

---

**GMC response**  
**Green Paper on *Modernising the Professional Qualifications Directive***  
**31 August 2011**

**Introduction**

1. The General Medical Council (GMC) is the independent regulator for doctors in the UK. Our purpose is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine.
2. There are currently over 245,000 doctors on the UK Medical Register; 23,550 (9.6%) of these doctors qualified in other parts of the European Economic Area. In 2010, we granted registration to over 2,900 doctors under the provisions of the Directive.
3. The law gives the GMC four main functions:
  - keeping up-to-date UK registers of qualified doctors
  - fostering good medical practice in the UK
  - promoting high standards of medical education in the UK
  - dealing firmly and fairly with doctors practising in the UK whose fitness to practise is in doubt.
4. We believe the fundamental purpose of medical regulation is to ensure safety and quality of care for patients. We support the principles of the single market and the benefits that can flow from the free movement of professionals. However, we believe the single market must make sure there is high quality in healthcare and that the protection of the public and patients is the first priority.
5. We welcome the opportunity to respond to the Green Paper, which should be considered alongside our experience report prepared in September 2010 and our response to European Commission consultation in March 2011. Our response stresses the need for assurances that the review will safeguard the public interest.

**Question 1: Do you have any comments on the respective roles of the competent authorities in the Member State of departure and the receiving Member State?**

6. We remain unconvinced that a card would improve professional mobility.

7. The high number of EEA qualified doctors we register in the UK (in 2010 we granted registration to over 2,900 doctors under the provisions of the Directive) does not suggest that there are any problems that a professional card is required to solve. Instead, it may have the undesired effect of creating an additional bureaucratic hurdle for both sets of competent authorities and restricting the already limited checks we, as a regulator, are allowed to undertake on migrating European doctors. As such it could put patients and the public at risk.

8. The Green Paper suggests that under a card system, authorities in the host member state would not need “to verify all the information that has already been examined by the member state of departure”. This suggests that the existence of a card would be enough to confirm that the professional can practise in the host member state.

9. While we welcome greater cooperation from the member state of departure in the recognition process, a card could not provide us, employers or patients, with the same level of assurance as our current checks. A card is likely to be the subject to fraud, with serious implications for the integrity of our and others’ registration processes. If the card were not linked to a live register, it could easily become out of date and would not contain any record of patient safety concerns that arose after the card was issued. As such it would provide false assurance and jeopardise patient safety.

10. As we continue to see certificates and documents that have been issued in error and without due care by some competent authorities in other EEA countries, we have severe concerns about the suggestion that the card could become the sole source of information on which to base the recognition decision. We believe that the host competent authority must be able to verify the documents required for recognition.

11. For general systems, there would be no added value for the competent authority of establishment to carry out an “initial verification”. The GMC believes that the receiving or host competent authority is best placed to assess whether the education and training of a migrant doctor is comparable to the one in the host member state and whether compensation measures are required.

12. The Commission has already invested substantial resources in the Internal Market Information (IMI) system, which provides a cost-effective mechanism for information exchange between competent authorities. A more comprehensive use of IMI, rather than a new, unproven card, is more likely to facilitate the recognition process.

13. For example, instead of a card, we would support the routine direct exchange of Certificates of Current Profession Status (CCPS)<sup>1</sup> and all other required documentation between competent authorities through the IMI system.

14. We agree that it should be mandatory for competent authorities to be registered with IMI. Enforceable deadlines to ensure that users respond to IMI requests in an effective and timely manner would also be a welcome development.

15. We also believe that IMI should remain a mechanism for the exchange of information. Suggestions that a register could be created within IMI to hold information about professionals would not be proportionate, would lead to duplication of data that competent authorities already hold and, if not continuously updated, would become an unreliable source of information.

16. Instead, we call on the Commission to encourage competent authorities to share information directly, and enable them to make the information they hold publicly available. For example, the GMC has a web-based searchable list of registration and disciplinary information that is freely and securely available to the public. In the UK this not only supports the data that competent authorities exchange on a bilateral basis but also enables patients to make more informed choices about the practitioners they consult or may choose to consult. A positive way of improving transparency would be for the European Commission to promote similar publicly available web-based information for competent authorities, patients and employers.

