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**GMC response**  
**Public Consultation on the Recognition of Professional Qualifications**  
**Directive**  
**March 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 239,300 doctors on the UK Medical Register. 23,033 (9.6%) of these doctors qualified in other parts of the European Economic Area.
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. The GMC believes 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 understand 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. Recent events in the UK have highlighted some of the regulatory gaps that have the potential to harm patients and undermine confidence in both the single market in general and healthcare in particular. In an environment where health professionals and patients are encouraged to move across member states a risk to patient safety in one member state can be a risk in another. It is therefore essential that EEA doctors, exercising their rights of free movement, are only granted recognition when they are known to be appropriately qualified and fit and safe to practise.

6. The GMC welcomes the opportunity to respond to the consultation, which should be considered alongside our experience report submitted in September 2010. Our response stresses the need for further clarity on the specific measures the EC is likely to bring forward in a revised Directive and assurances that the review will safeguard the public interest.

**Question 1: Do you have any suggestions for further improving citizen's access to information on the recognition processes for their professional qualification in another Member State?**

**Question 2: Do you have any suggestions for the simplification of the current recognition procedures? If so, please provide suggestions with supporting evidence.**

7. We understand the European Commission's drive to simplify the procedure for professionals wishing to move across Europe and having their qualifications recognised. We fully agree that there are advantages in having a system that allows the full exploitation of labour mobility to match demand and supply of professionals who are up to date and fit to practise. However, the desire to simplify the system should not be at the expense of patient safety. In the case of medical professionals, it is essential that doctors registered with the GMC are fit and safe to practise.

8. The high levels of EEA practitioners coming to practise in the UK, suggest that UK medical registration procedures, as currently defined, do not represent an obstacle to the movement of doctors to the UK. Furthermore data that we collect from our registrants suggests that EEA doctors do not have difficulty dealing with the registration process. An independent poll commissioned by the GMC from Ipsos MORI found that in over 80% of cases applicants are satisfied with our registration process.

9. This does not mean there is no room for improvement. Feedback we have received suggests that there is confusion among doctors over whether particular specialties are recognised for mutual recognition. This is an area that could benefit from further guidance. The development of the *User Guide* and the service provided by *National Contact Points* are a step in the right direction, but specific information for doctors explaining why some qualifications are not listed in the Directive would be welcome.

10. Further simplification and clarity for professionals and patients could be achieved by developing a legislative instrument dedicated solely to the mobility of healthcare professionals. This, in our view, would better take into account the distinct nature of healthcare provision and ensure appropriate patient safeguards across Europe.

**Question 3: Should the Code of Conduct become enforceable? Is there a need to amend the contents of the Code of Conduct? Please specify and provide the reasons for your suggestions.**

11. As we indicated in our experience report, we have serious concerns about the *Code of Conduct* as adopted by the European Coordinating Group in April 2010, and

would not wish for it to be included in the Directive. The Code prevents competent authorities from requiring original and officially translated copies of documentation and from requesting doctors to verify their identity. Given the risk to patients and the public that would inevitably arise from a fraudulent recognition and registration<sup>1</sup>, we believe that special provisions should be made for healthcare professionals to support Recital 6 in the Directive which states that: “The facilitation of service provision has to be ensured in the context of strict respect for public health and safety and consumer protection”.

12. Basic checks on the qualifications and documents that are submitted to us in our view do not impose any unnecessary barrier to free movement upon applicants, who are appropriately qualified and fit to practise, and are essential in the prevention of fraud and identity theft.

13. In the context of simplification, we would call on the Commission to incorporate the Certificate of Current Professional Status<sup>2</sup> (CCPS), also known as the Certificate of Good Standing, to the documents listed in Annex VII.

14. We understand that the certificate is already widely used by competent authorities for healthcare professionals both within<sup>3</sup> and outside<sup>4</sup> the EEA. The inclusion of the certificate in the Directive has the potential to contribute to greater consistency of registration and disciplinary information exchange between competent authorities, at the point of registration, for healthcare professions providing cross-border healthcare. It also contributes to patient safety in Europe by providing some assurance for regulators that individuals are fit, competent and safe to practise when they seek registration in another European country. We would also encourage the Commission to develop the Internal Market Information (IMI) system to enable competent authorities to exchange the certificates securely through IMI.

