

UEMS Section of Neurosurgery
Minutes of Meeting: Sunday 29th March 2009, Marseille, France.

Present:

B Maillet, Secretary General UEMS
J Schramm, President EANS
KW Lindsay, Past President EANS and Chair of JRAAC
O Sparrow – Joint EANS/UEMS Examination Committee
T Trojanowski – President UEMS Section Neurosurgery

Austria – B. Richling, Prof Ungersboeck
Belgium – J van Loon, J Verlooy
Bulgaria – not represented.
Croatia – P. Miklic
Czech Republic – not represented
Denmark – not represented
Estonia – not represented
Finland – not represented
France – not represented
Germany – M. Bettag, J-C Tonn
Greece – P. Selviaridis
Israel – Z. Feldman
Italy – M. Collice
Latvia – not represented
Lithuania – A. Tamasauskas
Luxembourg – G. Matge
Netherlands – J.J. Mooij
Norway – not represented
Poland – T. Trojanowski
Portugal – M. Cunha e Sa
Romania – I. OGREZEANU, I Poata
Slovakia – J. Steno
Slovenia – not represented
Spain – M. Manrique
Sweden – K Cesarini
Switzerland – not represented
Turkey – A Unlu
UK – A. Kemeny
Ukraine – not represented

ESSFN – Y. Lazorthes, G. Broggi

- 1 **Welcome:** TT welcomed all delegates to the meeting, particularly Bernard Maillet, Secretary General of the UEMS, who had always been a great friend and supporter of the section, particularly in terms of administration and advice.

Minutes of Previous Meeting and Agenda: both were approved unanimously.

President's Report:

TT advised that whilst this was his first Section meeting as Chairman, he had already attended a meeting in Brussels on 21st January of all UEMS Section Chairmen and Secretaries. Having celebrated its 50th anniversary in 2008, the UEMS had considered its role and position, as well as its achievements, during the meeting.

Representatives of the UEMS' 38 sections discussed a number of issues.

Postgraduate training – it was felt that greater effort from the sections was required with regards to this field.

European work force – a green paper is being prepared about the workforce in health services in Europe; the main rationale behind this being concerns for the future relating to changing demography and an ageing population. TT had been asked to answer a number of questions regarding the role of neurosurgery, and given the timescale for response (25th March) had dealt with this himself, rather than referring it to the Section as a whole. He felt that the increased workload for neurosurgeons as a result of ageing was negligible.

However, there was another associated point – medical specialists themselves were ageing, as studying medicine became less attractive than in the past. A potential gap between supply and demand was developing, and action was required to safeguard against a possible shortage of doctors.

An increasing tendency appeared to be developing to facilitate the training of specialists even at the expense of lowering quality – TT was not entirely comfortable with this.

Neurosurgery should adopt an open attitude. Recent reports suggest that the number of specialists being trained is about right; the recent Workforce Planning report suggests an average of 2000 cases per annum per million population. On average, neurosurgeons carry out 200 operations each year (variation between 70 and 300), which suggests that there is little need for more than ten neurosurgeons per one million population.

Issues relating to the quality/safety of e-health, tele-medicine and e-teaching had also been raised. The representatives of each section had been asked to provide reviewers to comment on the quality of e-teaching. TT commented that it would be useful if all Section members would be prepared to review the teaching programmes which become available on the web. CESMA was dealing with these issues; its remit was not simply specialist examinations, but also assessment – along the same lines as JRAAC. The joint CESMA committee is chaired by Parigi, a paediatric surgeon, and it was suggested that KWL should contact Parigi (Prof. Gian Battista Parigi, MD, e-mail: gparigi@unipv.it) in order that our work through JRAAC could be incorporated in this general organisation

There had been a number of applications from specialist societies related to neurosurgery for inclusion of their own particular sections within the UEMS. Hand surgery, for example, had applied, and it was suggested that Neurosurgery Section members should propose one or two names of neurosurgeons with particular competence in this area, in order that neurosurgery could be represented.

Emergency medicine was also trying to develop its own section. This attempt had been criticised by Professor Polonius, head of the Section of Surgical Specialties, who deemed emergency medicine to be part of all surgical specialties rather than a discipline in its own right. It was explained that there were three groups of specialists within the UEMS, and neurosurgery was part of the “surgical disciplines” group, of which Professor Dunlop was chair.

The European Accreditation Council for Postgraduate Training had been established.

European Working Time Directive – it had been decided that “inactive” on call time should be treated identically to “active” on call time. Therefore the employer must pay the employee for such time, which will count towards the maximum aggregate time allowable during the week.

An opt out is now impossible after three years. It is uncertain whether those who have already signed an opt out are excluded from the new rule, or included within its provisions.

Report by Professor Maillet, Secretary General of the UEMS.

BM reported to the Section of Neurosurgery as detailed in the attached report. He explained that “particular competences” such as oncology, hand medicine and emergency medicine would have their own specific representation as “divisions” in the UEMS in future.