**Question 2: Do you agree that a professional card could have the following effects, depending on the card holder's objectives?**

**a. The card holder moves on a temporary basis (temporary mobility):**

**Option 1: the card would make any declaration which Member States can currently require under Article 7 of the Directive redundant.**

**Option 2: the declaration regime is maintained but the card could be presented in place of any accompanying documents.**

17. We do not support the Commission's suggestions (under options 1 and 2) that the issuing of a professional card should replace the prior declaration and the current requirements of Article 7, particularly the requirements of Article 7.2, and Article 7.4. The latter allows a prior check of the qualification and is essential to reduce the risk to the public<sup>2</sup>. We believe that these are essential for public protection and that the temporary and occasional provisions in the Directive should not become a route to evade regulatory scrutiny.

**b. The card holder seeks automatic recognition of his qualifications: presentation of the card would accelerate the recognition procedure (receiving Member State should take a decision within two weeks instead of three months).**

<sup>1</sup> See Agreement One and Annex 2 of the [Edinburgh Agreement](#).

<sup>2</sup> See section 3.2.1 (page 10) of the Green Paper.

18. It is not necessary to adopt a professional card to shorten the recognition procedure. The GMC already processes automatic recognition decisions within one month and agrees with the suggestion in the Green Paper that the deadline for automatic recognition of decisions (on submission of a complete application), could be decreased in consultation with competent authorities.

19. To give competent authorities the necessary time to adapt their administrative processes we would encourage the Commission to reduce the deadline gradually.

**c. The card holder seeks recognition of his qualifications which are not subject to automatic recognition (the general system): presentation of the card would accelerate the recognition procedure (receiving Member State would have to take a decision within one month instead of four months).**

20. We doubt that the deadline under general system could be reduced from four months to one month given the time and resources required to undertake a comparison of the training and experience of a migrant professional. We firmly believe that a card or e-certificate would not contain the details necessary to carry out the assessment to the satisfaction of the regulator and the public, and would not simplify the process.

**Question 3: Do you agree that there would be important advantages to inserting the principle of partial access and specific criteria for its application into the Directive? (Please provide specific reasons for any derogation from the principle.)**

21. The European Court of Justice judgment<sup>3</sup> is clear that partial access should only be granted if the differences in activities are too great for the gap to be bridged by compensation measures, and if there are no valid public reasons to prohibit such partial access.

22. Therefore, we believe strongly that medical professionals should be exempt from the principle of 'partial access'. Allowing a migrant to practise as a doctor in a limited capacity, when compensation measures cannot make up the difference in training, would pose a serious risk to patients and would be prohibitively difficult for both regulator and employer to assure.

23. The concept also raises wider questions about the integrity of education systems in the host member state should migrants be given the opportunity to access the profession partially and eventually gain full recognition through this route. This assumes that professional experience can always compensate for the lack of education and training.

24. The Commission should also consider the wider implications of this principle for citizens in the home member state who have not achieved the minimum training requirements. Unless carefully defined, partial access may lead to inequitable treatment of doctors trained in the UK when compared to migrants. This could undermine the Directive's minimum training requirements and is reflected in a

---

<sup>3</sup> European Court of Justice judgment, 19 January 2006, [C-330/03](#), Colegio de Ingenieros de Caminos, Canales y Puertos, paragraph 40.2.

subsequent judgment of the Court which states that the right of freedom of movement “does not, in order to be given practical effect, require that access to a professional activity in a member state be subject to lower requirements than those normally required by nationals of the State”<sup>4</sup>.

**Question 6: Would you support an obligation for Member States to ensure that information on the competent authorities and the required documents for the recognition of professional qualifications is available through a central on line access point in each Member State? Would you support an obligation to enable online completion of recognition procedures for all professionals? (Please give specific arguments for or against this approach).**

25. We fully agree that the visibility of *National Contact Points* should be improved. They play a central role in signposting professionals to the appropriate competent authority and provide essential information on recognition to migrant professionals.

26. However, we do not support the proposal that *National Contact Points* should be made responsible for administrative procedures as they would not have the necessary expertise to deal with each individual profession. Operating as an intermediary in the way suggested by the Green Paper may well create an additional tier of bureaucracy, slow down the recognition process, and complicate procedures for both the professional and competent authority.

27. It would also remove the direct link between the professional and the host competent authority. This might have implications both for the professional’s preparedness to practise and induction to a new country, but also the assurances competent authorities need about the doctor’s qualification and fitness to practise.

28. In addition, it assumes that competent authorities across the EEA have similar responsibilities and duties and that professional regulation is the same across the EEA. We would like to ensure that incoming doctors are aware of their ethical and professional duties as medical practitioners in the UK, as well as the role and purpose of the GMC as the regulator for the medical profession.