15. We note the comparison in the consultation document between the role of the *Contact Points* as defined by the recognition Directive and the *Points of Single Contact* under the Services Directive. The reference seems to imply that the Commission is keen to move to a position where the *Contact Points* would orchestrate all the procedures, formalities and applications that a professional may need to complete, liaising, as necessary, with regulators in the host member state.

<sup>1</sup> As indicated in the GMC experience report, we have several examples of applicants presenting documentation that have been issued erroneously or without due care by recognition bodies both within and outside the EEA. We have also experienced a number of cases of fraud and identity theft.

<sup>2</sup> See Agreement One and Annex 2 of the [Edinburgh Agreement](#). The template for the certificate was developed and adopted by the Healthcare Professionals Crossing Borders (HPCB) initiative in 2005 in collaboration with the Alliance of UK Healthcare Regulators on Europe (AURE), the Standing Committee of European Doctors (CPME), the Conférence Européen des Ordres des Médecins (CEOM), the European Council of Nursing Regulators (FEPI), the Pharmaceutical Group of the European Union (PGEU), the Council of European Dentists (formerly EU Dental Liaison Committee), the European Council of the Liberal Professions (CEPLIS), and the Standing Committee of Nurses of the EU (PCN).

<sup>3</sup> Informal research carried out by the Danish coordinator for the Directive in July shows that the certificate is in use for healthcare professionals in at least 14 EEA countries. Not all EEA countries responded.

<sup>4</sup> The International Association of Medical Regulatory Authorities (IAMRA) has also adopted a template for certificate at its conference in September 2010. This is consistent with the European CCPS. See: <http://www.iamra.com/pdf/resolution-10-2.pdf>

The GMC is concerned that operating as an intermediary in this way, the *Contact Point*, is likely to become an additional tier of bureaucracy between the professional and the GMC potentially creating unnecessary delays and misunderstandings which would ultimately not benefit the professional wishing to move.

**Question 4: Do you have any experience of compensation measures? Do you consider that they could have a deterrent effect, for example as regards the three years duration of an adaptation period?**

16. The GMC has not had any cases of applicants requiring compensation measures for basic medicine. For those applicants undergoing a general systems assessment for specialist or GP recognition, any recommendations made for an adaptation period are very specific and provided in line with the requirements of the relevant curriculum. At the end of our assessment, we provide a clear recommendation to the applicant, the time in which we expect it can be achieved, as well as suggesting what evidence can be provided to the GMC to demonstrate that the requirements have been fulfilled.

17. Article 14.1 in the Directive allows member states to require applicants to complete adaptation periods of up to three years. While general systems applications are rare for doctors, we do believe that competent authorities should continue to be able to exercise discretion in relation to the length of time needed for a doctor to reach the necessary skills and knowledge to reach the standard<sup>5</sup> as defined in the Directive. We note the Commission's suggestion that a three-year compensation measure could represent a deterrent to mobility, however we believe that the primary consideration in these cases should be the right of patients and the public to receive safe and high quality care and that, if required, competent authorities like the GMC should have the option to recommend an adaptation period of a maximum of three years. Furthermore, in the UK, the imposition of an adaptation period to gain specialist or GP recognition would not stop doctors with a recognised primary medical qualification from gaining registration and a licence to practise in the UK.

18. We therefore believe that the three-year threshold should be maintained to allow flexibility in this area and to enable doctors to achieve the skills, knowledge and competencies necessary for safe and high quality practice. Furthermore, we believe that the undertaking of any adaptation period, which in the UK is embedded within the National Health Service, will support free movement. It will ensure that migrants can practise at the same level as their counterparts and increase their employment opportunities within the UK.

**Question 5: Do you support the idea of developing Europe-wide codes of conduct on aptitude tests or adaptation periods?**

19. We agree with the Commission's assessment that devising adaptation periods and/or aptitude tests can be demanding and resource intensive for the host member state. However, we are concerned that a code of conduct in this area may unnecessarily constrain our ability to devise compensation measures suitable to the specific circumstances of professionals not meeting the standards of training

<sup>5</sup> A Certificate of Completion of Training (CCT) in the UK.

required in the UK. We believe it would be advisable to allow for a degree of flexibility in each individual case that might be lost through the imposition of a European-wide code. Instead, we would like to see greater sharing of good practice through the existing networks of competent authorities or through an online forum developed for this purpose.

