

European Curriculum for Emergency Medicine

A DOCUMENT OF THE EUSEM TASK FORCE ON CURRICULUM APPROVED BY THE COUNCIL AND FEDERATION NATIONAL SOCIETIES OF THE EUROPEAN SOCIETY FOR EMERGENCY MEDICINE, AND BY THE UEMS MULTIDISCIPLINARY JOINT COMMITTEE ON EMERGENCY MEDICINE

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The essential features of a clinical specialty include a unique field of action, a defined body of knowledge and a rigorous training programme. Emergency Medicine has a unique field of action, both within the Emergency department and in the community. The European Society for Emergency Medicine (EuSEM) first published a European Core Curriculum for Emergency Medicine in 2002. The present paper presents the new and expanded version of the Curriculum. The document was developed by a Curriculum Task Force of EuSEM (which included representatives of 17 National Societies), has been reviewed by the Multidisciplinary Joint Committee of the Union Européenne des Médecins Spécialistes (MJC-UEMS), and finally approved by EuSEM on May 2009. This curriculum document not only incorporates the relevant body of knowledge and associated competencies but also establishes the essential principles for a rigorous training programme and should constitute a guideline for the development and organisation of recognised training programmes of comparable standard across Europe. The recommended minimum period of training for the specialists in Emergency Medicine is five years even though it is now accepted that the duration of a training programme should be determined more by the length of time needed to acquire the necessary competencies. European countries are encouraged to adopt this curriculum and to train Emergency Physicians to a European standard which will enable them to transfer their skills across national borders. [Emergencias 2009;21:456-470]

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1. Preface

Emergency Medicine has long been established as a primary medical specialty in Australasia, Canada, Ireland, the United Kingdom and the United States but the title of the specialty can cause confusion when translated into one of the many other languages of Europe. It is thus sometimes seen to be synonymous with emergency medical care and within the province and expertise of almost all medical practitioners. However, the specialty of Emergency Medicine incorporates the resuscitation and management of all undifferentiated urgent and emergency cases until discharge or transfer to the care of another physician. Emergency Medicine is an inter-disciplinary specialty, one which is interdependent with all other clinical disciplines. It thus complements and does not seek to compete with other medical specialties.

The European Society for Emergency Medicine (EuSEM) was established in 1994 and incorporates

a Federation of 24 European national societies of Emergency Medicine with more than 14,000 medical members. Emergency Medicine is currently recognised as a primary medical specialty in fifteen member states of the European Union (although only nine are listed in the relevant EU Directive¹) and in five EU countries it exists as a supra-specialty. The recommended minimum period of training is five years even though it is now accepted that the duration of a training programme should be determined more by the length of time needed to acquire the necessary competencies.

The essential features of a clinical specialty include a unique field of action, a defined body of knowledge and a rigorous training programme. Emergency Medicine has a unique field of action, both within the Emergency department and in the community, and this curriculum document not only incorporates the relevant body of knowledge and associated competencies but also establishes the essential principles for a rigorous train-

ing programme. Not all European countries may choose to pursue the path of a primary medical specialty at this stage but those that do so choose should be encouraged to adopt this curriculum and to train Emergency Physicians to a European standard which will enable them to transfer their skills across national borders. European countries where Emergency Medicine is developed or continues as a supra-specialty are encouraged to ensure that the competencies identified in this curriculum are achieved by the end of supra-specialty training.

EuSEM first published a European Core Curriculum for Emergency Medicine in 2002². This new and expanded version of the Curriculum presents a guideline for the development and organisation of recognised training programmes of comparable standard across Europe. The document was developed by a Curriculum Task Force of EuSEM which included representatives of 17 European National Societies of Emergency Medicine. It has been reviewed, amended and approved by the Multidisciplinary Joint Committee of the Union Européenne des Médecins Spécialistes (MJC-UEMS) and was endorsed by the Council of UEMS at a plenary meeting in Brussels on 25 April 2009.

2. Introduction

2.1 *The specialty of Emergency Medicine*

Emergency Medicine is a medical specialty based on the knowledge and skills required for the prevention, diagnosis and management of the acute and urgent aspects of illness and injury affecting patients of all age groups with a full spectrum of undifferentiated physical and behavioural disorders³. It is a specialty in which time is critical. The practice of Emergency Medicine encompasses the pre-hospital and in-hospital reception, resuscitation and management of undifferentiated urgent and emergency cases until discharge from the Emergency Department or transfer to the care of another physician. It also includes involvement in the development of pre-hospital and in-hospital emergency medical systems.

2.2 *The European Curriculum for Emergency Medicine*

Any curriculum must state the aims and objectives, content, experiences, outcomes and

processes of the educational programme of a specialty⁴. It should include a description of the training structure, such as entry requirements, length and organisation of the programme including its flexibilities, and assessment system and a description of the expected methods of learning, teaching, feedback and supervision. The curriculum should cover both generic professional and specialty specific areas⁴. This document describes the recommended curriculum for Emergency Medicine training in Europe.

3. Competencies, knowledge and skills

The curriculum covers knowledge, skills and expertise which the trainee in Emergency Medicine must achieve and includes:

- Core Competencies of the European Emergency Physician.
- System-Based Core Knowledge.
- Common Presenting Symptoms.
- Special Aspects of Emergency Medicine.
- Core Clinical Procedures and Skills.

3.1 *Core competencies of the European Emergency Medicine*

Some of the competencies identified in this curriculum are those required of a hospital specialist in any medical discipline whilst others are more specific to the practice of Emergency Medicine. However, it is accepted that the levels of competence required of an Emergency Physician in specialised areas of medical practice should be limited to those which determine whether and when urgent or immediate more specialist referral is appropriate. Emergency Medicine complements and does not seek to compete with other hospital medical disciplines.

The areas of competency in Emergency Medicine, as previously defined⁵⁻⁷, are: Patient care; Medical knowledge; Communication, collaboration and interpersonal skills; Professionalism, ethical and legal issues; Organisational planning and service management skills; Education and research.

3.1.1 Patient Care

Emergency Physicians (EPs) care for patients with a wide range of pathology from the life threatening to the self limiting and from all age groups. The attendance and number of these patients is unpredictable and they mostly present with symptoms rather than diagnoses. Therefore

the provision of care needs to be prioritised, and this is a dynamic process. The approach to the patient is global rather than organ specific. Patient care includes physical, mental and social aspects. It focuses on initial care until discharge or referral to other health professionals. Patient education and public health aspects must be considered in all cases. To ensure the above patient care, EPs must particularly focus on the following:

3.1.1.1 Triage. EPs must know the principles of triage which is the process of the allocation and medical prioritisation of care for the pre-hospital setting, the Emergency department and in the event of mass casualties. It is based mainly on the evaluation of vital parameters and key symptoms to prioritise and categorise patients according to severity of injury or illness, prognosis and availability of resources.

3.1.1.2 Primary assessment and stabilisation of life threatening conditions. The ABCDE approach must be the primary assessment tool for all patients and does not require a diagnostic work-up. It is a structured approach with which to identify and resuscitate the critically ill and injured. EPs must be able to assess, establish and maintain: Airway [A], Breathing [B], Circulation [C], Disability [D] and Exposure [E] of the patient.