29. We believe that efforts should instead be targeted towards encouraging competent authorities to develop online application processes and provide clearer information about their procedures. This would facilitate access to the profession and make recognition processes more transparent, without some of the problems associated with making *National Contact Points* responsible for all administrative procedures.

**Question 7: Do you agree that the requirement of two years' professional experience in the case of a professional coming from a non-regulating Member State should be lifted in case of consumers crossing borders and not choosing a local professional in the host Member State? Should the host Member State still be entitled to require a prior declaration in this case? (Please give specific arguments for or against this approach.)**

---

<sup>4</sup> European Court of Justice judgment, 10 December 2009, [C-345/08](#), Pesla, paragraph 50.

30. Although this question is not directly relevant to the profession we regulate, we would like to take this opportunity to reiterate our concerns about the temporary and occasional provisions in the Directive. It remains our view that patients have the right to be protected by the regulatory system regardless of whether the healthcare professional treating them is in the country permanently or temporarily. We do not believe that there should be a separate regulatory regime.

31. In this context, we are also concerned that we will not be able to require a professional with temporary registration to take part in the UK's proposed revalidation process. Although each year only a small number of EEA doctors provide their services in the UK on a temporary and occasional basis, this route to registration opens the potential for doctors to avoid the requirements of revalidation.

32. We believe that competent authorities should be able to continue to require a prior declaration and the documentation necessary for pro-forma registration from doctors practising temporarily and accompanying consumers across borders.

**Question 9: Would you support the deletion of the classification outlined in Article 11 (including Annex II)? (Please give specific arguments for or against this approach).**

33. Although not directly applicable to medical qualifications, we believe that the European Commission should carefully consider the consequences of deleting Article 11, without replacing it with a suitable alternative.

34. It is important for competent authorities to compare general education levels to a commonly accepted framework. This reduces uncertainty and provides some level of confidence in the recognition system.

**Question 10: If Article 11 of the Directive is deleted, should the four steps outlined above be implemented in a modernised Directive? If you do not support the implementation of all four steps, would any of them be acceptable to you? (Please give specific arguments for or against all or each of the steps.)**

35. We agree with the European Commission that competent authorities imposing compensation measures should justify their decisions to migrating doctors and outline which "substantial differences" in training have been identified.

36. It is essential for competent authorities to have the flexibility to devise compensation measures that are most appropriate for the professional wishing to move, while ensuring adequate protection of the public in their jurisdiction. We do not believe that the development of a mandatory Europe-wide code of conduct to define common approaches for the development and implementation of compensation measures would be helpful. Instead competent authorities should be encouraged to share best practice and experience for the benefit of the professional and the patient.

**Question 11: Would you support extending the benefits of the Directive to graduates from academic training who wish to complete a period of remunerated supervised practical experience in the profession abroad? (Please give specific arguments for or against this approach.)**

37. We understand the Commission's wish to facilitate the mobility of graduates across Europe but do not share the view that the Directive is best placed to address this issue.

38. We fully support the principle of equal access for EEA nationals to periods of supervised practical experience. In the UK, EEA graduates who have not yet completed a traineeship as part of their basic medical education can gain provisional registration with the GMC and apply to the UK Foundation Programme<sup>5</sup>. Competitive entry to the Foundation Programme promotes high professional standards and ensures that only the most suitable medical trainees qualify for entry to the profession.

39. However, the organisation and delivery of supervised medical practice across the EEA and the expectations placed on a trainee differ significantly between member states. For this to work satisfactorily, only those at a comparable level should be able to access education and training in another member state. However, the mechanisms to determine such comparability do not yet exist. This will require an urgent audit of the minimum training requirements and moves towards an outcome based approach to assessment of education and training (see our response to question 14). In addition, training providers and regulators will need to be in a position to establish that the training received outside of the UK has been delivered to the standard required at home, but it seems doubtful that existing quality assurance regimes could provide this.

40. In light of these variations, and the inability to determine comparability, we do not see the added value of enshrining the principle of access to remunerated supervised practical experience in the Directive. We believe that the focus of the Directive should remain the mobility of fully qualified professionals.

