary angioedema	H	H
4	Atopic dermatitis (physiology, pathology, diagnosis, differential diagnosis, and treatment; long term management of persistent cases with special emphasis, on quality of life and school performance)	H	H
5	Contact dermatitis and other type IV reactions	H	I
6	Mastocytosis and related diseases like mast-cell activation syndrome and hereditary alpha tryptasemia (diagnosis and treatment; long term management)	H	H
G Food Allergy (mandatory)		K	S
1.	Epidemiology, types and natural history of food allergy	H	
2.	Manifestations of food allergy: a. Acute symptoms: : Vomiting, diarrhoea, abdominal pain, gastro-oesophageal reflux (GOR), and blood or mucus in stools. b. Chronic manifestations: i. Eosinophilic gastrointestinal disorders (EGIDs), including Eosinophilic Oesophagitis (EoE), Eosinophilic Gastritis and Eosinophilic Gastroenteritis ii. Non-IgE-mediated enteropathies, such as Food Protein-Induced Enterocolitis Syndrome (FPIES), Food Protein Induced Proctocolitis (FPIP) iii. Constipation and failure to thrive c. Extra-gastrointestinal symptoms (atopic dermatitis, urticaria, anaphylaxis, angioedema, rhino-conjunctivitis, asthma) d. Food-dependent exercise induced anaphylaxis (FDEIA)	H	
3.	Non-allergic adverse reactions to foods. Paediatric disorders mimicking food allergy	H	
4.	Most common food allergens and labelling regulations	H	
5.	Implications of egg allergy with vaccination (MMR, Influenza, Yellow Fever) and current recommendations	H	
6.	IgE mediated food allergy: diagnosis of causal food allergen by history	H	H
7.	IgE mediated food allergy: diagnostic relevance of determination of specific IgE, skin prick tests and atopy patch tests	H	H
8.	Use of molecular diagnosis in the management of food allergy	H	H
9.	Diagnostic challenge procedures in food allergy, including additives a. Open oral food challenges	H	H

	b. Double-blind placebo-controlled food challenge		
10.	Diagnostic elimination diet and supervised reintroduction	H	H
11.	Oral allergy syndrome (pollen-food syndrome)	H	
12.	Coeliac disease	H	
13.	Treatment of food allergy		
	a. Elimination diet (nutritional aspects, education, EU regulative re. labelling etc.)	H	H
	b. Symptomatic treatment	H	H
	c. Treatment of anaphylaxis (see I)	H	H
	d- SOTI (Specific Oral Tolerance Induction)	H	H
	e- EPIT (Epicutaneous Immunotherapy)	Optional	
14.	Nutrition in food allergy/intolerance	H	H
15.	Identify the types and indications of hypoallergenic formulas—including partially and extensively hydrolysed, amino acid–based, and rice formulas, in the prevention and management of Cow's Milk Allergy in infants and children .	H	
16.	Prognosis of food allergy; need for follow-up and re-challenges	H	H
H Insect venom and body allergy [1] (mandatory)		**K**	**S**
1.	Definition of insect venom, insect body and related allergy in children	H	
2.	Epidemiology of insect allergy in children	H	
3.	IgE mediated insect venom and body allergy: Diagnosis of causing insect allergen by history	H	H
4.	IgE mediated insect venom and body allergy: Diagnosis of causing insect allergen by skin tests, and *in vitro* IgE tests	H	H
5.	Recognize the possible role of the Sting Challenge Test in evaluating treatment response in children with Hymenoptera Venom Allergy.	H	H
6.	Prophylactic measures in insect allergy	H	
7.	Non allergic adverse reactions to insect venom and body material	H	
8.	Immunotherapy in *Hymenoptera venom* allergy (VIT), see K - Immunotherapy	H	H
9.	Non-immunological treatment of IgE mediated insect venom and body allergy	H	H

[1] Insect allergy should be defined as allergy to *Hymenoptera* venoms, other insect venoms like mosquito bites/ mosquito venom, insect and lower animal and plant allergens, e.g. midges, spiders, nematodes, green algae and other algae etc.

I Drug Allergy (mandatory)		K	S
1.	Definition and types of drug allergy in children. Paediatric disorders mimicking drug allergies	H	
2.	Epidemiology of drug allergy	H	
3.	Diagnostic procedures in drug allergy, skin prick tests, patch tests, intradermal tests, injection and oral challenge tests, *in vitro* IgE tests, methods for the measurement of tryptase and their interpretation	H	H
4.	Skin testing for drugs and biologicals, including protocols for beta-lactams, local anaesthetics, biologics	H	H
5.	Understand the principles and clinical utility of the Lymphocyte Transformation Test in assessing T-cell–mediated drug hypersensitivity.	I	
6.	Drug Provocation Tests (DPT): principles, indications, contraindications, safety	H	H
7.	Non allergic adverse reactions to drugs	I	
8.	Clinical characteristics and diagnosis of NSAID hypersensitivity	H	H
9.	Acute desensitization in drug allergy	H	H

J Anaphylaxis (mandatory)		K	S
1.	Definition of anaphylaxis and its main causes, namely foods, oral drugs, injected drugs, insect venoms, SCIT (injected drugs) and SLIT	H	
2.	Mechanisms of anaphylaxis: immunologic (IgE and non IgE mediated) and non-immunologic, mediators involved, (histamine, tryptases, cytoquines). Biphasic and protracted anaphylaxis.	H	
3.	Clinical manifestations of anaphylaxis (cutaneous, respiratory, gastrointestinal, cardiovascular, neurological) and the importance of its early identification. diferential diagnosis (vasovagal syncope, panic attacks, asthma) diagnostic criteria, use and interpretation of serum tryptase,	H	H
4.	Acute treatment of anaphylaxis emphasizing early adrenalin administration and life support measures (airway management, oxygen, IV fluids), indications for second dose adrenaline	H	H
5.	Complementary treatment of anaphylaxis besides adrenaline, post-treatment observation, guidelines for medical discharge	H	H
6.	Absolute indications and recommended indications for prescription of an adrenaline auto-injector	H	H
7.	Training with adrenaline auto-injector	H	H
8.	Relevant patient and caregiver education. Written emergency plan. Personalised individual plan	H	H
9.	Anaphylaxis at school. Preventive measures and emergency plans	H	H

K Preventive measures (mandatory)		K	S
1.	Definition of prevention ▪ Primary prevention ▪ Secondary prevention ▪ Tertiary prevention	H	
2.	Information and education	H	H
3.	Discussion of possible effect of avoidance/reduction of exposure to inhalant allergens (mites, moulds, dander, pollens, other)	H	
4.	Environmental treatment including diagnosis and measurement of allergen exposure	H	
5.	Dietary prevention ▪ Primary prevention in all infants a. Breast feeding ▪ Primary dietary prevention in high-risk infants a. Breast feeding	H	H

	b. The role of documented hypoallergenic formulas c. Knowledge about the early introduction of potentially allergenic foods d. Secondary dietary prevention in individuals with food allergy		
6.	Role of Skin Barrier Enhancement for Primary Allergy Prevention • Understand the pathophysiology linking skin barrier dysfunction and allergy. • Review evidence supporting skin care in infancy as a preventive strategy. • Implement practical emollient recommendations in clinical settings.	H	H
7.	Skin care for eczema	H	H
8.	Prevention of exposure to tobacco smoking (including electronic cigarettes) - Preventive measures against starting smoking or vaping - Measures to help stop smoking and vaping - Measures to prevent second-hand exposure to smoke and e-cigarette aerosols	H	H
9.	The possible role of pre-biotics, pro-biotics and symbiotics in allergy prevention	H	
10.	Anti-microbial stewardship and microbiome interactions. Pro/prebiotics in allergy prevention and management, effects of antibiotics on allergic disease risk		
11.	The possible role of specific nutrients (D- vitamin, E-vitamin, antioxidants, n3/n6 PUFA, etc)	H	
12.	Principles of treatment of exercise induced asthma	H	
13.	Physical training for asthmatics	H	H
14.	Occupational guidance	H	H

L Allergen Immunotherapy (mandatory)		K	S
1.	Organization of allergen vaccination/immunotherapy, the facilities, personnel, education and continuous training	H	H
2.	Methods used for allergen vaccination/immunotherapy (IT)	H	H
3.	Allergen vaccines/extracts used for immunotherapy (extracts, recombinant allergens, modified allergens) and their pharmacokinetics	H	
4.	Mechanisms of IT	H	H
5.	Indications and contraindications for IT	H	H
6.	Information to patients and parents in advance of a decision to start IT		H
7.	Allergy diagnosis (history, skin tests, in vitro allergen specific IgE, provocation tests), see B 1, Allergy Diagnosis, and asthma diagnosis, lung function, optimal asthma therapy, allergen avoidance, before the start IT (SCIT, IDIT, SLIT OIT and VIT)	H	H
8.	Subcutaneous immunotherapy (SCIT) : Dosing, dose schedules, top doses, intervals, duration long term prognosis preventive effects etc.	H	H
9.	SCIT, with allergen extracts/preparations of house dust mites, pollens, animal dander, food and *Hymenoptera* venoms	H	H
10.	Intradermal Immunotherapy (IDIT) Dosing, dose schedules, top doses, intervals (mainly experimental, not considered standard care yet)	I	Optional
11.	Sublingual immunotherapy (SLIT): Dosing, dose schedules, top doses, intervals, duration long term prognosis preventive effects etc.	H	H
12.	SLIT, with allergen extracts/preparations of house dust mites, pollens, animal dander and foods	H	H
13.	Oral immunotherapy with Food (OIT) in the management of selected children with Food Allergy.	H	H
14.	Epicutaneous immunotherapy (EPIT) see G-Food Allergy (mainly experimental, not considered standard care yet)	I	Optional
15.	IT: Supervision of asthma, environmental control, medication and allergen exposure	H	H
16.	IT: Long-term follow up of clinical and immunological results in children given IT	H	H
17.	Acute treatment of IgE-mediated drug allergic patients by modified rush desensitization,	H	H
18.	Anaphylaxis during SCIT, IDIT, SLIT and VIT Investigation of causes such as subclinical asthma, other ongoing allergic inflammation, recent exposure to known or non-diagnosed allergens, i.v. injection etc	H	H

M Drugs and biologics used for children and adolescents with allergic diseases (mandatory)		K	S
1.	First and second generation anti-histamines – indications, efficacy, pharmacokinetics, side effects, food and drug interactions	H	H
2.	Bronchodilators (short and long action beta agonists, anticholinergics) indications efficacy, pharmacokinetics, side effects, drug delivery devices	H	H
3.	Adrenaline - indications efficacy, pharmacokinetics, side effects, drug delivery devices (see J- Anaphylaxis)	H	H
4.	Topical and systemic steroids - indications, efficacy, pharmacokinetics, side effects	H	H
5.	Use of anti-leukotrienes, anti-IgE (Omalizulab) and other biologic modulators in the treatment of allergic diseases (Dupilumab, Mepolizumab, Benralizumab, Telezepelumab). Indications, age approvals and adverse effects,	H	H
6.	Indications, efficacy and safety of Immunosuppressive drugs in the treatment of allergic diseases (eg. calcineurine inhibitors, methotrexate, cyclosporin)	H	H
7.	Emerging therapies, like JAK inhibitors (e.g., upadacitinib, ruxolitinib) for atopic dermatitis and Syk inhibitors, anti-IL-31, microbiome therapies (investigational)	Optional	
8.	Medication safety, adherence and education. Techniques to optimize adherence in children. Parent and child education tools. Medication safety in schools and daycare settings	H	H
N Approach to the allergic child and his family (mandatory)		K	S
1.	History taking in allergic patients		H
2.	Recognizing clinical symptoms and signs of allergy	H	
3.	The “allergic march” and child with multi-systemic allergy	H	
4.	Communication with children of all ages and their parents, placing emphasis on counselling skills and provision of appropriate disease education in order to optimize patients' compliance	H	H
5.	Proper assessment and handling of family interactions and their impact on clinical symptoms and signs	H	H
6.	Social and psychological issues relevant for children and families with allergic diseases	H	H
O- Training Objectives – Adolescents & Young Adults (AYA) (mandatory)		K	S
1	Develop skills in delivering age-appropriate, patient-centred allergy care to adolescents and young adults.		H
2	Recognise the psychosocial and behavioural factors influencing allergy management (e.g. adherence, risk-taking, independence).		H

3	Demonstrate competence in managing common AYA allergy presentations (e.g. Food Allergy, Anaphylaxis, Asthma) in this age group	H	H
4	Communicate effectively about risk, emergency planning, and lifestyle factors (school, social settings, travel, alcohol, exercise).	H	H
5	Work collaboratively with families while respecting emerging autonomy and confidentiality		H
6	Support transition from paediatric to adult allergy services, including promoting self-management and health literacy		H
P Research (mandatory)		**K**	**S**
1.	Scientific literature appraisal		H
2.	Training in planning, conducting, evaluating and publishing research projects		H
3.	Practical experience in presenting results to national and international audiences in form of oral or poster presentations		H
4.	Understand the importance of clinical trials in advancing therapeutic knowledge about allergic diseases. Understand the importance of good clinical practice and paediatric trial ethics consent. Role of registries and real-world data.	H	
Q Teaching (mandatory)		**K**	**S**
1.	Informal teaching of junior doctors or nurses in Paediatric Allergology during clinical work	H	
2.	Formal lectures in PA to medical students, junior doctors or nurses	H	
3.	Knowledge and application of educational programmes for parents and patients in PA	H	
R Paediatric Respiratory Medicine: Physiology and Assessment (mandatory)		**K**	**S**
1.	Developmental anatomy and physiology of the respiratory system including ventilation–perfusion and gas exchange	H	
2.	Physiology and evaluation of cough, shortness of breath and noisy breathing	H	H
3.	Respiratory function testing in infants, preschool aged and cooperative children and adolescents: measurement and interpretation of spirometry and lung volumes, interruption technique, impulse oscillometry, plethismograpy, lung diffusion, rapid thoraco-abdominal compression	H	I
4.	Performance and interpretation of reversibility and bronchial provocation testing	H	H
5.	Indication, interpretation and basic principles of conventional radiography, computed tomography, magnetic resonance imaging, ultrasonography and isotope imaging methods	H	I

6.	Indications and interpretation of the various airway endoscopy procedures in children: flexible and rigid bronchoscopy, broncho-alveolar lavage, bronchial biopsies	I	
7.	Indications and interpretation of cardio-respiratory poligraphy	I	
8.	Bronchial responsiveness: measurement, affecting factors, mechanisms, epidemiology and clinical application. Unspecific and specific challenge tests. Exercise Challenge test	H	H
9.	Non-invasive inflammation markers (including performance and interpretation of exhaled nitric oxide measurements)	H	H
10.	Invasive inflammation markers	I	
S Paediatric Respiratory Medicine: Disorders (mandatory)		**K**	**S**
1	Diagnosis and management of congenital malformations affecting the respiratory system	I	I
2	Prevention, diagnosis and management of Bronchopulmonary Dysplasia and chronic lung disease of infancy	I	I
3	Diagnosis and management of Cystic Fibrosis lung disease	H	I
4	Allergic bronchopulmonary Aspergillosis and hypersensitivity Pneumonitis	H	I
5	Diagnosis and management of other infrequent or rare lung diseases (gastroesophageal reflux associated lung disease, bronchiolitis obliterans, primary ciliary dyskinesia, neuromuscular diseases, etc)	H	H
6	Rehabilitation in chronic respiratory disorders	H	I
7	Diagnosis of and screening for obstructive sleep apnoea and upper airway resistance syndrome and hypoventilation	H	I
8	Non-invasive mechanical ventilation	H	I
T Adult Pulmonology/Allergology (optional)		**K**	**S**
1.	Experience in long term course of allergic diseases and asthma into adulthood.		I
2.	Ability to ease transfer of adolescent patients to adult care		H
U Laboratory (Immunology oriented) (optional)		**K**	**S**
1.	Quantification of total and specific IgE	I	
2.	Identification and characterization of antigens	B	
3.	Preparation of antigens	B	
4.	Epitope mapping and microarrays	I	
5.	Detection and quantification methods for other antibodies	B	
6.	Quantification of cytokines and inflammation markers	B	
7.	Flow cytometry for immune profiling: e.g., Treg, Th2/Th1 ratio	B	

8.	Functional assays: proliferation assays (T-cell function); Cytokine secretion assays (ELISA, multiplex bead assays)	B	
9.	Allergen-specific T cell assays	B	
10.	Morphological and functional examination of cells and molecules involved in the mechanisms of hypersensitivity and immunopathology	B	
11.	Single-cell RNA sequencing in allergic inflammation	B	
12.	Omics approaches (proteomics, metabolomics) in allergy research	B	
13.	Genetic testing in immunodeficiency and primary atopic disorders (e.g., STAT3, DOCK8)	B	
14.	Study of immune complexes	B	
15.	Quantitative and functional study of complement	B	
16.	Studies of cell populations and cellular immunity	I	
17.	Aerobiology and environmental studies	I	

V- Immunodeficiencies (optional)		**K**	**S**
1	**Fundamental Immunology** a- Detailed knowledge of innate and adaptive immunity, including specific and non-specific immune responses b- Molecular and genetic basis of immune function and immune disorders c- Mechanisms underlying primary immunodeficiencies d- Causes and mechanisms of secondary immunodeficiency, including principles of immunosuppression	H H H H	
2	**Disorders -Primary Immunodeficiencies** 2.1: - Diagnosis and classification of primary immunodeficiencies a- B-cell disorders b- T-cell disorders c- Combined immunodeficiencies d- Phagocytic disorders e- Complement deficiencies 2.2- Clinical evaluation and management of children with immunodeficiency disorders 2.3 Recognition and management of infections in the immunocompromised child 2.4 Principles and application of antimicrobial prophylaxis in immunodeficient patients	I H I	I H I

3	**Advanced Therapeutics**		
	3.1 Indications, principles, and outcomes of hematopoietic stem cell transplantation (bone marrow transplantation) for immunodeficiency disorders	I	
	3.2 Basic principles of bone marrow manipulation and cellular therapies	I	
4	**HIV and Acquired Immunodeficiency**.		
	4.1 Recognition, diagnosis, and longitudinal management of children with HIV/AIDS	I	I
	4.2 Family-centered care, counselling, and psychosocial considerations in HIV infection		I
5	**Diagnostic Immunology** (See also optional module T)		
	5.1 Laboratory evaluation of the immune system:		
	a. Immunoglobulin measurement	H	
	b. Lymphocyte subsets	H	
	c. Functional immune assays	H	
	d. Genetic testing	H	
	5.2 Interpretation of immunological investigations in clinical context	H	H

Entrustable Professional Activities (EPAs)

A trainee who has successfully fulfilled the requirements outlined in the above syllabus should be considered capable of undertaking, with an appropriate level of autonomy, a set of core clinical activities in paediatric allergology. These activities link competencies to practical clinical actions and are used to guide teaching, assessment, and the progressive development of the trainee's autonomy throughout the training programme.
They integrate multiple professional competencies, including patient care, medical knowledge, communication skills, professionalism, and system-based practice. The minimal set of these activities is defined in the table below.

EPA No.	Entrustable Professional Activity	Key Clinical Components	Typical Training Context
1	Perform comprehensive allergy-focused history and physical examination in children	Atopic history, environmental exposure, family history, allergic march, comorbidities	Outpatient clinic
2	Diagnose common paediatric allergic diseases	Asthma, allergic rhinitis, food allergy, atopic dermatitis, urticaria, drug allergy	Outpatient / hospital
3	Interpret and perform allergy diagnostic tests	Skin prick test, specific IgE, component-resolved diagnostics, patch testing	Allergy laboratory
4	Manage acute allergic reactions and anaphylaxis	Recognition, adrenaline administration, emergency management, patient stabilization	Emergency / inpatient
5	Develop and implement management plans for chronic allergic diseases	Asthma control plans, eczema management, rhinitis therapy	Outpatient clinic
6	Perform and interpret allergen challenge testing	Oral food challenge, drug challenge	Specialized allergy unit
7	Prescribe and monitor allergen immunotherapy	Indications, contraindications, subcutaneous and sublingual immunotherapy	Allergy clinic
9	Perform and interpret spirometry and bronchial reversibility tests in cooperative patients	Procedural skill, data interpretation, quality and safety, patient communication	Allergy Clinic
10	Educate patients and families on allergy prevention and management	Allergen avoidance, emergency plans, use of auto-injectors	Clinic / patient education
11	Coordinate multidisciplinary care for complex allergic diseases	Collaboration with dermatology, pulmonology, ENT, nutrition, genetics, psychology	Multidisciplinary clinics
12	Manage complex or rare allergic and immunologic conditions	Mastocytosis, eosinophilic disorders, primary immunodeficiencies with allergic manifestations	Tertiary centre
13	Participate in research, quality improvement, and clinical audit in paediatric allergy	Evidence-based practice, clinical trials, guideline implementation	Academic setting

2. Organization of Training

a. Minimal duration of training

A medical doctor who has successfully completed his/her training of at least 3 years in general paediatrics, including adolescent medicine, will be eligible for access to further specialist training in Paediatric Allergology. A clinical training period of full-time employment of 24 months, is considered adequate, but in some countries a longer training may be found.

b. Schedule and Curriculum of training

The following training periods are designed to provide education and develop understanding across the modules outlined in the training syllabus. Training in certain modules may be delivered across more than one department or unit. Some modules may have already been fully or partially covered during prior general paediatric training (Common Trunk).

Paediatric Allergy Department or Unit (minimum 18 months)
Modules A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q (in some hospitals also R, S and V)

ENT outpatient clinic (minimum 30 hours practicing ENT techniques and kills)
Module E

Paediatric Dermatology outpatient clinic (minimum 30 hours practicing Dermatology Skills)
Module F

Paediatric Respiratory Medicine Department or Unit (minimum 3 months)
Modules R and S

Immunology oriented Laboratory (optional - minimum 1 month)
Modules A,B,C,T,U and V

Paediatric Infectiology and/or Immunnology or Allergology Department (optional minimum 1 month)
Module V

Adult Allergy or Pulmonology Department (optional-minimum 1 month)
Module T

This **Training Curriculum** proposes convenient practical ways to achieve training in the different modules. Simultaneous training in several modules is possible, provided such a combination can be accepted as reasonable. A complete training can consist of modules acquired in several different training centres. At least one of these training locations should fulfil the criteria for a primary centre.

c. Other requirements

Mandatory

Certified training in Advanced Paediatric Life Support

At least four presentations in scientific meetings (oral or posters) two of them as first author

Teaching experience with medical students or younger colleagues

Desirable

At least one scientific paper published in a peer reviewed Journal, preferably as first author

d. Assessment and Evaluation

Competency assessment

Competencies should be evaluated throughout the training period. There are several different tools for this, describing different aspects of training, some of which are set out below.
Formal and informal reflection on these assessments is an important aspect of their success.

Assessment	Purpose	Method
Mini clinical examination	Provides feedback on skills needed in clinical care	Trainer observes a trainee examining a patient and explaining the management plan to the parents
Case based discussion	Assesses clinical reasoning or decision making	Trainee presents a more complex case to the trainer and discusses the evidence or basis for diagnosis or treatment.
Directly observed procedural skills	Assesses practical skills	Trainee undertakes a practical skill whilst being observed
Leadership	Focuses on leadership skills	A trainee is observed leading a team (eg during a resuscitation)
Handover assessment tool	Evaluates handover skills	Handover episodes are supervised and discussed
Discussion of correspondence	Assesses letter writing skills	Clinic letters or discharges are reviewed and discussed
Multi-source feedback	Provides wider feedback on the performance of the trainee	Confidential comments from a wide range of colleagues, patients and the trainee are sought

A formal assessment of theoretical knowledge is recommended, ideally as part of a national final examination.
The EAACI/UEMS Paediatric Knowledge Exam represents a specialized track within the European Academy of Allergy and Clinical Immunology (EAACI) Knowledge Exam, specifically designed for healthcare professionals specializing in paediatric allergology and clinical immunology. This examination evaluates the essential theoretical knowledge and clinical understanding required to diagnose and manage allergic and immunologic conditions in children and adolescents.
It is suggested that national training authorities consider recognizing this exam as an optional alternative to national knowledge assessments, where appropriate.

d- Governance

Participation in Audit project
The trainee should conduct at least one systematic style review of a topic and in addition prepare a detailed evidence-based appraisal of a diagnostic test or a therapeutic intervention.

IV – TRAINING REQUIREMENTS FOR TRAINERS (TEACHERS) IN PAEDIATRIC ALLERGOLOGY

1.- Process of recognition as a trainer

a Requested qualification and experience

The training staff in a Centre should include at least two trainers. The Training Programme Director (TPD) must have been practising Paediatric Allergology for at least five years and must hold specialist accreditation in this area recognised by EAP/EBP.