**Question 6: Do you see a need to include the case-law on “partial access” into the Directive? Under what conditions could a professional who received "partial access" acquire full access?**

20. As indicated by the European Court of Justice (ECJ) judgment, we firmly believe that medical professionals should be exempt from the principle of ‘partial access’. Allowing a migrant that is not fully qualified to practise as a doctor in a limited capacity could be a serious risk to patients.

21. 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.

22. 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, the principle may lead to unequal treatment between individuals in training in the UK and migrants. This is helpfully reflected in the 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>6</sup>.

**Question 7: Do you consider it important to facilitate mobility for graduates who are not yet fully qualified professionals and who seek access to a remunerated traineeship or supervised practice in another Member State? Do you have any suggestions? Please be specific in your reasons.**

**Question 8: How should the home Member State proceed in case the professional wishes to return after a supervised practice in another Member State? Please be specific in your reasons.**

23. We understand the European Commission’s desire to facilitate the mobility of graduates across Europe. It would be essential that only those that are at a comparable level of their training can gain access to education and training in another member state, but the mechanisms to determine such comparability do not yet exist and are dependent on moving towards a more outcome/competency based approach (see our response to questions 22-24). 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.

<sup>6</sup> ECJ judgment of 10 December 2009, C345/08, Pesla, paragraph 50.

**Question 11: What are your views about the objectives of a European professional card? Should such a card speed up the recognition process? Should it increase transparency for consumers and employers? Should it enhance confidence and forge closer cooperation between a home and a host Member State?**

**Question 12: Do you agree with the proposed features of the card?**

**Question 13: What information would be essential on the card? How could a timely update of such information be organised?**

**Question 14: Do you think that the title professional card is appropriate? Would the title professional passport, with its connotation of mobility, be more appropriate?**

24. The consultation refers to the possible introduction at European level of professional identity cards. At first sight this appears to offer the prospect of a useful tool to facilitate the free movement of doctors throughout the EEA. On examination though, the card brings significant risks.

25. The GMC believes that there must be clarity about the problems that such a card seeks to solve. In recent years, various aims for a proposed card have been stated, such as the harmonisation of existing card-based record/identification systems, the facilitation of exchange of information between regulators, the identification of healthcare professionals for employers and the facilitation of temporary and occasional mobility.

26. A card that serves only as a basic photo identity card, rather than a secure chip card containing electronically readable data, is open to fraud and forgery and could present a serious risk to patient safety. As we continue to see certificates and documents that have been issued erroneously and without due care by some competent authorities in other EEA countries, we have severe concerns about the card being used as the sole source of information on which to base the recognition decision.

27. While the card could in principle store further information we believe that the IMI system already provides a cost effective tool for the secure information exchange between competent authorities without some of the risks of a card system. We therefore believe that resources should be better targeted at improving IMI.

28. A professional card containing microchip-based data would need to be able to operate across all regulatory jurisdictions of the EEA. Information would need to be uploaded effectively and efficiently on the card and would need to be readable in a format and language that is accessible and understandable to every competent authority. As some professionals will be simultaneously registered in more than one jurisdiction it would also need to be usable by more than one competent authority concurrently. This is to ensure a complete record of the professional is provided and to avoid the risk that professionals only use their 'clean' card to obtain registration as a basis from which to secure employment. Any card system would also need to

minimise the risks that could arise through the loss of cards and consider the costs of any replacements.

29. The information being suggested as the basis of the European professional card is already held by competent authorities. Any additional source of this data presents a level of duplication and an additional regulatory burden. We believe it could become a disproportionate and costly response to the challenge of effective information exchange between competent authorities as well as an additional bureaucratic hurdle for migrating professionals.

30. In the short term we believe efforts would be better focused on supporting competent authorities to share information directly and more effectively and enabling them to make the information they hold publicly available.

31. For example, the GMC makes a web-based searchable list of registration and disciplinary information freely and securely available. In the UK this not only supports the information 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 European level cooperation to promote similar publicly available web-based information to competent authorities, patients and employers.

