General Medical Council

Regulating doctors
Ensuring good medical practice

GMC's Response to National Coordination Points Consultation on the European Qualifications Framework

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 239,000 doctors with a licence to practise on the UK Medical Register. Of those, around 22,600 (9.5%) 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. If you require further information about this paper, please contact us by email: gmc@gmc-uk.org or tel. 0161 923 6602.

1. Sectoral Mobility

1. What mechanisms exist to facilitate professional or occupational mobility in your sector (please comment in particular upon mechanisms for the transfer of skills and qualifications)?

4. Basic medical and specialist training in Europe is covered by the mutual recognition of professional qualifications Directive (2005/36/EC). The Directive was transposed into UK law by way of amendment to the 1983 Medical Act.

5. The legislation provides that if a doctor holds a qualification listed in Annex V of the Directive and meets the minimum training requirements, they are entitled to be registered in another EEA country on the basis of mutual recognition.

6. When a doctor's training and experience does not meet these conditions, recognition is still covered by 2005/36/EC but under the *general system.* This process involves a comparison of the applicant's training with our national training to check whether there are substantial differences. Our procedure is not restricted to training that we recognise in the UK. We also look at specialties not recognised and where they reach the appropriate standard doctors can also enter the specialist register

7. The Directive also facilitates mobility for medical professionals on a temporary and occasional basis, typically for highly specialised surgical procedures or training. To ensure patient safety, we verify the applicant's qualification before they start the temporary provision of services.

8. The GMC has taken a particular interest in ensuring that no unnecessary barriers face individuals with disabilities who wish to pursue medical careers. To this end we have published two editions of our guidance to medical schools on encouraging disabled students, *Gateways to the Professions.*

9. Within GMC approval of curricula and assessment systems, doctors in the EU can seek consideration of previous postgraduate training that is equivalent to some of the postgraduate training curricula but taken outside of the UK. This learning (skills, knowledge, experience) may be taken into account when determining the total length of the specialty training

2. What barriers to professional or occupational mobility exist, either specific to your sector or more generally (please comment in particular upon barriers to the successful transfer of skills and qualifications)?

10. Directive 2005/36/EC removes barriers to the free movement of healthcare professionals by assuming comparability and equivalency of medical education and qualifications across the EEA. Providing a doctor holds a medical qualification deemed to have met certain minimum standards (expressed in length of training and hours of study), they can exercise their right of free movement and mutual recognition within the EEA.

11. However, assuming the equivalency of medical qualifications provides limited practical value in assuring other member states about the standards of medical education and training of migrants. The Directive's focus on time served in training rather than the outcomes provides few assurances about the quality of medical education received in another EEA state. This creates a lack of trust in education systems between member states and has the potential to create barriers to the free movement of doctors. In addition, the fact that there is no minimum language requirement provides little assurances to patients.

12. We are also aware that the annexes of the Directive are out of date. It would be beneficial if these were updated more frequently (annually as a minimum), with input from the relevant authoritative bodies, and if the dissemination of new versions of the Directive was facilitated in a more structured and timely fashion to all competent authorities either through the national coordinator or via direct communication from the European Commission. We have evidence of a recent example in which a doctor was issued with a Certificate of Good Standing (CGS) from the GMC but was refused recognition by the German authorities for a technicality relating to the name of the qualification listed. Although the qualification was the same in content, its name differed slightly to the corresponding qualification in the annex of the Directive because it had been updated after the CGS was issued. We also have examples were the annexes have been updated but other countries not accept the "old" name of the qualification although it was relevant at the time. This indicates that the current system for updating the annexes seems and recognition of information contained in previous versions of the annexes is inadequate and may present a barrier to professionals wishing to be registered in another EEA country.

13. The European Commission has started its evaluation of Directive 2005/36/EC and is planning to propose new legislation in 2012. We understand that the Commission will be looking at how to break down further barriers to the mobility of professionals. To better understand the education requirements in the Directive, the Commission has recently awarded a research contract to *GHK consulting* to investigate the links between Directive 2005/36/EC and the Bologna process. We understand that it will focus on medical qualifications in particular and will evaluate the role that the Bologna tools could play in a revised proposal. This may have an impact on medical education in the UK and we will be monitoring developments closely.

14. It is also important to note that recent examples in both the UK and EEA demonstrate that the free movement of healthcare professionals, without sufficient patient safeguards, undermines the mutual recognition system and weakens public trust in foreign-trained professionals, particularly when fitness to practise information is not shared proactively between jurisdictions.

3. How important is professional or occupational mobility for your sector (please provide all or any available data on the number of incoming or outgoing workers in your sector; where percentages exist or where data is relevant to specific years, please also provide this data)?

15. The UK has, for many years, been a net importer of doctors, from both Europe and internationally. Approximately 37% of those doctors on the register gained their primary medical qualification in countries other than the UK.

16. The GMC supports the free movement of doctors in the EU and the principle of recognition of professional qualifications; for decades the UK health system has benefited from high level of mobility, receiving many dedicated professionals who contribute positively to healthcare in this country.

4. Are there particular professions or levels or types of jobs e.g. management, technical, production, within which mobility is more prevalent for your sector?

- ☐ Yes
- ☐ No
- ☑ Not applicable

Where Yes, please provide detail:

17. The UK law requires any doctor who treats patients to be registered with the GMC with a licence to practise. While doctors work in many different environments, only those who are registered with a licence to practise can, for example:

- work as a doctor in the NHS, other health services or in independent practice
- write prescriptions
- sign death and cremation certificates.

18. Doctors who do not have a licence to practise are more likely to be working, for example, as lecturers in a medical school, as non-clinical ?managers, or outside the UK. Organisations, such as the NHS and other healthcare providers, are required to ensure that the doctors they employ have a licence to practise.