3.1.1.3 Focused medical history. EPs must focus the initial medical history on presenting complaints and on clinical findings as well as on conditions requiring immediate care.

3.1.1.4 Secondary assessment and immediate clinical management. EPs must perform secondary assessment with a timely diagnostic work-up focusing on the need for early action. Clinical management must also include further aspects of health (physical, mental and social).

3.1.1.5 Clinical decision making. EPs must be able to make clinical decisions including: re-triage; immediate and/or definitive care provided in the ED; planning for admission or discharge.

3.1.1.6 Clinical documentation. EPs must make contemporaneous medical records which focus on: relevant medical history; main complaints and abnormal findings; provisional diagnosis and planned investigations; results of investigations; treatment; conclusions and management decisions; patient information.

3.1.1.7 Re-evaluation and further management. EPs must perform continuous re-evaluation of the patient, with adjustment of the provisional diagnosis and care when it becomes necessary.

3.1.2 Medical knowledge and clinical skills

Emergency Physicians (EPs) need to acquire the knowledge and skills described in sections 3.2, 3.3, 3.4 and 3.5.

3.1.3 Communication, collaboration and interpersonal skills

Emergency Medicine is practised in difficult and challenging environments. Effective communication is essential for safe care and for building and maintaining good relationships avoiding barriers such as emotions, stress and prejudices. EPs must be able to use both verbal and non-verbal communication skills, as well as information and communication technology. In the case of a patient who is incompetent by virtue of age or mental capacity, communication should be with a parent or other legal representative. EPs must be able to demonstrate communication and interpersonal skills that include the following:

3.1.3.1 Patients and relatives. EPs should give special attention to involving the patient in decision-making, seeking informed consent for diagnostic and therapeutic procedures, sharing information, breaking bad news, giving advice and recommendations on discharge and also communicating with populations with language barriers.

3.1.3.2 Colleagues and other health care providers. Important skills for an EP are sharing information on patient care, working as a member or the leader of a team, referring and transferring patients.

3.1.3.3 Other care providers such as the police, the fire department and social services. EPs must respect patient confidentiality.

3.1.3.4 Mass media and the general public. EPs must be able to interact with the mass media in a constructive way, giving correct information to the public and at the same time respecting the privacy of the patient.

3.1.4 Professionalism and other ethical and legal issues

3.1.4.1 Professional behaviour and attributes. The general professional behaviour and attributes of Emergency Physicians must not be adversely in-

fluenced by working in stressful circumstances and with a diverse patient population. They must learn to identify their educational needs and to work within their own limitations. They must be self-motivated even at times of stress or discomfort. They must recognise their own as well as system errors and value participation in the peer review process^{8,9}.

3.1.4.2 Working within a team or as a leader of a team. EPs must understand the role of colleagues in other specialities and must be able to lead or to work effectively even in a new or large team often under considerable stress.

3.1.4.3 Delegation and referral. EPs must understand the responsibilities and potential consequences of delegating, referring to a colleague in another discipline or transferring the patient to another doctor, health care professional or health care setting.

3.1.4.4 Patient confidentiality. EPs must understand the law regarding patient confidentiality and data protection. They must know what confidentiality problems arise when dealing with relatives, the police, EMS communication, telephone discussions and the media.

3.1.4.5 Autonomy and informed consent. EPs must respect the right of competent patients to be fully involved in decisions about their care. They must also value the right of competent patients to refuse clinical procedures or treatment. They must understand how the ethical principles of autonomy and informed consent affect emergency practitioners.

3.1.4.6 The competent/incompetent patient. EPs must be able to assess whether a patient has the competence to make an informed decision. They must also understand the legal rights of a guardian or adult with power of attorney and when they treat minors. They must be familiar with those aspects of mental health legislation which relate to competence.

3.1.4.7 Abuse and violence. EPs must be able to recognise patterns of illness or injury which might suggest physical or sexual abuse or domestic violence to children or adults. They must be able to initiate appropriate child or adult protection procedures. They must also learn to prevent and limit the risks of violence and abuse to staff working in an emergency setting.

3.1.4.8 Do not attempt to resuscitate (DNAR) and limitations of therapeutic interventions. EPs must learn to discuss with colleagues and in a professional and empathic manner with relatives the initiation or possible discontinuation of active interventions when this is considered to be medically appropriate¹⁰. They must understand when and how they should use advance directives such as living wills and durable powers of attorney.

3.1.4.9 Medico-legal issues. EPs must operate within the legal framework of the country in which they are working.

3.1.4.10 Legislation and ethical issues in Emergency Medicine. EPs should have an understanding of ethics and law, as well as the legal aspects of bioethical issues in Emergency Medicine. They must be able to make a reasoned analysis of ethical conflicts and develop the skills to resolve ethical dilemmas in an appropriate manner. They must also look to the law for guidance, although the law does not always provide the answer to many ethical problems.

Ethics in Emergency Medicine help to prepare EPs to face new ethical dilemmas in their practice^{9,11}. The use of ethical analysis provides the framework for determining moral duty, obligation and conduct. EPs must learn to identify, refine, and apply general moral principals to their practice related to: Patient autonomy (informed consent and refusal, patient decision making capacity, treatment of minors, advance directives, the obligations of the Good Samaritan statutes); End of life decisions (limiting resuscitation, futility); The physician-patient relationship (confidentiality, truth telling and communication, compassion and empathy); Issues related to justice (duty, ethical issues of resuscitation, health care rationing, moral issues in disaster medicine, research, resuscitation issues in pregnancy).

3.1.5 Organisational Planning and Service Management Skills

This competence is needed to enhance the safety and quality of patient care and work environment. Emergency Physicians must continuously adapt and prioritise existing and available resources to meet the needs of all patients and maintain the quality of care.

3.1.5.1 Case management. EPs must be able to provide and balance the different care processes between the individual patient and the total case-mix. After primary and secondary assessment,

they may refer a patient to another point of contact within the health care or social network. They must provide clear guidance to those patients discharged without formal follow up.

3.1.5.2 Quality standards, audit and clinical outcomes. It is important that EPs use evidence-based medicine and recognise the value of quality standards to improve patient care which is effective and safe. They must be able to undertake audit and use clinical outcomes, including critical incident reporting, as ways of continuously improving clinical practice.

3.1.5.3 Time management. EPs must be able to manage the individual patient as well as the overall patient flow in a timely manner which is dependent upon available resources, accepted medical standards and public expectation. EPs must also learn to manage their own time in an effective way.

3.1.5.4 Information management. EPs often manage patients for whom limited information is available. They may need to communicate with other agencies to obtain relevant information whilst respecting the confidentiality of the patient. Patient data collected during the process of care must be accessible to all involved health care professionals through adequate documentation. EPs need a broad knowledge of the latest advances in medicine and must be able to access and manage information relevant to the specific care of an individual patient.