He then invited questions from the floor. Andras Kemeny issue of the EWTD, and the fact that it was compromising globalisation, and relations with US/Canadian colleagues conflicted with the European Working Time Directive – in the US, they were having difficulties in reducing their working time to 80 hours per week. The US Board of medical specialties had expressed concern at the emerging divergence between training in Europe and in the US.

TT explained that in Poland, hospitals were increasingly contracting private practices (frequently consisting of a single doctor only) as institutions serving the hospital, thus “getting round” the provisions of the EWTD.

BM confirmed that the maximum figure of 48 hours per week was applicable per employer, rather than per employee, and that it applied only to employed, rather than self-employed people.

The proposed cross border treatment directive was also mentioned. It would be possible to seek treatment outside the patient’s own country (a) in the case of emergency – as at present and (b) where appropriate treatment was not readily available in the patient’s own country.

TT referred to the harmonisation of training programmes and examinations throughout Europe. He expressed his view that it would probably be impossible for a central body to review and approve all Training Programmes. This would have to be done on a national basis, with the central European body simply approving the system used by the national review body. BM felt that the fact that many countries were unaware of the UEMS rules would cause difficulties. TT believed that the Section should explain its expectations, and that countries whose own systems meet these expectations should be granted accreditation as reviewers, following minimum requirements.

JCT referred back to the part of TT’s report which referred to the implications for neurosurgery of the ageing population, and made the point that this was likely to result in a

significant increase in spine cases. TT agreed with this, and suggested that the UEMS Section should appoint a special task force to evaluate the likely implications for neurosurgery. JJM advised that spine cases undertaken by neurosurgeons in the Netherlands had increased by 10% in the last ten years, and that a further increase of 5% over the next ten years was anticipated.

Owen Sparrow pointed out that the expansion/contraction of orthopaedic spinal surgery would be a big factor. Whilst spinal surgery by neurosurgeons was an expanding field within the UK, this would vary from country to country.

4 Secretary's Report

MCeS clarified that "added competence" referred to a specific field within the specialty, whereas "particular competence" referred to a specific field shared with other disciplines – eg interventional neuroradiology. He made the point that it should be the scientific society (the EANS) rather than the legislative body (the UEMS) that formulates such definitions.

5 Treasurer's Report

Johannes van Loon delivered the attached report.

6 Report of President of JRAAC: K.W. Lindsay

KWL reported that since the last meeting in Brussels, two units had been visited: St Galen (Guy Matge and Evelyne Emery) and Gotsepe (Jan Jakob Mooij and Ken Lindsay). These visits were to be discussed at the coming JRAAC meeting.

Only one subsequent application had been received, from Gaze Hospital in Ankara. Milan, Sofia and Kassel had all expressed an interest in applying, but nothing formal had been received.

KWL advised that he had drawn up a spreadsheet setting out statistics of all previous meetings for review during the coming JRAAC meeting. The median ratio between operations performed: trainees was 270.

7 Report by the President of the EANS

In the absence of Johannes Schramm, Susie Hide reported that

The Executive Committee of the EANS had agreed in principle to form Sections – the details of whose structure and remit were yet to be established.

A move to a new rhythm for the European Congress had also been agreed; there would be three years between the forthcoming meeting in Rome 2011 and the subsequent meeting in 2014, and thereafter Congresses would be held every two years.

A fee increase for individual members had been agreed; to 200 Euros per annum for Full members, and 125 Euros per annum for Junior and Retired members.

The EANS finances were now in a much more stable position overall.

8 Training Charter on Neurosurgery in Movement Disorders – Yves Lazorthes

The number of operations in each category which the trainee must carry out was discussed. Whilst the numbers were relatively low, an element of safety was implied by the fact that the supervisor must trust the trainee to carry out the operations on his own.

There was discussion about the most appropriate term for those applying for “specialist” status. KWL suggested that the term “Fellow” should be used in place of “trainee” – BM suggested “candidate”, which was adopted by the meeting.

The question of how many countries actually offered movement disorders surgery was raised. YL advised that he was working with the Medtronic Academy on the accreditation of centres. 16 centres had already been assessed in France, ten in Spain and six in Italy. AK was concerned about the acceptance of data from a commercial concern. TT advised that the programme should be accepted, but that National Societies should make an inspection of the training programmes prior to granting accreditation.

JT highlighted the potentially dangerous situation in which a candidate from a country where no training is available obtains accreditation abroad, by doing just two operations single handed. What would be the situation when he returned to his own country – would he be responsible for these operations in his own department?

MCeS stressed that it was important not to adopt a punitive system – instead, candidates should be encouraged to take back the experience they have gained at a recognised centre of excellence, to start work in an organised fashion on their return. The general view was that, whatever the concerns about the proposed system, it was an improvement on the current situation, where someone can simply attend a course run by Medtronic, and then begin their practice.

JJM mentioned the fact that the supervisor can ensure that his fellow has been brought up to the requisite standard.

After this discussion, the Section agreed unanimously to the draft.