19. The General Medical Council does not hold employment records for doctors and hence cannot provide information on whether professionals registered with us are actually practising.

20. We should also clarify that we register doctors according to the speciality in which they first entered the specialist register, which means that we currently do not hold information on their current field of practise although this is in process of being addressed.

21. In addition, the GMC does not keep a record of doctors who have left the UK to work abroad and many doctors retain registration whilst they are outside the UK. As a result, we are unable to provide details about the types of doctors that are more likely to move.

2. Qualifications and Referencing Activity

1. Are there activities specific to your sector that focus upon the referencing of qualifications, in part or in full, to National Qualifications Frameworks in the UK?

☑ Yes

☐ No

Where Yes, please describe:

22. Undergraduate medical courses must comply with the GMC's requirements in *Tomorrow's Doctors* which in turn must be consistent with National Qualifications Frameworks. We have liaised with the Quality Assurance Agency for Higher Education (QAA) in light of the need to ensure that UK medical qualifications are appropriately represented in the NQFs. These frameworks have been assessed against European standards and deemed satisfactory.

23. The European Qualifications Framework is not referenced in 2005/36/EC and therefore has limited practical value in facilitating medical mobility. In addition, the 2008 EQF Recommendation explicitly states that it does not affect the recognition of professional qualifications under the Directive.

24. However, we understand that in the European Commission's review of the Directive, it will look to update the minimum training requirements and will assess its future interaction with the EQF.

25. As previously explained, the classification of educational levels under Directive 2005/36/EC is based on length of courses i.e. it is input-oriented, whilst the EQF classifications are described in terms of learning outcomes i.e. it is output-oriented. In the context of our concerns about the comparability of European medical qualifications, the integration of the EQF into the Directive could have some practical benefit for improving trust between member states. However this needs to be considered in detail and we will be following and evaluating the Directive's review closely.

2. Are there activities specific to your sector that focus upon the direct referencing of qualifications, in part or in full, to the European Qualifications Framework?

☐ Yes

☑ No

Where Yes, please describe:

26. Undergraduate medical courses must comply with the GMC's requirements in *Tomorrow's Doctors* which in turn must be consistent with the European Qualifications Framework. In the preparation of the 2009 edition of *Tomorrow's Doctors* we considered the outcomes of the Tuning project as well as European Directive 2005/36/EC. We are in contact with regulatory bodies across Europe.

3. Are there activities specific to your sector that focus upon promoting National or European Qualifications Frameworks through publishing or certificating levels of achievement?

- [x] Yes
- [ ] No

Where Yes, please describe:

27. *Tomorrow's Doctors* sets out the levels of achievement for UK primary medical qualifications. It is consistent with the National and European Qualifications Frameworks and European Directive 2005/36/EC.

4. Are you aware of any (self-funded or externally-funded) projects at national or European level that aim to relate sectoral qualifications, at one or more levels, to National or European Qualifications Frameworks?

- [ ] Yes
- [x] No

Where Yes, please describe:

28. The European Tuning project on medical qualifications may be worth further investigation.

3. Awareness

1. Prior to participating in this survey, were you aware of the existence of the European Qualifications Framework (EQF)?

- [x] Yes
- [ ] No

2. Are you, or were you, aware that the referencing of the National Qualifications Frameworks (NQF) in the UK - namely the Scottish Credit and Qualifications Framework (SCQF), the Credit and Qualifications Framework for Wales (CQFW) and the Qualifications Credit Framework (QCF) - to the European Qualifications Framework (EQF) is now completed?

- [x] Yes
- [ ] No

3. Are you, or were you, aware that National Co-ordination Points (NCP) exist in all European Union Countries for the management and implementation of National Qualifications Frameworks, including formal referencing to the EQF?

- [x] Yes
- [ ] No

4. Are you familiar with, or have you had past contact with, one or more of the NCP established in the UK (Scottish Credit and Qualifications Framework Partnership; Welsh Assembly Government; OFQUAL and CCEA)?

☐ Yes

☑ No

Where Yes, please provide detail:

29. We have not had direct contact with the National Co-ordination Points but liaise with the Quality Assurance Agency for Higher Education (QAA). We are in regular contact with the relevant authorities but not in their capacity as NCPs.

4. Future Focus

1. Considering the answers provided in Section 1 (Sectoral Mobility), how useful do you perceive the European Qualifications Framework to be, in terms of facilitating professional or occupational mobility within your sector?

30. The European Qualifications Framework is not referenced in 2005/36/EC and therefore has limited practical value in facilitating medical mobility. In addition, the 2008 EQF Recommendation explicitly states that it does not affect the recognition of professional qualifications under the Directive.

31. However, we understand that in the European Commission's review of the Directive, it will look to update the minimum training requirements and will assess its future interaction with the EQF.

32. As previously explained, the classification of educational levels under Directive 2005/36/EC is based on length of courses (i.e. it is input-oriented), whilst the EQF classifications are described in terms of learning outcomes (i.e. it is output-oriented). Given our concerns about the comparability of European medical qualifications, the integration of the EQF into the Directive could have some practical benefit for improving trust and comparability of qualifications across member states. However this needs to be considered in detail and we will be following the debate closely and contributing to the Directive's review.

2. Are you interested in participating in future activities or developments involving the referencing or promotion of qualifications for your sector?

☑ Yes

☐ No

3. Are you interested in participating in a knowledge-sharing event involving EQF National Coordination Points and other Sectoral or Professional Bodies in the UK (such an event is currently forecast for February 2011)?

☑ Yes

☐ No

Where Yes, please provide contact details below: