Executive Summary

1 The General Medical Council (GMC) is an independent organisation that helps to protect patients and improve medical education and practice across the UK.

- We decide which doctors are qualified to work here and we oversee UK medical education and training
- We set the standards that doctors need to follow, and make sure that they continue to meet these standards throughout their careers
- We take action to prevent a doctor from putting the safety of patients, or the public's confidence in doctors, at risk.

2 In this submission we highlight issues linked to our view that patient safety in the context of the mobility of health professionals within Europe should be included as a priority for the EU and for the UK Government’s vision for the future of the EU.

3 We believe that European legislation, particularly that governing the movement of healthcare professionals, should give greater priority to patient protection, while continuing to facilitate professional mobility. With doctors now apparently the most mobile profession in Europe, we believe this issue has increased resonance and relevance.

4 We would therefore wish the Government to consider whether any or all of these issues might be usefully included in the negotiations around the UK’s role in the European Union – we are not seeking better terms for the UK than other member states, but we believe reform in this area would result in better protection for all Europe’s patients.

5 Every patient should receive a high standard of care. Our role is to help achieve that by working closely with doctors, their employers and patients, to make sure that the trust patients have in their doctors is fully justified.
We are calling for patient safety, in the context of the mobility of health professionals within Europe, to be included for the UK Government’s vision for the future of the EU

As part of this, we are calling for regulators to be able to refuse recognition, or impose additional measures, on doctors who have not practised medicine for a number of years before coming to the UK

It would be safer, fairer and more reassuring for the public for there to be a single standard for entry to the register that everyone can rely on. We are therefore developing a licensing assessment to create a straightforward and transparent route to medical practice in the UK. We would very much like to ensure that all new doctors joining the medical register meet this standard

We are calling for the provisions around temporary and occasional doctors to be tightened so that regulators across Europe can assure themselves that doctors coming to practise under this regime are safe and fit to practise

We are calling on the European Commission to undertake a full, independent assessment of the impact of the European professional card on nurses, pharmacists and physiotherapists in order to identify any patient safety concerns before it is extended to doctors.

Introduction

The principle of free movement of labour is fundamental to the EU and brings many benefits, including in medicine, and EEA doctors have made a considerable contribution to the NHS. But while the underlying principle of free movement has remained constant, the EEA has grown dramatically in size and diversity to its current composition of 32 countries. Medical migration within the EEA is now on an entirely different scale than when the UK became a member in the 1970s, and the economic downturn from 2008 has made the UK more attractive to doctors, particularly from eastern and southern Europe

There are currently more than 267,000 doctors on the UK Medical Register; more than 29,000 (11%) of them qualified in other parts of the European Economic Area. In 2014, we granted registration to just under 4,000 doctors who qualified in the EEA.

As patterns of migration have changed, so too has the practice of medicine. Modern medicine is not simply a question of technical skills: it is culturally and context specific, and it is high risk. In order to practise safely in another country, doctors need the requisite skills, knowledge and behaviours, as well as an appreciation of local social norms and patient expectations. In the UK context, doctors also need to understand the structure and ethos of the NHS.
It is important that European legislation keeps pace with both increased mobility and indeed the increasingly complex practise of medicine. We do not believe that has happened.

We have strong evidence that doctors from other European Economic Area (EEA) countries (and elsewhere in the world) can get into difficulty in the UK, reflected in complaints to us from the public, employers, healthcare professionals and bodies acting in a public capacity. But for EEA doctors – unlike doctors from elsewhere in the world – the recognition of professional qualifications Directive prevents us from assessing whether they have the right knowledge, skills and behaviours to practise safely in the UK.

Our view – which is shared by other medical regulators in other EEA countries - is that the Directive does not strike the right balance between patient safety and healthcare professional mobility. There needs to be greater priority given to patient protection. This is a view that we have consistently maintained but, with doctors now apparently the most mobile profession in Europe (in terms of establishing a practice in a member state other than the state in which they are fully qualified to practise), it is one that we feel has increased resonance and relevance.