In accordance with the recommendation of the ETR Review Committee and the UEMS Enlarged Executive Committee, the Training Programme Director must have successfully completed a recognised **Training-the-Trainer Course** (or an equivalent faculty development programme) designed to prepare physicians for educational and supervisory responsibilities in postgraduate medical training.

A trainer is a professional with recognised expertise in Paediatric Allergology or in other relevant related fields. Their contribution to the training programme may be focused specifically on these areas of specialisation. Both educational supervisors and trainers must have at least two years of post-certification experience in Paediatric Allergology or in a related complementary specialty relevant to Paediatric Allergy training.

Trainers and educational supervisors involved in the supervision and assessment of trainees are expected to undertake appropriate faculty development, including recognised **Training-the-Trainer or medical education courses**, in order to ensure adequate preparation for their educational, supervisory and assessment responsibilities.

When an aspect of training cannot be provided in one centre, arrangements must be made for the trainee to receive this training in another suitable centre under the supervision of a trainer approved for that purpose.

a. Core competencies for trainers

Trainers should develop and implement an individualised training programme for each trainee, taking into account the trainee's competencies, learning needs and the facilities available within the institution. The training programme should be reviewed regularly in order to allow appropriate flexibility and to facilitate early identification of problems or deficiencies. Trainers should work with the trainee to establish and maintain a Personal Development Plan (PDP).

Trainers should demonstrate competencies in clinical teaching, supervision, provision of structured feedback, and trainee assessment. They should be familiar with the principles of competency-based medical education, including the use of workplace-based assessment tools and portfolio-based learning.

2- Quality management for trainers

Trainers are responsible for the regular appraisal and assessment of trainee progress. Appraisal consists of identifying learning needs and determining the evidence required to demonstrate that these needs have been addressed. Assessment evaluates progress against the defined objectives of the training programme.

Trainee assessment should include consideration of:

- Training and career ambitions
- Training experience in relation to the syllabus
- Achievements in relation to the current training plan

To provide a close personal monitoring of the trainee during his/her training, the number of trainees should not exceed the number of teachers in the centre.

Trainers will meet the trainee at the beginning of the programme to define the educational contract for that trainee. Reviews of progress should take place at 3 monthly intervals during the first year of training to appraise the individual.

An assessment should be undertaken after the first year, to review competencies achieved and to allow progress within the teaching programme. Assessments should be detailed and contain statements of theoretical and practical experience accumulated by the trainee. It is expected that the trainee will also provide an account of the training received and problems encountered (portfolio). Reports will be submitted to the TPD or national body.
Final assessment should ideally be at the national level

V- TRAINING REQUIREMENTS FOR TRAINING INSTITUTIONS

1. Process for recognition as training centre

a. General requirements

A training centre can be a single institution or a group of related establishments.

Affiliation

Paediatric Hospitals, Paediatric Departments in University Hospitals, Paediatric Departments in other reference Hospitals and if not available, Allergy Units or Departments with significant Paediatric Allergology activity, preferably in an autonomous unit, may also be accepted.

Preferential denomination: Paediatric Allergy Department, Clinic or Unit.

b. Accreditation of Centres

For each EU Member country, a list of centres, units, training directors, tutors and teachers should be compiled and updated on an annual basis. Each centre is characterised by the available modules or areas of teaching activity, tutors and teachers available and the size of the clinical practice as defined by the needs of the trainee.

c. Central Monitoring authority for Paediatric Allergology at EC level

It is expected that each country where PA is officially recognized has its own system of centre and specialist certification and training program accreditation. Although regulatory bodies in each country are autonomous in establishing their own rules, it is desirable that they follow as closely as possible European guidelines for training programs and centre certification.

The European certification of training institutions can be accomplished both in countries where PA is already recognized, in this case at the request or with the agreement of national regulatory bodies and in countries without a national recognition of PA in which case it may be a stimulus for the recognition of the sub-speciality. The European recognition of training institutions will ultimately be part of a joint process involving EAP-UEMS and the specialist society. It is anticipated that SP-EAACI and ETC-PA will be endorsed by EBP and EAP-UEMS to execute this task. A list of the names and characteristics of existing national training centres will be created and held by SP-EAACI/ETC-PA and EBP/EAP-UEMS who will oversee quality assurance of the recognised centres at periodic intervals (desirably every 5 years), using the guidelines suggested by the UEMS. In countries where national certification clearly meets European standards, this can be endorsed by SP-EAACI/ETC-PA and EBP-EAP/UEMS.

d. Requirement on staff and clinical activities

The Training Centre may consist of more than one centre in close collaboration and should include at least two paediatricians certified in Paediatric Allergology and

desirably one in Paediatric Respiratory Medicine and one in Paediatric Gastroenterology. Part of the clinical and scientific training can also be located to other units, provided there is a close collaboration with the Training Centre.

The medical staff should have clinical, teaching and research activity.

It is important to have nurses and non-medical staff with expertise in allergy testing, pulmonary function, psychological and social work, nutrition, physiotherapy etc. and patient education, who might also participate in teaching and research activities.

The Training Centre should have the capacity to diagnose and treat paediatric patients of all ages, including adolescents, with any allergic disease in any organ system.

Outpatient clinic with enough primary attendances and return visits to allow meaningful education of trainees and assure they get enough experience. The number of trainees must be adjusted to the number of attending patients. There must be also available hospital beds for admission of patients with allergic diseases.

The clinical activities of a primary Paediatric Allergology Training Centre should be sufficiently diverse to support comprehensive training across modules A to P of the Training Syllabus. There is no fixed requirement for the number of patients treated, whether as inpatients or outpatients, as this will depend on the range of pathologies encountered and the number of trainees and trainers involved.

There should be clinical conferences on specific subjects and patients on a periodic basis (optimally every week).

e. Scientific activity

The centre should have the capacity to perform clinical research and to cooperate in laboratory research, assuring that the trainees are involved in scientific activities and publications. They should, acquire and develop skills for critical evaluation of published studies. Thus, regular research seminars on paediatric allergology and related disciplines should be arranged.

f. Requirement on equipment. Accommodation and other resources

i. Premises

Besides the general facilities assumed to be available in an average Hospital or Clinic, the Training Centre should provide:

- One consulting room for each doctor during his/her service in the outpatient ward
- Facilities for allergy skin testing
- Facilities for non-specific and specific allergy bronchial challenge testing with appropriate ventilation, i.e. with equipment for active evacuation of air at the site of the test, and safety prescriptions
- Facilities suitable for oral, nasal and conjunctival challenge testing
- Facilities for pulmonary function testing of different kinds
- Facilities for allergen immunotherapy near the nurse/assistant's room

- Meeting room for staff
- Access to specialized books and journals in a library and on the internet
- General teaching and learning facilities, like computers, internet, data-show etc

ii. Equipment

Training Centres should have available the specific equipment necessary for the comprehensive care of allergic children, to be able to fulfil the learning objectives of the European Training Syllabus in Paediatric Allergology, including all relevant diagnostic and therapeutic methods

Basic essential

- Basic paediatric office equipment (stethoscopes, otoscopes, scales, etc)
- Allergen extracts for the different kinds of tests
- Preparations for direct and equipment for indirect bronchial challenge testing
- Peak-flow meters
- Spirometer/s
- Facilities for bronchial provocation tests with equipment for evacuation of allergen/methacholine/histamine-containing air
- Spacers and face masks
- Placebo inhaler devices
- Refrigerator(s) and freezers
- Facilities for exercise testing
- Equipment for the determination of exhaled Nitric Oxide

Emergency equipment

- Necessary equipment for cardio-pulmonary resuscitation and severe anaphylaxis treatment according to established good practice rules

Desirable

- Rhinomanometer
- Tympanogram equipment
- Audiometry equipment
- Equipment for Plethysmography
- Infant pulmonary testing equipment
- Equipment for testing inert gas wash out
- Equipment for cold air hyperventilation tests
- Equipment for flexible bronchoscopy
- Equipment for testing pH in the oesophagus
- Equipment for oesophago-gastroscopy, colonoscopy and rectoscopy

iii. Laboratory resources

All relevant current laboratory studies to investigate allergic children should be available either in the Training Centre or in a clinical laboratory directly cooperating with the Training Centre.

iv. Other resources in close collaboration

- An X-ray department with modern equipment should be available for close cooperation.
- ENT department with doctor(s) with an interest in paediatric allergology
- Dermatological department with dermatologist(s) interested in paediatric allergology
- Respiratory medicine department with a doctor trained in paediatric diagnostic techniques.
- Nutritionist experienced in paediatrics or preferably in paediatric allergology
- Child psychiatry or social worker and psychologist with training in family therapy and group therapy
- Physiotherapist and or other person trained in physical training

2. Quality management within training institutions

Achieving excellence in the training of healthcare professionals in Paediatric Allergology requires the implementation of a robust, transparent, and coordinated quality management framework. This framework should encompass rigorous accreditation procedures, strong principles of clinical governance, forward-looking manpower planning, and effective systems for continuous evaluation.

Training institutions should be accredited in accordance with European standards, as defined by the relevant European scientific societies and endorsed by the European Academy of Paediatrics (EAP) and the European Board of Paediatrics (EBP). Training programmes must align with the UEMS guidelines to ensure consistency and quality across Europe.

At the heart of high-quality training lies clinical governance, which safeguards accountability within clinical teaching environments. Governance structures must oversee clinical outcomes, uphold ethical standards, and integrate patient safety into the core of the educational experience.

Strategic manpower planning is essential to meet the future needs of paediatric allergy care. Institutions must anticipate evolving workforce needs and adapt their recruitment strategies to ensure enough qualified specialists.

To support ongoing quality improvement, institutions should generate regular reports outlining key performance indicators, trainee progress, and curricular updates. These reports should inform both internal quality reviews and external audits.

Regular external audits, conducted by independent professional bodies at the national level, are crucial for maintaining high standards. It is recommended that at least one or more leading centres in each country be accredited by the EAP/EBP, in collaboration with the Paediatric Section of EAACI and the country's National PA Society or PA Section of the National Paediatric Society. These centres would act as national reference hubs, setting benchmarks in training excellence and facilitating the progressive accreditation of additional institutions across the country. This desirable collaborative, network-based model promotes consistency, quality, and mutual support throughout Europe.

Ensuring the transparency of training procedures is essential to build confidence among trainees, healthcare institutions, and the public. Transparent practices should encompass selection criteria, curriculum content, teaching and assessment methods, faculty qualifications, and feedback systems.

Finally, a clearly defined structure for coordination of training must be in place at both the national and institutional levels. This includes delineated roles for training directors, academic committees, and clinical supervisors to ensure coherent, well-integrated programme delivery across all participating sites.

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14. UEMS Council for European Specialists Medical Assessment (CESMA). guideline for the quality control on behalf of UEMS-CESMAof European postgraduate medical assessment

VII -GLOSSARY/ACRONYMS

Acronym Meaning

AYA	Adolescents and Young Adults
BAT	Basophile Activation Test
CPD	Continuing Professional Development
DPT	Drug Provocation Test
EPA	Entrustable Professional Activity
EAACI	European Academy of Allergy and Clinical Immunology
EAP	European Academy of Paediatrics
EBP	European Board of Paediatrics
EC	European Community
ENT	Ear Nose and Throat
EPAL	European Paediatric Allergy
EPIT	Epicutaneous Immunotherapy
ETC-PA	European Training Committee Paediatric Allergology
ETR	European Training Requirements
EU	European Union
HRT	Histamine Realeasing Test
IDIT	Intradermal Immunotherapy
IT	Immunotherapy
MMR	Measles, Mumps and Rubella
OIT	Oral Immunotherapy
NTAs	National Training Authorities
PDP	Personal Development Plan
TARC	Thymus and Activation-Regulated Chemokine
SCIT	Subcutaneous Immunotherapy
SLIT	Sublingual Immunotherapy
TPD	Training Program Director
UEMS	European Union of Medical Specialists
VIT	Venom Immunotherapy
WMA	World Medical Association

VIII - APPENDICES

In this agreement it is stated that ***"****The Section on Paediatrics will safeguard the interests of the UEMS approved Subspeciality of "Pediatric Allergology". EAACI supports the concept that Paediatric Allergology should be a Subspeciality within Paediatrics,"*

Appendix 1 - UEMS Charter on Training of Medical Specialists in the EU

UNION EUROPÉENNE DES MÉDECINS SPÉCIALISTES
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CHARTER on TRAINING of MEDICAL SPECIALISTS in the EUROPEAN COMMUNITY

Charter adopted by the Management Council of the UEMS, October 1993

Introduction

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A . PREAMBLE

The Treaty of Rome provides for the free exchange of persons, services, goods, and capital within the European Community. Free exchange of persons and services within the medical sector has been achieved by mutual recognition of basic and specialist medical qualifications brought into effect by the Commission of the European Communities (EC) in 1975. The Directives have been consolidated in the **Directive 93/16/EEC of 5 April 1993**.

The Directive 93/16 specifies in its articles:

4. Each Member State shall recognize the diplomas, certificates and other evidence of formal qualifications in specialized medicine awarded to nationals of Member States by the other Member States in accordance with Articles 24, 25, 26 and 29 and which are listed in Article 5, by giving such qualification the same effect in its territory as those which the Member State itself awards.

24. Member States shall ensure that the training leading to a diploma, certificate or other evidence of formal qualifications in specialized medicine, meets the following requirements at least:
    (a) it shall entail the successful completion of six years' study within the framework of the training course referred to in Article 23 (basic medical training);
    (b) it shall comprise theoretical and practical instruction;
    (c) it shall be a full-time course (or equivalent part-time training according to Article
    25) supervised by the competent authorities or bodies ;

(d) it shall be in a university centre, in a teaching hospital or, where appropriate, in a health establishment approved for this purpose by the competent authorities or bodies;
(e) it shall involve the personal participation of the physician training to be a specialist in the activity and in the responsibilities of the establishments concerned.

26. Member States shall ensure that the minimum length of the specialized training courses mentioned below may not be less than the following: Article 26-27.

42. Member States shall designate the authorities and bodies competent to issue or receive the diplomas, certificates and other evidence of formal qualifications as well as the documents and information referred to in this Directive and shall forthwith inform the other Member States and the Commission thereof.

B. OBJECTIVES of the Charter on training of medical specialists in the EC

The Charter describes the requirements for adequate training, which prepares specialists for practice of their specialty at an appropriate level in any Member State of the EC. The definition of the content of this training is necessary to further the harmonization of training into medical specialties in the EC. This charter divides the requirements regarding content of training into a general part, defined by the European Union of Medical Specialists (UEMS), and a specific part for each recognized specialty, defined by the UEMS Specialized Sections.

C. DEFINITIONS

C.1 The **UEMS (Union Européenne des Médecins Spécialistes)** is the representative organization of all medical specialists in the EC. The UEMS is constituted by the representative organizations of medical specialists in the member states of the EC and the EFTA countries as well as associate members and observers from other European countries.

C.2 A **Specialty** is a nationally or internationally recognized area of medical specialization for which a structured postgraduate training programme exists.

C.3 A **UEMS/Specialized Section** is the representative body of physicians in the EC in any given specialty. Members of the UEMS/Specialized Sections are appointed by the appropriate professional organizations of the specialties in the EC member states and EFTA countries in accordance with UEMS rules of procedure. The UEMS/Specialized Sections deliberate and make proposals on matters of concern to their particular specialty and submit their findings to the UEMS in order that they may be coordinated as necessary with the interests of the other specialties and the profession as a whole.

C.4. A **National Board** is the (representative) national (professional) organization, which monitors the training of medical specialists in each of the member states according to the rules in existence within the EC and within the EC member states. Its task includes setting national standards and supervising the following:

- duration of training,
- contents of training,
- quality control,
- control of capacity of training according to demand,
- procedures for entrance of training,
- assessments or other means of qualification.

C.5 A **European Board** is a body set up by the relevant UEMS/Specialized Section with the purpose of guaranteeing the highest standards of care in the specialty concerned in the EC member states by ensuring that the training of specialists is raised to an adequate level. This aim is achieved by the following means:

- recommendations for setting and maintaining standards of training,
- recommendations for training quality,
- recommendations for setting standards and recognition of training institutions,
- monitoring of the contents and quality and the evaluation of training in the EC member states,
- facilitation of exchange of trainees between the EC member states
- facilitation of free movement of specialists in the EC.

C.6 - The **National Authority** is the body responsible for qualification of medical specialists in each member state of the EC. It can be a combination of competent professional or university organizations, a national Board or a national governmental authority advised by a professional authority. It sets standards in accordance with national rules and EC legislation as well as considering UEMS/European Board recommendations. In some cases, the National Authority is organized regionally within the country with national coordination.

CHARTER on TRAINING of MEDICAL SPECIALISTS in the EC

1. CHAPTER 1, NATIONAL AUTHORITY

1.1. Article 1

NATIONAL AUTHORITY

At national level, the training of medical specialists is regulated by a National Authority, which can be a combination of competent professional or university organizations, a national Board or a national governmental authority advised by a professional authority. It sets standards in accordance with national rules and EC legislation as well as considering UEMS/European Board recommendations. In some cases, the National Authority is organized regionally within the country with national coordination.

1.2 . Article 2

RECOGNITION of TEACHERS and TRAINING INSTITUTIONS

The National Authority is responsible for selecting and approving training institutions and teachers at national level in accordance with national rules and EC legislation as well as considering UEMS/European Board recommendations.

1.3. Article 3

QUALITY ASSURANCE

The National Authority is responsible for setting up at national level a programme for quality assurance of training and of teachers and training institutions in accordance with national rules and EC legislation as well as considering UEMS/European Board recommendations.

1.4. Article 4

QUALIFICATION of MEDICAL SPECIALISTS

The National Authority is responsible for implementing at national level a system of qualification of medical specialists in accordance with national rules and EC legislation as well as considering UEMS/European Board recommendations.

1.5. Article 5

MANPOWER PLANNING

The National Authority in cooperation with national professional and/or scientific organizations in the specialty concerned is responsible for developing a manpower planning policy at national level which aims at balancing demand and training for medical specialists in the EC member state concerned. The National Authority should be involved in the implementation of this policy.

1.6. Article 6

REGISTER of MEDICAL SPECIALISTS

The National Authority or its delegate is responsible for keeping a register at national level of medical specialists with data about their specialty, competences and other relevant matters. Medical specialists should practise one recognized specialty or group of related specialties only except in specifically permitted instances. The standard requirements for qualification in each specialty may not be lessened when a specialist is recognized in more than one specialty.

2 CHAPTER 2, GENERAL ASPECTS of TRAINING of MEDICAL SPECIALISTS

2.1. Article 1

SELECTION for and ACCESS to the TRAINING of MEDICAL SPECIALISTS

Teachers and training institutions or other responsible bodies select and appoint trainees who are suitable for the specialty concerned in accordance with an established selection procedure. This selection procedure should be transparent, and application should be open to all persons who have completed basic medical training.

2.2. Article 2

DURATION of TRAINING

The duration of training of medical specialists should be sufficient for training in the full range of the specialty and for independent practice of the specialty after completion of training. Training should by preference take place in a full-time appointment. For part-time training an individually tailored programme should be approved by the National Authority.

2.3. Article 3

COMMON TRUNK

For internal medicine and related specialties, for surgical specialties and for paediatric specialties general training in fundamental knowledge and skills will take place in common trunk training for the respective specialty. All trainees should have training in administration, management and economics of specialized medicine.

2.4. Article 4

TRAINING PROGRAMME, TRAINING LOGBOOK

Training should take place following an established programme with specified contents approved by the National Authority in accordance with national rules and EC legislation as well as considering UEMS/ European Board recommendations. The different stages of training and the activities of the trainee should be recorded in a training log-book.

2.5. Article 5

QUALITY ASSURANCE

The National Authority together with the teachers and training institutions should implement a policy of quality assurance of the training. This may include visits to training institutions, assessments of the training, monitoring of the logbook or other means. Visitation of training institutions by the National Authority should be conducted in a structured manner.

2.6. Article 6

NUMERUS CLAUSUS

The National Authority should implement regulation of access to training in any specialty in accordance with national manpower planning projections in the EC member state.

2.7. Article 7

TRAINING ABROAD in the EC

Trainees should have the opportunity to be trained in recognized training institutions in other EC member states during their training with approval of their training programme by the National Authority of the country of origin. National Authorities can recognize training in non-EC countries if they so wish.

3. CHAPTER 3, REQUIREMENTS for TRAINING INSTITUTIONS

3.1. Article 1

RECOGNITION of the TRAINING INSTITUTIONS

Training institutions shall be recognized by the National Authority.

3.2. Article 2

SIZE of the TRAINING INSTITUTION

Training should take place in an institution or group of institutions which together offer the trainee practice in the full range of the specialty with consultations and practical procedures that are sufficiently varied and quantitatively and qualitatively sufficient, including inpatient care, day care and outpatient (ambulatory) training. Allied specialties should be present to a sufficient extent to provide the trainee with the opportunity of developing his/her skills in a team approach to patient care. Sub specialized institutions may be recognized by the National Authority for periods of the training.

3.3. Article 3

QUALITY ASSURANCE of the TRAINING INSTITUTION

The training institution should have an internal system of medical audit or quality assurance including features such as mortality conferences, reporting of accidents in accordance with a structured procedure. Furthermore, various hospital activities in the field of quality control such as infection control and drugs and therapeutics committees should exist. Visitation of training institutions by the National Authority should be conducted in a structured manner.

3.4. Article 4

TEACHING INFRASTRUCTURE of the INSTITUTION

In the institution, the trainee should have space and opportunities for practical and theoretical study. Access to adequate national and international professional literature should be provided as well as space and equipment for practical training of techniques in a laboratory setting.

4. CHAPTER 4, REQUIREMENTS for the post of CHIEF of TRAINING

4.1. Article 1

QUALIFICATION of the TEACHER

The chief of training should have been practising the specialty for at least 5 years after specialist accreditation or should have completed a specific training programme before recognition as such. There should be additional teaching staff. The chief of training and the staff should be practising the specialty in its full extent. Sub specialized teachers may be recognized by the National Authority for periods during the training.

4.2. Article 2

TRAINING PROGRAMME

The training programme for each trainee should be structured in accordance with national rules and EC legislation as well as considering UEMS/European Board recommendations.

4.3. Article 3

TEACHER/TRAINEE RATIO

The ratio between the number of qualified specialists on the teaching staff and the number of trainees should provide close personal monitoring of the trainee during his/her training and provide adequate exposure of the trainee to the training.

5. CHAPTER 5, REQUIREMENTS for TRAINEES

5.1. Article 1

EXPERIENCE

To build up his/her experience, the trainee should be involved in the treatment of a sufficient number of outpatients (ambulatory) and inpatients and perform an adequate number of procedures of sufficient diversity.

5.2. Article 2

LANGUAGE

The trainee should have sufficient linguistic ability to communicate with patients and to study international literature and communicate with foreign colleagues.

5.3. Article 3

LOGBOOK

The trainee should keep his/her personal log-book or equivalent up to date according to national rules and EC Directives as well as considering UEMS/European Board recommendations.

6. CHAPTER 6, REQUIREMENTS for the particular SPECIALTY: to be filled in by the appropriate UEMS Specialist Section

6.1. Article 1

CENTRAL MONITORING AUTHORITY for Individual Specialties at EC level:

1.1. There should be a monitoring authority for each individual specialty in the EC. This may be the UEMS/Specialized Section itself, the European Board or a body with close links with these institutions.
1.2. General standards for recognition of institutions and teachers in the specialty should be laid down.
1.3. A programme for quality assurance of training in the specialty should be laid down.
1.4. The system for recognition of quality in the specialty should be monitored.
1.5. The system for manpower planning in the specialty should be monitored.

6.2. Article 2

GENERAL ASPECTS of TRAINING in the SPECIALTY:

Specific rules should be laid down for the following aspects:

2.1. Selection for and access to the specialty.
2.2. Determination of the adequate duration of the training in the specialty.
2.3. Definition of the common trunk in training in the specialty.
2.4. Implementation of a training programme with specified contents and a training log-book in the specialty.
2.5. Implementation of a system of quality control and assessment of training in the specialty.
2.6. Implementation of numerus clausus, if necessary, within the framework of man- power planning policy in the specialty.
2.7. Facilitation of training periods abroad in the EC during the training for the specialty.