32. The GMC will continue to consider the implications of a professional card but remains cautious about its introduction at European level on the basis of proportionality, patient safety and costs.

33. Before a decision is taken on whether the introduction of a card is desirable and achievable we would urge the Commission to carry out an independent impact assessment to establish the practical, economic, financial, social, geographic, and public safety aspects of any card proposal. This should consider the following questions:

- a. The purpose of a card and whether it is the most appropriate and proportionate solution to facilitate mobility?
- b. Whether and how the card could speed up the recognition process?
- c. Whether and how it would increase transparency for competent authorities?
- d. Whether and how it would enhance confidence and forge closer cooperation?

**Question 15: What are your views about introducing the concept of a European curriculum – a kind of 28th regime applicable in addition to national requirements? What conditions could be foreseen for its development?**

34. Although it is unclear whether this question applies to the sectoral professions, we urge the Commission to proceed with caution and consider the following areas in relation to the development of European curricula. At the outset, it

would be essential to establish which organisations should be responsible for the development of European curricula and European training programmes and ensure that competent authorities, professions, and educational bodies (such as royal colleges in the UK) are involved in this work. We would also call on the Commission to consider how these curricula would be implemented across member states in light of differing health delivery systems and health needs of the population; and to establish the training methods and the content, level and structure of courses that would eventually lead to the award of European qualifications in line with any European curricula. There would also need to be clear mechanisms, with legal status, to ensure European curricula are developed appropriately and updated regularly. Any European training programmes would also need to be quality assured to provide confidence to the professionals, the public, competent authorities and national health services.

**Question 16: To what extent is there a risk of fragmenting markets through excessive numbers of regulated professions? Please give illustrative examples for sectors which get more and more fragmented.**

35. At present there is wide diversity of regulators and competent authorities comprising a range of structures, approaches, and emphases. Some are government bodies, some are self-regulatory, and others are professional associations with a regulatory function as part of a wider role. This diversity reflects the conventions and history of regulation in each member state.

36. We believe that a harmonised model would be neither beneficial nor desirable. Each approach, is arguably, appropriate to each individual jurisdiction and is a member state competence. We do believe that public and patient protection should be at the heart of all regulatory approaches.

37. We would however like to see greater clarity over main contact points, particularly in federal jurisdictions, where there is more than one organisation holding information about a health and social care professional's registration history. Confusion and complex organisational relationships and structures make the process of information sharing between member states, and even within member states, time consuming and may not always result in a responsive and effective regulatory approach.

38. We feel that the Commission has a role to play in encouraging clarity of regulatory structures to facilitate the free movement of regulated professionals while ensuring that competent authorities share information and communicate in a timely and effective way. Initiatives like IMI, the informal networks of competent authorities and Healthcare Professionals Crossing Borders, have already helped our understanding of how medical regulation is defined and organised in other countries and we hope the Commission will continue to encourage these activities.

**Question 17: Should lighter regimes for professionals be developed who accompany consumers to another Member State?**

**Question 18: How could the current declaration regime be simplified, in order to reduce unnecessary burdens? Is it necessary to require a declaration where**

**the essential part of the services is provided online without declaration? Is it necessary to clarify the terms “temporary or occasional” or should the conditions for professionals to seek recognition of qualifications on a permanent basis be simplified?**

**Question 19: Is there a need for retaining a pro-forma registration system?**

**Question 20: Should Member States reduce the current scope for prior checks of qualifications and accordingly the scope for derogating from the declaration regime?**

39. 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. It is therefore essential that doctors coming to work for a short time are required to provide the same information as other applicants. This will ensure that public confidence in the provision of health services is not undermined. In this context we believe that it is essential for us to require pro-forma registration supported by a prior and annual declaration system and adequate checks to protect patient safety.

40. We also call on the Commission to maintain the prior authorisation schemes for medical professionals laid out in Article 7.4. We strongly refute the suggestion that a prior declaration alone would adequately protect patient safety. We view the provisions in this article essential for the maintenance of public confidence in the regulation of the medical profession. It is also essential to retain the annual declaration to be able to assess accurately whether an applicant has become established or continues to provide temporary and occasional services.