3.1.5.5 Documentation. EPs are responsible for clear, legible, accurate, contemporaneous and complete records of patient care where the author, date and time are clearly identified. Documentation is a continuous process and all entries must be made in real time as far as possible.

3.1.6 Education and research

3.1.6.1 Self education and improvement. EPs must develop their knowledge and practice in EM by continuous education. They have to identify areas for personal improvement and learn to implement patient care based on scientific evidence.

3.1.6.2 Teaching skills. EPs must be involved in teaching undergraduate, graduate and post graduate health care students, and the general population. They must also continuously develop the skills to be effective teachers.

3.1.6.3 Critical appraisal of scientific literature. EPs must be able to investigate and evaluate their own practice. They must learn to use evidence-based medicine and guidelines, where applicable, and become familiar with the principles of clinical epidemiology, biostatistics, quality assessment and risk management.

3.1.6.4 Clinical and basic research. EPs must understand the scientific basis of EM, the use of scientific methods in clinical research and the fundamental aspects of basic research. They must be able to critically review research studies and be able to understand, present and implement them into clinical practice. They should understand the process of developing a hypothesis from a clinical problem and of testing that hypothesis. They should also understand the specific aspects of obtaining consent as well as the ethical considerations of research in emergency situations.

3.2 System-based core knowledge

This section of the curriculum gives an index of the system-based core knowledge appropriate to the management of patients presenting with undifferentiated symptoms and complaints. This list is mostly given in the following sequence: congenital disorders, inflammatory and infectious disorders, metabolic disorders, traumatic and related problems, tumours, vascular disorders ischaemia and bleeding, other disorders. These lists cannot be exhaustive (Table 1).

3.3 Common presenting symptoms

This section of the Curriculum lists the more common presenting symptoms of patients in the emergency setting. The differential diagnoses are listed according to the systems involved and then in alphabetical order. The diagnoses requiring immediate attention, in terms of potential severity and need of priority, are highlighted in bold. These lists of possible diagnoses cannot be exhaustive (Table 2).

3.4 Specific aspects of Emergency Medicine

These aspects of EM are included in Table 3.

3.5 Core Clinical Procedures and Skills

Finally, Table 4 outlines the skills and basic procedures expected of a specialist in EM.

Table 1. System-based core knowledge**CARDIOVASCULAR EMERGENCIES IN ADULTS AND CHILDREN**

- Arrhythmias.
- Congenital heart disorders.
- Contractility disorders, pump failure: cardiomyopathies, congestive heart failure, acute pulmonary oedema, tamponade, valvular emergencies
- Inflammatory and infectious cardiac disorders.
- Endocarditis, myocarditis, pericarditis.
- Ischaemic heart disease.
- Acute coronary syndromes, stable angina.
- Traumatic injuries.
- Vascular and thromboembolic disorders: aortic dissection/aneurysm rupture, deep vein thrombosis, hypertensive emergencies, occlusive arterial disease, thrombophlebitis, pulmonary embolism, pulmonary hypertension.

DERMATOLOGICAL EMERGENCIES IN ADULTS AND CHILDREN

- Inflammatory and Infectious disorders.
- Skin manifestations of: immunological disorders, systemic disorders, toxic disorders.

ENDOCRINE AND METABOLIC EMERGENCIES IN ADULTS AND CHILDREN

- Acute presentation of inborn errors of metabolism.
- Adrenal insufficiency and crisis.
- Disorders of glucose metabolism.
- Hyperosmolar hyperglycaemic state, hypoglycaemia, ketoacidosis.
- Thyroid disease emergencies: hyperthyroidism, hypothyroidism, myxoedema coma, thyroid storm.

FLUID AND ELECTROLYTE DISTURBANCES

- Acid-Base disorders.
- Electrolyte disorders.
- Volume status and fluid balance.

EAR, NOSE, THROAT, ORAL AND NECK EMERGENCIES IN ADULTS AND CHILDREN

- Bleeding.
- Complications of tumours: airway obstruction, bleeding.
- Foreign bodies.
- Inflammatory and Infectious disorders: angio-oedema, epiglottitis, laryngitis, paratonsillar abscess.
- Traumatic problems.

GASTROINTESTINAL EMERGENCIES IN ADULTS AND CHILDREN

- Congenital disorders: Hirschsprung's disease, Meckel's diverticulum, pyloric stenosis.
- Inflammatory and Infectious disorders: appendicitis, cholecystitis, cholangitis, diverticulitis, exacerbations and complications of inflammatory bowel diseases, gastritis, gastroenteritis, gastro-oesophageal reflux disease, hepatitis, pancreatitis, peptic ulcer, peritonitis.
- Metabolic disorders.
- Hepatic disorders, hepatic failure.
- Traumatic and mechanical problems: foreign bodies, hernia strangulation, intestinal obstruction and occlusion.
- Tumours.
- Vascular disorders: Ischaemia and Bleeding; ischaemic colitis, upper and lower gastrointestinal bleeding, mesenteric ischaemia.
- Other problems: complications of gastrointestinal devices and surgical procedures.

GYNAECOLOGICAL AND OBSTETRIC EMERGENCIES

- Inflammatory and Infectious disorders: mastitis, pelvic inflammatory disease, vulvovaginitis.
- Obstetric emergencies: abruptio placentae, eclampsia, ectopic pregnancy, emergency delivery, HELLP syndrome during pregnancy, hyperemesis gravidarum, placenta praevia, post-partum haemorrhage.
- Traumatic and related problems: ovarian torsion.
- Tumours.
- Vascular disorders: Ischaemia and Bleeding; vaginal bleeding

HAEMATOLOGY AND ONCOLOGY EMERGENCIES IN ADULTS AND CHILDREN

- Anaemias.
- Complications of lymphomas and leukaemias.
- Congenital disorders: haemophilias and Von Willebrand's disease, hereditary haemolytic anaemias, sickle cell disease.
- Inflammatory and Infectious disorders: neutropenic fever, infections in immuno-compromised patients.
- Vascular disorders: Ischaemia and Bleeding: acquired bleeding disorders (coagulation factors deficiency, disseminated intravascular coagulation), drug induced bleeding (anticoagulants, antiplatelet agents, fibrinolytics), idiopathic thrombocytopenic purpura, thrombotic thrombocytopenic purpura.
- Transfusion reactions.

IMMUNOLOGICAL EMERGENCIES IN ADULTS AND CHILDREN

- Allergies and anaphylactic reactions.
- Inflammatory and Infectious disorders: acute complications of vasculitis.

INFECTIOUS DISEASES AND SEPSIS IN ADULTS AND CHILDREN

- Common viral and bacterial infections.
- Food and water-borne infectious diseases.
- HIV infection and AIDS.
- Common tropical diseases.
- Parasitosis.
- Rabies.
- Sepsis and septic shock.
- Sexually transmitted diseases.
- Streptococcal toxic shock syndrome.
- Tetanus.