6.3. Article 3

REQUIREMENTS for TRAINING INSTITUTIONS

Specific rules should be laid down concerning:

3.1. Recognition of training institutions for the specialty.
3.2. The size and diversity of the training institution or group of institutions, the number of admissions to the institution(s) including day care, outpatient (ambulatory) activity and inpatient care, the number and diversity of practical procedures as well
as appropriate access to other relevant specialties.
3.3. Quality assurance in the institution. Visitation of training institutions by the National Authority should be conducted in a structured manner.

6.4. Article 4

REQUIREMENTS for TEACHERS within the specialty:

4.1. The chief of training should have been practising the specialty for at least 5 years after specialist accreditation or should have completed a specific training programme before recognition as such. There should be additional teaching staff.
The teacher and the staff should be practising the specialty in its full extent. Sub specialized teachers may be recognized by the National Authority for periods during the training.
4.2. The teacher should work out a training programme for the trainee in accordance with the trainee's own qualities and the possibilities of the institution, which also complies with national rules and EC Directives and considers UEMS/European Board recommendations.
4.3. The ratio between the number of qualified specialists in the teaching staff and the number of trainees should provide a close personal monitoring of the trainee during his/her training and provide adequate exposure of the trainee to the training.

6.5 - Article 5

REQUIREMENTS for TRAINEES

5.1. Experience: To build up his/her experience, the trainee should be involved in the treatment of a sufficient number of inpatients, day care patients, and outpatients (ambulatory) and perform a sufficient number of practical procedures of sufficient diversity.
5.2 . The trainee should have sufficient linguistic ability to communicate with patients and to study international literature and communicate with foreign colleagues.

5.2. The trainee should keep his/her personal logbook or equivalent up to date according to national rules and EC Directives as well considering UEMS/European Board recommendations.

Training requirements for each specialty separately: see Chapter 6

Appendix 2- Training Requirements for the Speciality of Paediatrics

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Training Requirements for the Specialty of Paediatrics

European Standards of Postgraduate Medical Specialist Training

(old chapter 6)

Preamble

The UEMS is a non-governmental organisation representing national associations of medical specialists at the European Level. With a current membership of 34 national associations and operating through 40 Specialist Sections and European Boards, the UEMS is committed to promote the free movement of medical specialists across Europe while ensuring the highest level of training which will pave the way to the improvement of quality of care for the benefit of all European citizens. The UEMS areas of expertise notably encompass Continuing Medical Education, Post Graduate Training and Quality Assurance.

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

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

More than a decade after the introduction of this Charter, the UEMS Specialist Sections and European Boards have continued working on developing these European Standards in Medical training that reflects modern medical practice and current scientific findings. In doing so, the UEMS Specialist Sections and European Boards did not aimed to supersede the National Authorities' competence in defining the content of postgraduate training in their own State but rather to complement these and ensure that high quality training is provided across Europe.

At the European level, the legal mechanism ensuring the free movement of doctors through the recognition of their qualifications was established back in the 1970s by the European Union. Sectorial Directives were adopted and one Directive addressed specifically the issue of medical Training at the European level. However, in 2005, the European Commission proposed to the European Parliament and Council to have a unique legal framework for the recognition of the Professional Qualifications to facilitate and improve the mobility of all workers throughout Europe. This Directive 2005/36/EC established the mechanism of automatic mutual recognition of qualifications for medical doctors according to training requirements within all Member States; this is based on the length of training in the Specialty and the title of qualification.

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

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

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

Introduction

General Policy Statement

The objectives of the European Board of Paediatrics (EBP) are to assess, set standards for and progressively harmonize the content and quality of training and continuing medical education in all fields of paediatrics within the member states of the European Union (EU) and the other European countries.

There is a trend towards increasing specialization within paediatrics which has progressed to different degrees in different parts of the EU and some of the fields of paediatrics encompassed by the EBP have become recognized in some countries as well-defined or even totally independent paediatric specialties.

The trend towards greater specialization is supported by the EBP whenever consistent with improved standards of clinical practice and training. However, in order to meet the needs of the many European hospitals which are not large enough to justify the same highly compartmentalized departments of paediatrics that have become the norm in most teaching centres it is essential to ensure that paediatricians are able to obtain broadly based training across all the various fields. This makes it essential for newly emerging paediatric specialties to continue to collaborate closely within the well-defined framework of the EBP.

In order to encourage beneficial specialization, while maintaining the integrity of paediatrics as a whole, it is the policy of the EBP to establish Paediatric Specialty Boards to accommodate the special requirements of well-defined areas of paediatric practice.

Paediatric specialty Boards have responsibility for establishing and monitoring standards of training within their specific field of paediatrics while the EBP functions as a "*common house of paediatrics*" to coordinate the interrelationship, recommendations and actions of the Paediatric Specialty Boards as they develop.

The EBP will require input from the Specialty Boards in common trunk training. It is empowered to issue European Board of Paediatrics Certificates of Quality of Training (EBPCQT) in the paediatric specialties on the recommendation of its Paediatric Specialty Boards.

The EBP cooperates with national professional authorities and especially with the scientific organisations in the process of standardisation and harmonisation of paediatric curricula.

The standardisation efforts are paralleled with the continuous development of paediatric qualification, validation, certification, recertification, professional development and CME processes and projects.

The EBP enhances strategies to see the Board qualification (Fellowship of the EBP) legally adopted in the countries aiming to a common European qualification process, that also respects national and regional peculiarities.

Training Policy and requirements

The EBP, composed of representatives of the national professional paediatric organisations, the national scientific paediatric organisations and the universities promotes the cooperation between these entities and the harmonisation of paediatric training programs in the EU.

It acts as a coordinating and monitoring body for the training in paediatrics in the EU and formulates standards, mentioned hereafter, for the training institutions, the teachers and the trainees within the specialty of paediatrics.

Teachers and training institutions select and appoint trainees who are suitable for paediatrics. In order to train the most suitable individuals for this specialty, a selection procedure on a national basis must be set up. This selection procedure must be transparent and application must be open to all persons who have completed basis medical training.

The duration of paediatric training should be five years, after having completed medical school.

A three-year basic training program should be incorporated in the full training during which the paediatric trainee shall acquire a central core of knowledge embracing physiology, development and growth, metabolism and nutrition, immunology and infectious diseases, pathology, neonatology, trauma and resuscitation, emergency and intensive care, safeguarding.

The common trunk training in general paediatrics sets the foundation for an additional 2 (to 3) years in one of the three options the discipline of paediatrics can encompass:
· Primary care or community paediatrics
· Secondary care or hospital-based general paediatrics
· Tertiary care or hospital-based paediatric subspecialities (see list in Annex 2).

Trainees must acquire experience in each of the areas of responsibility as given under the syllabus of general paediatrics, in a structured and approved training program. Skill experience should be documented in adequate log-books. Credit as paediatrician can only be claimed when the trainee has actively participated in all phases of treatment; has made or confirmed the diagnosis, participated in the selection of the appropriate procedure, has either performed or been responsibly involved in performing procedures and has been a responsible participant in both acute and chronic care.

The National Training Authorities (NTA) and/or the EBP, together with the teachers and training institutions shall implement a policy of quality assurance of the training. This includes visits to training institutions, assessment during training, monitoring of the log-books or other means. Visitation of training institutions by the NTA and/or the EBP shall be conducted in a structured manner.

Each country should train only enough paediatricians to meet its own requirements. A European quorum, suggested by the EBP, should be established on an annual basis between member states of the EU. Trainees should have the opportunity to be partly

trained in recognized training institutions both in other member states of the EU as well as outside the EU. These training periods have to be approved by the NTA. The EBP shall maintain a list of training centres in the EU willing to exchange trainees. The EBP strongly recommends a period of basic or clinical research within the training program.

Training institutions need be recognized by their proper NTA.

Training must take place in an institution or group of institutions which together offer the trainee practice in the full range of the specialty as defined in the syllabus. Consultations and procedures should be sufficiently varied, quantitatively and qualitatively sufficient, and include training in inpatient care, day care and ambulatory care.

Neighbouring specialties must be present to a sufficient extent to provide the trainees the opportunity of developing their skills in a team approach to patient care. Super specialised institutions may be recognized by the NTA for periods of training.

The training institution must have an internal system of paediatric audit/quality assurance including features such as mortality and morbidity conferences and structured incident-reporting procedures. Furthermore, various hospital activities in the field of quality control such as infection control and drugs and therapeutic committees should exist. Visitation of training centres by the NTA or the EBP shall be conducted in a structured manner.

In the training centre the trainee should have space and opportunities for practical and theoretical study. Access to adequate national and international professional literature should be provided (library) as well as space and equipment for practical training of techniques in a laboratory setting.

The chief of training should have been practicing paediatrics for at least 5 years after specialist accreditation and must have been recognized by his NTA. The Chief of training and his associate training staff should be actively practicing paediatrics.

The training program should be structured in accordance with national rules and EU/EBP recommendations. The ratio between the number of specialists on the teaching staff and the number of trainees at any given moment should be tailored so as to provide close personal monitoring of the trainees as well as adequate exposure of the trainees to sufficient practical work.

To build up their experience the trainees should be involved in the management of a sufficient number of inpatients, day care patients and ambulatory patients. They must perform a minimum number of practical procedures. The amount and diversity of these procedures is set by the NTA and agreed by the EBP.

The trainees must have sufficient linguistic ability to be able to communicate with patients, to study international literature and to communicate with foreign colleagues. The trainees shall keep up their personal log-books according to national rules and EU/EBP recommendations.

TRAINING REQUIREMENTS FOR TRAINEES

1. Content of training and learning outcome

Paediatrics is an independent medical specialty based on the knowledge and skills required for the prevention, diagnosis and management of all aspects of illness and injury affecting children of all age groups from birth to the end of adolescence, up to the age of 18 years.[2] Eighteen years of age has also been retained by the Global Pediatric Education Consortium to define the field of paediatrics.[3]

Paediatrics is not just about the recognition and treatment of illness in babies and children. It also encompasses child health, which covers all aspects of growth and development and the prevention of disease.

The practice of Paediatrics encompasses several aspects including *preventive paediatrics, social and community paediatrics* as the influence of the family and other environmental factors play a large role in the development of the child, and *acute and specialised paediatrics.* These specialised areas include many conditions that require life-long management and follow-up before a smooth transition of care to adult services.

The paediatrician must have acquired and must maintain *"Theoretical knowledge"* in basic sciences required in the practice of paediatrics, namely genetics, physiology of organ development, growth and nutrition, immunology and infectious diseases, pharmacology and metabolism, and *"Practical and clinical skills"* relating to diagnosis and therapy. He/she must also acquire good knowledge and attitudes in relation to communication and interpersonal skills, ethics and professionalism, patient safety and quality improvement.

The Common Trunk Curriculum comprehensively describes *"Theoretical knowledge"* and *"Practical and Clinical Skills"* (basis for an individual "Log-book") mandatory for the qualification as General Paediatrician. The syllabus which is part of the Common Trunk should not be viewed as static, but will be continuously revised and updated by the members of the EBP. It is noted that research and changes in medicine may lead to significant changes. 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.

a. Theoretical knowledge

The specialty of general Paediatrics requires documented and assessed knowledge (see appendix 1) in:

1) Adolescent pathology
2) Allergy

[2] Convention on the rights of children adopted by the UN General Assembly resolution 44/25 of 20 November 1989, entry into force 2 September 1990. http://www.ohchr.org/en/professionalinterest/pages/crc.aspx (access 23 Sept 2015)
[3] http://www.globalpediatrics.org/globalcurriculum/curriculumdownloadpdf.html

3) Cardiology
4) Community medicine
5) Dermatology
6) Diseases of the Orbita and Eyes
7) ENT Disorders
8) Endocrinology & Diabetes
9) Emergency medicine
10) Gastrointestinal & Hepatic diseases
11) Genetics & Dysmorphology
12) Haematological & Oncological Disorders
13) Infectious and Immune deficiencies
14) Mental health & Behavioural Disorders
15) Metabolic Diseases
16) Neonatology
17) Nephro-Urology Disorders
18) Neurology & Neuromuscular Disorders
19) Pre-, Peri-, and Post-surgical Care
20) Respiratory Disorders
21) Rheumatic Diseases
22) Sports Medicine

b. Practical and Clinical Skills

The speciality of general Paediatrics requires assessed and documented numbers for "Practical Skills":

TRAINEES WILL BE ABLE TO PERFORM INDEPENDENTLY	Common Trunk General Paeds.
Capillary or peripheral blood samplings	✓
Electrocardiogram	✓
Lumbar puncture	✓
Urethral catheterization, supra-pubic aspiration of urine	✓
Collection of blood from central lines	✓
Umbilical venous and artery cannulation and sampling	✓
Bag, valve and mask ventilation	✓
External chest compression	✓
Tracheal intubation of term newborn babies	✓
Tracheal intubation of preterm babies and older children	✓
Administration of exogenous surfactant	✓
Safeguarding	✓
Administer intradermal, subcutaneous, intramuscular & intravenous drugs	✓
Needle thoracocentesis for pleural effusion or pneumothorax	*
Insertion of intraosseous needle	*
Percutaneous long line insertion	*
Abdominal paracentesis	*

* May need supervision

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

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Candidates for the qualification in general paediatrics should have followed the ERC resuscitation course and being certified in Cardio-Pulmonary Resuscitation in both neonates and children.

c. Practical and Clinical Skills

The EBP has established a formal process for assessing training and qualifications in general Paediatrics. The details are provided in Appendix 1.

II. TRAINING REQUIREMENTS FOR TRAINERS

Process for recognition as trainer

The Section of Paediatrics of the UEMS and the EBP offer the opportunity to senior paediatricians to obtain the qualification of *'Fellow of the European Board of Paediatrics'* as Honorary Fellows; award of an Honorary European Diploma in Paediatrics.

Experienced and practicing specialized paediatricians with at least 10 years of continuous service in formally recognized posts can apply for an Honorary Diploma and be exempted form the examination process.

Applications should be submitted to the Secretariat of the European Academy of Paediatrics/Paediatric Section of the UEMS (secretariat@eapaediatrics.eu).

A complete application should include (all documents in English):

1) A letter from the applicant highlighting the reasons he is worthy of an Honorary Diploma. Emphasis should be given to clinical experience as well as research and educational achievements.

2) Four letters from peers in support of the application, specifically highlighting the reasons for which the applicant is worthy of an Honorary Diploma. Two letters have to be provided by peers who know the applicant personally and have worked with him/ her for at least 5 years and two from independent referees with a sound international reputation. The letters must analyse the overall achievements of the applicant and give emphasis to his/ her suitability as a trainer in paediatrics; this needs to be measured against the well established criteria of the country where the applicant is practicing.

3) A copy of the applicant's complete CV, and a passport size photo.

4) Payment of the application fees (amount to be determined on yearly basis) to the account of the EAP/UEMS section of paediatrics:

A subcommittee appointed by the President of the EBP made of members from the EAP Executive as well as National Representatives evaluate the applications and give a recommendation to the EAP that finally decides regarding the acceptance or not of the application (majority of at least 2/3 of the members). A

successful applicant is awarded the title of Honorary Fellow of the European Board of Paediatrics. Unsuccessful applicants are encouraged to apply for the exam in order to get the Fellowship of the EBP qualification.

The robust process of applications for Honorary Diplomas and the fact that it is mandatory that applicants have to provide evidence and relevant references (national and international) confirming their competence as paediatric trainers and this has to be reviewed and accepted by the EBP.

III. TRAINING REQUIREMENTS FOR TRAINING INSTITUTIONS

Process for accreditation of centres for training in general paediatrics

The EAP/UEMS section of paediatrics considers the accreditation of centres in Europe for training in General Paediatrics to be of paramount importance.

The process of application and evaluation prior to accreditation for training is based on the well established relevant practice of the UEMS; the steps are as follows:

1. Initially, the **Centre has to submit an application to the EBP including:**

a) A formal letter by the Chairman stating the wish of the Centre to apply and highlighting the history of the centre, it's major achievements and providing evidence of recognition of it's status at a national and international level.

b) A report regarding the Centre and the Training Programme. The information must cover the following domains:
- Brief history of the Centre and general description of paediatric activity
- Brief description of the training setting
- Trainee paediatricians (Residents, Clinical Fellows, PhD Students, Visiting Fellows) who worked and were trained in the Centre for minimum time of one year in the last 10 years
- Faculty (junior and senior)
- Number of children cared at the Centre per year over the last 5 years
- Facilities available (clinical, research, educational)
- Library facilities
- Best 20 papers in the last 5 years including at least one of the trainee
- Grants for scientific projects in the last 5 years
- Courses, lectures and other teaching initiatives in the last 5 years
- Graphs, tables, reports or any other material that describe the work of Centre and especially its training programme can be included.

c) A fee (determined on a yearly basis) has to be paid to the account of the EAP UEMS Section of Paediatrics of the along with the initial application.

2. The application will be forwarded via e-mail to the EBP Chairman (cc. to the EAP Secretariat) and will be reviewed by a subcommittee of the EBP prior to its review by the EAP General Assembly at the next business meeting for approval

or return to the applicants requesting more information. The application has to be submitted to the EAP at least 4 weeks prior to the business meeting.

3. If the initial application is approved, then the next step is to organize a visit to the Centre of a Committee of 3 members: two from the EBP and one external reviewer. The Committee will visit the Centre on site and meet with the Chairman, the Faculty and the Trainees and review on site the work of the Centre in all the domains of the original application. The visit will last one day and it will be strictly professional with no social programme. The Centre applying for accreditation needs to cover the travel and accommodation expenses of the members of the Committee. An effort is made so that the members are from countries close to the applying Centre to minimize the expenses.

4. Following the visit, the Committee will produce a report and scoring of the Centre in the same domains of the initial application.

Each domain will be scored from 0-3:

0: insufficient/ absent
1: sufficient
2: good
3: excellent

A minimum score of 36 (75%) is required for the Committee to give a positive recommendation to the EBP. This will be presented at the next business meeting of the EAP where a vote will be taken by all members regarding the approval of the application ; a 2/3 majority is needed for approval.

5. If approved the Centre will be awarded the Accreditation for Training Certificate of the EAP/UEMS section of Paediatrics.

Annex 1 – The European Curriculum for Common Trunk in Paediatrics
Cf. Attached document.

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Appendix 2 – The approved syllabi for paediatric subspecialty training

Paediatric specialties	European Paediatric Societies	Specialty delegates
Allergology (2005, revised 2011)	EAACI	Jose Lopes Santos (P)
Cardiology (2005)	AEPC	-
Dermatology (pending)	?	Arnold Oranje (NL)
Endocrino & Diabetes (1998)	ESPE	Feyza Darendelider (TU)
Emergency Medicine (2011)	EuSEM	Jean-Christophe Mercier (F)
Gastroenterology & Hepatology (1998, revised 2009)	ESPGHAN	Alan Philips (UK) David Bransky (IL)
Hemato-Oncology (2001, revision just received 2013	ESPHI/SIOPE	Ricardo Riccardi (I)
Immunology (1998)	?	Maria Xanthou (GR)
Infectious Diseases (2003)	ESPID	Andrew Cant (UK)
Intensive Care Medicine (pending)	ESPNIC	Jan Hazelzet (NL)
Metabolic Diseases (2001)	SSIEM	John Walter (UK)
Neonatology (1998, revised 2007)	ESN	Neil Marlow (UK) Mats Blennow (S)
Nephrology (1999, revision in progress)	ESPN	Pierre Cochat (F) Peter Hoyer (D)
Neurology (2002, revised 2010)	EPSN	Colin Kennedy (UK) Lars Palm (S) Dana Craiu (HU)
Pulmonology (2005)	ERS	Robert Ross-Russel (UK)
Rheumatology (1998, revised 2008)	ESPR	Traudel Saurenmann (CH)

Appendix 3 – UEMS ETR Template

EUROPEAN UNION OF
MEDICAL SPECIALISTS
The advocate of medical specialists

UEMS 2025/07

Training Requirements for the Specialty of …

European Standards of Postgraduate Medical Specialist Training

Table of Content

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 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 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 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 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 …

3. Aims of the Specialty

4. Procedure of ETR Development/ Revision

II. TRAINING REQUIREMENTS FOR TRAINEES

1. Trainee in …

A medical trainee is a doctor who has completed their general professional training as a medical doctor and is trained and assessed in an accredited training programme leading towards medical specialist registration. Variably known in different countries as an intern, or registrar.

2. Content of training and learning outcomes

'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.

a. Competencies required of the trainee

'Competency' means knowledge, skills and professionalism. ***Competency*** *implies a specific set of skills and behaviours which allow appropriate tackling of a task.*

CanMEDS Framework

CanMEDS is a physician competency framework that describes the abilities of physicians required to effectively meet health care needs and groups them thematically under seven roles. The role as medical expert is essential and in the centre, and is linked to the roles as Communicator, Collaborator, Leader, Health Advocate, Scholar and Professional. A competent physician seamlessly integrates the competencies of all seven roles.

i. Theoretical knowledge

Should include the main domains covered by the specialty with a short description of domains that the trainee should master in the specialty, to be listed in the Syllabus.

ii. Practical and clinical skills

Key skills to possess in this specialty
Both to be listed in the Syllabus and Curriculum

iii. Non-technical skills and professionalism

To be listed in the Syllabus and Curriculum.
The so-called soft CanMEDS competencies— communication, teamwork, leadership and professionalism— are usually integrated in clinical assignments. Physician's overall ability to perform a specific task includes multiple key skills from the the CanMEDS framework.

b. Levels of Competence

Competence *implies the legal recognition of an overall capability involving, through one or more steps in training, the successful achievement of one or more competencies. The ability to perform a task effectively is achieved through knowledge, technical and non-technical skills, professionalism and experience.*

Levels of competence *widely used are*

1: The trainee has observed, has knowledge of, describes

2: The trainee performs, manages, demonstrates under direct supervision

3: The trainee performs, manages, demonstrates under distant supervision

4: The trainee performs, manages, demonstrates independently

Entrustable Professional Activities (EPAs) *form a higher level of competence, and at the same time go beyond as they connect the competency framework to the workplace. EPAs are defined units of professional work that can be entrusted to a trainee once he/she has demonstrated sufficient competence to perform the activity independently, without assistance or need for advice. The UEMS strongly encourages to include EPAs in the ETR.*

When describing the level of competence for particular parts of the curriculum or for EPAs, including their assessment, the application of the different ***CanMED roles*** *may be helpful.*

3. Organisation of training

a. Schedule of training

Minimum duration of training

Include required timing

b. Curriculum of training

The European Specialist Curriculum must cover not only knowledge and skills, but also domains of professionalism. A 'Curriculum' is prescriptive or specific and refers to the entire content taught in the training programme. At the same time, it presents details about the objectives, academic content and the ***methodologies to be adopted*** *during training in order to achieve the aims.*

c. Assessment and evaluation

Assessment: The activity of evaluating the mastery of curriculum content, using pre-defined criteria, and passing a judgment by assigning a value (i.e. a grade or numerical value) to such mastery. It is a systematic approach intended to increase quality.

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

i. Formative Assessments

'Formative assessments' evaluate on trainees' understanding and progress during the training. They happen throughout the learning process. A Formative Assessment is carried out mainly to give feedback to the trainee to improve him/herself or others (e.g. teachers, accrediting bodies, examiners, educational institutions).

ii. Summative Assessments

A 'summative assessment' evaluates formally what trainees have learned and are competent to perform at the end of the learning process. The primary purpose of establishing whether performance measured at a single defined point in time meets established performance standards. If available, they include a UEMS Exit Examination.

e. Governance

III. TRAINING REQUIREMENTS FOR TRAINERS

1. Process for recognition as trainer

a. Requested qualification and experience

The director of the training programme should be a certified specialist with at least 5 years of practice after specialist certification. He or she should possess the proper educational, organisational and leadership qualities, especially considerable knowledge and experience in postgraduate training, and should have completed the 'Training the Trainer Courses'

Trainers should be certified specialists. It is recommended that trainers are at least certified speialists with a minimum of 3 years of practice.

b. Core competencies of trainers

Special Qualifications of the trainers (if not covered by EU Directive on Professional Qualifications) should include but not be limited to the following:
Trainers should

I. *know all aspects of the given specialty curriculum and and the problems related to its clinical implementation.*
II. *be familiar with principles of modern medical education with focus on assessment tools, how to support trainees in difficulty and how to give effective feedback, including career advice.*
III. *be able to promote trainee's competencies including ethical behaviours and humanistic values as well as trainee's scientific curiosity.*
IV. *further develop their own leadership and mentorship competencies.*

2. Quality management for trainers

Ample time should be assigned to the daily management of the training programme. Adequate administrative support should be provided.