**Question 12: Which of the two options for the introduction of an alert mechanism for health professionals within the IMI system do you prefer?**

**Option 1: Extending the alert mechanism as foreseen under the Services Directive to all professionals, including health professionals? (The initiating Member State would decide to which other Member States the alert should be addressed.)**

**Option 2: Introducing the wider and more rigorous alert obligation for Member States to immediately alert all other Member States if a health professional is no longer allowed to practise due to a disciplinary sanction? (The initiating Member State would be obliged to address each alert to all other Member States.)**

41. We agree with the Commission that option 2 would protect patients in a more effective way. We fully support the inclusion in the Directive of an alert mechanism underpinned by a legal obligation on regulators to inform all other member states immediately when action is taken against a doctor's registration. The alert should

---

<sup>5</sup> The Foundation Programme is a two-year generic training programme which forms the bridge between medical school and specialist/general practice training.

apply to all restrictions placed on a doctor's right to practise and not just when they have been removed from the register.

42. Although the current Directive includes a requirement to exchange information about the good standing of applicants at the point of registration, there is no requirement on regulators proactively to disclose actions they take on a doctor's fitness to practise.

43. Our experience is that member states are often reluctant to share information because of perceived limitations imposed by national data protection and privacy legislation. This has led to situations where doctors have been disciplined or suspended in one jurisdiction while continuing to practise in another, thereby posing a serious risk to patient safety.

44. We welcome the Green Paper's proposal to introduce a more rigorous alert mechanism. Mandatory registration with the system<sup>6</sup>, and a proactive alert mechanism administered through IMI, would alleviate the data protection concerns of those regulators that are currently unable to share information. It would also make sure that unsafe professionals are not able to move around Europe with impunity.

45. We believe that option 1 would not be sufficiently robust. A decision to trigger an alert should not be based on a judgement about whether the doctor is likely to provide services in another member state. A competent authority will not necessarily be in a position to make such an assessment, or hold information on whether a doctor is simultaneously registered in more than one country.

46. We also encourage the Commission to consider extending the alert mechanism to the exchange of intelligence about individuals that try to register with fake diplomas or false identities.

47. To ensure the effectiveness of the alert mechanism, it would also be helpful to identify which organisations in the member states are responsible for taking action against a doctor's registration (suspensions, conditions, warnings, erasures) when their fitness to practise is impaired. Our experience shows that in many countries recognition and fitness to practise functions are carried out by separate organisations, sometimes at regional and local level. This creates confusion and potentially a risk to patient safety, especially if information about a doctor's fitness to practise is not communicated effectively to the relevant organisation(s). For the IMI alert mechanism to be effective, all organisations responsible for recognition, registration and fitness to practise would need to be registered on IMI.

**Question 13: Which of the two options outlines above do you prefer?**

**Option 1: Clarifying the existing rules in the Code of Conduct;**

**Option 2: Amending the Directive itself with regard to health professionals having direct contact with patients and benefiting from automatic recognition.**

<sup>6</sup> Registration with IMI should be mandatory for all national, regional and local organisations responsible for taking action against a doctor's registration (suspensions, conditions, warnings, and erasures).

48. We welcome the acknowledgment in the Green Paper of the importance of language skills for healthcare professionals. The ability of a doctor to communicate effectively in the language of the host member state lies at the heart of good medical practice and should be a prerequisite for registration.

49. Clarifying the Code of Conduct might have some limited value as it would explain the role of competent authorities in the assessment of language and the type of evidence that may be required, but would not be robust enough to ensure public safety.

50. We believe that an amendment to the Directive would provide greater clarity and allow competent authorities to require evidence of language proficiency before registration. Option 2 represents a step in the right direction, but should be extended further. In the interest of public protection, all applicants for registration should be required to demonstrate their knowledge of the host country's language, regardless of whether they will be having direct contact with patients. Communication with colleagues and the wider healthcare team is just as important in making sure that patient safety is not compromised.

51. In addition, language checks should not be limited to automatic recognition cases. Under general systems "submitting an application in the language of the host member state"<sup>7</sup> would not be adequate proof that the migrating doctor has the necessary language knowledge to practise the profession. Furthermore, as compensation measures are not always applied to general systems cases, a number of applicants would be exempt from providing any evidence of language proficiency, under the scheme proposed by the Green Paper.

52. We call on the Commission to include a derogation in the Directive that would ensure that healthcare professional regulators can require evidence of language proficiency of doctors as part of the registration process, for both automatic recognition and general systems. We also believe that an assessment of language skills at the point of registration should not prevent employers from also satisfying themselves of an applicant's ability to perform the job for which they are recruiting.