MUSCULO-SKELETAL EMERGENCIES

- Congenital disorders: dislocated hip, osteogenesis imperfecta.
- Inflammatory and Infectious disorders: arthritis, bursitis, cellulitis, complications of systemic rheumatic diseases, necrotising fasciitis, osteomyelitis, polymyalgia rheumatica, soft tissue infections.
- Metabolic disorders: complications of osteoporosis and other systemic diseases.
- Traumatic and degenerative disorders: back disorders, common fractures and dislocations, compartment syndromes, crush syndrome, osteoarthritis, rhabdomyolysis, soft tissue trauma.
- Tumours: pathological fractures.

NEUROLOGICAL EMERGENCIES IN ADULTS AND CHILDREN

- Inflammatory and Infectious disorders: brain abscess, encephalitis, febrile seizures in children, Guillain-Barré syndrome, meningitis, peripheral facial palsy (Bell's palsy), temporal arteritis.
- Traumatic and related problems: complications of CNS devices, spinal cord syndromes, peripheral nerve trauma and entrapment, traumatic brain injury.
- Tumours: common presentations and acute complications of neurological and metastatic tumours.
- Vascular disorders: Ischaemia and Bleeding: carotid artery dissection, stroke, subarachnoid haemorrhage, subdural and extradural haematoma, transient ischaemic attack, venous sinus thrombosis.
- Other problems: acute complications of chronic neurological conditions (e.g. myasthenic crisis, multiple sclerosis), acute peripheral neuropathies, seizures and status epilepticus.

OPHTHALMIC EMERGENCIES IN ADULTS AND CHILDREN

- Inflammatory and Infectious disorders: conjunctivitis, dacryocystitis, endophthalmitis, iritis, keratitis, orbital and periorbital cellulitis, uveitis.
- Traumatic and related problems: foreign body in the eye, ocular injuries.
- Vascular disorders: Ischaemia and Bleeding.
- Retinal artery and vein occlusion, vitreous haemorrhage.
- Others: acute glaucoma, retinal detachment.

(Continuation)

Table 1. System-based core knowledge (*Continuation*)

PULMONARY EMERGENCIES IN ADULTS AND CHILDREN – Congenital: cystic fibrosis. – Inflammatory and Infectious disorders: asthma, bronchitis, bronchiolitis, pneumonia, empyema, COPD exacerbation, lung abscess, pleurisy and pleural effusion, pulmonary fibrosis, tuberculosis. – Traumatic and related problems: foreign body inhalation, haemothorax, tension pneumothorax, pneumomediastinum. – Tumours: common complications and acute complications of pulmonary and metastatic tumours. – Vascular disorders: pulmonary embolism. – Other disorders: acute lung injury, atelectasis, ARDS, spontaneous pneumothorax. PSYCHIATRIC AND BEHAVIOUR DISORDERS – Behaviour disorders: affective disorders, confusion and consciousness disturbances, intelligence disturbances, memory disorders, perception disorders, psycho-motor disturbances, thinking disturbances. – Common psychiatric emergencies: acute psychosis, anorexia and bulimia complications, anxiety and panic attacks, conversion	disorders, deliberate self-harm and suicide attempt, depressive illness, personality disorders, substance, drug and alcohol abuse. RENAL AND UROLOGICAL EMERGENCIES IN ADULTS AND CHILDREN – Inflammatory and Infectious disorders. – Epididymo-orchitis, glomerulonephritis, pyelonephritis, prostatitis, sexually transmitted diseases, urinary tract infections. – Metabolic disorders: acute renal failure, nephrotic syndrome, nephrolithiasis, uraemia. – Traumatic and related problems: urinary retention, testicular torsion. – Tumours. – Vascular disorders: Ischaemia and Bleeding. – Other disorders: comorbidities in dialysis and renal transplanted patients, complications of urological procedures and devices, haemolytic uraemic syndrome. TRAUMA IN ADULTS AND CHILDREN – Origin of trauma: burns, blunt trauma, penetrating trauma. – Anatomical location of trauma: head and neck, maxillo-facial, thorax, abdomen, pelvis, spine, extremities. – Polytrauma patient. – Trauma in specific populations: children, elderly, pregnant women.
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4. Structure of training of European Emergency Medicine Specialists

This part of the document is based on the standards of the World Federation for Medical Education (WFME) for Quality Assurance for Postgraduate Medical Education in Europe, of the Postgraduate Medical Education and Training Board (PMETB) for Curriculum Development, as well as the recommendations of the UEMS Charter on Training of Medical Specialists in the European Community^{4,12}.

The PMETB sets out the characteristics that curricula should display to be effective in guiding learning, teaching, and experience⁴. WFME specifies standards using two levels of attainment¹².

- Basic standard which is a minimum accreditation requirement to be met from the outset. Basic standards are expressed by a “must”.
- Standard for quality development which means that the standard is in accordance with international consensus about best practice for postgraduate medical education. Standards for quality development are expressed by a “should”.

4.1 Training process

Recognised specialist training in Emergency Medicine must conform to national and institutional regulations and must take into account the individual needs of trainees. It must encompass integrated and updated practical, clinical and theoretical instruction. It must be based on clinical participation and responsibilities in patient care.

The trainee must attain the core competencies described in the sections 3.1 and 3.5 of this document.

4.1.1 Training Structure

Each Training Programme (TP) must be recognised at national level in accordance with EU legislation as well as UEMS recommendations¹². The responsibility and authority for organising, coordinating, managing and assessing the individual training centre and the training process must be clearly identified and supervised in each centre by the National Training Authority (NTA) responsible for the Training Programme in the country¹². Emergency Medicine trainers and training Departments must be accredited in conformity with national and European standards.

4.1.2 Duration of Training

According to the UEMS Charter on Training the duration of training of medical specialists must be sufficient to ensure training for independent practice of the specialty after the completion of training¹². European medical specialty training in Emergency Medicine is governed by the EU Directive 2005/36/EC and is set at a minimum of 5 years of full-time training as a primary medical specialty¹. Within the 5 years of Emergency Medicine training a minimum of 3 years must be spent in an Emergency Department accredited for training. Training must take place in a full-time appointment or the equivalent length for a flexible part-time appointment according to national regulations.

Table 2. Common presenting symptoms**ACUTE ABDOMINAL PAIN**

- Gastrointestinal causes: appendicitis, cholecystitis, cholangitis, acute pancreatitis, complications of hernias, diverticulitis, hepatitis, hiatus hernia, inflammatory bowel disease, intestinal obstruction, ischaemic colitis, mesenteric ischaemia, peptic ulcer, peritonitis, viscus perforation.
- Cardiac/vascular causes: acute myocardial infarction, aortic dissection, aortic aneurysm rupture.
- Dermatological causes: herpes zoster.
- Endocrine and metabolic causes: Addison's disease, diabetic ketoacidosis, other metabolic acidosis, porphyria.
- Gynecological and Obstetric causes: complications of pregnancy, ectopic pregnancy, pelvic inflammatory disease, rupture of ovarian cyst, ovarian torsion.
- Haematological causes: acute porphyria crisis, familial mediterranean fever, sickle cell crisis.
- Musculo-skeletal causes: referred pain from thoraco-lumbar spine.
- Renal and Genitourinary causes: pyelonephritis, renal stones.
- Respiratory causes: pneumonia, pleurisy.
- Toxicology: poisoning.
- Trauma: abdominal.