The programme director should be responsible for creating a safe and prosperous learning environment. He/she should ensure that there is an appropriate balance between service and training, He/she should meet regularly with the trainees, ascertain that necessary assessments are carried out and provide support and advice regarding professional development.

There should be a minimum number of specialists on the staff to ensure adequate supervision of trainees.
Staff policy should include support for trainers including psychological support and offer training in medical education, especially encourage continuous professional development for programme directors and trainers, including relevant 'Training the Trainers Courses'.
The evaluation of mentors by trainees should be implemented.

IV. TRAINING REQUIREMENTS FOR TRAINING INSTITUTIONS

3. 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; kind and minimal number of (surgical) procedures
Range of clinical specialties required for the training programme
Composition and availability of faculty
Training programme defined, guidelines application
Trainee / trainer ratio
Relevant scientific activity
A system for support, counselling and career guidance of trainees

b. Requirement on equipment, accommodation

Medical-technical specialty-specific *equipment*
*Clinical and educational a*ctivities supporting trainee's acquisition of competence.

Opportunities for Research and Development
Information technology support: those required for research, healthcare information systems, patient data, electronic or distance learning resources
Virtual and artificial intelligence resources
Physical spaces for study to ensure a learning environment
*Physical spaces and resources for research_*

4. Quality management within training institutions

Accreditation and reaccreditation by the national competent authority
Clinical Governance
Manpower planning as part of the defined national manpower plan
Regular report on teaching and scientific activities sent to relevant authorities
External auditing
Internal auditing and quality assurance
Transparency of training programmes
Structure for coordination of training
Framework of approval – how are they approved

References

Glossary including list of acronyms with explanations

Contributions

Appendices including general UEMS documents

List of general UEMS documents

To be included as appendices where applicable to the specialty:
Document written by TF Green and Sustainable Medical Practice
Document written by TF Equality, Diversity and Inclusivity
Training objectives for UEMS specialists pertaining to the care of adolescents and young adults (version sept 2022)
Genetics + Genomics for UEMS ETRs_220303

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Appendix 4 – Training objectives for UEMS specialists pertaining to the care of adolescents and young adults

Training objectives for UEMS specialists pertaining to the care of adolescents and young adults

Version September 2022

Context

Worldwide, the specific health needs of adolescents and young adults (AYAs) defined as individuals aged 10 to 24 are increasingly recognized. This phase of exploration and of shaping of one's identity drives both opportunities and risks, such as improved self-confidence, health enhancing behaviours, or poor therapeutic adherence, lack of long-term vision, which potentially interfere with treatment. Both specialists and primary care practitioners (e.g. in-practice paediatricians, family physicians, school doctors) can play a pivotal role in tailoring their approach to the specific needs of AYAs. This training package has been developed by members of the UEMS Multidisciplinary Joint Committee in Adolescent Medicine and Health (Chair, Prof. P.-A. Michaud, Lausanne, Switzerland), an initiative launched by the European Academy of Pediatrics. The content has been carefully discussed and reviewed by the MJC members, as well as an international group of experts working in the field and belonging to the Euteach training program (www.euteach.com).

The present document lists a set of practical, clinically oriented, holistic objectives that should allow all European specialists and primary care providers (paediatricians and family doctors) to respond better to the special health care needs of AYAs. They are competency-based and integrate knowledge, attitude and skills. In this respect, they are inspired by the CanMEDS model, as well as the "EPA" (Entrustable Professional Activities) approach. They can be freely adapted to the specific health care approaches and topics of various UEMS specialties (including paediatricians) and family doctors. Additionally, they should be applied taking into account the variety of cultural and legal frames of European countries. In the near future, it is foreseen to develop an accompanying tutorial (content, slides and videos) to assist trainers in implementing and developing teaching sessions.

The health care provider initiates and conducts the consultation with an AYA patient in a developmentally appropriate way (considering the patient's puberty stage, age as well as cognitive & affective level)

- ✓ Offers a setting that respects privacy and guarantees a trustful, empathetic and respectful relationship with the patient,
- ✓ Explains confidentiality and makes sure to get time alone with the patient for an appropriate part of the consultation. Agrees with the AYA what to disclose or not to disclose to the parent/guardians by the end of the consultation
- ✓ Uses developmentally appropriate communication skills: adapts language and wording to the age/cognition, verifies that the patient understands the information
- ✓ Clarifies the reason for the consultation and its goal and process. Gives the parents/guardians time to voice their worries
- ✓ Is attentive to cues for undisclosed problems ("hidden agenda").
- ✓ Assesses the adolescent's capacity in autonomous decision making (competence)
- ✓ Involves the parents/guardians in the evaluation, treatment and further measures, balancing the importance of the patient's privacy and increasing autonomy on one hand, and the communication within the family on the other hand
- ✓ Pays attention to the needs of AYAs minority groups, low socio-economic groups, homeless, refugees, LHBTI. Collaborates with trained interpreter when meeting AYA & family of foreign origin/cultural context.

The health care provider assesses and responds to the patient's lifestyle/behaviour in a non-judgmental way, paying extra attention to areas prone to be problematic in the age group and the AYA's resources *(The HEADSSS acronym provides useful guidance in this regards)*

- ✓ Assesses the patient's cognitive and affective development and daily functioning
- ✓ Identifies AYA's personal and environmental resources/protective factors, including the presence of trusted adult(s)
- ✓ Discusses daily leisure, diet, sports and social activities
- ✓ Assesses school/academic performance, screens for learning difficulties and other conditions (developmental/neurocognitive) leading to poor academic outcomes
- ✓ Screens for overt and covert symptoms of depression and/or anxiety in exploring mood, behaviour and expectations. Identifies self-harm, suicidal ideation and former or planned suicide attempts, as well as any victimization or violence
- ✓ Explores the value of substance use from the patient's viewpoint, the patient's use/misuse of drugs, the associated risk factors, the perceived range of consequences and the preparedness for change
- ✓ Discusses screen/internet/social media misuse and its health consequences
- ✓ Respectfully explores sexuality and reproductive life, including questions of gender identity and sexual orientation. Responds appropriately to common situations
- ✓ Assesses safe/unsafe sexual behaviour and risk for sexually transmitted infection and treats or refers for treatment; identifies need for contraception and responds empathetically to a suspected or verified pregnancy (pregnancy test, referral)
- ✓ Opens up for disclosure of subjection to violence and involvement in criminal activity.

The health care provider performs a physical examination taking into account the patient's growth and development

- ✓ Explains the process of any physical examination and the reasons for it
- ✓ Adapts the examination to the AYA's complaints/symptoms, physical/sports activity, social and professional background
- ✓ Follows a sequence that respects patient comfort and intimacy
- ✓ Evaluates and comments the patient's pubertal stage (e.g., Tanner stage)
- ✓ Assesses systems that change particularly during puberty (skeletal, sight, skin etc.)
- ✓ Investigates body shape's representations and self-image within the cultural and social context

The health care provider provides appropriate care to an AYA living with a chronic condition and facilitates transition and adaptation to adult health care settings

- ✓ Assesses the impact of chronic condition on patient's daily functioning
- ✓ Fosters an inter-professional approach and collaborates with the appropriate resources and people to assist the patient in coping with the chronic condition and life
- ✓ Promotes optimal adolescent development: minimizes the impact of the chronic condition on education and social life together with interdisciplinary team members
- ✓ Promotes self-confidence and capacity in managing health and illness
- ✓ Beyond the care of the chronic condition itself, addresses the basic health care needs of the patient; (HEADSSS, immunization, complaints regarding general health)
- ✓ Participates in the transition process from paediatric to adult health care settings: preferred age for transfer, adolescent's expectations, available support during transition (e.g. clinical nurse, social worker and psychologist) and joint consultation with both paediatric and adult health care provider. Actively involves the AYA in all decisions regarding transition.

Training tool

Teachers and mentors who want to set-up training sessions (bedside, small groups. Lectures) can access to a series of concrete training tools which have been specifically developed by EuTEACH faculties (www.euteach.com) to cover the UEMS training objectives. They can be particularly useful to professionals who are not familiar with the field of adolescent medicine and health. They are *freely accessible* at: https://moodle.unil.ch/course/view.php?id=24722. Once on the website, click on "invite" and use the password: euteach2022

In addition, the Euteach website offers a set of educational illustrations as how to organize and deliver effective and interactive training:

https://www.unil.ch/euteach/home/menuinst/how-to-teach/interactive-teaching-methods.html

Appendix 5 – European Training Requirement for Certification of Added Qualification for Transitional Care of Adolescents and Young Adults

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EUROPEAN TRAINING REQUIREMENT

for *Certification of Added Qualification*

FOR TRANSITIONAL CARE OF ADOLESCENTS AND YOUNG ADULTS

European standards of postgraduate medical specialist training

UEMS Council October 2025

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Table of Content:

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 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.

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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

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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

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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.

2. Certification of Added Qualification for Transitional care for adolescents and young adults

Rationale

Adolescents (ages 10–19) and young adults (ages 20–24) make up approximately 25% of the population in the European Union. Due to advancements in pediatric and neonatal care, an increasing number of adolescents and young adults (AYAs) are living with chronic, complex, or rare conditions that require long-term management. Many carry the burden of chronic illness, emerging autonomy, and identity development while navigating care systems that may not be responsive to their needs. Transitions are common from pediatric to adult medical care and Child and Adolescent Mental Health Services (CAMHS) to adult psychiatry. This is especially relevant for individuals with developmental and psychiatric comorbidities. In these cases, diagnoses made in CAMHS can help identify ongoing developmental disorders that lead to functional impairments and increase the risk of emerging psychiatric issues, which require careful transitional care. The

success of pediatric care has resulted in a growing demand for coordinated, developmentally appropriate adult healthcare for young people. However, over 60% of these individuals disengage from care within two years of transitioning to adult services.

In this document, "adolescents and young adults" will be abbreviated as "AYAs," and the term "youth" will refer to individuals aged 15 to 24, by the World Health Organization's (WHO) standards.

Transition is not just a single event or an administrative handover; it is a sensitive developmental phase and clinical process that involves medical, psychosocial, educational, legal, and behavioral changes. While transfer means the actual transfer and referral of a patient and their healthcare information to a new setting, typically occurring at a defined point in time, transition should be seen as a process spanning several years and three stages: 1) preparation in pediatric services beginning by the age of around 12 years; 2) planned transfer of care and necessary information, potentially including a joint appointment with pediatric and adult healthcare providers at least when healthcare needs are complex; and 3) patient-centered adjustment of adult-oriented services to the developmental needs of young adults. Transition refers to a purposeful, planned process that addresses the medical, psychosocial, and educational/vocational needs of AYAs as they move from child-centered to adult-oriented healthcare systems. Effective transition encompasses, but is not limited to, transfer. If not appropriately managed, transition can lead to disruptions in care, loss to follow-up, disengagement from care, and increased healthcare utilization in later years. This can result in delayed diagnoses, complications from unmanaged conditions, worsening mental health, and emotional distress. The risk is particularly significant for individuals with chronic conditions, where maintaining continuity and adherence to treatment is crucial for lifelong management. Therefore, it is essential to minimize dropout rates during transition.
Despite the clear evidence and growing awareness of this issue, transition readiness is rarely assessed systematically, and the age of transfer can vary between 15 and 21 years across Europe. While research suggests that healthcare transition should be based on an individual's maturity and readiness rather than fixed age limits, this patient-centered approach is seldom implemented in practice. Additionally, although validated assessment tools are available, transition readiness is not routinely or systematically evaluated. Inconsistent policies, differing definitions of maturity, and legal discrepancies regarding consent, confidentiality, and capacity further complicate transition practices[1].

[1] World Health Organization and Unicef. Child and Adolescent Health In The WHO European Region – Fact Sheet. Available at: https://www.unicef.org/eca/media/38451/file/Providing%20services%20to%20adolescents.pdf

Most European countries signed the UN Convention on the Rights of the Child. This convention acknowledges that minors' rights to decision-making should be based on their evolving maturity rather than their age alone. All clinical, legal, and policy decisions must be guided by the principle of acting in the child's or adolescent's best interest[2]. However, young adults, while legally autonomous, remain economically, socially, and psychologically vulnerable. From a public health perspective, prioritizing their care leads to long-term benefits, as adult health outcomes are closely linked to health behaviors and continuity of care during adolescence.

To address these issues, every healthcare provider working with AYAs must be skilled in transitional care. This involves understanding both typical and atypical biological, psychological, sexual, cognitive, and social development that occurs beyond the legal age of majority. Providers should assess patients' capacity for autonomous decision-making using tools endorsed by the World Health Organization (WHO)[3], navigate the ethical and legal frameworks that vary across different age groups, and support self-management and future planning. This is particularly important when identity, adherence, and health literacy evolve.

Many healthcare providers, especially those in adult care, report feeling unconfident in delivering transitional care, despite recognizing the importance of youth-centered communication and shared decision-making. They often lack the structured training and resources to implement these practices effectively. However, managing transition can not rest solely with pediatric or child and adolescent psychiatry teams for optimal outcomes. Adult specialists must be prepared to receive and continue care for young adults transitioning to their services, identify and address gaps in care for those who never experienced structured pediatric care, adjust consultations and interventions to meet the evolving needs of young adults, collaborate with pediatric providers, primary care, child and adolescent psychiatrists, and community services. Transitional care providers should be trained to prioritize the well-being of youth as a clinical outcome. This includes addressing nutrition, sleep, stress, and social connection, and promoting resilience through trauma-informed, empowerment-based care.

Transitional care is essential for all clinicians who work with AYAs; it is not just a niche area of expertise. The engagement of AYAs improves when services are culturally safe and inclusive, and

[2] United Nations. Convention on the Rights of the Child. 1989. Available at: https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-child
[3] World Health Organization. Assessing and supporting adolescents' capacity for autonomous decision-making in health care settings: a tool for health-care providers. 2021. Available at: https://iris.who.int/bitstream/handle/10665/350193/9789240039582-eng.pdf

when shared decision-making is prioritized. Recent frameworks recommend using structured self-assessment tools, encouraging open dialogue, and providing health literacy support, mainly focusing on digital platforms. These elements are essential for promoting AYAs' self-management and well-being during transition. When transition is appropriately structured and tailored to the developmental needs of young people, it leads to better engagement, adherence to treatment, and long-term health outcomes. By providing healthcare providers with specific knowledge, skills, and tools related to transitional care, we can create systems that support young people as they transition into adulthood, rather than hinder them.

Purpose and scope: why certification matters

The transition from pediatric to adult care requires more than just disease-specific expertise; it necessitates a deep understanding of autonomy, health literacy, and support for psychosocial resilience. Even in cases where transition programmes are available, many AYAs enter adult services without adequate preparation. This inconsistency in access to such programmes highlights the need for healthcare providers to possess universal competencies in transitional care. As proposed in this document, the Certification of Added Qualification (CAQ) in Transitional care for AYAs aims to standardize the competencies related to transition across various pediatric and adult specialties. This certification equips clinicians with the necessary tools to ensure continuity of care, facilitate safe and patient-centered handovers, and support young people during one of the most sensitive phases of their healthcare journey. The certification promotes youth-friendly care regardless of the following factors:

- ✓ whether the patient is newly transferred or experiencing a relapse in young adulthood.
- ✓ whether the diagnosis was made in pediatric or adult care settings.
- ✓ whether a formal transition clinic is available.
- ✓ whether the provider works in primary, secondary, or tertiary care.

This transitional care ETR offers flexibility; it can be pursued as a Continuing Professional Development (CPD) module, as an elective within a residency or fellowship programme, or as a stand-alone qualification recognized under national or UEMS frameworks.

The ETR proposes a structured framework for a CAQ in Transitional care, applicable across pediatric and adult specialties, including child and adolescent psychiatrists. Its goals include:

- ✓ Standardizing transition-related competencies and equipping specialists with the necessary knowledge, skills, and attitudes in transitional care.
- ✓ Supporting healthcare professionals in managing care for AYAs with or without chronic conditions.
- ✓ Enhancing multidisciplinary collaboration between pediatric and adult services.

- ✓ Promoting safe handovers and ensuring continuous follow-up.
- ✓ Reducing loss to follow-up, improving self-management skills, and empowering young individuals by supporting their autonomy, personal growth, participation in education or work, social inclusion, and a meaningful life aligned with their values and aspirations.
- ✓ Supporting health care professionals/trainees in leading or contributing to transition initiatives, and promoting research and quality improvement in transitional care.

Global context and policy alignment

The WHO, in its 2015 and 2023 frameworks, along with other major international professional bodies, highlights the essential role of trained providers in delivering adolescent- and youth-friendly healthcare that responds to the specific developmental and systemic needs of AYAs. In the "Global Accelerated Action for the Health of Adolescents" (AA-HA!) report published in 2023[4], the WHO reinforces the importance of health professionals addressing this critical life stage with competence, respect, and structure. The report emphasizes the need for all health providers to be trained in adolescent-responsive care, including developing competencies for transitioning from pediatric to adult services.

In 2022, the European Academy of Paediatrics and the UEMS approved the "Training Objectives for UEMS Specialists About the Care of Adolescents and Young Adults." This updated European ETR for the CAQ in transitional care builds on that foundation.
The framework aligns with key international standards, promoting clinical governance and harmonizing European transitional care. Structured training and certification that recognize the unique healthcare needs of young adults can significantly reduce care discontinuity and fragmentation. Additionally, these measures support sustainable workforce development, improve long-term health outcomes and well-being, address health inequities during the transition to adulthood, enhance patient engagement, and empower young people in their healthcare journeys.

A competency-based approach to transition

This ETR is based on the principles of Competency-based medical education (CBME) and aligns with the World Federation for Medical Education (WFME) Global Standards for Postgraduate Medical Education (2023). It emphasizes outcome-based training, accountability, and learner-centered progression. The ETR reflects the evolving nature of medical practice by integrating

[4] World Health Organization. Global Accelerated Action for the Health of Adolescents (AA-HA!) - Second edition. 2023 Available at: https://www.who.int/publications/i/item/9789240081765 (chapter 5, section 3.1)

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Entrustable Professional Activities (EPAs) that relate to the CanMEDS roles. These EPAs serve as workplace-based, observable measures of real-life readiness, rather than relying on time-based learning.

Trainees will participate in supervised clinical encounters, structured didactic teaching, and reflective practice. Competency will be assessed through direct observation, workplace-based assessments (such as mini-clinical evaluation exercises (mini-CEX) and case-based discussions), and the achievement of EPA milestones. Key training outcomes include being entrusted with core EPAs independently, demonstrating skills in care planning, ethical decision-making, and interprofessional collaboration, and gaining a holistic understanding of the transition process as a continuum of care.

Completing the CAQ will improve continuity of care for AYAs across various specialties. It will also enhance health literacy and autonomy among young patients, increase patient and family satisfaction, and promote health equity by reducing care fragmentation and disengagement from the healthcare system. Ultimately, transitional care should not be viewed as an optional skill but as an essential aspect of safe and ethical medical practice. The CAQ in Transitional care aims to ensure that every specialist working with AYAs is equipped to contribute confidently and competently to this critical stage of life.

3. Aims of the Certification of Added Qualification (CAQ) for Transitional care for adolescents and young adults

This CAQ equips clinicians with the skills to effectively lead, deliver, and coordinate high-quality, developmentally appropriate care for AYAs transitioning from pediatric to adult healthcare systems. The CAQ prepares clinicians for leadership roles in transitional care across clinical, educational, and policy areas.

As part of clinical and developmental competence, trainees will integrate biological, developmental, psychological, social, cognitive, and ethical aspects into individualized care for AYAs. They will provide inclusive, developmentally sensitive care for AYAs with and without chronic or complex conditions. Additionally, trainees will demonstrate expertise in managing common conditions within this population, including internal diseases, mental health, reproductive and developmental issues, or physical impairments.

As part of structured and competency-based care, trainees will utilize validated tools (e.g., transition readiness assessments), EPAs, and knowledge of the unique needs of AYAs to guide and evaluate the transition process. They will create care plans tailored to the AYAs' maturity,

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legal status, and psychosocial context, ensuring safe and continuous care across the pediatric-adult interface.

As part of interdisciplinary collaboration and communication, trainees will work alongside specialists from various fields and primary care providers. They will engage families, caregivers, and community partners in coordinated care and facilitate shared care planning through effective team communication.

Regarding leadership, advocacy, and system improvement, trainees will advocate for youth-friendly and equitable care models within healthcare institutions. They will identify gaps in transition services, support policy or pathway development, and lead or contribute to local, regional, or national transitional care initiatives. Furthermore, they will promote research and quality improvement in delivering transitional care.

This CAQ aims to harmonize transitional care standards across Europe and empower clinicians to lead change that reduces fragmentation and improves long-term outcomes for young people navigating adult healthcare systems.

4. Procedure of ETR Development/Revision

Development Process

This ETR was initiated and drafted by the Multidisciplinary Joint Committee (MJC) on Adolescent Medicine and Health under the European Union of Medical Specialists (UEMS). The development process involved a structured, collaborative, and multidisciplinary approach that drew on the expertise and experience of:

- ✓ UEMS Specialist Sections and Boards relevant to AYAs' care;
- ✓ Youth representatives and patient advocacy organizations;
- ✓ Faculty members from international academic and professional networks, including the European Training in Effective Adolescent Care and Health Team (EuTEACH), the European Academy of Paediatrics (EAP), the International Association for Adolescent Health (IAAH), the European Union for School and University Health and Medicine (EUSUHM), and the European Union of General Practitioners (UEMO).

The ETR is evidence-informed and aligned with global standards. It is based on several core reference frameworks, including:

- ✓ The UEMS-endorsed 2022 Training Objectives for Adolescent Care Specialists;

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- ✓ The WHO Core Competencies in Adolescent Health and Development (2015), including its educational toolkit for pre- and post-graduate medical training;
- ✓ The WHO Global Accelerated Action for the Health of Adolescents (AA-HA!) framework (2023);
- ✓ The International Association for Adolescent Health (IAAH) Education Committee Policy Statement on Education and Training of Healthcare Providers (2022);
- ✓ Peer-reviewed literature and consensus guidelines covering transitional care, ethics, patient engagement, and multidisciplinary practice;
- ✓ Feedback and iterative consultation with UEMS delegates, external experts on Adolescent and School Medicine, Medical education, and training institutions.

This comprehensive process ensures that the ETR addresses current clinical needs, incorporates educational innovations, and reflects policy developments in transitional care for AYAs.

Revision Process

The ETR will undergo a systematic and transparent review in line with UEMS guidelines to remain current and relevant.

1. *Regular review cycle* - the ETR will be reviewed and updated every five years. However, updates may occur sooner if there are significant changes in European training structures, adolescent health policy, or advancements in transitional care.
2. *Revision responsibility* - revisions will be coordinated by the MJC on Adolescent Medicine and Health, in collaboration with the ETR Review Committee of the UEMS Council.
3. *Consultation and consensus* - updates will involve consultation with national authorities, UEMS Specialist Sections and Boards, academic institutions, professional societies, and youth/patient representatives (AYAs and caregivers) to ensure inclusive and representative decision-making.
4. *Alignment with standards* - all updates will ensure continued alignment with CanMEDS roles and frameworks, World Federation for Medical Education (WFME) standards, national and European accreditation criteria for postgraduate medical education, and evolving models of EPAs and assessment tools.
5. *Overlap and integration* - the review will also assess overlaps with related specialties and ensure coordinated integration of shared competencies in adolescent and transitional care.

This organized development and revision process ensures that the ETR remains a dynamic, relevant, and high-quality training framework for clinicians working with AYAs in transition throughout Europe.

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II. TRAINING REQUIREMENTS FOR TRAINEES

a. Definition of trainee in the Added Qualification for Transitional care for adolescents and young adults

A trainee seeking a CAQ in Transitional care for AYAs is a licensed medical specialist who has already completed core postgraduate specialty training. This trainee now engages in structured, competency-based training in transitional care.

The trainee is expected to develop expertise in managing the medical, psychological, developmental, and social needs of AYAs aged 10–24 years. The focus is ensuring safe, patient-centered, and effective transitions from pediatric to adult health care.