**Question 14: Would you support a three-phase approach to modernisation of the minimum training requirements under the Directive consisting of the following phases:**

**a. the first phase to review the foundations, notably the minimum training periods, and preparing the institutional framework for further adaptations, as part of the modernisation of the Directive in 2011-2012;**

**b. the second phase (2013-2014) to build on the reviewed foundations, including, where necessary, the revision of training subjects and initial work on adding competences using the new institutional framework; and**

**c. the third phase (post-2014) to address the issue of ECTS credits using the new institutional framework?**

<sup>7</sup> Page 71, [European Commission Evaluation of the Professional Qualifications Directive](#) (5 July 2011)

53. The minimum training times set out in the Directive are useful, however the lack of transparency on the nature and content of medical education and training or the skills, knowledge and competencies acquired means that the level of assurance that states can draw from the training obtained by migrants is limited.
54. We welcome the focus in the consultation on minimum training requirements and agree that the European Commission should engage in a thorough review of the criteria for automatic recognition. This is necessary to ensure that it is modernised to reflect current practice in medical education and training.
55. However, we have concerns that the three phase approach proposed in the Green Paper will not be sufficiently robust, transparent or objective to restore trust and confidence in the system.
56. To ensure public protection, competent authorities, employers and patients must have better assurances that the qualifications included in the Directive are genuinely comparable. It is not clear how the Commission intends to “clarify and adapt the foundation of the training requirements” in phase one, without first carrying out an audit of basic and specialist medical qualifications across Europe. This should be a means of identifying ‘content comparability’ and become the basis from which to develop the minimum training requirements in terms of learning outcomes.
57. As part of this process, we also believe that work should be undertaken to assess the extent to which basic medical training includes clinical and theoretical training. In the UK, the standards outlined in *Tomorrow’s Doctors (2009)* require practical experience of working with patients throughout all years of basic medical training, increasing in duration and responsibility as training progresses. We understand that in some member states there is considerably less emphasis on exposure to patients, which has implications for the preparedness to practise in the UK of some migrating doctors.
58. We also have concerns about the lack of detail in the Green Paper about the proposed use of implementing or delegated acts in a second phase. The existing comitology process is not sufficiently transparent and does not formally involve the competent authorities. Any new procedure must therefore be clearly defined, objectively organised and formally involve the competent authorities.
59. We would suggest that the Informal Network of Medical Competent Authorities play a key role in the process to review and develop the minimum training requirements and the criteria for automatic recognition. The involvement of the Informal Network would also help create an effective European forum for the coordination of medical training, which has been absent since the abolition of the Advisory Committee on Medical Training (ACMT) in 2005.
60. The involvement of the network would also ensure the establishment of a process by which the minimum training requirements are reviewed on an ongoing basis rather than the one-off exercise that the Green Paper suggests. This will be essential to establish and maintain confidence in the mutual recognition system in the future.

61. We question the added value of the third phase outlined in the Green Paper. We are not convinced that incorporating the voluntary European Credit Transfer and Accumulation System (ECTS) in the Directive would facilitate automatic recognition, when there is little evidence that the system is being used by medical schools and training providers.

62. In this context, we await with interest the outcome of the *Study evaluating the Professional Qualifications Directive against recent educational reforms in EU member states* which GHK Consulting is currently undertaking for the European Commission.

**Question 15: Once professionals seek establishment in a Member State other than that in which they acquired their qualifications, they should demonstrate to the host Member State that they have the right to exercise their profession in the home Member State. This principle applies in the case of temporary mobility. Should it be extended to cases where a professional wishes to establish himself? (Please give specific arguments for or against this approach.) Is there a need for the Directive to address the question of continuing professional development more extensively?**

63. We are concerned that the Directive, as it currently stands, does not allow competent authorities to assure themselves that migrant doctors have kept their skills and competence up to date since the award of their qualification. In some cases we have had to register migrating doctors who have not practised for many years since qualifying. This weakens the level of confidence that competent authorities can have in the skills and knowledge of incoming doctors and the automatic recognition system itself.

64. We support the suggestion in the Green Paper that a doctor needs to be established to benefit from automatic recognition. However, establishment alone does not provide any evidence about the continuous competence of a medical professional. We believe that the host competent authority needs stronger assurances that an incoming professional has kept their skills and knowledge up to date.