**Concerns with current EU legislation**

In 1975, the so-called ‘Doctors Directive’ established minimum training requirements for primary medical and specialist qualifications. Doctors whose qualification met these minimum requirements were entitled to have them recognised in all EEA countries (the EU plus Norway, Iceland, Switzerland and Lichtenstein). The provisions were updated throughout the 1980s before being finally consolidated into the recognition of professional qualifications Directive (the Directive or RPQ), which was adopted in 2005. This Directive covers more than 800 regulated professions across Europe and was recently revised. The updated provisions come into effect in January 2016.

The Directive sets out obligations on member states to recognise the medical qualifications held by doctors from within the EEA and, as a consequence, doctors’ freedoms to establish themselves and provide services in another member state. It provides a legal definition of ‘basic medical training’, which is based on length of the training rather than the content or quality and stipulates recognition deadlines, documentation and language requirements associated with recognition.

For a limited number of professions (including doctors) the Directive allows for qualifications to be recognised automatically across the EEA. This means that the host state only has the ability to check whether or not the qualifications are in line with what is required under the Directive before granting ‘automatic recognition’. The GMC, with other UK health regulators, lobbied vocally against aspects of the proposed
Directive before 2005 including the concept, which was then novel, of ‘temporary and occasional’ registration.

15 The Directive is legally binding on the UK. In other words, the UK Government is required to implement the Directive by way of national legislation. In terms of doctors, amendments are made to the Medical Act to bring the Directive into force in the UK. Business, Innovation & Skills (BIS) is the lead UK government department in connection with the Directive, with the Department of Health (DH) overseeing the necessary changes to our – and other healthcare professional regulators – primary legislation.

The revised Directive

16 Amendments to the Directive were agreed by the European Commission in 2013 and will come into force in January 2016. Following an extensive engagement campaign with the UK Government, UK and European regulators, MEPs and the EU institutions, the GMC was successful in securing some important amendments to the Directive that helped to support high standards of medical education and training including:

- The introduction of a mandatory proactive fitness to practise alert mechanism among competent authorities;

- The introduction of the European professional card as an online certificate and not as a physical card as originally proposed and a decision not to apply the card to doctors in the first phase;

- A new definition of basic medical training which safeguards UK graduate entry programmes. This now stipulates that training should last 5 years AND 5,500 hours rather than the proposed 6 years AND 5,500 hours which would have made the current UK Graduate Entry Programmes non-compliant as they are counted as only 5 years - 4 years at university plus one year in the Foundation programme as a provisionally registered doctor

- Substantially stronger and clearer language checking powers for all health professions (in part reflecting the changes made to the Medical Act in 2014).

17 However, the revised Directive also introduced some new aspects which we contend raise serious concerns about patient safety. The most significant of these are outlined below.

Temporary and occasional services

18 The Directive allows doctors and other health professionals to come to the UK to provide ‘temporary and occasional’ services as long as they are established elsewhere in the EEA. The principle of temporary and occasional registration was originally introduced in 2005 but it is currently little used for doctors coming to the UK.
However, the revised Directive now requires that all such applications be accessible online from January 2016 which will make this option more visible to potential registrants from elsewhere in Europe. It is therefore possible we will see an increase in applications for temporary and occasional status.

19 The Directive prevents us from carrying out even basic checks on such doctors:

- A doctor is entitled to access the medical profession and treat patients simply by submitting a declaration of his or her intention to provide medical services together with certain other documents

- We cannot check that a doctor is safe to see patients (a limitation which applies to all EEA doctors benefiting from free movement, not just under the temporary and occasional’ provisions)

- We cannot require such doctors to take part in revalidation - an on-going demonstration, legislated by the UK Parliament, that they remain up to date and fit to practise – this includes an annual appraisal and a requirement to undertake Continuing Professional Development

- Although we can refuse to issue a licence to practise if a temporary and occasional doctor has not demonstrated the necessary knowledge of English, there is a ‘risk window’ in that, at the time that their entitlement to access the medical profession technically arises (on receipt of the declaration and supporting documents), we will not have had an opportunity to assess whether a doctor can speak English

- We are restricted in the way in which we can monitor such doctors

- We cannot charge a fee of any kind, which means that other doctors practising in the UK must bear the cost of regulation for this group.