The training can be undertaken in various ways, including:

1. As a part of CPD;
2. As a defined module within residency or fellowship training;
3. As a stand-alone module leading to a recognized CAQ under national or UEMS-recognized guidelines.

b. Content of training and learning outcomes

Definition of Transitional care:

In healthcare, "transition" refers to the purposeful, planned process of preparing and supporting AYAs as they move from child- or youth-oriented healthcare services to adult-oriented services. For AYAs with chronic or complex health conditions, structured transitional care and competency-based interventions are essential to prevent gaps in care and to avoid declines in health outcomes[5]. For any AYAs transitioning into adult-oriented services, regardless of chronic illness status, including those who may have developmental, psychosocial, or situational health needs, this transition involves adolescent-friendly care to ensure continuity of care. In both cases, this patient-centered approach considers biological, developmental, cognitive, psychological, and social factors and emphasizes equity. It aims to promote health across different systems during a crucial developmental period. Transitional care during AYAs' years integrates medical, emotional, legal, and vocational aspects, acknowledging that healthcare

[5] Campbell F, et al. Transition of care for adolescents from paediatric services to adult health services. Cochrane Database Syst Rev. 2016;4(4):CD009794.

navigation, self-management, adherence, and outcomes are influenced by developmental stages rather than chronological age.

c. Competencies required of the trainee

In transitional care, competencies address the complexity of supporting AYAs during sensitive life stages. This requires adapting care to their developmental, psychosocial, legal, and healthcare contexts. Competencies include cognitive, procedural, interpersonal, and reflective domains, and they are best organized according to the internationally recognized CanMEDS Framework. Training should prepare trainers to promote "graduated autonomy" — the gradual transfer of decision-making responsibility to the young person, customized to their developmental stage, cognitive capacity, and readiness.

CanMEDS-based competency roles in transitional care

Upon completion of the training, the trainee will be expected to demonstrate the following competencies:

CanMEDS Role	Competency description	Examples in Transitional Care
Medical Expert	Demonstrates clinical expertise and applies decision-making tailored to the development and chronic conditions of AYAs.	Provides evidence-based, developmentally age- and maturity-appropriate care tailored to AYAs with acute, chronic, or complex health needs; integrates disease-specific knowledge in the context of youth development; uses validated psychosocial and readiness screening tools (e.g., HEADSSS, SSHADESS, TRAQ, Transition-Q); identifies and manages gaps in care that may arise after transfer or during re-engagement with healthcare services; understands the principles and structure of the WHO International Classification of Functioning, Disability, and Health (ICF) checklist, including its application in assessing functional status, disability, and environmental factors relevant to transitional care; be able to use tools such as the WHODAS 2.0 or other validated instruments (e.g., SDQ, GAF) to assess functioning when appropriate.
Communicator	Communicates effectively while establishing youth-centered, developmentally appropriate, trauma-informed, and confidential	Explains consent and autonomy to AYAs; balances parental involvement with patient privacy; builds trust in youth who have experienced trauma and applies trauma-informed principles to engage AYAs in shared decision-making; adapts communication strategies to

	communication with AYAs and families; respects diversity in communication.	the language preferences, sensory abilities, and functional communication needs of AYAs, including use of interpreters, sign language, alternative and augmentative communication (AAC) methods, and proxy communication where appropriate, to ensure equitable participation in care.
Collaborator	Collaborates effectively with professionals from various fields and sectors to facilitate transition planning and ensure coordinated care.	Communicates with colleagues and coordinates joint consultations between pediatricians, adult care providers, social workers, and education professionals (involving mental health services if necessary) as part of transitional care planning. Leads multidisciplinary team meetings and supports transitions within complex care pathways; works in partnership with a multidisciplinary team, ensuring that functional impairments and contextual barriers are addressed.
Leader/ Manager	Identifies obstacles to effective transitions, such as gaps between pediatric and adult services, and advocates for institutional support for transition models.	Leads initiatives to improve the quality of care and helps incorporate transitional care into service models and the implementation of transition clinics; enhances or develops institutional policies that support structured transition pathways and improves the documentation of transition plans; manages and adapts resources in fragmented or under-resourced services.
Health Advocate	Promotes equitable, inclusive, age-appropriate, and culturally sensitive care for all AYAs, especially for vulnerable populations.	Advocates for migrant youth in transition and adapts care for LGBTQ+ adolescents, youth with disabilities, and those in out-of-home care; identifies and addresses social determinants of health and transition challenges that stem from poverty, discrimination, or stigma.
Scholar	Committed to critical appraisal, teaching, and research to improve transitional care.	Engages in quality improvement audits; presents cases at journal clubs; evaluates transition models and initiatives; participates in academic activities promoting best practices in structured care transitions.
Professional	Demonstrates ethical integrity in all professional interactions, respects autonomy, and is committed to lifelong learning.	Maintains confidentiality under challenging cases; demonstrates self-awareness of biases and limitations in expertise; uses a portfolio and feedback to foster growth; engages in ongoing professional development.

These competencies ensure trainees can provide interdisciplinary, developmentally responsive, ethically grounded, and practically effective care to AYAs across pediatric and adult European healthcare systems.

i. Theoretical knowledge

The knowledge on transition care includes medical information and understanding of developmental, psychosocial, legal, and systems-level factors necessary for effectively managing the transition from pediatric to adult care.

Trainees must develop proficiency in the following theoretical domains:

No.	Domain	Detailed content outline and Learning Outcomes
1.	*Adolescents and young adults' health in Europe*	✓ Describe the epidemiology, demographics, morbidity/mortality trends in AYAs in the country of practice and regional variances. ✓ Identify vulnerable subgroups and their implications for care and policy.
2.	*Normal development from early adolescence to young adulthood (10–24 years)*	✓ Describe physical, psychosocial, cognitive, emotional, and sexual development ✓ Understand the development of autonomy, brain maturation, and identity formation. ✓ Assess how development impacts chronic disease management and healthcare transitions
3.	*Chronic health conditions and transitional care models*	✓ Understand the challenges AYAs face with chronic or rare conditions, including immunization plans and pharmacological aspects of therapies. ✓ Evaluate structured models (e.g., Got Transition, NICE QS140, disease-specific pathways). ✓ Apply validated transition readiness tools (e.g., TRAQ) to guide planning and follow-up. ✓ Conduct psychosocial assessment using HEADSSS, SSHADESS, or similar strength-based psychosocial assessments to explore health, home, education/employment, activities, safety, and support systems. ✓ Assess and discuss the strengths, aspirations, and personal goals of AYAs to foster motivation, self-efficacy, and resilience. ✓ Discuss adherence, reproductive health, long-term planning, and barriers to transfer while maintaining a balanced, strengths-based approach. ✓ Assess functioning using ICF-based tools (e.g., ICF Checklist, WHODAS 2.0) to identify activity limitations, impairments, and understand the

		impact of chronic diseases, neurodevelopmental, cognitive, and mental health conditions on daily life, evaluate activity limitations, and contextual barriers to health. ✓ Recognize how functioning outcomes can guide multidisciplinary transition planning, ensuring that personal capabilities and resources are incorporated into each personalized transition plan, academic/professional development, and autonomy. ✓ Foster an atmosphere of empowerment, resilience, and shared decision-making throughout the transition process.
4.	*Legal and ethical aspects of healthcare*	✓ Interpret national and EU frameworks related to consent, assent, autonomy, confidentiality, and safeguarding. ✓ Apply shared decision-making and manage ethical dilemmas. ✓ Follow human rights-based care standards.
5.	*Social determinants of health*	✓ Analyze the impact of social, economic, and environmental factors on health. ✓ Identify risk and protective factors. ✓ Develop strategies to reduce inequity and support resilience.
6.	*Communication and health literacy*	✓ Apply age- and developmentally appropriate communication techniques, including motivational interviewing, coaching strategies, and digital health in consultations in compliance with confidentiality boundaries, and patient-centered care. ✓ Promote self-management and enhance health literacy.
7.	*eHealth, digital technologies, and telemedicine*	✓ Use and navigate electronic health records and patient portals effectively to support continuity, coordination, and quality of care. ✓ Apply telemedicine appropriately, demonstrating the ability to assess its suitability for individual AYAs, clinical situations, and follow-up needs, while recognizing its limitations. ✓ Critically evaluate digital engagement tools for their clinical relevance, accessibility, and data security in the AYA population. ✓ Recognize and address the social media impact on AYAs' health, well-being, and health-seeking behavior ✓ Integrate discussions of safe and responsible online behavior into clinical encounters.
8.	*Interprofessional collaboration and education*	✓ Understand the roles of multidisciplinary team members (e.g., transition coordinators, psychologists, nurses). ✓ Participate in shared care planning and handover processes.
9.	*Leadership and physician wellness*	✓ Foster respectful, inclusive team dynamics and mentoring of peers. ✓ Demonstrate accountability in care coordination, communication, and follow-through.

		✓ Identify signs of burnout and apply strategies to foster resilience and reflective practice.
10.	*Quality improvement, patient safety, and resource stewardship*	✓ Identify risks of poor transition (e.g., dropout, adverse events). ✓ Incorporate patient perspectives into quality improvement.
11.	*Mental, cognitive, and behavioral health*	✓ Identify and manage mental health disorders, learning disabilities, neurodiversity, substance use, and self-harm. ✓ Address behaviors, school performance, academic achievements, and coping mechanisms compassionately.
12.	*Safety, violence, and risk reduction*	✓ Recognize signs of abuse, violence, or neglect. ✓ Understand risk-taking in youth with chronic conditions and implications for safe care transition.
13.	*Special populations and equity considerations*	✓ Adapt care for vulnerable and marginalized groups (e.g., refugees, LGBTQ+, youth in custody or care, youth with developmental disorders, and ADHD). ✓ Identify intersecting identities and address access barriers with cultural humility.

Learning Format and Level

All theoretical competencies must be achieved at Competence Level A (knowledge/awareness). Theoretical training should be reinforced through structured educational activities, such as case-based seminars, simulations, webinars, e-learning modules, journal clubs, reflective case discussions, and interdisciplinary learning opportunities. Knowledge from undergraduate medical education (e.g., anatomy, pathophysiology, pharmacology, and clinical pharmacology) is assumed. And it should be further developed during training, emphasizing content specific to AYAs and the transition process.

ii. Practical and clinical skills

Application knowledge in a clinical setting is a fundamental goal of training in transitional care. Developing practical and clinical skills is essential due to the unique complexities of AYAs' health, particularly during the transition from pediatric to adult services. These practical skills should be applied across physical, psychological, and social health domains. These competencies should reflect developmental sensitivity, promote interprofessional coordination, and incorporate a biopsychosocial approach to care.

Practical skills must be acquired at least at a competence level C (with distant supervision), while core EPAs require competence at level D (for independent practice). Skills should be practiced across various care settings, including outpatient clinics, multidisciplinary meetings, acute care services, and community-based environments.

This section summarizes essential practical and clinical skill areas, mapped to the CanMEDS roles and aligned with the UEMS "Training Objectives for UEMS Specialists About the Care of Adolescents and Young Adults" (2022), included in Appendix 1.

No.	Practical and clinical skills	Detailed content outline and Learning Outcomes
1.	*Developmentally appropriate consultation*	✓ Conduct confidential, respectful consultations adapted to age, maturity, and cognitive and emotional level, promoting trust and independence/autonomy. ✓ Adapt communication to the young person's language preferences and functional abilities, including the use of interpreters, sign language, alternative or augmentative communication methods, or proxy communication where required, to ensure full participation. ✓ Create a safe space for disclosure and build trust using appropriate language and rapport-building techniques. ✓ Apply frameworks such as HEADSSS, SSHADESS, or similar validated tools for structured psychosocial assessments. ✓ Clarify boundaries of confidentiality, involving caregivers appropriately. ✓ Assess decision-making capacity and encourage autonomous health choices.
2.	*Comprehensive lifestyle and behavioral assessment*	✓ Identify health risks, including screen time, diet, physical activity, substance use, and sexual behaviors. ✓ Screen for mental health conditions using validated tools (e.g., Patient Health Questionnaire-9 (PHQ-9), General Anxiety Disorder-7 (GAD-7), Strengths and Difficulties Questionnaire (SDQ)), developmental disorders (e.g., autism spectrum disorders, ADHD), and learning difficulties. ✓ Assess health literacy, self-care practices, and adherence. ✓ Recognize protective factors, resilience, and personal strengths.
3.	*Physical examination adapted to*	✓ Conduct respectful, developmentally sensitive physical exams, including genital exams when indicated. ✓ Interpret pubertal stage (e.g., Tanner scale), recognizing normal and abnormal variants.

	adolescents and young adults	✓ Explore self-image, body perception, and the physical impact of chronic illness.
4.	*Management of chronic conditions and transition to adult care*	✓ Address developmental, academic, and psychosocial challenges linked to chronic illness. ✓ Develop and implement individualized, written transition plans in collaboration with the patient and team. ✓ Promote patient engagement, self-efficacy, and shared decision-making. ✓ Organize and participate in joint pediatric–adult consultations and interprofessional meetings. ✓ Evaluate functioning using the ICF framework to identify activity limitations and contextual factors.
5.	*Preventive care and health promotion*	✓ Promote vaccination, sexual health, sleep hygiene, physical activity, and nutrition. ✓ Provide anticipatory guidance adapted to the developmental stage. ✓ Implement screening protocols (e.g., screening for sexually transmitted infections (STIs), obesity, and mental health).
6.	*Acute and emergency care*	✓ Identify and manage urgent or crises (e.g., suicide risk, substance intoxication, acute pain episodes). ✓ Coordinate with emergency, psychiatric, and crisis services. ✓ Apply trauma-informed care principles and initiate brief interventions.
7.	*Ethical, legal, and cultural competence*	✓ Respect for autonomy, beneficence, non-maleficence, and justice by the fundamental principles of bioethics. ✓ Navigate ethical dilemmas related to confidentiality, consent, and capacity, based on national legal frameworks, to avoid inequitable care. ✓ Manage disclosures of abuse or risk appropriately, following legal and institutional guidelines. ✓ Provide culturally sensitive care, using interpreters or mediators as needed. ✓ Advocate for inclusive care environments, addressing bias and stigma.
8.	*Digital and telehealth competence*	✓ Use digital platforms and teleconsultation tools to conduct remote AYAs' care when clinically appropriate, particularly when access to in-person services is limited (e.g., during epidemics, in rural or underserved areas, or when mobility is restricted). ✓ Assess when telehealth is suitable for patients, noting that some situations, like first-time consultations and specific examinations,

		require in-person visits (e.g., first-time consultations, specific physical examinations such as gynecology or abdominal pain) ✓ Identify and manage the risks and opportunities of digital tools, social media, and patient portals in AYA healthcare, balancing accessibility and engagement with potential harms. ✓ Ensure privacy, confidentiality, and safe communication, particularly when working with minors, and adhere to relevant legal and ethical standards. ✓ Ensure awareness of AI-assisted tools, digital ethics, and cybersecurity risks in youth health data

These competencies should be developed during clinical rotations, interprofessional simulations, case discussions, transition clinics, and supervised consultations. Assessment methods include direct observation, mini-CEX, EPAs, reflective case logs, structured feedback, case-based discussions, multi-source feedback (MSF), and supervisor reviews. Trainees are encouraged to engage in real-life transition cases and interdisciplinary teamwork, which will provide exposure to various models of care. Aligning with the CanMEDS roles ensures these skills are integrated into a holistic, high-quality practice.

iii. Non-technical skills and professionalism

Non-technical skills are crucial in transitional care, where relational dynamics, patient sensitivity, ethical complexity, and cross-sector collaboration play significant roles. These competencies align with the core CanMEDS roles – Communicator, Collaborator, Leader, Health Advocate, Scholar, and Professional – and are integrated across all clinical care, learning, and assessment. They are essential when caring for AYAs, a group navigating medical, emotional, and psychosocial transitions.

Medical professionalism is essential for providing high-quality, youth-centered transitional care. It fosters trust, safety, and ethical integrity in interactions with AYAs and their families. Since the transition process often involves sensitive decisions regarding consent, confidentiality, mental health, autonomy, and legal status, trainees must develop the skills to address these issues responsibly and with consideration of developmental factors. Training programmes should prepare trainees to collaborate with parents or caregivers, balancing the young person's right to confidentiality and autonomy with the supportive role of families. Flexible models should be employed, adjusting family involvement based on developmental readiness, cultural context, and specific health needs.

Below is the competency framework required at Level D (Independent) upon completion of the CAQ in Transitional care:

No.	Core Statements (Domains)	Learning Outcomes
1.	*Ethical practice and patient advocacy*	✓ Uphold confidentiality and informed consent while navigating evolving autonomy in AYAs. ✓ Balance individual rights with safeguarding and mandatory reporting obligations. ✓ Advocate for the rights and access of marginalized youth (e.g., refugees, LGBTQ+, youth in care).
2.	*Reflective practice and clinical excellence*	✓ Engage in continuous self-directed learning and evidence-based care. ✓ Acknowledge personal limitations and seek supervision when needed. ✓ Participate in error analysis, ethical discussions, and case reviews. ✓ Apply functioning-oriented thinking, including frameworks like ICF, to comprehensively assess functioning and disability across domains such as mobility, cognition, self-care, and participation, patient needs, and guide biopsychosocial care planning.
3.	*Leadership, accountability, and teamwork*	✓ Lead and contribute to interdisciplinary transition planning. ✓ Foster respectful, inclusive team dynamics and mentoring of peers. ✓ Demonstrate accountability in care coordination, communication, and follow-through.
4.	*Communication and interpersonal skills*	✓ Build rapport and therapeutic relationships with AYAs and families. ✓ Navigate sensitive, complex conversations with clarity, empathy, and youth-centeredness. ✓ Demonstrate cultural humility in cross-cultural encounters and adapt communication to the developmental stage.
5.	*Diversity, inclusion, and health equity*	✓ Identify and challenge unconscious bias in healthcare delivery. ✓ Tailor care to reflect the needs of diverse AYA populations and social determinants of health. ✓ Collaborate with youth-led and community organizations to improve system responsiveness.
6.	*Resilience and well-being*	✓ Demonstrate awareness of burnout risks in transitional care settings. ✓ Employ reflective practice, time management, and peer support. ✓ Promote healthy workplace environments and a culture of collegiality and compassion.

Integration into training and assessment

Professionalism and non-technical skills in transition care encompass ethical practice, reflective learning, effective communication, and a commitment to justice and equity. These competencies

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are essential for providing effective, ethical, and developmentally appropriate care. These were modeled throughout training and reinforced through faculty role modeling, reflective writing, and structured feedback. By adhering to these principles, specialists certified in transitional care contribute to the health and well-being of individuals and society. By aligning these values with clinical practice, professionals can ensure their work remains patient-centered, equitable, and upholds the highest ethical standards.

Trainees should receive formative and summative feedback through faculty role-modeling during clinical supervision, structured debriefings, case reviews, reflective writing in learning portfolios, and multi-source feedback (MSF) from colleagues, staff, patients, and mentors.

By aligning professional values with daily practice, certified specialists in Transitional care enhance the health system's capability to meet the evolving needs of AYAs, supporting positive long-term health trajectories across Europe.

c. Levels of competence in Transitional care

Training progression in transitional care is based on the principle of progressive independence. This progression is assessed through various domains: knowledge (both theoretical and clinical understanding), practical technical skills (clinical procedures and their application), and non-technical competencies (such as communication, professionalism, leadership), along with clinical judgment in specific contexts. These assessments define the trainee's development and the level of competence expected upon completing their training, reflecting the ability to perform professional tasks safely and independently. Each domain specifies the learning outcomes necessary to achieve the required competency levels determined by UEMS standards. The learning outcomes outlined in this document describe the competencies needed to perform skills and manage patients in independent, autonomous practice.

This progression is essential in transitional care due to the interdisciplinary, developmental, legal, and ethical complexities of working with AYAs. Competency includes not just knowledge but also communication, collaboration, and self-awareness.

Most core clinical and communication competencies in this training should be achieved at Level D, especially regarding independent management of transition planning, confidentiality, consent, and interdisciplinary collaboration. However, not all trainees are expected to reach Level D in every domain; independent performance (Level D) is required in at least three core EPAs, with Level C expected across all domains. Continuous professional development will further enhance

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the number and level of competencies beyond the core content of ETRs. Competency development will follow the UEMS-recommended framework of progressive independence, with levels defined as follows:

Level	Clinical role description	Knowledge	Skills	Non-technical competencies
A *Observer*	Passive observer under close supervision in structured teaching or clinics.	Understands the principles of transitional care, including developmental differences in AYAs, basic transition models, legal concepts, and the concept of functioning and its relevance in AYAs' health.	Observes consultations on transitions and assessments of patients conducted by experienced clinicians.	Understands team members' roles, listens attentively, and starts reflecting on personal values and biases. Recognizes that functioning is a key component of AYAs' well-being and observes how it influences care.
B *Direct supervision*	Performs tasks with the supervisor present and guidance at each step.	Demonstrates an understanding of chronic conditions and transition protocols with guidance. Describes the domains of functioning and contextual factors using ICF terminology.	Performs parts of the transition assessment while providing immediate feedback (e.g., HEADSSS, SSHADESS, readiness tools). Applies basic functional assessment tools (e.g., WHODAS 2.0 short form) with supervision.	Practices communication with AYAs and their caregivers, coaching interactions; discusses the importance of confidentiality and informed consent. Examines the effects of functional limitations and discusses when referrals for assessment may be necessary.
C *Distant supervision*	Takes responsibility for patient care with a supervisor accessible but	Shows clinical reasoning and the ability to integrate knowledge of developmental and psychosocial factors. Explains	Manages transition planning under remote supervision, with feedback mechanisms, initiates interprofessional	Facilitates discussions, anticipates ethical challenges, seeks feedback, and engages in self-reflection.

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	not always present.	how functioning, environment, and disability interact in AYAs' care.	meetings, and uses validated tools (e.g., TRAQ). Integrates functioning assessments into care planning (e.g., full WHODAS 2.0 or ICF checklist).	Integrates functioning perspectives into care planning
D *Independent*	Practices independently and may supervise others; demonstrates entrustable professional behavior.	Effectively implements evidence-based approaches and adapts transition models to fit clinical settings.	Leads multidisciplinary care, facilitates joint consultations, and independently implements care plans. Entrusted with all relevant EPAs.	Acts ethically, manages conflict, supervises junior trainees, and mentors peers in transitional care. Entrusted with all relevant EPAs.

Trainees should present their completed curriculum (module) when applying for positions across Europe. This includes details about the clinical experiences they participated in and their overall professional development. A well-organized logbook or portfolio should outline the activities and clinical exposure they undertook, records of EPAs achieved, and the assessment tools used. Additionally, it should contain documentation of supervision, self-assessments, and progress evaluations. This approach ensures transparency, supports mobility, and aligns with the European Qualifications Framework (EQF) and the CanMEDS competencies.

Transitional Care-Specific Entrustable Professional Activities (EPAs)

EPAs are specific, observable units of professional practice that can be entrusted to a trainee once they have demonstrated sufficient competence to perform them independently and safely, without direct supervision. EPAs are an essential link between competency frameworks, such as CanMEDS roles or WFME domains, and real-world clinical responsibilities. This connection is vital to ensuring both patient safety and professional accountability.

EPAs are the foundation for a progressive and flexible training approach, allowing trainees to advance at their own pace and ensuring they are ready based on demonstrated competence. In the context of transitional care, EPAs are particularly important because they address the complexities of managing AYAs across varying developmental, legal, and psychosocial areas, often within fragmented pediatric and adult care systems. Entrustment involves more than

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simply completing tasks; it includes trust in the trainee's judgment, professionalism, communication skills, and ability to deliver safe, developmentally appropriate care. EPAs also include evaluations of functioning and participation across medical, psychological, and social domains, using the ICF checklist and WHODAS 2.0 when applicable. This approach guarantees a comprehensive understanding of the capabilities of AYAs and the contextual factors that affect the continuity of care and outcomes.

Transitional care EPAs are designed to align with the UEMS (European Union of Medical Specialists) Educational Training Requirements (ETRs) and reflect key EU directives that promote transparency, professional mobility, and competence-based training. These EPAs support the objectives of Directive 2005/36/EC and Directive 2013/55/EU, which aim to harmonize recognition of qualifications, establish modular, lifelong learning pathways, such as the CAQ, and facilitate mobility of qualified professionals between EU countries. Additionally, Directive 2011/24/EU highlights the importance of continuity of care and interoperability – goals that EPAs help achieve by standardizing transitional care competencies across different specialties and countries.

Drawing on CanMEDS 2015, WFME 2023 postgraduate standards, and WHO's adolescent health frameworks (2015, 2023), these EPAs convert essential competencies into observable and assessable clinical activities. They provide healthcare providers with the practical tools and professional behaviors necessary to deliver care responsive to AYAs. They ensure it is adolescent-responsive, developmentally appropriate, safe, and equitable as they transition to adult health systems.

Transitional care involves a complex interplay of clinical medicine, developmental psychology, patient autonomy, legal variation, and gaps within health systems. EPAs help standardize care by ensuring that clinicians can manage critical transition-related tasks safely and independently. They set minimum expectations for clinical and non-clinical care of AYAs, while supporting developmentally tailored, equitable, and inclusive care. Additionally, EPAs foster interdisciplinary collaboration between pediatric and adult services, support cross-specialty adaptability, and create structured pathways for CPD or CAQ. Moreover, they empower institutions to measure and monitor training outcomes effectively. Regarding the pilot of time-variable flexibility, it is important to maintain EPA-based benchmarks while acknowledging that some trainees may progress at different rates. This reflects a move from time-based to mastery-based training, highlighting competency by design.

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Transitional care operates at the intersection of clinical medicine, developmental psychology, patient autonomy, legal framework variations, and health system gaps. EPAs play a crucial role in standardizing care by:

- ✓ Ensuring that clinicians can safely and independently manage critical tasks related to transitions;
- ✓ Defining minimum expectations for both clinical and non-clinical care for AYAs;
- ✓ Supporting care that is developmentally appropriate, equitable, and inclusive;
- ✓ Promoting interdisciplinary collaboration between pediatric and adult services;
- ✓ Allowing for adaptability across specialties while providing structured pathways for CPD or CAQ;
- ✓ Enabling institutions to measure and monitor training outcomes effectively.

Transitional Care EPAs are designed to be flexible and applicable across various medical specialties, including pediatrics and adult medicine, mental health specialists, and general practice/family medicine. They can also be utilized in mixed services, such as transitional care clinics, adolescent units, and outpatient clinics. Additionally, they can support CPD modules, national boards, or UEMS-recognized CAQ processes. Interprofessional teams, including those in school and occupational health, primary care, and rare disease networks, can also benefit from these EPAs.
Each of the seven EPAs (Appendix 2) includes the following components: a rationale and scope that explains its relevance, specifications, core tasks, and the competencies required for execution. It also outlines the potential risks of failing to perform the EPA properly, aligns with CanMEDS roles, and maps to the necessary knowledge, skills, and attitudes. Furthermore, it recommends assessment tools, specifies the expected level of entrustment, and suggests a timeline for maintenance, such as reassessment (recertification) or ongoing competence.

Entrustment decisions enhance accountability, patient safety, and cross-border recognition of qualifications. By integrating EPA-based education into transitional care, Europe can promote standardized practices, facilitate the mobility of specialists, and ensure that young people receive coordinated, respectful, and effective care during one of the most vulnerable periods of their health journey.

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Transitional Care EPAs summary table (full description of EPAs is presented as Appendix 2)

EPA No.	Title	Specifications	CanMEDS Roles	Entrustment Target	Core Assessment Tools
1	Conduct a transition-oriented consultation.	Includes developmental, cognitive/learning, psychosocial, and medical assessments tailored to AYAs. Use structured tools (e.g., HEADSSS, SSHADESS, TRAQ) to address social context, life changes, and transition readiness.	Medical expert, Communicator, Collaborator, Health advocate, Scholar	Level D	Mini-CEX, case-based discussion, short practice observation, OSCE, portfolio (reflection logs, transition plans), evaluation of work product (consultation notes, letters), patient/family feedback
2	Manage confidentiality, evolving capacity for decision-making, and medical autonomy in AYAs.	Adhere to ethical and legal obligations related to consent, data sharing, and capacity. Maintain autonomy while ensuring safety in line with General Data Protection Regulation (GDPR) and WHO guidelines.	Professional, Communicator, Health advocate, Leader	Level D	Direct observation of communication skills, case-based discussion, legal/policy review, OSCE (ethico-legal scenario), longitudinal practice observation, ethics/peer feedback, portfolio reflections
3	Identify and address developmental, cognitive, and psychosocial factors affecting AYAs during the transition.	Screen for and manage mental health problems, trauma, risky behaviors, and social determinants. Connect AYAs with educational and professional resources, integrate care, and reduce long-term attrition. Conduct assessments of functioning, using	Medical expert, Scholar, Health advocate, Collaborator, Communicator	Level C–D	Mini-CEX, case-based discussion, short practice observation, validated questionnaires (PHQ-9, GAD-7, SDQ, CRAFFT), structured mental state exam, multi-source feedback, reflective logs

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		the ICF checklist, WHODAS 2.0, the GAF scale, etc. When appropriate, coordinate with rehabilitation or other services due to functioning or disability, as national or local laws require.			
4	Promote health equity and provide inclusive, culturally safe care	Tailor care according to individual identity, needs, literacy, and service access. Address systemic bias and provide equitable care planning, especially for LGBTQ+ youth, migrants, and underserved populations.	Health advocate, Professional, Communicator, Collaborator	Level C	Equity checklists, simulation (bias/cultural sensitivity), structured peer/AYA feedback, MSF (esp. nurses/interpreters), evaluation of work product (transition plan/equity documentation)
5	Coordinate the complex, interdisciplinary transfer of AYAs' care	Lead structured handovers between paediatric and adult services, including social, educational, and community stakeholders/systems. Ensure continuity for complex and high-risk patients.	Leader, Collaborator, Medical expert, Communicator	Level D	Direct observation of handovers, transition plan audit, simulation, MSF (incl. allied professionals), portfolio, longitudinal practice observation, evaluation of work product (referral letters, summaries, care plans)
6	Empower AYAs for self-management and shared decision-making	Guide AYAs in developing independence, life skills, and adherence to their treatment plans. Involve	Health advocate, Scholar, Communicator, Professional	Level D	Mini-CEX (goal-setting), case-based discussion, TRAQ, role play/OSCE, AYA/caregiver feedback, portfolio

		caregivers in a way appropriate for each developmental stage to facilitate the transfer of responsibility. Use validated readiness tools, such as the Transition Readiness Assessment Questionnaire (TRAQ), to support this process.			reflections, mentor reviews, longitudinal practice observation
7	Integrate digital tools and eHealth in transitional care	Use telemedicine, digital health tools (apps), EMRs, and platforms for communication, care, and education, ensuring safety, confidentiality, and inclusion; utilize family-supervised digital resources when necessary.	Scholar, Communicator, Leader, Health advocate	Level C	Digital literacy checklist, OSCE (teleconsultation/e-consultation), simulation (digital safety), portfolio review of digital cases, youth/family feedback, evaluation of work product (telehealth notes, digital documentation)

3. Organization of training

a. Schedule of training

Minimum duration of training

The recommended minimum duration for structured training in Transitional care is 4 to 12 weeks. This training should be delivered through online (virtual) and in-person (onsite) learning, with at least two weeks completed onsite to ensure direct clinical exposure. The duration may vary based on national frameworks, training intensity, and whether the programme is integrated into all adult specialties' curriculum or offered as a CAQ.

The training should provide exposure to outpatient clinics and community-based settings, including primary care, where most transitional encounters with AYAs occur. If available,

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participants should engage in dedicated transition clinics and rotate through child and adolescent psychiatry services, adult psychiatry, joint consultations with CAMHS and adult mental health services, chronic care specialties, and school or occupational health. Additionally, they should participate in joint consultations between pediatric and adult care teams, actively engage in interdisciplinary case reviews, contribute to transition pathway planning, and conduct post-transfer follow-up.

This structured approach offers trainees longitudinal, developmentally sensitive, and system-level insights into the transition process, from early planning and readiness assessment to transferring care and providing post-transfer support.

Timing and evaluation structure

Trainees may complete different EPAs across multiple institutions or rotations. To qualify for certification, completing and documenting all seven EPAs is compulsory. Flexibility is maintained to accommodate different national systems, but institutions are encouraged to implement midpoint (formative) evaluations. These evaluations help review progress and provide targeted feedback based on the development of EPAs, final assessments, or project submissions. This process should align with the EPAs' achievement and the CanMEDS roles. A structured portfolio or logbook should track EPA completion, reflective learning, and competency growth.

National authorities are responsible for determining the specific timing of summative assessments. However, training centers must ensure that trainees receive regular supervision, mentorship, and feedback throughout their training period, with EPA-based progress serving as a guide for certification readiness.

b. Curriculum of training

The ETR for the CAQ in Transitional care aims to ensure that trainees develop clinical competence, professional integrity, and a comprehensive understanding of healthcare systems across various settings. This is achieved by imparting essential knowledge, both clinical and non-clinical skills, and caring for AYAs. The training incorporates structured educational formats and workplace-based learning. Learning outcomes are organized around core competencies and role integration as defined by the CanMEDS framework. These are operationalized through assessments linked to EPAs and reflection on practice. The curriculum is tailored to the interdisciplinary nature of transitional care and considers the evolving developmental, psychosocial, and legal complexities facing the AYAs population.

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The curriculum is designed with modular flexibility, allowing for variable progression over time. This structure facilitates trainees' advancement toward independently managing real-world responsibilities in transitional care and aligning with CanMEDS roles and WFME standards. It includes the following core domains:

Domain	Learning objectives/outcomes	Educational methods
1. Biopsychosocial development	Understand typical and atypical physical, emotional, cognitive, and sexual development during adolescence; recognize how neurodiversity and identity formation affect health; apply structured developmental assessment tools.	Interactive lectures, case discussions, simulation, reflective exercises, and short practice observation of consultations.
2. Transitional care frameworks	Utilize structured transition models, identify barriers to successful transitions, use readiness assessment tools (e.g., TRAQ), document findings in portfolios, and distinguish between transfer and transition.	Clinical rotation, workshops, case-based learning, joint pediatric-adult clinics, evaluation of work product (transition plans, readiness documentation).
3. Mental, developmental, and cognitive health and risk behaviors	Recognize early signs of mental distress, substance use, developmental disorders, cognitive/learning disabilities, and trauma; provide trauma-informed care that is developmentally appropriate; apply validated screening tools (e.g., PHQ-9, CRAFFT, SDQ, WHODAS 2.0 short form).	Role-play, interprofessional teaching, simulation, case discussions, structured mental state/cognitive examination training, learning disabilities assessment, psychiatric interviewing, and open dialogue techniques.
4. Chronic conditions in transition	Manage disease-specific care during transitions. Understand challenges related to medications and medical devices, adherence, comorbidities, and polypharmacy in AYAs. Conduct a comprehensive assessment of functioning, and when appropriate, coordinate with rehabilitation or other services due to functioning or disability, as required by national or local laws. Evaluate documentation for accuracy and completeness.	Specialty-specific clinical training, portfolio reflection, interdisciplinary rounds, and evaluation of work product (care plans, referral letters).
5. Reproductive and sexual health	Counsel AYAs on consent, contraception, gender identity, STIs, and confidentiality	Youth-focused consultations, ethics seminars, OSCEs,

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	with cultural competence; demonstrate communication in a supervised setting.	communication skills training, and short practice observation of counseling sessions.
6. Ethics and legal frameworks	Navigate issues of confidentiality, capacity, consent, GDPR compliance, and professional responsibilities across different age groups; critically review documentation for legal/ethical compliance.	Legal case simulations, small-group seminars, policy reviews, ethics-focused OSCEs, and work product revaluations (documentation for compliance with GDPR and consent process).
7. Health equity and vulnerable groups	Identify and address barriers for AYAs from marginalized groups, such as migrants, LGBTQ+ youth, AYAs with neurodevelopmental disabilities (e.g., autism, ADHD), and those in foster care; also, understand the social determinants of health; demonstrate inclusive communication and care planning.	Equity checklists, DEI modules, community-based projects, multidisciplinary simulation, and multi-source feedback from AYAs and peers regarding inclusivity.
8. Digital health and communication	Integrate telemedicine and online tools into AYAs' care while ensuring data protection and inclusivity; address digital literacy and cyber safety; use digital tools appropriately and document their usage; utilize family-supervised digital resources when necessary.	eHealth simulations, digital tool evaluations, OSCE stations, patient feedback on teleconsultations, and evaluation of work product (telehealth notes, EMR entries).
9. Empowerment and self-management	Enhance health literacy, encourage shared decision-making, and promote school progress, professional development, and autonomy; assist AYAs in establishing personalized care and life goals; demonstrate coaching and monitoring of shared decision-making.	Motivational interviewing practice, portfolio coaching, self-assessment tools, patient navigator shadowing, and longitudinal practice observation of shared decision-making.
10. Leadership and interdisciplinary work	Lead interdisciplinary teams, contribute to institutional and national policies, and advocate for transitions; demonstrate leadership behaviors in supervised settings.	Quality improvement project, joint care planning workshops, policy roundtables, team debriefs, and direct/longitudinal observation of leadership in team meetings.

Trainees are expected to apply a curriculum focused on EPAs tailored to transitional care. This includes work-based assessments such as Mini-clinical evaluation exercises (Mini-CEX), case-

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based discussions, and multi-source feedback (MSF). They will also receive longitudinal supervision from mentors and trainers. They will complete a portfolio and logbook with reflections, self-assessments, and evidence of their competencies. This integrated curriculum lays the foundation for trainees to provide developmentally appropriate, ethically grounded, and system-aware care to AYAs across Europe.

c. Assessment and evaluation

A structured and robust approach to assessment and evaluation is essential for maintaining high standards in transitional care training. The goal is to support a culture of continuous assessment that balances both the formative progress evaluation and summative assessment. This can be achieved using a multi-source, real-time framework that integrates frequent structured workplace-based assessments (WPBAs), such as the Mini-CEX and multi-source feedback (MSF), short and longitudinal practice observations, and evaluation of work products, along with longitudinal assessment portfolios that include reflection, planning, and documented EPA-based entrustment decisions. Competence committees synthesize data from diverse feedback sources to support fair, evidence-based, data-driven judgements on progression. This comprehensive approach ensures that trainees gain knowledge and the skills and professional attitudes required to apply it confidently and safely in real clinical environments. Such an evaluation approach reflects performance tied to EPAs, the framework promotes reflective practice, and improves coaching interactions, creating a clear picture of readiness for independent practice. This allows for reliable, defensible entrustable decisions, ensures comparability across training settings, and supports the mobility of qualifications across Europe in line with UEMS, CanMEDS, and WFME principles.

Definitions and Purpose

- ✓ *Assessment* refers to the systematic process of evaluating a trainee's achievement of learning outcomes. This includes formative and summative assessments and involves assigning a value or grade based on clear, predefined criteria. Assessment aligns with EPAs and supports both quality assurance and professional development.
- ✓ *Evaluation* is broader and involves making judgments about the quality of a trainee's performance and progress, the effectiveness of the educational environment, and the attainment of programme goals.

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i. Formative Assessments

Purpose: To monitor progress, provide feedback, and support development. Formative assessments occur throughout the programme, helping trainees reflect, improve, and engage in self-directed learning. These assessments are mapped to specific EPAs and CanMEDS roles.

Formative assessment tool	Function
Mini-CEX (clinical evaluation exercise)	Observation of AYA consultations in real-time, accompanied by immediate feedback.
Direct observation of procedural skills	Supervised practice of practical or communication-based tasks, such as discussions on confidentiality.
Case-based discussion	A critical review of AYA cases, focusing on aspects such as readiness, ethical dilemmas, and psychosocial challenges.
Teaching observation	Feedback from peers or mentors regarding teaching practices or advocacy efforts directed at colleagues or families.
Structured feedback sessions	Feedback from supervisors should be provided using structured rubrics aligned with EPAs.
Reflection logs	Reflections written by trainees on challenges related to transitions and ethical cases.
Portfolio review	Regular reviews by a mentor or Programme Director will assess the accumulated evidence and learning progress.
Multi-source feedback (MSF)	Comprehensive feedback from peers, nurses, AYAs, families, and allied professionals regarding teamwork and communication.
Feedback tools (e.g., patient/parent questionnaires)	Assess the effectiveness of communication, building trust, and the approach to shared decision-making.
Short practice observation	A focused review of a single clinical encounter, such as a consultation or a discussion about disclosures, with immediate feedback provided.
Longitudinal practice observation	Evaluation of professional development and consistency in multiple interactions or continuity of care scenarios.
Evaluation of work product	Review transition-related documentation (e.g., care plans, referral letters, and transition summaries) to ensure accuracy, clarity, and a youth-centered approach.

Each trainee must maintain a clinical logbook documenting various AYA cases and transitional care activities, a portfolio that includes reflective writings, completed EPA checklists, records of multidisciplinary participation, feedback reports, and a personal development plan.

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ii. Summative Assessments

Purpose: To certify that the trainee is prepared for independent practice at the expected level of competence. Summative assessments are conducted at specific points, such as at the end of a programme or module, by national or UEMS-level processes. These assessments ensure that the trainee has acquired all the necessary competencies to manage transitional care responsibilities independently.

Summative assessment tool	Function
OSCE (Objective structured clinical exam)	Simulated youth scenarios include situations such as capacity assessments, digital consultations, and conflicts regarding consent.
Workplace-based assessment	Directly reviewing the performance of trainees in clinical settings or during handovers.
EPA-specific entrustment decisions	Supervisor assessments should utilize structured EPA checklists to evaluate Level C or D achievement.
Final discussion	Evaluates ethical reasoning, interdisciplinary planning, and communication strategies.
Final portfolio and/or Transition project review	A synthesis of reflective work, documented EPAs, and examples of structured transition planning.
Evaluation of work product	Final review of care plans, handover letters, and transition documentation for the summative certification process.

All final assessments must demonstrate the integration of clinical competence, professionalism, ethical reasoning, and collaboration across systems.

iii. EPA-Based Evaluation:

Each trainee will be assessed against the 7 EPAs defined in the curriculum:

EPA tracking strategy	Tool/Source
Entrustment decisions	According to the EPA, the supervisor conducts reviews based on the documented entrustment levels (A–D).
EPA-specific checklists	Skill-based rubrics that are aligned with the CanMEDS roles and clinical milestones.
Portfolio mapping to EPAs	Documentation of tasks, reflections, case summaries, and feedback
Assessment of digital and equity competence	Digital literacy checklists, equity audits, and OSCE stations

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The Programme Director is responsible for ensuring that all components of the portfolio and assessments are completed before the CAQ is awarded. Based on national certification requirements, the certification may be valid for five to ten years (recertification cycles). After this period, recertification requires health professionals to demonstrate ongoing practice and continuous professional development in transitional care, according to national standards. This includes completing a minimum recommended number of Continuing Medical Education (CME) hours in transitional care every five years and dedicating a portion of those hours to specific areas such as youth-centered communication, legal and ethical updates, or chronic care management. Non-formal learning experiences like quality improvement projects, youth-led training, participation in transitional care networks, contributions to scientific articles, engagement with educational training resources, programme development, and fulfilling other requirements are encouraged.

This framework ensures that assessment focuses on testing knowledge and certifying the readiness to deliver safe, coordinated, and developmentally appropriate care to AYAs. This approach aligns with the objectives of the CanMEDS, UEMS, and WFME frameworks for outcome-based, high-quality postgraduate medical education.

e. Governance

Effective governance ensures that the Transitional Care ETR upholds educational integrity, aligns with national and European standards, and provides consistent, high-quality training. It involves clearly defined roles and responsibilities among the Programme Director, trainers, mentors, and training institutions.

The Programme Director oversees its structure, ensuring its content aligns with national and European frameworks. This role involves coordinating curriculum delivery and providing support to trainees. The Programme Director plays a crucial role in evaluating the programme and guiding trainees effectively. Key responsibilities include ensuring adherence to assessment standards, conducting regular reviews with each trainee, and offering individualized coaching and remediation. Additionally, the Programme Director oversees summative assessments and prepares trainees for certification.

Programmes should include Competence committees, which are trained review panels that regularly assess EPA progress. They synthesize data from multiple sources, such as EPAs, multi-source feedback (MSF), and portfolios, to make holistic decisions regarding entrustment and trainee progression. Competence Committees must implement structured and transparent decision-making processes that include anti-bias principles. All members should undergo regular

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training in recognizing implicit bias, cultural safety, and equitable assessment practices. This training is essential to ensure that decisions regarding entrustment and certification are fair, consistent, and inclusive.

Each trainer supervises clinical learning, providing real-time feedback and coaching while assessing trainees based on EPAs. Mentors facilitate continuous development by guiding reflective practices, offering career orientation, and helping create personal development plans. Additionally, faculty development that includes coaching skills is essential for supporting and sustaining the growth of trainees.

III. TRAINING REQUIREMENTS FOR TRAINERS

1. Process for recognition as a trainer

a. Requested qualification and experience

Transitional care trainers are crucial in providing high-quality, developmentally appropriate education and should be formally acknowledged through national or institutional frameworks. Their qualifications must encompass both clinical expertise and teaching competency.

Trainers in transitional care should:

- ✓ Be certified specialists in relevant clinical disciplines such as pediatrics, adolescent medicine, child and adolescent psychiatry, psychiatry, internal medicine, general practice/family medicine, public health, or other specialties;
- ✓ Have at least three years of post-specialist clinical experience in their area of practice and be recognized by national regulatory or accrediting authorities;
- ✓ Actively engage in direct clinical care involving AYAs, including responsibilities related to their transition;
- ✓ Be recognized as qualified trainers by national regulatory or accrediting authorities;
- ✓ Complete comprehensive, formal, structured faculty development "Training the Trainers" programmes in medical education and mentorship. These programmes should cover areas such as assessing EPAs using narrative feedback, coaching for performance improvement, leading competence committees, promoting reflection, and professional identity formation. This training should align with UEMS guidance, WFME recommendations, and national standards, demonstrating the ability to apply these concepts in real-world training environments.

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Additionally, the roles of Programme Directors and mentors include:

- ✓ Programme Directors must be certified specialists with at least five years of post-certification experience and demonstrate formal training and leadership in postgraduate education, curriculum implementation, and quality management.
- ✓ Mentors should have at least five years of post-specialist clinical practice, actively participate in teaching and mentoring, and be officially appointed by the training programme or a national authority. While mentors may also serve as trainers, their primary focus should be on providing personalized guidance and supporting the longitudinal development of trainees.

b. Core competencies of trainers

All trainers must exhibit skills beyond clinical knowledge, especially in postgraduate education and the development of learners.

Domain	Required Competencies
Curriculum expertise	Comprehensive understanding of transitional care, adolescent development, the CAQ curriculum, and the EPA framework; ability to apply CanMEDS roles in training design.
Educational skills	Understanding the principles of modern medical education, including formative and summative assessments, as well as educational methodologies such as simulation, OSCE, and portfolio assessment.
Assessment and feedback	Proficient in providing constructive, actionable feedback; utilizing tools such as MSF, Mini-CEX, case-based discussions, and EPA checklists; and assisting trainees experiencing difficulties.
Mentoring and supervision	Ability to create a safe and inclusive learning environment; provide career guidance and supervise reflective practices and self-assessment.
Professionalism and role-modelling	Dedicated to ethical behavior, youth-centered values, and equitable care; demonstrate commitment to equity and inclusion by completing periodic bias recognition, cultural safety, and developmentally appropriate communication training; capable of modeling professional standards and compassionate values in clinical practice.
Interdisciplinary leadership	Encourage interprofessional learning and collaboration among specialties; participate in co-teaching and navigate complex transitional care cases.
Ongoing professional development	Dedication to ongoing enhancement in clinical teaching, CPD activities, and engagement in educator peer networks.

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Trainers should model ethical and professional behavior while engaging in reflective practices, prioritizing their well-being to maintain effective education. Resilient educators are better equipped to mentor trainees and create a safe, youth-responsive learning environment.

2. Quality management for trainers

Ensuring the quality and accountability of trainer performance is essential for achieving educational excellence. Institutions and Programme Directors are critical in implementing systems that foster continuous development and quality assurance.

Institutional and Administrative Support

Institutions must allocate protected time and provide administrative support for training and supervision responsibilities. It is essential to have qualified trainers to maintain safe trainee-to-trainer ratios and ensure continuous supervision. Programme Directors should monitor trainer workloads to balance service and teaching, thereby preserving educational quality.

Trainer skills improvement and evaluation

- ✓ Develop faculty development frameworks to ensure that trainers are proficient in coaching, providing feedback, and understanding assessment literacy.
- ✓ All trainers should have access to CPD and training in medical education, focusing on youth engagement, EPAs, integration of CanMEDS roles, ethics of transition, anti-bias, and cultural safety.
- ✓ Institutional support should also include resources for psychological well-being, mentoring skills, and interprofessional collaboration.
- ✓ Trainers must undergo regular evaluations, including structured feedback from trainees (e.g., anonymous surveys or multi-source feedback), peer or supervisor reviews of teaching performance, and analyses of trainee outcomes and EPA achievement rates.
- ✓ The results of these evaluations should be used to identify trainers who need improvement, recognize high-performing educators, and promote best practices across programmes.

Trainer resilience and capacity building

Trainers play a crucial role as role models, and their well-being directly affects the quality of teaching and patient safety. Institutional policies aimed at developing trainers should include dedicated time for supervision, access to psychological support, opportunities to participate in peer reflective groups, and ongoing professional development. The UEMS recommends that trainers engage in CPD, emphasizing leadership, well-being, and burnout prevention. All of these resources are vital for maintaining educational quality and clinical excellence.

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IV. TRAINING REQUIREMENTS FOR TRAINING INSTITUTIONS

1. Process for recognition as a training center

a. Requirement on staff and clinical activities

Institutions must adhere to well-defined structural, clinical, and academic standards to ensure high-quality and harmonized training in Transitional Care for AYAs across Europe.

Minimal number of patients cared for as inpatients and as outpatients; a minimal number of (surgical) procedures

Training centers must ensure that trainees can access diverse AYAs in outpatient and inpatient settings across disciplines relevant to transitional care. This includes a minimum of 20 documented outpatient encounters and at least five inpatient cases, which should reflect the wide array of transitional needs for AYAs. Additionally, trainees are encouraged to participate in joint consultations or shadowing opportunities in multidisciplinary or transition-specific clinics whenever possible.

Range of clinical specialties required for the training programme

The programme must expose trainees to core disciplines, including adolescent medicine, pediatrics, and internal medicine. Additionally, trainees should gain experience in at least three other relevant specialties based on their foundational training. These may include child and adolescent psychiatry, adult psychiatry, adult medical specialties, gynecology or urology, physical and rehabilitation medicine, psychology, public health, school or occupational health, special educators, and general practice/family medicine. The training setting should accurately reflect the real-world environment of transitional care, encompassing community-based and outpatient services, often the primary points of contact for AYAs.

Composition and availability of faculty

Every trainee must have an assigned educational supervisor, a certified specialist in adolescent, pediatric, or adult specialties related to transitional care. Supervisors must be available for at least three formal review meetings throughout the training period: at the beginning, midpoint, and end. Additional ad hoc meetings are encouraged as needed. Mentors and Programme Directors should be available to support the ongoing development of trainees, promote reflective practice, and assist in integrating EPA-based learning. Trainees should be able to change supervisors, if necessary, with clearly defined institutional policies to facilitate this process.

Training programme defined, guidelines for application

Institutions must implement a structured training plan that delivers all components of the certified curriculum. A minimum of 4–12 weeks is required (depending on programme intensity), including both onsite (in-person) and virtual (online) training.

Core educational formats should include:
- ✓ outpatient and bedside teaching
- ✓ case-based learning
- ✓ structured role-play and communication training
- ✓ journal clubs and evidence-based medicine sessions
- ✓ audit and quality improvement activities
- ✓ interdisciplinary team meetings and transition planning sessions
- ✓ simulations (e.g., confidentiality scenarios, digital consultations)
- ✓ patient-led teaching, where possible

Every trainee should conduct a final review of their portfolio and EPAs during a structured exit meeting.

Trainee /trainer ratio
Research shows that trainee fatigue and staff shortages directly lead to increased clinical errors and negatively impact learning and patient care. Institutions should maintain a trainee-to-trainer ratio of 4 to 6 trainees per trainer. Exceptions can be made in larger or networked programmes, but the ratio should not exceed 7 to 1. These guidelines help promote safe clinical practice, support professional development, and reduce the risks associated with burnout. They also facilitate meaningful supervision, personalized feedback, and opportunities for direct observation and assessment of EPAs.

Relevant scientific activity
Training institutions should promote academic exploration in adolescent health and transitional care. They should encourage participation in case presentations, scientific professional conferences, research methodology workshops, and projects on quality improvement or service evaluation. Additionally, trainees should be required to submit at least one scholarly work, including a conference abstract, poster, publication draft, or a structured transition project report. Maintaining a logbook and portfolio of scientific activities for each trainee is also important.

A system for support, counselling, and career guidance of trainees
Training institutions need to establish a strong and structured support system for trainees. This system should include individualized mentorship, regular career planning, and reflective supervision. Mentors must assist trainees with self-assessment, goal setting, and progression towards key competencies. This provides opportunities to pursue CAQ, or CPD modules, and leadership roles in transitional care. Regular discussions should focus on academic progress, personal development, and potential career pathways. Additionally, institutions must provide trainees with access to confidential psychological and emotional support services, especially considering the emotionally complex nature of transitional care for AYAs. These services should encompass counseling, peer support groups, and referral pathways, all within a culture that actively reduces stigma and encourages early help-seeking. Annual appraisals of trainers and educational staff should incorporate feedback from multiple sources, including trainees and institutional evaluation metrics, to enhance the quality of education and responsiveness to trainees' needs.

Promoting trainee well-being and supportive learning environments
Institutions must prioritize fair treatment, non-discrimination, and psychological safety for all trainees. They should establish clear procedures for addressing concerns confidentially and without the risk of retaliation. Creating a psychologically safe, inclusive, and developmentally sensitive training environment is essential for optimizing trainees' learning, performance, and retention. Research highlights that supportive mentorship, flexible training arrangements, protected time for rest and reflection, and acknowledgement of personal life circumstances (e.g., parenting, illness, burnout) are key drivers of educational success and professional sustainability. Trainees working in transitional care are frequently exposed to high psychosocial complexity and clinical uncertainty. As such, institutions must implement proactive well-being strategies, including accessible mental health and well-being resources, normalized channels for requesting help, routine wellness check-ins and reflection sessions, integration of mindfulness, empathy-building, and self-reflective practices into supervision and teaching. These strategies build resilience, prevent burnout, foster empathy, maintain professionalism, and promote safer, more compassionate patient care.

Support for trainer well-being and reflective supervision
Trainers and Programme Directors should receive ongoing support through designated time for teaching, access to national or European "Training the Trainers" updates, opportunities for peer networking, and leadership development initiatives. Institutions should prioritize the well-being and professional development of trainers and mentors. Structured support should include access to mental health services, training on burnout prevention, stress management resources, and

opportunities for reflective supervision. Trainers must be equipped to recognize early signs of distress in themselves and their trainees. When trainers receive adequate support, they become more effective in delivering education, providing mentorship, and ensuring patient safety.

b. Requirement on equipment, accommodation

To ensure that training institutions can support the development of competencies in Transitional care for AYAs, the following infrastructure and resources must be in place:

Medical-technical specialty-specific equipment
Training centers must ensure the following:
- ✓ Access to diagnostic and therapeutic equipment necessary for AYAs' care across various specialties, including gynecological and urological examination tools, psychiatric/psychometric assessment instruments, and other necessary testing based on specialty needs and requirements.
- ✓ Availability of age-appropriate tools and settings, including youth-friendly consultation rooms prioritizing privacy, informed consent, and effective communication.
- ✓ Implementation of electronic health records (EHR) systems that enable secure documentation, confidentiality management, and interdisciplinary information exchange.

Clinical and educational activities support trainees' competence acquisition and physical spaces for study to ensure a learning environment.
To effectively support both education and care delivery, institutions should provide the following:
- ✓ Dedicated and quiet workspaces for trainees, equipped with desks, ergonomic seating, internet access, and lockable storage for personal and sensitive materials.
- ✓ Private consultation rooms are suitable for individual, family, or group meetings, designed with youth-sensitive principles. These should ensure confidentiality, create a welcoming atmosphere, and include non-stigmatizing features.
- ✓ Meeting rooms equipped for multidisciplinary team discussions, supervision, teaching sessions, and hybrid learning that combines in-person and remote participation.
- ✓ Shared interprofessional environments, such as adolescent or transitional care clinics, to promote exposure to team-based care.

Opportunities for Research and Development, and physical spaces and resources for research
Institutions should create an environment that promotes:
- ✓ Participation in clinical research, audits, and quality improvement projects focused on AYAs' health and care transitions.

- ✓ Designated time within the training programme for research activities.
- ✓ Access to institutional review boards, supervisors, and support staff for statistical or research needs.
- ✓ Opportunities to present research at local, national, or European conferences, including those in AYAs' transitional care or medical education.

Information technology support: those required for research, healthcare information systems, patient data, electronic or distance learning resources
- ✓ Up-to-date library resources include physical and online access to medical journals, e-books, clinical guidelines (e.g., NICE, WHO, EU), and educational databases.
- ✓ Robust computing and digital infrastructure, such as computers with secure clinical access, licensed medical and research software (e.g., case logbooks and epidemiological research), learning management systems or e-learning platforms for remote modules and recorded seminars.
- ✓ AI-supported and simulation tools, where available, to train skills such as digital consultations, confidentiality scenarios, and case-based reasoning (e.g., preparation for OSCE and ethical dilemmas).

Virtual and Artificial Intelligence Resources
Institutions must provide or facilitate the following:
- ✓ Access to webinars, telemedicine simulations, and virtual case reviews.
- ✓ Digital literacy training modules and preparation for e-consultation related to EPA 7 (eHealth integration).
- ✓ Secure platforms for submitting portfolios, EPA checklists, assessments, and reflections.

Additionally, digital tools should support real-time communication with mentors, encourage peer collaboration, and provide access to patient education resources.

2. Quality management within training institutions

Practical training in Transitional care for AYAs necessitates a strong governance system that guarantees AYAs responsive healthcare, consistent educational standards, clinical excellence, and accountability. This system should include accreditation, regular audits, faculty development, transparent reporting, and alignment with national and EU health workforce strategies.

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Accreditation and reaccreditation by the national competent authority
All institutions that offer the CAQ in Transitional care must be formally accredited by their national competent authority. Accreditation is granted based on several criteria, including institutional capacity, clinical volume, educational infrastructure, and the qualifications of trainers. Reaccreditation must occur at least every five years and is based on measurable standards such as clinical outcomes, trainees, patients, families, and other third parties' feedback, EPA entrustment rates, and research activity. Institutions must demonstrate compliance with national and European training regulations, as outlined in Directives 2005/36/EC and 2013/55/EU, which pertain to professional mobility and training quality.

Clinical Governance
Institutions must commit to clinical governance frameworks by providing safe, evidence-based care responsive to AYAs. This includes implementing policies that ensure patient confidentiality, consent, and legal protection. Additionally, there should be mechanisms to address patient safety, incident reporting, and continuous quality improvement. For trainees, it is essential to guarantee mentorship, supervision, and access to interdisciplinary consultation, including mental health, reproductive health, and AYAs' health.

Manpower planning is part of the defined national manpower plan.
Training centers must align with national and European health workforce planning to ensure the availability of qualified professionals in AYAs' transitional care. This involves monitoring demographic trends and the prevalence of chronic diseases among youth. Additionally, it is important to ensure a balanced distribution of trainees in high-need areas and to maintain sustainable trainee-to-trainer ratios, ideally at 4:1 or lower. Furthermore, resources should be provided for the long-term development of workforce capacity.

Regular reports on teaching and scientific activities are sent to the relevant authorities
Centers are required to submit annual reports to the appropriate authorities or national bodies. These reports should include the following information: the number of trainees and trainers; a description of structured training activities, such as seminars, bedside teaching, and simulations; completion rates for portfolios and logbooks; research projects, publications, and conference presentations by trainees; feedback mechanisms and quality improvement measures.

Internal auditing and quality assurance
Internal audits must be conducted at least once a year to review teaching quality, EPA implementation, assessment systems, trainee supervision and progression, and trainer development and support.

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External auditing
External audits should be conducted during the reaccreditation process or through national training oversight bodies. These audits may include peer reviews from other institutions or representatives from the UEMS. Additionally, audits should assess compliance with the WFME 2023 Postgraduate Medical Education (PGME) standards, including patient-centered care, digital learning, and interdisciplinary collaboration.

Transparency of training programmes
Training institutions should maintain clear and accessible documentation regarding the curriculum and essential requirements for EPAs, criteria for entry and progression, opportunities for research, clinical placements, the structure of supervision, and mentor assignments. They should also outline grievance procedures and support mechanisms available for trainees.
Training centers need to publish detailed information about their services, their staff's specialties and expertise, and the training programme's overall structure. There should be readily available contact information for a designated individual who can address inquiries from prospective trainees.

Progression through the training programme should be evaluated based on clear and transparent criteria. Any delays in a trainee's progress should be communicated in advance, except in cases involving health issues or professional conduct. Moreover, support systems must be established to assist trainees who face challenges in meeting training requirements. Prospective trainees must have access to public information (e.g., via websites or national registries), including the name of a designated programme contact.

It is recommended that structured program-level evaluations be periodically conducted to monitor educational effectiveness, trainee satisfaction, and alignment with national standards administered by the Competence Committee.

Structure for the coordination of training
Each Organizing Department must appoint a Programme Director, a certified specialist with at least five years of post-certification clinical and educational experience. The Programme Director should have completed formal training, such as the UEMS, national, or local training center recognized "Training the Trainers" course, and demonstrate formal training and leadership in postgraduate education, curriculum implementation, and quality management. The Programme Director oversees curriculum delivery, assessments, and coordination between mentors and trainers, and organizes and delivers the training programme locally. For larger training schemes,

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appointing a deputy or forming a training committee may be necessary to manage the programme effectively.

In cases where training placements are spread across multiple sites, it is important to carefully balance the educational benefits with the impact on the trainee's personal and family life.
A Training Committee is recommended in larger centers, especially when training spans multiple specialties or institutions. Coordination meetings should be held regularly (at least twice a year) between Programme Directors, mentors, and trainers to review progress and provide updates on the curriculum.

Framework of approval – how are they approved
Every programme must receive formal national approval, coordinated by the appropriate certifying or governmental authority in AYAs' health, transitional care, or medical education. The implementation of the transitional care curriculum must adhere to the following requirements: periodic national or regional inspections, compliance with the approved ETR and CanMEDS-aligned EPAs, feedback from stakeholders (including trainees, trainers, patients, and their families), and a review of cross-border compatibility and transferability, as outlined in Directive 2011/24/EU on cross-border healthcare.

By incorporating EPAs, CanMEDS roles, and a learner-centered progression that varies over time, this ETR reflects the latest advancements in postgraduate medical education and serves as a model for harmonizing transitional care training across Europe.

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Glossary including a list of acronyms with explanations

AAC – alternative and augmentative communication
AA-HA! – Global Accelerated Action for the Health of Adolescents
ADHD – attention-deficit hyperactivity disorder
AMSE – the Association of Medical Schools in Europe
AYAs – adolescents and young adults
CAMHS – Child and Adolescent Mental Health Services
CanMEDS – Royal College of Physicians and Surgeons of Canada Physician Competency Framework
CAQ – Certification of Added Qualification
CBME – competency-based medical education
CPD – Continuing Professional Development
CRAFFT – Car, Relax, Alone, Forget, Family & Friends, Trouble – a health screening tool designed to identify substance use, substance-related riding/driving risk, and substance use disorder among youth ages 12–21. (*Available at: Get the CRAFFT – CRAFFT*)
CRAFFT + N – Car, Relax, Alone, Forget, Family & Friends, Trouble, Nicotine (*Available at: 2.1-CRAFFTN_Selfadministered_2018-04-23.pdf*)
EAP – the European Academy of Paediatrics
EMR – electronic medical records
EPAs – Entrustable Professional Activities

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EQF – European Qualifications Framework
ETR – European Training Requirement
EUSUHM – European Union or School and University Health and Medicine
EuTEACH – European training in effective adolescent care and health team
GAD-7 – General Anxiety Disorder-7 scale (*Available at: Patient Health Questionnaire (PHQ) Screeners. Free Download | phqscreeners*)
GAF – Global Assessment of Functioning Scale (*Available at: Microsoft Word - axisv.doc*)
GDPR – General Data Protection Regulation
HEADSSS – Home, Education/Employment, Activities, Drugs, Sex and relationships, Self-harm and depression, Safety and abuse (Questionnaire) (*Available at: 17.-HEADSSS-Assessment.pdf*)
EHR – electronic health records
IAAH – International Association for Adolescent Health
ICF – WHO International Classification of Functioning, Disability, and Health
mini-CEX – mini-clinical evaluation exercises
MJC – Multidisciplinary Joint Committee
MSF – multi-source feedback
NICE – National Institute for Health and Care Excellence
NICE QS140 – NICE Quality standard 140: Transition from children's to adults' services (*Available at: Overview | Transition from children's to adults' services | Quality standards | NICE*)
NMCAs – National Medical Competent Authorities
OSCE – Objective structured clinical exam
PGME – Postgraduate Medical Education
PHQ-9 – Patient Health Questionnaire-9 (*Available at: Patient Health Questionnaire (PHQ) Screeners. Free Download | phqscreeners*)
SDQ – Strengths and Difficulties Questionnaire (*Available at: sdqinfo.org/py/sdqinfo/b0.py*)
SSHADESS – strengths, school, home, activities, drugs, emotions/eating, sexuality, safety (Questionnaire) (*Available at: Chapter 32: The SSHADESS Screening: A Strength-Based Psychosocial Assessment*).
STI – Sexually transmitted infections
TRAQ – Transition Readiness Assessment Questionnaire (*Available at: The TRAQ in Different Languages*)
UEMO – European Union of General Practitioners
WFME – World Federation for Medical Education
WPBAs – workplace-based assessments
WHO – World Health Organization
WHO-5 – The World Health Organization-Five Well-Being Index (*Available at: The World Health Organization-Five Well-Being Index (WHO-5)*)

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WHODAS 2.0 – WHO Disability Assessment Schedule 2.0 (*Available at: WHODAS-03(23Nov09).book*)

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Appendices, including general UEMS documents

Appendix 1. Training objectives for UEMS specialists pertaining to the care of adolescents and young adults (version Sept 2022)
Appendix 2. Entrustable professional activities (EPAs) in Transitional Care for Adolescents and Young Adults (AYAs)
Appendix 3. Document written by TF Green and Sustainable Medical Practice (available at https://www.uems.eu/documents)
Appendix 4. Document written by TF Equality, Diversity and Inclusivity (available at https://www.uems.eu/documents)

APPENDIX 1
Training objectives for UEMS specialists pertaining to the care of adolescents and young adults, Version September 2022

Context
Worldwide, the specific health needs of adolescents and young adults (AYA), defined as individuals aged 10 to 24, are increasingly recognized. This phase of exploration and shaping one's identity drives opportunities and risks, such as improved self-confidence, health-enhancing behaviors, poor therapeutic adherence, and lack of long-term vision, potentially interfering with treatment. Both specialists and primary care practitioners (e.g., in-practice pediatricians, general practice/family medicine specialists, and school physicians) can play a pivotal role in tailoring their approach to the specific needs of AYAs. This training package has been developed by UEMS Multidisciplinary Joint Committee members in Adolescent Medicine and Health (Chair, Prof. P.-A. Michaud, Lausanne, Switzerland), an initiative launched by the European Academy of Pediatrics. The content has been carefully discussed and reviewed by the MJC members and an international group of experts working in the field and belonging to the Euteach training program (www.euteach.com).

The present document lists a set of practical, clinically oriented, holistic objectives that should allow all European specialists and primary care providers (pediatricians and family physicians) to respond better to the special health care needs of AYAs. They are competency-based and integrate knowledge, attitude, and skills. In this respect, they are inspired by the CanMEDS model and the "EPA" (Entrustable Professional Activities) approach. They can be freely adapted to the specific healthcare approaches and topics of various UEMS specialties (including pediatricians) and family physicians. Additionally, they should be applied considering the variety of cultural and legal frameworks of European countries. Soon, it is foreseen to develop an accompanying tutorial (content, slides, and videos) to assist trainers in implementing and developing teaching sessions.

The health care provider initiates and conducts the consultation with an AYA patient in a developmentally appropriate way (considering the patient's puberty stage, age, as well as cognitive & affective level)
- ✓ Offers a setting that respects privacy and guarantees a trustworthy, empathetic, and respectful relationship with the patient,
- ✓ Explains confidentiality and makes sure to get time alone with the patient for an appropriate part of the consultation. Agrees with the AYA on what to disclose or not to disclose to the parent/guardians by the end of the consultation

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- ✓ Uses developmentally appropriate communication skills: adapts language and wording to the age/cognition, verifies that the patient understands the information
- ✓ Clarifies the reason for the consultation, its goal, and process. Gives the parents/guardians time to voice their worries
- ✓ Is attentive to cues for undisclosed problems ("hidden agenda").
- ✓ Assesses the adolescent's capacity for autonomous decision-making (competence)
- ✓ Involves the parents/guardians in the evaluation, treatment, and further measures, balancing the importance of the patient's privacy and increasing autonomy on one hand and the communication within the family on the other hand
- ✓ Pays attention to the needs of AYA minority groups, low socio-economic groups, the homeless, refugees, and LGBTQ. Collaborates with a trained interpreter when meeting AYAs & their families of foreign origin/cultural context.

The health care provider assesses and responds to the patient's lifestyle/behavior in a non-judgmental way. paying extra attention to areas prone to be problematic in the age group, and the AYA's resources *(The HEADSSS acronym provides valuable guidance in this regard)*
- ✓ Assesses the patient's cognitive and affective development and daily functioning
- ✓ Identifies AYAs' personal and environmental resources/protective factors, including the presence of a trusted adult(s)
- ✓ Discusses daily leisure, diet, sports, and social activities
- ✓ Assesses school/academic performance, screens for learning difficulties and other conditions (developmental/neurocognitive) leading to poor academic outcomes
- ✓ Screens for overt and covert symptoms of depression and/or anxiety in exploring mood, behavior, and expectations. Identifies self-harm, suicidal ideation, and former or planned suicide attempts, as well as any victimization or violence
- ✓ Explores the value of substance use from the patient's viewpoint, the patient's use/misuse of drugs, the associated risk factors, the perceived range of consequences, and the preparedness for change
- ✓ Discusses screen/internet/social media misuse and its health consequences
- ✓ Respectfully explores sexuality and reproductive life, including questions of gender identity and sexual orientation. Responds appropriately to everyday situations
- ✓ Assesses safe/unsafe sexual behavior and risk for sexually transmitted infection and treats or refers for treatment; identifies need for contraception and responds empathetically to a suspected or verified pregnancy (pregnancy test, referral)
- ✓ Opens up for disclosure of subjection to violence and involvement in criminal activity.

The healthcare provider performs a physical examination, taking into account the

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patient's growth and development
- ✓ Explains the process of any physical examination and the reasons for it
- ✓ Adapts the examination to the AYAs' complaints/symptoms, physical/sports activity, social, and professional background
- ✓ Follows a sequence that respects patient comfort and intimacy
- ✓ Evaluate and comment on the patient's pubertal stage (e.g., Tanner stage)
- ✓ Assesses systems that change, particularly during puberty (skeletal, sight, skin, etc.)
- ✓ Investigates body shape's representations and self-image within the cultural and social context

The health care provider provides appropriate care to an AYA living with a chronic condition and facilitates transition and adaptation to adult health care settings
- ✓ Assesses the impact of a chronic condition on the patient's daily functioning
- ✓ Fosters an inter-professional approach and collaborates with the appropriate resources and people to assist the patient in coping with the chronic condition and life
- ✓ Promotes optimal adolescent development: minimizes the impact of the chronic condition on education and social life, together with interdisciplinary team members
- ✓ Promotes self-confidence and the capacity to manage health and illness
- ✓ Beyond the care of the chronic condition itself, addresses the basic health care needs of the patient (HEADSSS, immunization, complaints regarding general health)
- ✓ Participates in the transition process from pediatric to adult health care settings: preferred age for transfer, adolescent's expectations, available support during the transition (e.g., clinical nurse, social worker, and psychologist), and joint consultation with both pediatric and adult health care provider. The AYA is actively involved in all transition decisions.

Training tool
Teachers and mentors who want to set up training sessions (bedside, small groups, Lectures) can access a series of concrete training tools developed by EuTEACH faculties (www.euteach.com) to cover the UEMS training objectives. They can be handy to professionals who are not familiar with the field of adolescent medicine and health. They are *freely accessible* at the following link.
In addition, the Euteach website offers a set of educational illustrations on how to organize and deliver effective and interactive training: https://www.unil.ch/euteach/home/menuinst/how-to-teach/interactive-teaching-methods.html
Document *"Training objectives for UEMS specialists pertaining to the care of adolescents and young adults, Version September 2022"* is available at: https://www.uems.eu/documents

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support or hinder self-care and health management is also essential. This assessment can be carried out directly as part of the structured transition model visit or indirectly included in any consultation with the AYA.