41. In this context, we call on the Commission to ensure that the regulation of the medical profession is not undermined by a revised e-commerce Directive and any developments in relation to telemedicine. It is essential that patients across Europe are adequately protected and that regulators can assure themselves that the doctors they register are fit and safe to practise and to ensure that if there is a problem with the care, conduct, or competence of a visiting practitioner, the competent authority is able to take action.

**Question 22: Do you see a need to modernise the minimum training requirements? Should these requirements also include a limited set of competences? If so what kind of competences should be considered?**

**Question 23: Should a Member State be obliged to be more transparent and to provide more information to the other Member States about future qualifications which benefit from automatic recognition?**

**Question 24: Should the current scheme for notifying new diplomas be overhauled? Should such notifications be made at a much earlier stage? Please be specific in your reasons.**

42. 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 to ensure that it is modernised to reflect current practice in medical education and training.

43. The mutual recognition of professional qualifications assumes comparability of medical education across the EEA. It is on the basis of medical qualifications that are deemed to have met certain minimum standards, that doctors can exercise their right of free movement within the EEA. The minimum times for training set out in the Directive are useful, but the lack of overall consistency of approach between member states means that the level of assurance that states can draw from the training obtained by migrants is limited.

44. The specific requirements of article 24.3 of the Directive remain relevant and up to date. However, in many respects they are so broadly drawn and general that they are of limited practical value in providing assurance about the standards of medical education and training that have been undertaken by migrant doctors and their preparedness to practise in the host country. At the same time, the focus on time served rather than the outcomes of training has imposed constraints which have impeded us in developing undergraduate medical education in line with the UK's needs. This is not helped by the fact that although the Directive is quite clear that training should comprise 5,500 hours or six years' training, there have been attempts to impose a much more restrictive interpretation on what the Directive requires.

45. There is a lack of any information about the nature and content of medical training, and of the skills, knowledge, and competencies required of trained doctors in other member states. Without this information it is not possible for competent authorities to be assured of the quality of education elsewhere. This is compounded by the general nature of the standards on curriculum content and delivery required in the Directive, and the lack of information about how those standards are quality assured. In addition, comparability is largely based on length of training rather than training content or the range of competencies that medical education develops. The overall result is that competent authorities cannot have full confidence in each other's medical training and education.

46. In addition, the scope of medical practice can differ between member states. What is a routine treatment or procedure for a General Practitioner in the UK, for example, may not be within the normal scope of a doctor trained from another EEA country. Moreover, in some member states graduates may have strong theoretical training but less clinical experience than is deemed desirable in other countries. Healthcare systems and structures also differ substantially across Europe. In the NHS, for example, we have a 'consultant led' system which is reflected in the training that doctors undertake. We also have a specific on call system which means our doctors have to know the generality of a specialty. We understand that this not necessarily common in the rest of Europe and gives rise to a patient safety risk where the expectations placed upon a doctor working in one jurisdiction, but trained in another, are not met.

47. In our view, the abolition of the Advisory Committee on Medical Training (ACMT), when the Directive was revised in 2005, has led to a situation where there is currently no European forum for the co-ordination of training and no satisfactory

route by which the formal views of competent authorities can be made available to the Commission.

48. We believe there is a need for an urgent audit of basic and specialist medical qualifications in Europe as a means of identifying and confirming 'content comparability'. The findings should be used as a basis from which to develop the minimum training requirements. These should be developed in terms of learning outcomes rather than inputs (hours and length of study).

49. In this context we would like to highlight the work carried out by the UK Academy of Medical Royal Colleges on a set of common competences 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.

50. We would also support a better notification system for the inclusion of new diplomas in the Annexes of the Directive to ensure that doctors do not experience unnecessary delays in the recognition process. In this context, we urge the Commission to consider a system whereby automatic recognition criteria are periodically reviewed to ensure that they keep up with developments in the field of medical education.

51. We welcome the suggestion that there should be further transparency on the content of medical education and training across Europe and encourage the Commission to invite competent authorities to contribute to discussions on minimum training requirements.