20 The principle of temporary and occasional work is not new but is currently little used. It does have value if used appropriately – for example, by doctors providing medical services to national teams competing in sporting events such as the recent Rugby World Cup. However the mandatory introduction of an online application form from January 2016 will make this option more visible. Furthermore the introduction of the European professional card (see below) is likely to make the temporary and occasional regime easier to access and therefore more attractive.

21 We are calling for the provisions around temporary and occasional doctors to be tightened so that regulators across Europe can assure themselves that doctors coming to practise under this regime are safe and fit to practise.

The European professional card
The European professional card is intended to provide an online, faster method of recognition for professionals wishing to establish themselves in another member state or deliver professional services across borders on a temporary and occasional basis by issuing an electronic certificate.

It will apply to nurses, pharmacists and physiotherapists from January 2016 and is likely to come into force for doctors in 2018. It will mean that UK regulators will have:

- A limited role in issuing the authorisation to practise in the UK for those providing services on a temporary and occasional basis. This responsibility will pass on to the regulator in the home member state
- Limited power to turn down an application or challenge the authorisation decision made by another member state should any information be missing or give rise to concerns
- Strict time limits within which we should make our decisions, with tacit recognition of qualifications allowed where these time limits are not met.

We are calling on the European Commission to undertake a full, independent assessment of the impact of the card on nurses, pharmacists and physiotherapists in order to identify any patient safety concerns before it is extended to doctors.

Assuring migrating doctors are up to date

In addition, the Directive does not allow regulators to assure themselves that migrant healthcare professionals have kept their skills and competence up to date since the award of their qualification. EEA doctors have an entitlement to be registered regardless of recent practice or experience.

We are calling for regulators to be able to refuse recognition, or impose additional measures, on doctors who have not practised medicine for a number of years before coming to the UK.

Assumed equivalence of specialist training

Further, professional mobility rests mainly on assumed equivalence of specialist training curricula agreed in the 1970s. The equivalence is based on minimum training periods, rather than on curricula content or outcomes. This means that for the majority of EEA qualified doctors, we can have no evidence or assurance that they can practise safely – other than the qualifications that they hold as listed in the Directive and the Certificate of Current Professional Practice provided by their home regulator.

It would be safer, fairer and more reassuring for the public for there to be a single standard for entry to the register that everyone can rely on. We are therefore
developing a licensing assessment to create a straightforward and transparent route to medical practice in the UK. We would very much like to ensure that all new doctors joining the medical register at least meets this standard. We would encourage the UK Government to include commitments to this assessment in its future vision for the EU.

The UK Government’s vision for the EU

29 We believe that patient safety should be included as a priority for the EU and for the UK Government’s vision for the future of the EU.

30 As well as strengthening patient protection we believe this could increase the attractiveness of the UK health system and UK medical education to overseas applicant and therefore have a positive impact on economic and healthcare priorities.

31 We know that many UK and European regulators share our concerns and are likely to be supportive of attempts to protect patient safety in this area. We work closely with our medical regulatory counterparts across the UK and Europe and convene a bi-annual meeting of regulators to discuss developments in the rules governing professional mobility. Through this forum we have adopted policy positions on a wide range of patient safety concerns that are shared by regulators across Europe, such as the European professional card and its future application to doctors.

32 The principle of free movement of labour is fundamental to the EU and is highly unlikely to be unpicked while the UK remains a member state. Free movement brings many benefits, including in medicine, and EEA doctors have made a considerable contribution to the NHS. But while the underlying principle of free movement has remained constant, the EEA has grown dramatically in size and diversity and the practise of medicine has grown more complex and potentially dangerous. Mobility of professionals brings economic benefits to the UK but this should not be at the cost of patient safety.

33 We would therefore wish the Government to consider whether any or all of these issues might be usefully included in the negotiations around the UK’s role in the European Union – we are not seeking better terms for the UK than other member states, but we believe reform in this area would result in better protection for all Europe’s patients.