EPA 1	Conduct a transition-oriented consultation.
Key tasks	✓ conduct consultations adapted to the individual's age, maturity, cognitive/emotional level, and communication abilities. ✓ use interpreters, sign language, alternative and augmentative communication (AAC), or proxy communication as needed to ensure mutual understanding and patient engagement. ✓ assess the developmental maturity of the individual and explore their social support using tools like HEADSSS, SSHADESS, and similar assessments. ✓ screen for decision-making maturity and transition readiness using the TRAQ tool. ✓ evaluate transition-related health literacy and life skills. ✓ discuss expectations and clarify the visit's purpose, agenda, and duration. ✓ address confidentiality and explain its limitations. ✓ conduct a structured biopsychosocial interview, focusing on strengths and protective factors. ✓ identify social determinants, life goals, and anticipated social transitions (e.g., education, school performance, employment, living arrangements, relationships). ✓ screen for general physical and mental health, developmental disorders, learning disorders, lifestyle choices, and risky behaviors. ✓ for minors, identify the needs and challenges of caregivers related to the adolescent's condition and provide adequate support. ✓ review pediatric health, therapies, adherence, side effects, and immunization records. ✓ check current healthcare contacts and ensure continuity of care plans. ✓ build rapport and address any revealed risks or healthcare needs. ✓ collaborate with pediatric teams and child and adolescent mental health care teams.
Potential risks in case of failure or if missed	✓ missed diagnoses (e.g., mental health, substance use, or social vulnerabilities) or other underrecognition of issues ✓ delayed intervention ✓ ineffective patient engagement and non-adherence to treatment plans ✓ fragmented care, leading to disjointed patient experiences ✓ discontinuity in care and loss of follow-up after patient transfer ✓ legal risk arising from misunderstandings regarding autonomy and confidentiality

	✓ poor long-term health outcomes, poor professional development, and lack of autonomy
CanMEDS roles	Medical expert, Communicator, Collaborator, Health advocate, Scholar
Required knowledge, skills, attitudes	***Knowledge*** – understanding the developmental stages of adolescence and emerging adulthood; transition policies; readiness models; and adequate documentation. Familiarity with psychosocial screening frameworks, life skills, autonomy, and consent laws. Awareness of the needs and concerns of AYAs, as well as psychosocial issues and common challenges they face, knowledge of chronic condition trajectories and adolescent-specific difficulties, along with principles of trauma-informed care. ***Skills*** – proficiency in motivational interviewing, active listening, tailored to the AYA, recognition of cultural diversity, risk screening and psychosocial support, development of transition plans, shared decision-making and interdisciplinary communication, use of electronic medical records. ***Attitudes*** – demonstrating a youth-centered approach, and effectively adapting communication to meet language, cultural, and functional needs; documentation should reflect how these strategies supported shared understanding; key attitudes – respect for autonomy, privacy, diversity, empathy, patience, cultural humility, flexibility, non-judgmental communication, and proactive thinking in transition planning.
Assessment tools	*To assess knowledge* – case-based discussion (focusing on developmental stages and HEADSSS, SSHADESS, or similar frameworks), portfolio entries that include reflection logs, transition plans, TRAQ readiness tools; *To assess skills* – mini-CEX (consultation performance assessment), short practice observation (to evaluate trust-building, confidentiality), OSCE scenarios (to evaluate structured communication and consultation skills); *To assess attitudes* – evaluation of work product (consultation notes, summary letters, communication with primary care providers), multi-source feedback (from peers, patients, families, team members).
Entrustment target	Level D
Period to expiration if not practiced	Recertification should be completed according to national recertification cycles or after significant updates to transition care policy or AYA care standards.

EPA 2
MANAGE CONFIDENTIALITY, EVOLVING CAPACITY FOR DECISION-MAKING, AND MEDICAL AUTONOMY IN ADOLESCENTS AND YOUNG ADULTS (AYAS)

Rationale:
During the transition from dependency (when legal minors may be mature enough to make certain decisions) to adulthood (when individuals are adults but may still need additional support to make a successful transition), it is important to understand the changing rights, different laws on consent and confidentiality, and the professional obligations in other jurisdictions, accompanied by ethical considerations and empowerment strategies. This EPA focuses on ethical and legal care, supporting and promoting autonomy and trust.

Specification:
Address the practical, emotional, and legal implications of working with adolescents and young adults (AYAs) and their ability to give informed consent, rights to confidentiality, data protection, and information disclosure.

EPA 2	Manage confidentiality, evolving capacity for decision-making, and medical autonomy in AYAs.
Key tasks	✓ assess the capacity of AYAs to make shared decisions and, if applicable, document the rationale for medical autonomy; ✓ clarify the laws on consent; ✓ ensure confidentiality and demonstrate a commitment to support and maintain mutual trust between the caregiver and the AYAs. ✓ regularly provide time for patients to be alone during at least part of the consultation. ✓ ethically involve caregivers, and inform adolescents and caregivers about confidentiality and its limitations or exceptions. ✓ make sure the patient genuinely agrees to the participation of student or junior staff, and allow for the option to withdraw consent during the consultation or examination. ✓ address exceptions and situations of partial autonomy, especially when parental or caregiver involvement is complex (e.g., risks of harm, reporting requirements, crises that may require a temporary suspension of confidentiality, and multidisciplinary safeguarding actions). ✓ adhere to General Data Protection Regulation (GDPR) and national legislation regarding consent. ✓ inform and implement proper documentation procedures for at-risk patients (e.g., those experiencing honour-based oppression or similar

	issues). ✓ encourage discussion of sensitive topics, while, if appropriate, advise against impulsive or excessive disclosures of sensitive information, particularly if follow-up may not be feasible.
Potential risks in case of failure or if missed	✓ loss of patient trust or confidentiality ✓ legal and ethical violations ✓ harm due to inappropriate autonomy ✓ reduced patient engagement and non-compliance ✓ undocumented decisions leading to inconsistency in care
CanMEDS roles	Professional, Communicator, Health advocate, Leader
Required knowledge, skills, attitudes	***Knowledge*** – understanding of national and EU laws, such as GDPR; awareness of e-records for at-risk patients; knowledge of minors' legal rights, consent thresholds, and confidentiality standards; familiarity with ethics frameworks emphasizing autonomy and beneficence; comprehension of WHO guidelines for assessing and supporting the capacity for autonomous decision-making. ***Skills*** – proficient in ethical reasoning and decision-making; capable of mediating and resolving conflicts; skilled in legal and clear communication with diverse stakeholders; adept at maintaining precise legal documentation. ***Attitudes*** – commitment to respecting the autonomy, rights, and dignity of AYAs; integrity; ethical and cultural sensitivity; a non-judgmental approach; dedication to transparency, positive youth development, and youth empowerment.
Assessment tools	*To assess knowledge* – legal case-based discussions (focusing on consent, confidentiality, data protection), legal and policy review (including national laws, GDPR, UEMS guidance); *To assess skills* – direct observation of communication and procedural skills (related to confidentiality discussions), objective structured clinical examination (OSCE) (with ethical–legal scenario), longitudinal practice observation (to ensure consistency in supporting autonomy); *To assess attitudes* – ethics feedback (from supervisors, peers, AYAs), portfolio reflections on ethical dilemmas encountered during practice.
Entrustment target	Level D
Period to expiration if not practiced	Recertification should be completed according to national recertification cycles or whenever there are significant legal updates.

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EPA 3
IDENTIFY AND ADDRESS DEVELOPMENTAL, COGNITIVE, AND PSYCHOSOCIAL FACTORS AFFECTING ADOLESCENTS AND YOUNG ADULTS (AYAS) DURING THE TRANSITION

Rationale:
Existential, developmental, cognitive, psychosocial, and mental health problems are prevalent in adolescents and young adults (AYAs) with chronic diseases. They are an integral part of the transition process, as it is their main priority. To provide holistic care, addressing these stressors for AYAs is important. This EPA assesses identity, education, employment, sexual well-being, family planning, future goals, and coping strategies.

Specification:
Identify and address common factors that can negatively affect AYAs in transition and overall quality of life in chronic and complex conditions. This includes psychosocial well-being, resilience, employability, academic opportunities, housing options, presence or absence of social or relational support, and AYA-specific needs. It is important to consider their emerging identity formation, to carry out screening on mental health, cognitive/learning abilities, and substance use, social stressors, resilience, explore lifestyle choices, and provide practical or emotional support.

EPA 3	Identify and address psychosocial factors affecting AYAs during the transition.
Key tasks	✓ conduct open, developmentally appropriate mental health conversations and structured mental state exams by a trusted clinician, especially when self-reports are insufficient or suggest distress and mental health difficulties ✓ assess AYA's situation, mental health and social support using validated Patient-Reported Outcome Measures (PROMs) as needed (e.g., WHO-5, PHQ-9, GAD-7, SDQ) in electronic versions when it's possible. ✓ conduct a comprehensive assessment of functioning, using WHODAS 2.0, the ICF checklist, GAF scale, or other tools to understand the patient's capabilities; when appropriate, coordinate with rehabilitation or other services due to functioning and disability by national and local laws. ✓ screen for self-harm, family conflict, and trauma. ✓ screen for substance use using the CRAFFT, and/or CRAFFT+N tools. ✓ assess and discuss how a disability or chronic condition may affect developmental domains, cognitive abilities, and psychosocial functioning. ✓ evaluate the need for referral or follow-up for developmental, cognitive, mental health, or substance use concerns.

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	✓ promote resilience and coping strategies, including counseling and encouraging a healthy lifestyle. ✓ address emotional distress related to transitions, stigma, school/work changes, and family/peer dynamics. ✓ integrate mental health care into overall treatment. ✓ discuss issues related to identity, relationships, and existential questions. ✓ explore sexual health and well-being generally, and in the context of living with or receiving treatment for a chronic condition or disability (including menstrual health and gender identity issues). ✓ identify potential needs for vocational or educational services and facilitate referrals or contact.
Potential risks in case of failure or if missed	✓ missed or late diagnoses (e.g., depression, eating disorders, ADHD) ✓ unaddressed trauma ✓ suicide or self-harm risk ✓ short- and long-term disengagement from self-management and healthcare follow-up, poor health outcomes ✓ school or work drop-out and absences
CanMEDS roles	Medical expert, Scholar, Health advocate, Collaborator, Communicator
Required knowledge, skills, attitudes	***Knowledge*** – developmental psychology focusing on AYAs; understanding developmental stages and identity formation; trauma-informed care approaches; awareness of neurodiversity; understanding of gender and sexual development; knowledge of local support services. ***Skills*** – proficiency in motivational interviewing techniques for AYAs; experience with risk assessment and screening; short-term counseling abilities; mental health first aid; interdisciplinary referral and care planning. ***Attitudes*** – empathy and active listening; openness to diverse identities and needs; a youth- and family-centered approach; commitment to empowerment, resilience-building, and harm reduction; emphasis on cultural safety and inclusivity.
Assessment tools	*To assess knowledge* – case-based discussions focusing on developmental and psychosocial challenges, use of validated tools (CRAFFT, PHQ-9, SDQ, and structured mental state examination); *To assess skills* – mini-CEX (for psychosocial assessment encounters), short practice observation targeting developmental and psychosocial assessment; *To assess attitudes* – multi-source feedback (from team members, AYAs, and families), reflective logs (to evaluate aspects of identity, resilience, coping).
Entrustment target	Level C–D
Period to expiration if not practiced	Recertification should be completed according to national recertification cycles or after significant changes in practice, policy, inactivity, or major guideline updates.

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EPA 4
PROMOTE HEALTH EQUITY AND PROVIDE INCLUSIVE, CULTURALLY SAFE CARE

Rationale:
Healthcare inequalities disproportionately affect marginalised, vulnerable adolescents and young adults (AYAs), including migrants, refugees, LGBTQ+ young people, and people experiencing poverty. The EPA defines how to provide safe, inclusive, appropriate, and timely transitional care.

Specification:
Identify systemic barriers and apply equity-focused, culturally safe approaches to communicating, planning services, and providing inclusive and accessible care for AYAs. It is important to address health inequalities by tailoring care and considering language, gender, socio-economic status, trauma history, and individual capacity.

EPA 4	Promote health equity and provide inclusive, culturally safe care.
Key tasks	✓ identify the social determinants of health, which include housing, economic status, immigration issues, education, work, social networks, and sexual identity; ✓ use equity checklists and address implicit biases; ✓ apply culturally appropriate communication techniques; ✓ use interpreters and cultural liaisons as needed; ✓ adapt care for neurodiverse youth or those with low literacy skills; ✓ implement trauma-informed care practices; ✓ ensure shared decision-making between caregivers and adolescents; ✓ create an appropriate environment for encounters by identifying and addressing any physical, emotional, or other barriers in the setting; ✓ adjust and accommodate follow-up and treatment plans according to cognitive, cultural, socio-economic, or other factors; ✓ assess how the beliefs of both AYAs and their caregivers or trusted adults impact the condition and its treatment; ✓ evaluate the need for education or additional support for caregivers and trusted adults to enhance their ability to support the AYAs and promote their autonomy; ✓ connect to community services.
Potential risks in case of failure or if missed	✓ dropout from care ✓ patient disengagement and systemic mistrust ✓ health inequities ✓ loss of referrals to social services for financial assistance

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	✓ poor health outcomes
CanMEDS roles	Health advocate, Professional, Communicator, Collaborator
Required knowledge, skills, attitudes	***Knowledge*** – Understanding health disparities and principles of health equity; developing transcultural competence; recognizing intersectionality; implementing inclusive communication practices; addressing communication barriers for AYAs; utilizing nonverbal communication aids; and being informed about LGBTQ+ issues. ***Skills*** – recognizing and mitigating biases; engaging in cross-cultural and inclusive communication; planning equity-based care; working effectively with underserved communities; and facilitating shared decision-making. ***Attitudes*** – embracing humility and persistence; fostering inclusivity, openness, and reflexivity; committing to justice and social accountability; and demonstrating flexibility.
Assessment tools	*To assess knowledge* – equity checklists to identify systemic barriers and recognize biases, simulation with bias and cultural safety scenarios; *To assess skills* – case-based discussions focusing on equity and accessibility planning, structured feedback from peers, nurses, and AYAs regarding inclusivity; *To assess attitudes* – multi-source feedback (from supervisors, allied professionals, AYAs), evaluation of work product such as transition plans, and documentation to ensure they reflect inclusivity and accessibility.
Entrustment target	Level C
Period to expiration if not practiced	Undergo diversity, equity, and inclusion (DEI) training every five to ten years based on national or local certification requirements.

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EPAS
COORDINATE COMPLEX, INTERDISCIPLINARY TRANSFER OF ADOLESCENTS AND YOUNG ADULTS' (AYAS') CARE

Rationale:
Successful transition of complex cases involving adolescents and young adults (AYAs) requires collaboration between pediatric and adult health services. In the transition from pediatric to adult care education, mental health and social sectors might be involved, especially for individuals with chronic illnesses or disabilities. This EPA focuses on continuity, consistency, and success in managing high-risk cases.

Specification:
Coordinate and manage the interdisciplinary transition of AYAs with chronic or rare conditions, as well as complex medical, neurological, or psychosocial needs, as they move into adult care. This process may involve working with education, justice, and social care systems where needed and relevant.

EPA 5	Coordinate complex, interdisciplinary transfer of AYAs' care.
Key tasks	✓ develop individualized written transition plans in collaboration with the patient; ✓ coordinate referrals by preparing both the patient and their family for the transfer process; ✓ actively seek ways to involve schools, social services, and other community supports to facilitate the transition in various aspects; ✓ address the concerns of AYAs and their caregivers or trusted adults regarding the transfer; ✓ lead multidisciplinary case meetings, engaging both pediatric and adult teams in joint planning, and social services in collaboration with AYAs and their families, if applicable; ✓ collaborate with the referring parties (pediatric or others) and the parties receiving the referral; ✓ ensure continuity of care post-transfer, making sure that access to healthcare (including prescriptions and communication) is uninterrupted, especially for complex or rare diseases; ✓ monitor the adaptation process post-transfer and follow up as needed; ✓ request feedback after the transfer.
Potential risks in case of failure or if missed	✓ care fragmentation, , and patient drop-out ✓ gaps in treatment and poor adherence ✓ decompensation, readmissions, or complications

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	✓ poor health outcomes ✓ patient and family distress or disorientation
CanMEDS roles	Leader, Collaborator, Medical expert, Communicator
Required knowledge, skills, attitudes	Knowledge – familiarity with general transition frameworks such as the Six Core Elements, Got Transition, and Stepstones; understanding of chronic illness-specific transition models; awareness of care pathways across youth services Skills – proficient in project management and handover coordination; effective in team leadership and interprofessional teamwork; skilled in inter-agency communication; capable of facilitating joint visits; experienced in crisis planning and safety-netting. Attitudes – committed to accountability and team collaboration; proactive and advocacy-oriented; inclusive of families; patient and flexible; persistent; and knowledgeable in holistic/system thinking.
Assessment tools	*To assess knowledge* – joint case presentation (interdisciplinary transition plan), case-based discussion (complex cases); *To assess skills* – direct observation of team handovers, simulation (complex interdisciplinary scenario), longitudinal practice observation (repeated team coordination); *To assess attitudes* – multi-source feedback (including input from allied professionals), evaluation of work product (referral letters, transition summaries, care plans, trajectory review), portfolio (examples of collaborative practice).
Entrustment target	Level D
Period to expiration if not practiced	Recertification should be completed according to national recertification cycles or following any restructuring or reform of the health system.

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EPA 6
EMPOWER ADOLESCENTS AND YOUNG ADULTS (AYAS) FOR SELF-MANAGEMENT AND SHARED DECISION-MAKING

Rationale:
Adolescents and young adults (AYAs) who have become more responsible for their care during the transition period need to develop the self-management skills necessary for shared decision-making, so that AYAs can adhere to their treatment regimen and self-care, become more self-confident, and achieve better long-term health outcomes. This EPA highlights how to provide a supportive and safe environment for self-management and improve problem-solving skills in AYAs.

Specification:
Improve self-care behaviors and skills of AYAs with chronic conditions related to health literacy, goal setting, and self-management by structured training, coaching, and shared decision-making. This approach is essential to promote long-term engagement and success.

EPA 6	Empower AYAs for self-management and shared decision-making.
Key tasks	✓ assess readiness for self-management using tools like the Transition Readiness Assessment Questionnaire (TRAQ) or other readiness assessment tools; ✓ apply motivational interviewing techniques; ✓ explore knowledge about the condition, medications, medical devices, appointments (including healthcare organization and regulations), and previous health history; provide education as needed; ✓ increase awareness among AYAs about their strengths, resources, and protective factors; ✓ encourage communication and boost confidence in shared decision-making; ✓ promote responsibility through goal-setting and self-monitoring; ✓ validate positive health behaviors and acknowledge achievements; ✓ empower autonomy by supporting the patient and caregivers in gradually shifting responsibility, and facilitate support from trusted adults or partners as they transition into young adulthood; ✓ utilize patient organizations, peer groups, or young advisory boards in individual encounters and while planning transition strategies; ✓ encourage patients and caregivers to participate in peer learning; ✓ review personal goals and plans regularly.

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Potential risks in case of failure or if missed	Low confidence and dependency, poor adherence, incomplete transfer, regression in adult care, poor health outcomes, and caregiver burnout or resistance.
CanMEDS roles	Health advocate, Scholar, Communicator, Professional
Required knowledge, skills, attitudes	***Knowledge*** – understanding the principles of adolescent development and autonomy, behavior change theories, health coaching models, and motivational enhancement techniques. ***Skills*** – proficient in coaching and teaching, utilizing strengths-based goal-setting, engaging caregivers in supportive care, and evaluating readiness for change. ***Attitudes*** – maintain a supportive and empowering approach, foster a growth mindset, and respect the learning curve and developmental timing of AYAs.
Assessment tools	*To assess knowledge* – case-based discussions on health literacy, goal-setting, and decision-making theory, the TRAQ tool for assessing self-management readiness; *To assess skills* – mini-CEX (focusing on goal setting and decision-making consultation), objective structured clinical examination (OSCE), or role play with standardized patients to assess shared decision-making scenarios, longitudinal practice observation to track progression of shared decision-making; *To assess attitudes* – feedback of AYAS and their caregivers (regarding empowerment and communication), portfolio reflections on challenges of coaching self-management, mentor reviews assessing attitudes toward empowerment and partnership.
Entrustment target	Level D
Period to expiration if not practiced	Recertification should be completed according to national recertification cycles.

	Skills – conducting telehealth consultations, managing risks in digital communication, creating youth-centered messaging, and detecting digital red flags. ***Attitudes*** – an openness to innovation, a proactive approach to promoting cyber literacy, and caution in safeguarding personal boundaries.
Assessment tools	*To assess knowledge* – digital literacy checklist (safe use of platforms), portfolio review of digital cases (telehealth, apps, EMR usage); *To assess skills* – objective structured clinical examination (OSCE) station (teleconsultation, eHealth integration), simulation (technical scenario, confidentiality in digital use), evaluation of work products (telehealth notes, use of eHealth tools, eHealth documentation); *To assess attitudes* – feedback from AYAs and families regarding their experience with digital care, and platform audits to ensure inclusive and safe use of digital tools.
Entrustment target	Level C
Period to expiration if not practiced	Recertification should be completed according to national recertification cycles or when significant national or EU legislation changes occur.

Appendix 6 ESPACI-EAACI agreement May 16th 2001

In this agreement it is stated that ***"The Section on Paediatrics will safeguard the interests of the UEMS approved Subspeciality of "Pediatric Allergology"****. EAACI supports the concept that* ***Paediatric Allergology should be a Subspeciality within Paediatrics****,"*

CONTRACT

Whereas the European Academy of Allergology and Clinical Immunology (EAACI) and the European Society of Pediatric Allergy and Clinical Immunology (ESPACI) wish to merge ESPACI with the EAACI Section on Pediatrics, both parties agree that:

1.) All present members of ESPACI should be transferred to the Section on Pediatrics. Future membership of the Section will be governed by the by-laws for EAACI Sections, as amended from time to time according to the constitution of EAACI.

2.) The chairman of the Section on Pediatrics is automatically a member of the Executive Committee of EAACI with full voting rights. The Executive Committee will rely on the Section on Pediatrics for advice on matters related to Pediatric Allergy.

3.) The Section on Pediatrics is expected to collaborate with other Pediatric societies/organizations and to organize independent meetings. These meetings should not compete directly with the annual congresses of EAACI. The Section should inform the EAACI executive committee about such meetings, but the EAACI Executive Committee will not interfere in the programme or planning of such joint meetings.

4.) The Journal "Pediatric Allergy and Immunology" will continue as an independent Pediatric journal and will become the official journal of the Section on Pediatrics. All EAACI members will be able to receive PAI either in addition to "Allergy" (European Journal of Allergy and

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Clinical Immunology) or as an alternative, subject to financial agreement with the publishers Munksgaard.

5.) The Section on Pediatrics will take over the assets of ESPACI and will continue to have full responsibility for its separate accounts and finances. The Section on Pediatrics may seek independent sponsors for Pediatric activities. Approaches to sponsors for financial support should be discussed with the EAACI president. A financial balance sheet will be prepared annually and presented to the Section at their annual Business Meeting, and to the EAACI Executive Committee.

6.) The Section on Pediatrics will safeguard the interests of the UEMS approved subspeciality of "Pediatric Allergology". EAACI supports the concept that Pediatric Allergology should be a Subspeciality within Pediatrics, and agrees that the Section on Pediatrics handles Pediatric problems in relation to authorities and related societies.

7.) The Section on Pediatrics has the right to form Working Groups to consider Pediatric and related issues.

8.) EAACI position papers and policy statements are created through Task Forces. The Section on Pediatrics has the right to propose the formation of Task Forces on Pediatric and related issues, subject to the by-laws in force at the time.

9.) The Section on Pediatrics has the right to be represented in EAACI Task Forces that concern pediatric allergologic issues. Under current EAACI by-laws, all Task Force members have to be approved by the EAACI executive committee. The Pediatric Section chairman is ex officio a member of the EAACI executive committee and will therefore

be informed of all new Task Forces. Pediatric representatives should be proposed by the Section chairman, on the advice of the Section board.

10.) In the case of difficulties, both EAACI and the Section on Pediatrics undertake to seek resolution by negotiation.

11.) In the event of unbridgeable difficulties, members of the Section on Pediatrics may choose to demerge and reform ESPACI as an independent entity. Such a decision requires the approval of a simple majority of the members of the Paediatric Section.

12.) In this event, EAACI undertakes that the assets of the Section on Pediatric will be divided, in order to return to the reconstituted ESPACI such sum as shall be agreed to represent the financial contribution of ESPACI at the time of the merger, with appropriate adjustment according to the financial activities of the merged Section during its period of activity.

Oslo, Rome, Southampton and Berlin, 10th May 2001

For ESPACI:

Sten Dreborg
President

Bodo Niggemann
Honorary Secretary

For EAACI:

Sergio Bonini
President

Anthony Frew
Secretary-General

One original of this agreement will be kept by the Secretaries.