ALTERED BEHAVIOUR AND AGITATION

- Psychiatric causes: acute psychosis, depression.
- Cardiac/Vascular causes: hypertension, vasculitis.
- Endocrine and metabolic causes: hypoglycaemia, hyperglycaemia, electrolyte imbalance, hyperthermia, hypoxaemia.
- Neurological causes: cerebral space-occupying lesions, dementia, hydrocephalus, intracranial hypertension, CNS infections.
- Toxicology.
- Alcohol and drug abuse, poisoning.

ALTERED LEVEL OF CONSCIOUSNESS IN ADULTS AND CHILDREN

- Neurological causes: cerebral tumour, epilepsy and status epilepticus, meningitis, encephalitis, stroke, subarachnoid haemorrhage, subdural and extradural haematoma, traumatic brain injury.
- Cardiovascular causes: hypoperfusion states, shock.
- Endocrine and metabolic causes: electrolyte imbalances, hepatic coma, hypercapnia, hypothermia, hypoxia, hypoglycaemia/hyperglycaemia, uraemia.
- Gynecological and Obstetric causes: eclampsia.
- Infectious causes: septic shock.
- Psychiatric causes: conversion syndrome.
- Respiratory causes: respiratory failure.
- Toxicology: alcohol intoxication, carbon-monoxide poisoning, narcotic and sedative poisoning, other substances.

BACK PAIN

- Musculo-Skeletal causes: fractures, intervertebral disc strain and degeneration, strain of muscles, ligaments and tendons, spinal stenosis, arthritides, arthrosis.
- Cardiovascular causes: aortic aneurysm, aortic dissection.
- Infectious causes: osteomyelitis, discitis, pyelonephritis, prostatitis.
- Endocrine and metabolic causes: Paget's disease.
- Gastrointestinal causes: pancreatitis, cholecystitis.
- Dermatological causes: herpes zoster.
- Gynecological causes: endometriosis, pelvic inflammatory disease.
- Haematological and Oncological causes: abdominal or vertebral tumours.
- Neurological cause: subarachnoid haemorrhage.
- Renal and Genitourinary causes: renal abscess, renal calculi.
- Trauma.

BLEEDING (NON TRAUMATIC)

- Ear, Nose, Throat causes: ear bleeding (otitis, trauma, tumours), epistaxis.
- Gastrointestinal causes.
- Haematemesis and melaena (acute gastritis, gastro-duodenal ulcer, Mallory Weiss syndrome, oesophageal varices) rectal bleeding (acute diverticulitis, haemorrhoids, inflammatory bowel disease, tumours).

- Gynecological and Obstetric causes: menorrhagia/metrorrhagia (abortion, abruptio placentae, tumours).
- Renal and Genitourinary causes: haematuria (pyelitis, tumours, urolithiasis).
- Respiratory causes: haemoptysis (bronchiectasia, pneumonia, tumours, tuberculosis).

CARDIAC ARREST

- Cardiac arrest treatable with defibrillation: ventricular fibrillation, pulseless ventricular tachycardia.
- Pulseless electric activity: Acidosis, hypoxia, hypothermia, hypo/hyperkalaemia, hypocalcaemia, hypo/hyperglycaemia, hypovolaemia, tension pneumothorax, cardiac tamponade, myocardial infarction, pulmonary embolism, poisoning.
- Asystole.

CHEST PAIN

- Cardiac/vascular causes: acute coronary syndrome, aortic dissection, arrhythmias, pericarditis, pulmonary embolism.
- Respiratory causes: pneumonia, pneumomediastinum, pneumothorax (especially tension pneumothorax), pleurisy.
- Gastrointestinal causes: Gastro-oesophageal reflux, oesophageal rupture, oesophageal spasm.
- Musculo-Skeletal causes: costosternal injury, costochondritis, intercostal muscle pain, pain referred from thoracic spine.
- Psychiatric causes: anxiety, panic attack.
- Dermatological causes: herpes zoster.

CRYING BABY

- Infections: herpes stomatitis, meningitis, osteomyelitis, urinary tract infection; testicular torsion, trauma, teeth problems.
- Cardiac: arrhythmias, congestive heart failure.
- Reaction to milk, reaction to medications, reflux.
- Immunisation and allergic reactions, insect bites.
- Eye: corneal abrasions, glaucoma, ocular foreign bodies.
- Some gastrointestinal causes: hernia, intussusception, volvulus.

DIARRHOEA

- Infectious causes: AIDS, bacterial enteritis, viral, parasites, food-borne, toxins.
- Toxicological causes: drugs related, poisoning (including heavy metals, mushrooms, organophosphates, rat poison, seafood).
- Endocrine and metabolic causes: carcinoids, diabetic neuropathy.
- Gastrointestinal causes: diverticulitis, dumping syndrome, ischaemic colitis, inflammatory bowel disease, enteritis due to radiation or chemotherapy.
- Haematological and Oncological causes: toxicity due to cytostatic therapies.
- Immunology: food allergy.
- Psychiatric disorders: diarrhoea "factitia".

DYSPNOEA

- Respiratory Causes: airway obstruction, broncho-alveolar obstruction, parenchymal diseases, pulmonary shunt, pleural effusion, atelectasis, pneumothorax.
- Cardiac/vascular causes: cardiac decompensation, cardiac tamponade, pulmonary embolism.
- Ear, Nose, Throat causes: epiglottitis, croup and pseudocroup.
- Fluid & Electrolyte disorders: hypovolaemia, shock, anaemia.
- Gastrointestinal causes: hiatus hernia.
- Immunological causes: vasculitis.
- Metabolic causes: metabolic acidosis, uraemia.
- Neurological causes: myasthenia gravis, Guillain Barré syndrome, amyotrophic lateral sclerosis.
- Psychiatric disorders: conversion syndrome.
- Toxicology: CO intoxication, cyanide intoxication.
- Trauma: flail chest, lung contusion, traumatic pneumothorax, haemothorax.

Table 2. Common presenting symptoms (*Continuation*)**FEVER AND ENDOGENOUS INCREASE IN BODY TEMPERATURE**

- Systemic infectious causes: sepsis and septic shock, parasitosis, flu-like syndrome.
- Organ-specific infectious causes: endocarditis, myocarditis, pharyngitis, tonsillitis, abscesses, otitis, cholecystitis and cholangitis, meningitis, encephalitis.
- Non-infectious causes: Lyell syndrome, Stephen-Johnson syndrome, thyroid storm, pancreatitis, inflammatory bowel disease, pelvic inflammatory disease, toxic shock.
- Haematological and Oncological causes: leukaemia and lymphomas, solid tumours.
- Immunological causes: arteritis, arthritis, lupus, sarcoidosis.
- Musculo-Skeletal causes: osteomyelitis, fasciitis and cellulitis.
- Neurological causes: cerebral haemorrhage.
- Psychiatric causes: factitious fever.
- Renal and Genitourinary causes: pyelonephritis, prostatitis.
- Toxicology.

