The Journal of Laryngology & Otology
May 2000, Vol. **114,** pp. 331–335

Global Training in ORL-HNS

Training in otorhinolaryngology: a European perspective

Paul van den Broek, M.D., Ph.D., F.R.C.S. (Ed.)

Key words: Education, graduate; Education, medical, continuing; Otolaryngology; Europe

Introduction

It seems that the 'United States of Europe' are becoming a reality despite the many political problems that still need to be solved. At present, 15 countries are members of the Union, including Finland, Austria and Sweden, that were the last to join in 1995. Thus the Union encompasses a population of 380 million people and as such is the largest population block and economic power in the world. Already many countries bordering the Union have applied for membership and within the next 10 years we will probably see significant expansion of the Union. Although there is no real political Union for everyone as yet, a process is undoubtedly in motion which cannot and will not be reversed despite the enormous scepticism.

As part of the unification process, many decisions have been made, that will have an impact on the life of every citizen in the Union. In 1988 a directive was issued through which all university degrees are recognized within the Union. This recognition of university degrees has been formalized by law in the treaty of Maastricht in 1992. For doctors this has meant that they can move freely and practise in all the member countries. The only restriction that a host country can make is to require mastery of the native language. Strangely enough, the expected large migration of doctors has not occurred. Even in countries with a high density of doctors, even with unemployment, doctors do not seem to feel the need to move away. The most plausible reasons are the differences in language, living conditions and family customs, but perhaps even more, the significant differences in medical culture. Without elaborating on this point, it can be said that there are great differences in the practice of medicine between countries. This is reflected in the number of doctors per head of the population, the ratio between general practitioners and specialists, the prescription of medication, the number of operations and many other factors.

The UEMS

Even in the early days of the Union, then still called the EEC, (European Economic Community), doctors were creating a forum for the exchange of ideas concerning training and practise of doctors in the Union. At first, the Community forum was strongly dominated by the French speaking members, but since the entry of the British, there has been a gradual shift towards English as the primary language. However, all official business has to be done in the 11 official languages of the Union.

The UEMS (Union Européenne de Médecins Spécialistes) represents the European specialists. The national professional organisations of each country have chosen the members to represent their country in the UEMS.

The UEMS has 34 specialist sections, in accordance with the specialties that are formally recognized in at least one third of the countries in the Union. Over the past 10 years, much progress has been made by the UEMS in making proposals for specialist training programmes that reflect agreement on the desired length and content of training in the different European countries. The European Charter on the training of medical specialties, that has resulted from this, contains a major section with requirements for the general aspects of training in all the specialties, but also a separate chapter for each specialty with specific requirements. The specialist section for otorhinolaryngology/head and neck surgery has laid the foundations for a European Training programme in otorhinolaryngology/head and neck surgery. Subsequent presidents, could present definite proposals for the contents of the training programme in the form

From the Department of Otorhinolaryngology, Academisch Ziekenhuis Nijmegen, The Netherlands.

https://doi.org/10.1258/0022215001905689 Published online by Cambridge University Press

of a logbook, which should be held by each doctor in training and presented for inspection when he/she finishes training.

Planning of manpower

The present great diversity in specialist medicine organization between European countries means that training programmes show major differences. Simo *et al.*[1] published a survey of the contents of the training programmes in otorhinolaryngology in the different European countries and concluded that there are still significant differences that relate mostly to the number of otorhinolaryngologists per head of the population in the member states. This certainly also bears relation to the way medicine is organized. In countries in which the general practitioner plays a central role in health care provision, such as for instance in the UK, the Netherlands and Scandinavian countries, many of the daily simple routine ENT interventions, i.e. medical treatments, are performed by the general practitioner, whereas in other countries, these are done by the otolaryngologist mainly on an out-patient basis.

As yet there is no agreement on the number of specialists that are needed to ensure optimal care for patients with ear, nose and throat problems.

The specialty, having existed for over a hundred years in most countries, has undergone significant change over the past 25 years. The spectacular development of diagnostic procedures, microsurgery in all fields of the specialty and head and neck reconstructive surgery, requires a higly skilled group of future specialists. However, only a limited number of talented young otolaryngologists can and should be trained to treat the rare pathology for which these skills are essential.

Very little is known about the manpower in otorhinolaryngology needed to serve an average population. According to Ruby,[2] a ratio of one physician: to a population of 40 000 is probably ideal. According to the WHO, this might be 1:30 000 if the work includes primary care.

In the Netherlands the number of specialists averages 1:40 000, but in the UK this is 1:120 000, while in most other countries it varies from 1:15 000 to 1:30 000.

It is obvious that with such disparity, daily practice will show considerable differences. In the coming years, it would be logical for the countries participating in the UEMS to review their training programmes and to decide how many fully qualified ENT specialists need to be trained to guarantee adequate care. This is not an easy task.

European training programme

The European training programme allows certain diversity in practice, but the core programme covers the full extent of the specialty. This may not be exactly the same for all the countries – for instance in some countries thyroid surgery is performed by general surgeons – but overall there is excellent uniformity.

The European training programme is very similar to that of the American Academy of Otolaryngology. Consequently, there is excellent delineation of the scope of the specialty according to an international standard. The European programme consists of the acquisition of theoretical knowledge of anatomy, physiology and pathology of the head and neck area, as well as the theoretical foundations of audiology, phoniatrics, vestibulology, allergy, immunology, oncology and the basic principles of plastic and reconstructive surgery.

Theoretical knowledge must be acquired by all trainees and should be tested preferably before, or during, the first year of training. Failing the examination can be reason for exclusion. Practical training consists of a graded increase in clinical responsibility and surgical experience with the most common procedures of the specialty. Furthermore, the trainee should show evidence of having performed clinical or basic research.

An exhaustive list of the diagnostic procedures (A), conservative managements (B) and operative treatments (C) has been prepared by the committee of the European Board and the list is printed in a logbook which can be obtained from the national representatives of the UEMS.

The skills to be acquired are classified in three categories: I = independently performed, S = performed under supervision and A = training by assistance. The latter category is made up of procedures that can form part of an advanced programme of sub-specialization. It is important that all trainees have at least some exposure to the latter, in order to become acquainted with the possibilities and limitations of highly specialized procedures. Fellowship programmes have already been started in some countries, for instance in head and neck surgery and otology. In Appendices 1 and 2, examples are given of the classification of procedures in the logbook of the European training programme.

The logbook will be the most important document for a trainee; it will monitor the progress in training and enable the Certifying Board to judge the eligibility for a European Certificate.

Certification

At present, certification of doctors and specialists is the responsibility of the national bodies. As mentioned previously, university degrees are recognized without restriction within the European committee. For specialists certified by the national boards, there are only two conditions to ensure recognition: first, the duration of training, which for otorhinolaryngologists has been fixed at five years and second, knowledge of the language of the host country. This says nothing about the content or the quality of the training programme and as we all know, the significant differences between countries still need to be solved.

The European training programme has been developed to ensure an optimal level of training for future generations of otorhinolaryngologists.

https://doi.org/10.1258/0022215001905689 Published online by Cambridge University Press

Such programmes already exist in a good number of centres in the European countries, but many others cannot offer the full extent and quality of the European training programme.

The best way to maintain the desired quality of training is to organize site visits which offer the opportunity to check the training programme, the facilities and the progress being made by the trainees. This could be done by international colleagues who report back to the European Board. When a programme receives approval, the Board can issue a certificate for the European Training Centre.

Many problems will have to be solved before site visits can be implemented. At present, there seems to be little political interest in spending money on European harmonization in medical practice and specialist training. Health care already consumes a large portion of national budgets and there is a constant drive to reduce costs that keep rising in most countries. So, what should be our main aims for the next decade? Would it be realistic to expect that the 15 countries of the Union will have harmonized their specialist training programmes within the next 10 years? Some other specialties seem to have moved more in that direction than ENT.

Demographic changes

Many factors affect the daily practice of doctors and also otorhinolaryngologists. For example, demographic factors, mainly ageing of the population, will mean a shift towards intensified care for elderly people. Furthermore, there have been demographic changes in the population of doctors. In many countries, there has been a significant increase in the number of women medical students and this is also apparent in the increasing number of women otolaryngologists. The younger generation is less inclined to accept the long working hours, which used to be customary in most countries. The countries with socialized medicine, such as the Scandinavian countries, have regulated working hours, which usually means less time spent at the clinic.

Changing pattern of diseases and treatment based on careful population studies

Over the past 25 years, we have seen a significant decline in the number of some procedures such as for instance tonsillectomies and it seems likely that grommet insertion for otitis media with effusion will also decrease. A shift is already apparent towards conservative management of sinusitis and OME by paediatricians and general practitioners.

Patient assertiveness

Increasing levels of schooling and education for patients mean that more adequate reactions are required from doctors. Patients are gradually becoming more and more knowledgeable about disease and treatment. The television and the Internet act as sources of information and it is not uncommon for a doctor to have to answer questions about treatment that he or she had never heard before. A patient will not be happy if the doctor cannot answer such questions. Health economy and health politics are closely related and they both have a heavy impact on daily medical care. Politicians want the highest possible quality of care for the lowest price. This is natural, but advances in medicine are very costly, contrary perhaps to the progress in many other fields. As the cost keeps rising, doctors will be obliged to help find solutions, otherwise they will have to accept the decisions made by politicians and health insurance companies. Bureaucracy is one of our greatest enemies.