**Question 27: Do you see a need for taking more account of continuing professional development at EU level? If yes, how could this need be reflected in the Directive?**

52. The GMC is working on plans to change the way doctors in the UK are regulated to practise medicine. All doctors in the UK are required by law to hold a licence to practise if they wish to undertake certain activities, for example holding certain posts, prescribing medicines and signing statutory certificates. In future, licences to practise will require periodic renewal (referred to as 'revalidation'). This means doctors must undertake the periodic renewal of their licence by demonstrating that they continue to be up to date and fit to practise. We anticipate that the new arrangements will come into force in late 2012.

53. To revalidate, doctors will need to collect evidence about their practice which shows how they are complying with the professional standards set by the GMC. The information required will vary depending on the nature of the doctor's practice, but will include material such as audit data, outcome data, and evidence of participation in appropriate Continuing Professional Development (CPD).

54. We do not believe that revalidation should set prescriptive requirements for CPD in terms of structured packages of learning delivered by accredited providers. Our professional guidance, [Good Medical Practice](#) requires doctors to keep their 'knowledge and skills up to date' and 'regularly take part in educational activities that

maintain and further develop [their] competence and performance'. To support doctors and those appraising them we have identified core principles<sup>7</sup> that should guide doctors in their CPD activity.

55. The Directive as it currently stands does not allow competent authorities to assure themselves that the migrant doctors they register have kept their skills and competence up to date since the award of their professional qualifications. We do not consider that the Directive should impose minimum CPD or revalidation requirements of the kind used in relation to medical education and training for the purposes of mutual recognition. However, the inability of member states to obtain assurance of an individual's competence inevitably weakens the level of confidence that competent authorities can have in the competence of doctors entering the host state.

56. In this context we welcome the focus in the consultation on the requirements on doctors to maintain and improve their knowledge and skills throughout their careers. Member states have been and/or are developing systems that best suit their national requirements. To this end we urge the Commission to refer more generally to competence assurance mechanisms as a wider term that encompasses schemes such as CPD and revalidation. We also welcome the Commission's suggestions that only those doctors that have satisfied the competence assurance requirements in the home member states should be eligible for automatic recognition in the host member state.

**Question 28: Would the extension of IMI to the professions outside the scope of the Services Directive create more confidence between Member States? Should the extension of the mandatory use of IMI include a proactive alert mechanism for cases where such a mechanism currently does not apply, notably health professions?**

**Question 29: In which cases should an alert obligation be triggered?**

57. It is essential that doctors and healthcare professionals, exercising their rights of free movement, are only granted and maintain registration when they are known to be fit and safe to practise and have no conditions or limitations on their registration. Patient safety and our knowledge of a doctors' fitness to practise relies on other competent authorities sharing this information. If information is not shared a doctor could be disciplined or suspended in one jurisdiction while continuing to practise in another thereby posing a serious risk to patient safety.

58. We believe that an 'alert mechanism' for healthcare professionals, which was recently supported in the European Parliament report on [Reducing health inequalities](#)<sup>8</sup>, is essential to maintain confidence in the recognition system and to maintain public safety. We understand that such a mechanism is already provided for in the Services Directive (2006/123/EC) through IMI. This requires member states to inform their counterparts about any service activities that might cause serious damage to health or safety of persons or the environment. However, we understand

<sup>7</sup> To view the GMC's guidance on CPD, visit: [http://www.gmc-uk.org/education/continuing\\_professional\\_development/cpd\\_guidance.asp](http://www.gmc-uk.org/education/continuing_professional_development/cpd_guidance.asp)

<sup>8</sup> See paragraph 48 of the EP report.

that the strict pre-conditions required for its use, particularly those concerning data protection, have limited its impact.

59. A decision to trigger an alert should not be based on a judgment about whether the individual is likely to provide services in another member state, since the competent authority will not be in a position to make such an assessment or hold information on whether the professional is registered in more than one country. Therefore, it is essential that any proposal to adopt the 'alert mechanism' supports proactive information sharing with competent authorities in all member states.

60. 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 provides 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.

61. We would encourage the Commission to consider whether the alert mechanism could be used to support the exchange of intelligence about individuals that try to register with fake diplomas or false identities.

62. We invite the Commission to consider whether the work undertaken by HPCB through its [MoU on case-by-case and proactive information sharing](#) could form the basis of further dialogue on how best to define the alert mechanism and when it ought to be triggered.