65. We agree that the Directive should not impose minimum continuous professional development or revalidation criteria. It is important that member states retain the required flexibility to develop systems that best suit their national requirements.

66. Instead, we believe that the Directive should link automatic recognition with a requirement to demonstrate up to date knowledge and skills. Proof of continuing competence could be provided in a number of ways. For example, through a certificate issued by the competent authority of establishment, if a mandatory scheme exists, or through proof of relevant and satisfactory training and employment issued by an employer.

67. The GMC plans to introduce a system of 'revalidation' by which doctors will need to demonstrate periodically (usually every five years) that they are up to date and fit to practise in order to maintain their licence. We anticipate that the new

arrangements will come into force towards the end of 2012. Once in place, a doctor migrating from the UK will be able to demonstrate their continuing competency and thereby their entitlement to the automatic recognition of their qualification.

68. Where a professional cannot provide proof of continuous competence, competent authorities should have the discretion to assess applicants under general systems and, if appropriate, apply compensation measures.

69. We understand that the Commission is concerned that requiring proof of continuing competence might be premature given that not all member states have mandatory systems in place. However, the process does not need to be burdensome and would increase trust and confidence in the mutual recognition system.

**Question 16: Would you support clarifying the minimum training requirements for doctors, nurses and midwives to state that the conditions relating to the minimum years of training and the minimum hours of training apply cumulatively? (Please give specific arguments for or against this approach.)**

70. We would like to emphasise that the requirements of basic medical training are already clearly set out in Article 24 of the Directive and provide for years and hours of study to be considered as alternatives. We also believe that the reference to the duration of basic medical training in Article 25<sup>8</sup> should be made consistent with Article 24.

71. Several member states, including the UK, have already established intensive graduate-entry programmes which are compliant with the current Directive. Any attempts to change this definition will unnecessarily constrain member states in the development of their medical education and training in line with their healthcare needs and requirements.

72. Graduate-entry programmes play a key role in addressing shortages of medical professionals. This, we note, is one of the key aims identified by the European Commission for the review of Directive. They also have additional social benefits including enabling a more diverse medical student population and older and more mature individuals to pursue medicine as a second career.

73. All graduate entry courses in the UK have been quality assured by the GMC and meet the standards in *Tomorrow's Doctors*. Furthermore, a number of studies<sup>9</sup> have confirmed that graduate entry programmes are as robust as school leaver programmes.

74. With this in mind, we suggest that, instead of amending the Directive, an appropriate national body in each member state should be made responsible for

<sup>8</sup> Article 25.1: "Admission to specialist medical training shall be contingent upon completion and validation of six years of study as part of a training programme referred to in Article 24 in the course of which the trainee has acquired the relevant knowledge of basic medicine."

<sup>9</sup> [Comparing the performance of graduate-entry and school-leaver medical students](#), Medical Education, Volume 44, Issue 7 (June 2010); [Graduate entry to medical school? Testing some assumptions](#), Medical Education, Volume 38, Issue 7 (July 2010); [Preparedness for hospital practice amongst graduates of a problem-based, graduate-entry medical programme](#), The Medical Journal of Australia (2003).

confirming that the training fulfils the Directive's minimum training requirements. The Commission should also require member states to make quality assurance reports available on a regular basis. This approach would provide better assurances about the quality of training programmes across the EEA without undermining member states' flexibility.

**Question 17: Do you agree that Member States should make notifications as soon as a new program of education and training is approved? Would you support an obligation for Member States to submit a report to the Commission on the compliance of each programme of education and training leading to the acquisition of a title notified to the Commission with the Directive? Should Member States designate a national compliance function for this purpose? (Please give specific arguments for or against this approach.)**

75. We welcome the Green Paper's suggestion to improve the notification system for the inclusion of new diplomas in the Annexes of the Directive. We also support the proposal for a compliancy report to accompany new notifications to ensure that amended qualifications continue to meet the minimum training requirements.

76. In the absence of learning outcomes, it might be challenging for competent authorities to assess whether a new or amended qualification meets the requirements in the Directive. For the process to be meaningful, we suggest that an appropriate national body should highlight any substantive amendments in the content and delivery of the programme when communicating a title change to the Commission.

77. In addition, before qualifications are included in the Annexes, competent authorities in all the member states should be provided with detailed information about the qualifications that they will be required to recognise in the future.