Medicological considerations

Litigation is also increasing in Europe. New laws that have been passed in recent years have mainly been drawn up to protect the patient. A doctor has to do more and more work, especially of an administrative nature, to protect him or herself if a patient makes a complaint. Nobody has ever asked what these new laws mean to a doctor who has to see 30–40 patients a day, or even more.

It is difficult to predict exactly how these factors will affect the daily work of doctors and specialists. I do not belong to the culture pessimists who believe that the future for the next generation will necessarily be worse. Nevertheless it is our duty to provide a training programme that can prepare the future generation of otolaryngologists for the challenges of this new century. The UEMS has taken great initiative and should be supported strongly to further improve standards in all European countries.

References

1 Simo R, Hartley C, Saeed SR, Zarod AP, Taylor PH. Otorhinolaryngological training in Europe – A comparative study. *Clin Otolaryngol* 1997;**22**:332–42
2 Ruby RRF. Otolaryngological manpower in Canada in the year 2000. *J Otolaryngol* 1991;**20**:305–9

Address for correspondence:
Professor dr. P. van den Broek,
Keel-, Neus-en Oorheelkunde,
Academisch Ziekenhuis Nijmegen,
Radboud west,
Philips van Leydenlaan 15,
Postbus 9101,
6500 HB Nijmegen,
The Netherlands.

https://doi.org/10.1258/0022215001905689 Published online by Cambridge University Press

APPENDIX 1

V. Oral Cavity, Pharynx, Esophagus

	Profound knowledge, experience and skills in:	General i	General s	General a	Advanced
A. DIAGNOSTIC PROCEDURES					
a) CLINICAL EXAMINATION					
1	inspection and palpation of oral cavity and oropharynx	X			
2	nasopharyngoscopy	X			
3	hypopharyngoscopy	X			
4	oesophagoscopy	X			
5	endoscopic assessment of oral cavity, pharynx and oesophagus, with flexible and rigid endoscopes, including biopsies, preparation of swabs, washings, and related techniques.	X			
6	gustometry	X			
7	tests of salivation	X			
8	functional tests of swallowing disorders			X	
9	assessment of sleep-apnoea syndrome		X		
10	assessment of speech		X		
b) INTERPRETATION OF RELEVANT IMAGING					
11	ultrasound scan, conv. X-Ray, OPG, CT, MRI, esophagogramm	X			
B. Non-surgical Treatment					
12	inhalation therapy	X			
13	pharmacological therapy	X			
14	topical application of drugs	X			
15	swallowing and aspiration rehabilitation		X		
16	speech rehabilitation		X		
C. Surgical Treatment					
17	local and regional anaesthesia	X			
18	adenoidectomy	X			
19	tonsillectomy	X			
20	abscess tonsillectomy	X			
21	arrest of tonsillar haemorrhage	X			

https://doi.org/10.1258/0022215001905689 Published online by Cambridge University Press

APPENDIX 2

VI. Head and Neck

Profound knowledge, experience and skills in:

		General			Advanced
		i	s	a	
A. Diagnostic Procedures					
a) CLINICAL EXAMINATION					
	investigation of the cranial nerves				
1	clinical	X			
2	electrophysiological			X	
3	functional tests of salivary glands	X			
4	fine needle biopsy	X			
b) INTERPRETATION OF RELEVANT IMAGING					
11	ultrasound scan, conv. X-Ray, OPG, CT, MRI, esophagogramm	X			
B. Non-surgical Treatment					
6	pharmacological therapy	X			
7	conservative treatment of wounds	X			
	chemo-radiation-therapy				X
	application of botulinum toxin				X
C. Surgical Treatment					
8	local and regional anaesthesia	X			
9	management of wound breakdown			X	
10	management of open neck wounds	X			
11	fistula care	X			
	repair of fistula				X
12	extirpation of thyroglossal and branchial cysts and fistulae		X		
13	incision and drainage of abscess	X			
14	surgery of benign tumours			X	
	correction of malformations				X
	repair of injury				
15	management of soft tissue injuries of the lateral and middle part of the face	X			
16	combined fractures of the lateral and middle part of the face		X		X
17	osteosynthesis			X	

https://doi.org/10.1258/0022215001905689 Published online by Cambridge University Press