63. We would also like to see further coherence between the priorities for a revised data protection Directive, the forthcoming regulation on IMI and the review of Directive 2005/36/EC. The right to protect personal data should not prevent competent authorities from sharing fitness to practise<sup>9</sup> information about healthcare professionals in line with Articles 7 and 13 of Directive 95/46/EC on the protection of individuals with regard to the processing of personal data and on the free movement of such data. These provisions are essential in the context of Directive 2005/36/EC. In short, to ensure patient protection free movement of professionals must be accompanied by free movement of information.

### **Question 30: Have you encountered any major problems with the current language regime as foreseen in the Directive?**

64. As indicated in the experience reports submitted by competent authorities in September 2010, there are concerns that the current language provisions in Article 53 are not sufficient to ensure adequate public protection.

<sup>9</sup> Fitness to practise is the process by which concerns raised about a registered health professional's conduct, competence, physical or mental health, or criminal record, are investigated by a competent authority/regulator. This may lead to a health professional being prevented from practising or restrictions being placed on their practise in order to protect the public.

65. It is unclear whether article 53 enables competent authorities to assess the level of language proficiency of migrants at the point of registration. It remains our view that the ability of the professional to communicate effectively in the language of the host member state should be a prerequisite for registration and that we should be able to assess the knowledge of language where appropriate. We understand that a test may be applied in cases of doubt – as long as it is proportionate, appropriate, and not systematic.

66. Currently, EEA applicants to the GMC register do not need to pass a language assessment even in cases where there is doubt. We have recent examples of EEA doctors seeking recognition and registration with the GMC who are not able to communicate in English and were assisted by an interpreter. This is a serious cause of concern to us.

67. We also have examples of fitness to practise cases brought before the GMC where the lack of English language competence has been identified as a concern. These suggest that it is not always sufficient for employers to assess the language competence of EEA trained doctors.

a. Dr A was erased after the Panel found that during surgery they did not communicate effectively with colleagues. The doctor was apparently speaking in a foreign language and the assistant surgeon was unsure what assistance was required. The Panel concluded that communication with colleagues is an important part of medical practice and that it is unacceptable that Dr A's colleagues in the theatre were left not knowing what actions needed to be taken. According to the Panel Dr A's acts and omissions during the surgery were inappropriate and not of a standard expected of a registered medical practitioner.

b. Dr B was suspended for 12 months. During the fitness to practise case the Panel was asked to take account of the fact that English was not their first language. It found proven that they had poor inter-personal, team-working and communication skills and recognised that difficulties with the English language could have contributed to their problems.

c. Dr C was suspended for 6 months. The Panel took into account the fact that they had only recently arrived in the UK, were clearly unfamiliar with the environment of a British hospital, and were not working in their first language. Nevertheless the Panel found that their communication skills were not at a level to be expected of a registered medical practitioner.

d. In the case of Dr D the Panel imposed conditions for 12 months. It noted that the doctor's language is not English and agreed that an important component of their failings was due to communication.

e. Dr E received a warning after the Panel took into account that English is the doctor's second language and asked them to address a number of issues including their communications skills.

68. We believe that medical and other healthcare professionals differ significantly from other professions. The combination of vulnerable or potentially incapacitated patients, the sensitive and personal nature of healthcare, and the often immediate and emergency nature of care all impact on the choices and decisions patients make at the point of care. The mixture of private and public provision of healthcare is also an important consideration. Patients need to be assured that all healthcare professionals, regardless of the circumstance in which they are consulted (e.g. employed by the NHS, working independently in private practice) not only have the technical skill and competence to provide high quality care, but the ability to communicate with patients, their colleagues and the wider healthcare team in often high pressured environments.

69. We view the Commission as having a key role to play in ensuring that competent authorities are able to satisfy themselves about the language proficiency of migrant professionals at the point of registration. This as a regulatory matter with patient safety at its core.

70. We believe that the language provisions for doctors in the Directive should be strengthened to ensure that competent authorities are allowed to confirm the applicant has sufficient knowledge of language before registration. We call on the Commission to include a derogation in the Directive that would ensure that healthcare professional regulators like the GMC can assess the language knowledge of doctors in a proportionate manner as part of the registration process.

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