9 Added Competence Training Charter in Neuro-oncology : Manuel Cunha e Sa

The paper was carried unanimously, with the following amendments agreed:

Point 6 – Requirements for Individual Recognition of Competence: under bullet point 2, “the primary surgeon” should be required by “the surgeon responsible in the management of”

Point 7 – Requirements for Institutional Recognition of Competence: under bullet point 2, the phrase “including metastases” should be inserted after “30 additional tumours of other origin”.

Point 7 – under bullet point 6, the phrase “which need not be on site” should be inserted after “Neuropathology Laboratory”.

Point 7 – under bullet point 7, the phrase “or a close collaborator with a Medical Oncology Service” should be inserted after “There must be a Medical Oncology Service”

Point 7 – under bullet point 9, the phrase “or as an alternative there should be a collaboration with a Radiosurgery Service” should be changed to “...there must be a collaboration with a Radiosurgery Service”.

Point 7 – final paragraph, third line from the bottom, the spelling of “neuro-oncologic” should be corrected.

Point 8 – under bullet point 1 “national board” should be replaced by “appropriate board”

Point 8 – under bullet point 1 of “The Faculty”, the spelling of “or” in the third line from the top should be corrected to “of”.

MCeS commented that this paper should be seen as a “road map” for those wishing to establish a centre of excellence, and should not be too strictly interpreted.

10 Future development of European Examination in Neurosurgery:

Owen Sparrow

OS and BM advised that the activities of the Joint EANS/UEMS Examination Committee were covered by CESMA.

The need to increase access to the Part II examination was discussed. The examination had been opened to those outside UEMS/EANS countries, and the possibility of opening the exam to those in their final year of training was also discussed.

A separate bank account had been established for the Examination Committee, which would assist in the development of the Examination as a self financing entity.

OS advised that the Examination was seeking to increase the question bank for the Part I exam, and also to extend the number of examiners for the Part II examination. It had been decided to have a single Part II examination annually, to be held each year at the end of Winter or in early Spring. This year’s examination had been held in January in St Augustin near Bonn, and had worked well.

OS urged Section members to propose potential candidates for the Examination Committee. These people would require good spoken English, and a broad knowledge of neurosurgery rather than indepth specialist knowledge.

11 Particular competence in Neuro-Intensive Care Medicine – H Van Aken

As Mr Van Aken was not present, this topic was not discussed.

12 European Working Time Directive – An Update – JC Tonn

JCT advised that there was really very little new to report. The opt out was to be abandoned in three years, and there was discussion as to whether those contracts incorporating optouts would still be valid in three years. This situation could have a major impact – if even those contracts which had been signed and agreed were abandoned, then major reorganisation would be necessary.

All time – active or inactive – is now calculated as working time – and as a consequence, residents would need at least two or three years longer for their specialist training.

There was concern that the increasing incidence of postgraduate added competence training could in fact be used as an excuse to cut down the standard training time and programmes.

13 Road map for implementation of added competence programmes – B. Richling

A task force for the Neuro-endovascular specialty had been established, including neurosurgeons, neurointerventionists from neuroradiology, and neurologists providing a diagnostic component.

The idea was to allow fellows/candidates to rotate between centres; however this was proving difficult because of the different situations in different countries. For example, in Germany and Austria, the fellows' positions are attached to their own hospitals, and if they leave these to rotate, they automatically lose their positions.

BM advised that the Radiology Section had applied to create a new division of Interventional Radiology, which would not be neuro-specialised – something which BR perceived as a danger. BM suggested the creation of a division of Neuro-intervention.

BR advised that he wished to provide a formal basis on which to protect the position of those neurosurgeons who embolise, and JS commented that he believed that it was up to the leadership of the UEMS to ensure that the position of neurosurgeons who wished to embolise and were competent to do so was safeguarded in such a manner that they continue to be able to do so.

BM advised that there were no specifically protected areas – the key issue was that of the “most competent person” to undertake a particular task, which might of course vary from hospital to hospital

It was agreed unanimously by the Section (with the exception of Andras Kemeny) that BR should attend the next meeting of the UEMS Section of Neuroradiology, with a mandate for negotiations from the Section of Neurosurgery.

14 CME , Report of Permanent Working Group – Johannes van Loon

JvL expressed his concern about awarding CME credits to courses organised by commercial companies – whilst the course may contain much educational material, its content will inevitably be biased, and will therefore not meet strict EACCME criteria. MCeS commented that he did not feel this to be a “generic” issue – the decision should be made on a case by case basis, dependent upon the scientific quality of the meeting.

JS commented that speakers should be required to declare all their relevant interests – for example, stock options, consultancy etc; whilst OS suggested that full disclosure, including disclosure by each speaker, should be made a mandatory condition for the granting of accreditation. It was agreed that all interests must be disclosed in print, in the event programme, if an event is to be eligible for accreditation.

The possibility of shortening the CME application procedure was also discussed.

15 Date of Next Meeting

It was agreed that the usual date in late June/early July was too close to the date of the current meeting, and it was decided that TT should circulate proposals for the forthcoming meeting date amongst the members of the Section.