**Question 18: Do you agree that the threshold of the minimum number of Member States where the medical speciality exists should be lowered from two-fifths to one-third? (Please give specific arguments for or against this approach.)**

78. We do not believe it would be appropriate to lower the threshold of the minimum number of member states required to extend automatic recognition.

79. The current process by which new specialties are added to the Annexes in the Directive lacks transparency and credibility (see answer to question 17). It is unclear whether specialist qualifications are considered for inclusion on the basis of patient benefit and need and whether they undergo an objective assessment to establish content comparability. Until the process becomes more transparent and is based on genuine equivalency of qualifications and objective criteria for inclusion, automatic recognition should not be extended to new specialties and the threshold should not be lowered.

80. It should also be noted that the current Directive does not preclude member states from agreeing to recognise new specialties automatically between

themselves<sup>10</sup>. As a result, we do not see the current threshold as a significant barrier to a smaller number of member states agreeing to recognise each other's qualifications.

**Question 19: Do you agree that the modernisation of the Directive could be an opportunity for Member States for granting partial exemptions if part of the training has been already completed in the context of another specialist training programme? If yes, are there any conditions that should be fulfilled in order to benefit from a partial exemption? (Please give specific arguments for or against this approach.)**

81. We agree that enabling greater flexibility between specialties is an important and complex area of work, and one that the UK is seeking to address<sup>11</sup>. We would also like to highlight the work carried out by the UK Academy of Medical Royal Colleges on a set of common competences<sup>12</sup> for all specialty training including the training of GPs. These have been incorporated within each of the specialty curricula and assessment systems approved by the GMC. They cover core non-technical skills and knowledge, such as communication.

82. The focus of the existing Directive is the recognition of qualifications rather than periods of training. Any departure from this principle has the potential to undermine the conditions for automatic recognition, unless it is carefully considered. We believe that the general system already provides an effective route for migrating professionals to have periods of training and experience taken into consideration.

83. We therefore believe that the recognition of prior learning in specialist training should take place at the national level to ensure that it reflects medical practice in individual countries, and should not be included in the Directive.

**Question 24: Do you consider it necessary to make adjustments to the treatment of EU citizens holding third country qualifications under the Directive, for example by reducing the three years rule in Article 3 (3)? Would you welcome such adjustment also for third country nationals, including those falling under the European Neighbourhood Policy, who benefit from an equal treatment clause under relevant European legislation? (Please give specific arguments for or against this approach.)**

84. We do not believe that the adjustments suggested by the Green Paper are necessary. Further simplification of the current regime for EEA citizens, and third country nationals, with third country qualifications would undermine the robust checks we have in place for international medical graduates, which ensure that only those professionals that are safe and fit to practise gain access to the GMC register.

<sup>10</sup> Recital 20: "This Directive does not prevent member states from agreeing amongst themselves on automatic recognition for certain medical and dental specialties common to them but not automatically recognised within the meaning of this Directive, according to their own rules".

<sup>11</sup> The *Broad Based Framework* project aims to explore the feasibility of a two-year training route which will give trainees exposure to four specialties with similar attributes (general practice, psychiatry, paediatrics, and general medicine). It will develop doctors with a broad experience base and offer the potential to enter training for any of the four specialties.

<sup>12</sup> The [Common Competencies Framework](#) for doctors identifies the common competences that should be acquired by doctors in core and specialty training in the UK.

85. Competent authorities should not be required automatically to recognise EEA nationals with third country qualifications that have already gained recognition in an EEA country. The experience reports submitted by medical competent authorities show that some member states do not respect the Directive's minimum training requirements when they recognise third country qualifications. Until mechanisms are put in place to address these practices, it is essential that EEA nationals with third country qualifications continue to be considered under the general system.

86. We do not support the proposal to reduce the number of years of professional experience required for an EEA national with a third country qualification to benefit from recognition in another member state. This condition is essential to prevent professionals from 'forum-shopping' to circumvent the more stringent UK entry requirements for international medical graduates. It might also make it harder for a competent authority to assess the application and might lead to an increase in compensation measures.

87. Instead, we would encourage the Commission to define more clearly the requirement of "three years professional experience" under Article 3.3. The definition is open to interpretation and may allow for minimal experience or experience that is confined to highly restricted forms of practice. We would also welcome further provisions to enable competent authorities to satisfy themselves that the professional experience has been completed satisfactorily.

If you require further information about this paper, please contact us by email: [gmc@gmc-uk.org](mailto:gmc@gmc-uk.org) or tel. 0161 923 6602.