HEADACHE IN ADULTS AND CHILDREN

- Vascular causes: migraine, cluster headache, tension headache, cerebral haemorrhage, hypertensive encephalopathy, ischaemic stroke.
- Haematological and Oncological causes: brain tumours.
- Immunological causes: temporal arteritis, vasculitis.
- Infectious causes: abscesses, dental infections, encephalitis, mastoiditis, meningitis, sinusitis.
- Musculo-Skeletal causes: cervical spine diseases, temporomandibular joint syndrome.
- Neurological causes: trigeminal neuralgia.
- Ophthalmological causes: optic neuritis, acute glaucoma.
- Toxicology: alcohol, analgesic abuse, calcium channel blockers, glutamate, nitrates, opioids and caffeine withdrawal.
- Trauma: head trauma.

JAUNDICE

- Gastrointestinal causes: cholangitis, hepatic failure, pancreatic head tumour, pancreatitis, obstructive cholestasis.
- Cardiac/Vascular causes: chronic cardiac decompensation.
- Haematological and Oncological causes: haemolytic anaemias, thrombotic thrombocytopenic purpura, haemolytic uraemic syndrome, disseminated intravascular coagulation.
- Infectious causes: malaria, leptospirosis.
- Gynecological causes: HELLP syndrome.
- Toxicology.
- Drug induced haemolytic anaemias, snake venom.

PAIN IN ARMS

- Cardiac/Vascular causes: aortic dissection, deep venous thromboembolism, ischaemic heart disease.
- Musculo-skeletal causes: peri-arthritis, cervical spine arthrosis.
- Trauma.

PAIN IN LEGS

- Cardiac/Vascular causes: acute ischaemia, arteritis, deep venous thrombosis, superficial thrombophlebitis.
- Immunological causes: polymyositis.
- Infectious causes: arthritis, cellulites, necrotising fasciitis, osteomyelitis.
- Musculo-Skeletal causes: sciatalgia.
- Neurological causes: sciatica.
- Nervous system causes: peripheral nerve compression.
- Trauma.

PALPITATIONS

- Cardiac/Vascular causes: brady-arrhythmias (including sinus and AV blocks), extrasystoles, tachy-arrhythmias (including atrial fibrillation, sinus tachycardia, supraventricular tachycardia, ventricular tachycardia).
- Endocrine and metabolic causes: thyrotoxicosis.
- Toxicology: drugs.

SEIZURES IN ADULTS AND CHILDREN

- Neurological causes: generalised epilepsy, partial complex or focal epilepsy, status epilepticus.
- Cardiac/Vascular causes: hypertensive encephalopathy, syncope, dysrhythmias, migraines.
- Endocrine and metabolic causes: metabolic seizures.
- Gynaecological causes: eclampsia.
- Infectious causes: febrile seizures in children.
- Psychiatric causes: narcolepsy, pseudo-seizures.
- Respiratory causes: respiratory arrest.
- Toxicology: drugs/toxins.

SHOCK IN ADULTS AND CHILDREN

- Anaphylactic.
- Cardiogenic.
- Hypovolaemic.
- Obstructive.
- Septic.
- Neurogenic.
- Cardiac/Vascular causes: cardiogenic shock, arrhythmias.
- Endocrine and metabolic causes: Addison's crisis.
- Fluid and Electrolyte disorders: hypovolaemic shock.
- Gastrointestinal causes: vomiting, diarrhoea.
- Gynecological causes: toxic shock.
- Immunological causes: anaphylactic shock.
- Infectious causes: septic shock.
- Neurological causes: neurogenic shock.
- Trauma: hypovolaemic shock, neurogenic shock.

SKIN MANIFESTATIONS IN ADULTS AND CHILDREN

- Dermatological causes: eczema, psoriasis, skin tumours.
- Immunological causes: vasculitides, urticaria, Stevens-Johnson syndrome, Lyell syndrome.
- Infectious causes: viral exanthemas, meningococcaemia, herpes zoster/simplex, abscesses of the skin.
- Psychiatric causes: Self-inflicted skin lesions or from abuse.
- Toxicology.
- Haematological and Oncological causes: idiopathic thrombocytopenic purpura, thrombotic thrombocytopenic purpura.

SYNCOPE

- Cardiac/vascular causes: aortic dissection, cardiac arrhythmias (including brady-tachy syndrome, Brugada syndrome, drug overdose, long QT syndrome, sick sinus syndrome, torsades de pointes, ventricular tachycardia): other causes of hypoperfusion (including ischaemia, valvular, haemorrhage, obstruction: e.g. aortic stenosis, pulmonary embolism, tamponade): orthostatic hypotension.
- Endocrine and metabolic causes: Addison's disease.
- Fluid and Electrolyte disorders: hypovolaemia.
- Gastrointestinal causes: vomiting, diarrhoea.
- Neurological causes: autonomic nervous system disorder, epilepsy, vasovagal reflex.
- Toxicology: alcoholic or drug consumption.

URINARY SYMPTOMS (DYSURIA, OLIGO-ANURIA, POLYURIA)

- Renal and Genitourinary causes: acute renal failure, acute urinary retention, cystitis and pyelonephritis, prostatitis.
- Cardiac/Vascular causes: cardiac decompensation.
- Endocrine and metabolic causes: diabetes mellitus, diabetes insipidus.
- Fluid and Electrolyte disorders: hypovolaemia.

VERTIGO AND DIZZINESS

- Ear and Labyrinth causes: benign postural vertigo, Meniere's disease, otitis, vestibular neuritis, viral labyrinthitis.
- Cardiac/Vascular causes: arrhythmias, hypotension.
- Endocrine and metabolic causes: hypoglycaemia.
- Haematological and Oncological causes: anaemias.

(Continuation)

Table 2. Common presenting symptoms (*Continuation*)

– Nervous system causes: acoustic neuroma, bulbar or cerebellar lesions, multiple sclerosis, temporal epilepsy. – Psychiatric causes: anxiety. – Respiratory causes: hypoxia. – Toxicology: alcohol abuse, drugs and substances	– Ear, Nose, Throat causes: vestibular disorders. – Endocrine and metabolic causes: diabetic ketoacidosis, hypercalcaemia. – Fluid and Electrolyte disorders: hypovolaemia. – Gynecological and Obstetric causes: pregnancy. – Infectious causes: sepsis, meningitis. – Neurological causes: cerebral oedema or haemorrhage, hydrocephalus, intracranial space-occupying lesions. – Ophthalmological causes: acute glaucoma. – Psychiatric causes: eating disorders. – Renal and Genitourinary causes: renal calculi, uraemia. – Toxicology.
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VOMITING

- Gastrointestinal causes: appendicitis, cholecystitis, gastroparesis, gastric obstruction and retention, gastroenteritis, hepatitis, pancreatitis, pyloric stenosis, small bowel obstructions.
- Cardiac/Vascular causes: myocardial ischaemia.

4.1.3 Working Conditions

The working conditions and responsibilities of trainers and trainees must be defined and made known and should be in accordance with EU directives and regulations¹. The educational goals of the Training Programme and learning objectives of trainees must not be compromised by excessive reliance on trainees to fulfil institutional service obligations. The overall structuring of duty hours and on-call schedules must focus on the needs of the patient, continuity of care, and the educational needs of the trainee.

4.1.4 Assessment Methods and Tools

A portfolio based on the core curriculum must be used for assessment. In the portfolio the trainee documents the theoretical, clinical and practical experience. The acquired competencies must be validated by the trainers on an annual basis. The standard assessment methods must be formative and summative as previously defined¹⁴⁻¹⁷.

4.1.4.1 Formative assessment and Documentation. Formative assessment is used as part of an ongoing learning or developmental process in giving feedback and advice. It must provide benchmarks to orient the trainee. It must evaluate the trainee's progress and identify the strengths and weaknesses of that individual. The evaluation and any recommendations must be fully shared with the trainee.

The following should be part of formative assessment:

- Formal Documentation of trainee's development and progress.
- Workplace based Assessment:
 - Observed clinical care of unselected patients during working time.
 - Video or observed operating of the trainee within a team.
 - Mini Clinical Examination (or Direct Observation of Procedural Skills), to assess the knowledge,

procedural and practical skills and attitudes of the trainee's interaction with a patient.

- Case-Based Discussion, to explore clinical reasoning on a recent case.

- Non-workplace based Assessment. It includes processes such as case presentations, review of research in progress, review of critical incidents, review of teaching by trainee, role play/scenario teaching.

4.1.4.2 Summative assessment. Summative assessment is usually a test that takes place after a specified training period with the purpose of deciding whether the trainee has reached a standard to proceed to the next level of training or to be awarded a certificate of Completion of Training. The methods of summative assessment should include: Written examinations (multiple choice questions, short answered questions, essays); Oral and practical examinations (clinical vivas and objective structured clinical examinations or OSCEs, stations to assess medical knowledge, clinical, communication and ethical skills in short predetermined scenarios); Evaluation of trainee's Portfolio.

4.2 Faculty

All physicians should participate in practice-based training as emphasised by WFME¹². The faculty for Emergency Medicine must include a Training Programme Director (TPD) and an appropriate number of trainers. Trainers should devote a large proportion of their professional efforts to training and should be given sufficient time to meet the educational requirements of the programme.

4.2.1 Training Programme Director

The Training Programme Director must be a full time physician in the ED and must be either a specialist in Emergency Medicine (in countries where the speciality has been recognised for at

least 5 years) or a specialist who has been practising Emergency Medicine for at least 5 years. The Director must be approved by the National Training Authority and fully direct the Training Programme¹².

4.2.2 Trainers

Trainers must be either accredited by the NTA or selected by the TPD and accept responsibility for the day to day supervision and management of trainees as delegated by the TPD.

4.2.3 Trainer to EM Trainee Ratio

There must be a sufficient number of trainers in the ED to ensure adequate clinical instruction and supervision of trainees as well as efficient, high quality clinical care. The ratio of trainers to the number of trainees must be sufficient to allow training to proceed without difficulty and to ensure close personal interaction and monitoring of the trainee during their training¹. The recommended optimal trainer/emergency medicine trainee ratio is 1 to 2 during clinical work in the Emergency Department.

4.3 Trainees

All trainees must share responsibility with their trainers for their education. The trainees must be pro-active in identifying their own knowledge gaps and must take advantage of all the formal and informal learning opportunities offered.

4.3.1 Selection Procedure of Trainees

The selection and appointment of trainees must be in accordance with recognised selection procedure and agreed entry requirements¹.

4.3.2 Training Posts per Training Programme

Trainees must be in appropriately remunerated positions [1]. To ensure training and teaching of high quality the NTA must approve the maximum number of trainees per year and/or per Training Programme for accreditation purposes. The number of training posts must be proportionate to established criteria, including clinical/practical training opportunities based on case mix and volume, supervisory capacity and educational resources.

4.3.3 Supervision

Trainees must be supervised by trainers in such a way that the trainees assume progressively increasing responsibility according to their level of education, ability and experience. Schedules for trainers must be structured to ensure that supervi-

sion is readily available to trainees on duty. The level of responsibility accorded to each trainee must be determined by the TPD.

4.3.4 Experience

The trainee must learn through exposure to a full range of clinical cases and be able to appreciate the issues associated with the delivery of safe, high quality and cost effective health care. The trainee must be involved in the treatment of a sufficient number of patients and perform an adequate number of procedures of sufficient diversity¹². Administrative, teaching, and leadership skills must also be included in the Training Programme.

4.4 Training centres

A Training Centre is defined as a hospital or group of hospitals which together receive an appropriate case-mix and therefore offer the trainee experience in the full range of the specialty of Emergency Medicine [12]. Within the Training Centre there should be an ED with a patient load not less than 30.000-35.000 visits/year and which provides care at all hours. Each Training Centre must encompass relevant specialties in order to give the trainee the opportunity of developing their clinical skills and fulfilling the curriculum and their portfolio. It must provide both space and opportunities for practical and theoretical study as well as for research activities and critical appraisal of medical literature [1]. Trainees should have the opportunity to be trained for specified periods in recognized training centres within or outside the country approved by the NTA [1]. Training Centres must be approved and recognised by the NTA.

4.5 Evaluation of training

The NTA and the appropriate professional bodies must establish a mechanism for evaluation of the training process that monitors each of the following areas^{1,5}.

4.5.1 Evaluation of Training Centres

Accredited Training Centres must be evaluated in accordance with national rules and EU legislation as well as UEMS recommendations [12]. Evaluation must also take into account the spectrum of services within the hospital. Repeated negative evaluations can result in the withdrawal of accreditation of a Training Centre^{1,12}.

4.5.2 Evaluation of Training Programme

Regular internal and external evaluation of the

Table 4. Core clinical procedures and skills**CPR SKILLS**

- Cardio-pulmonary resuscitation procedures in a timely and effective manner according to the current ILCOR guidelines for adults and children.
- Advanced CPR skills (e.g. therapeutic hypothermia, open chest CPR).

AIRWAY MANAGEMENT SKILLS

- Open and maintain the airway in the emergency setting (insertion of oropharyngeal or nasopharyngeal airway).
- Endotracheal intubation.
- Alternative airway techniques in the emergency setting (e.g. laryngeal mask insertion, surgical airway).
- Difficult airway management algorithm.
- Use of rapid sequence intubation in the emergency setting.

ANALGESIA AND SEDATION SKILLS

- Assessment of the level of pain and sedation.
- Monitor vital signs and potential side effects during pain management.
- Provide procedural sedation and analgesia including conscious sedation (including testing of life support equipment).
- Use of appropriate local, topical and regional anaesthesia techniques.

BREATHING AND VENTILATION MANAGEMENT SKILLS

- Assessment of breathing and ventilation.
- Oxygen therapy.
- Interpretation of blood gas analysis, pulse oximetry and capnography.
- Bag-mask-valve ventilation.
- Thoracocentesis.
- Chest tube insertion, connection to under-water drainage and assessment of functioning.
- Non-invasive ventilation techniques.
- Invasive ventilation techniques.

CIRCULATORY SUPPORT AND CARDIAC SKILLS AND PROCEDURES

- Administration of fluids including blood and substitutes.
- Monitoring of ECG and the circulation.
- Defibrillation and pacing (e.g. cardioversion, transcutaneous pacing).
- Emergency pericardiocentesis.
- Vascular access (peripheral venous, arterial, and central venous catheterisation, intraosseous access).

DIAGNOSTIC PROCEDURES AND SKILLS

- Interpretation of ECG.
- Appropriate request and interpretation of laboratory investigations (blood chemistry, blood gases, respiratory function testing and biological markers).
- Appropriate request and interpretation of imaging (e.g. x-rays, ultrasound, CT/MRI).
- Performance of focused assessment of sonography.

ENT SKILLS AND PROCEDURES

- Anterior rhinoscopy.
- Insertion of nasal pack.
- Inspection of oropharynx and larynx.
- Otoscopy.
- Removal of foreign body if airway is compromised.
- Insertion and replacement of tracheostomy tube.

GASTROINTESTINAL PROCEDURES

- Insertion of nasogastric tube.
- Gastric lavage.
- Peritoneal lavage.

- Abdominal hernia reduction.
- Abdominal paracentesis.
- Measurement of abdominal pressure.
- Proctoscopy.

GENITOURINARY PROCEDURES

- Insertion of indwelling urethral catheter.
- Suprapubic cystostomy.
- Testicular torsion reduction.
- Evaluation of patency of urethral catheter.

HYGIENE SKILLS AND PROCEDURES

- Decontamination of patient and the environment.
- Patient isolation and staff protection.

MUSCULOSKELETAL TECHNIQUES

- Aseptic joint aspiration.
- Fracture immobilisation.
- Joint-dislocation reduction.
- Log roll and spine immobilisation.
- Splinting (plasters, braces, slings, tapes and other bandages).
- Management of compartment syndrome.
- Fasciotomy, escharotomy.

NEUROLOGICAL SKILLS AND PROCEDURES

- Evaluation of consciousness including the Glasgow Coma Scale.
- Fundoscopy.
- Lumbar puncture.
- Interpretation of neuro-imaging.

OBSTETRIC AND GYNAECOLOGICAL SKILLS AND PROCEDURES

- Emergency delivery.
- Vaginal examination using speculum.
- Assessment of the sexual assault victim.

OPHTHALMIC SKILLS AND PROCEDURES

- Removal of foreign body from the eye.
- Slit lamp.
- Lateral canthotomy.

TEMPERATURE CONTROL PROCEDURES

- Measuring and monitoring of body temperature.
- Cooling techniques (evaporative cooling, ice water or slush immersion).
- Internal cooling methods.
- Warming techniques.
- Monitoring heat stroke patients.
- Treatment and prevention of hyper- and hypothermia.

TRANSPORTATION OF THE CRITICALLY ILL PATIENT

- Telecommunication and telemedicine procedures.
- Preparation of the EMS vehicle.
- Specific aspects of monitoring and treatment during transportation.

WOUND MANAGEMENT

- Abscess incision and drainage.
- Aseptic techniques.
- Treatment of lacerations and soft tissue injuries.
- Wound irrigation and wound closure.

Training Programme must be assured in a systematic manner both as regards adherence to the curriculum and the attainment of educational

goals. Both trainees and trainers must have the opportunity to evaluate the programme confidentially and in writing at least annually. External

evaluation must be made by visiting representatives of the NTA. The TPD must use the results of all evaluations to improve the Training Programme.

4.5.3 Evaluation of Trainers

The TPD must evaluate trainer performance at least annually. This appraisal should include evaluation of clinical teaching ability, clinical knowledge, professional attitude and academic activities¹⁵.

4.5.4 Evaluation of Trainees

Specialist education and training must include continuous assessment which tests whether the trainee has acquired the requisite knowledge, skills, attitudes and professional qualities to practise in the specialty of Emergency Medicine. This must include formal annual and final evaluations.

The annual evaluation must formalise the assessment of a trainee's competence to promote the trainee's improvement.

Upon completion of the Training Programme the trainee must submit his/her portfolio. The TPD must provide an overall judgment about the trainee's competence and fitness to practice as an independent specialist in Emergency Medicine. The individual assessment should include a final formal examination (written, oral and practical).

4.5.5 Re-Accreditation of Emergency Physicians

All emergency physicians must follow national regulations for re-accreditation.

5. Future developments

In order to harmonise the quality of training in Emergency Medicine across Europe, the following additional steps should be considered.

5.1 European accreditation

European standards for accreditation of training centres, training programmes and theoretical and practical courses must be developed.

5.2 European examination

A European examination in Emergency Medicine which confirms successful completion of specialty training in Emergency Medicine in accordance with this curriculum could be developed and complement or replace national examinations¹³.

Addendum

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Plan Europeo de Estudios de Medicina de Urgencias y Emergencias

A document of the EuSEM Task Force on Curriculum approved by the Council and Federation National Societies of the European Society for Emergency Medicine, and by the UEMS Multidisciplinary Joint Committee on Emergency Medicine, and endorsed by the Council of UEMS at their plenary meeting in Brussels on 25 April 2009

Las características esenciales de una especialidad clínica incluyen un campo único de acción, un conjunto definido de conocimientos y un riguroso programa de formación. La Medicina de Urgencias y Emergencias (MUE) tiene un único campo de acción, tanto en el servicio de urgencias hospitalarias (SUH) como en la comunidad. La Sociedad Europea de la Medicina de Emergencia (EuSEM) publicó un documento "European Core Curriculum" (plan de estudios fundamentales para la MUE en 2002. El presente documento ofrece una versión nueva y extendida del plan de estudios. El documento fue elaborado por la comisión del plan de estudios de la EuSEM (que incluyen representantes de 17 sociedades nacionales), revisado por el Comité Multidisciplinario de la *Union Européenne des Médecins Spécialistes* (MJC-UEMS), y finalmente aprobado por la EuSEM en mayo del 2009. Este documento del plan de estudios no sólo incorpora un relevante cuerpo de conocimientos y competencias asociadas al mismo, sino que establece los principios esenciales para un riguroso programa de formación; y debería constituir una pauta para un desarrollo y organización comparable al de reconocidos programas estándar de educación a lo largo de Europa. El periodo mínimo de formación recomendado para los especialistas en MUE es de cinco años, aunque ahora se acepta que la duración del periodo de formación se debería determinar por el tiempo que se tarde en adquirir dichas competencias. Se recomienda a los países europeos que adopten este plan de estudios y que formen a médicos de urgencias en un estándar europeo que les permitirá transferir sus habilidades a través de sus fronteras. [Emergencias 2009;21:456-470]

Palabras clave: Medicina de Urgencias y Emergencias. Plan de estudios.