
**House of Lords Inquiry into the Review of the Professional
Qualifications Directive: Mobility of Healthcare Professionals**

Submission from the General Medical Council

17 June 2011

1. The General Medical Council (GMC) welcomes the opportunity to submit a response to the House of Lords inquiry. We set out below our view of the recognition of professional qualifications Directive based on the questions in the call for evidence.

Background

2. The GMC is the independent regulator of 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.

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. There are currently over 239,100 doctors on the UK Medical Register. 23,300 (9.7%) of these doctors qualified in other parts of the European Economic Area (EEA).

5. The GMC's powers to register and licence doctors are specified in the Medical Act 1983. The recognition of professional qualifications held by EEA nationals or those who are entitled to be treated as such is provided for by the 2005/36/EC Directive. This was transposed into UK law in 2007 by way of amendment to the 1983 Act.

6. 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 of the free movement of professionals. However, the fact that the freedom of movement, rather than the protection of the public, is the overriding aim of the Directive, can give rise to tensions. We believe that the single market must give a higher priority to the protection of the public and patients.

Question 1: What benefits are derived by healthcare professionals and patients from mobility?

7. The GMC supports the free movement of doctors in Europe and the principle of recognition of professional qualifications.

8. For decades, the UK health system has benefited from high levels of mobility, receiving many dedicated professionals who contribute positively to healthcare in this country. Approximately 37% of doctors on the register gained their primary medical qualification in countries other than the UK.

9. Similarly UK doctors have benefited from the training and work opportunities available to them in other European countries.

Question 2: What risks have you observed arising from mobility and to what do you attribute those risks?

10. Our primary purpose is to protect the health and safety of the public. With this in mind, we are concerned that gaps in the current regulatory framework have the potential to harm patients and undermine confidence in the free movement of professionals in the single market.

11. In an environment where health professionals and patients are encouraged to move across borders, a risk to patient safety in one member state can be a risk in another. It is therefore essential that EEA trained doctors, exercising their rights of free movement, are only granted and maintain registration when they are known to be fit and safe to practise.

12. Patient safety and our knowledge of a doctors' fitness to practise relies on other regulators sharing this information. However, Directive 2005/36/EC does not currently require regulators to proactively share disciplinary information. This means we are not always informed when action is taken against a doctor's registration. This poses a serious risk to patient safety.

13. The risks associated with the free movement of professionals should also be considered alongside the differences between healthcare systems and structures in Europe. The education and training of healthcare professionals is specific to each member state and delivered according to national requirements and service demands. A professional in one country has been trained to the standards appropriate for that specific context and might not automatically have the same skills as a professional from another member state. For example, in some EEA countries graduates may have strong theoretical training but have less clinical knowledge and experience or exposure to patients. This could give rise to situations where the expectations placed upon a doctor working in one jurisdiction, but trained in another, may not be met.

14. This is compounded by the lack of transparency and information about the nature and content of medical education and training and of the knowledge and competencies required of doctors in other parts of the EEA. Without this information, the regulator in the host member state cannot have full confidence in the quality of education and medical training delivered in another member state.

Question 3: Where do you think the balance should lie between a regime covering the mobility of all workers, including non healthcare workers, with the objective of maintaining high standards of patient safety?

15. Whilst we appreciate with the drive to boost European competitiveness, we do not believe that attempts to simplify recognition and reduce barriers to mobility through the deregulation of some sectors should apply to the health professions. Nor do we agree that there are unnecessary barriers in place to prevent the movement of doctors to the UK. The large number of EEA doctors registered with the GMC suggests that a further loosening of the regulatory requirements would not be desirable. We consider that patient safety should not in any way be compromised or undermined to meet the objective of increased mobility.

16. The current Directive covers over 800 professions and cannot be expected to accommodate the specific requirements of all. We therefore urge the European Commission to consider a separate legislative instrument dedicated solely to the safe mobility of healthcare professionals. This, in our view, would be a proportionate solution that would both take into account the distinct nature of healthcare provision and ensure that appropriate patient safeguards can be included in the European legislative framework.

Question 4: How content are you with the system of automatic recognition as currently applied to doctors, general care nurses, dentists, midwives and pharmacists? What suggestions do you have for improvements? Should it be extended at all to any other healthcare professionals?

17. 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. These 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.

18. From an administrative point of view, the system for automatic recognition has been helpful and is relatively straightforward for both the professional and the regulator. However, we believe that the criteria for automatic recognition no longer reflect current practice in medical education and training and needs to be thoroughly reviewed. The conditions for basic medical education, and the minimum training times for specialists and general practitioners, are of limited practical value in providing assurance about the standards of medical education and training undertaken and the continued competence of the migrant professional.

19. Comparability is largely based on length of training (inputs) rather the range of competences that medical education develops (outputs). In addition, 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 regulators to be assured of the quality of education elsewhere and the overall result is a lack of confidence in each other's medical training and education.

20. Furthermore, 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 view of competent authorities can be made available to the Commission. We believe that this has contributed to the lack of trust between member states in the quality of their education and training.

21. We consider that 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 could be used as a basis from which to develop the minimum training requirements in terms of learning outcomes rather than inputs (hours and length of study). We also 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. Regulators must be invited to participate and contribute to these activities.

22. We would also like to highlight that the Directive as it currently stands, does not allow regulators to assure themselves that the migrant doctors have kept their skills up to date since the award of their professional qualifications. The inability of member states to obtain assurance of an individual's competence inevitably weakens the level of confidence that regulators and patients can have in the competence of incoming doctors.

23. We do not consider that the Directive should impose minimum continuous professional development or revalidation requirements for the purposes of mutual recognition, but believe that only those doctors that have satisfied the competence assurance requirements in the home member states should be eligible for automatic recognition. This would improve confidence in the recognition system and provide greater assurances to patients that the doctors that treat them have kept their knowledge and skills up to date.

24. We also believe that any revision of the Directive should allow member states the flexibility to deliver and organise their medical education and training in line with their healthcare needs and requirements. For example, there have been attempts to impose a much more restrictive interpretation of the basic medical training provisions of the Directive (article 24). It has been suggested that the requirements (six years of study or 5,500 hours) should be considered cumulatively and should therefore be clarified in a revised Directive.

25. In our view the requirements of basic medical training are clearly set out in the Directive and provide for years and hours of study to be considered as alternatives. Any attempts to change this definition will unnecessarily constrain member states and will also have serious implications for those doctors that have already successfully qualified from the many graduate entry programmes available in the UK and elsewhere in Europe.

Question 5: To what extent do you consider that appropriate systems are in place for administrative cooperation between Member States, particularly as regards the fitness to practise?

26. There is currently a good level of administrative cooperation with other regulators at the point of recognition, but this is predominantly done on a reactive

basis. The Internal Market Information System (IMI) enables competent authorities to get answers and obtain information from their counterparts when there are justified doubts about a professional's competence and qualifications.

27. However, as registration with IMI is not compulsory for competent authorities, we sometimes find it difficult to receive replies to our requests. The system could be improved by making registration with IMI mandatory for authorities and by requiring them to respond to queries within the relevant timescales.

28. One of the key challenges to patient safety with the current Directive has been the extent to which other regulators proactively exchange fitness to practise information. Recent examples in both the UK and other European countries highlight that when this information is not shared, health professionals are able to continue working in one member state despite being suspended from practice in another. We believe that a revised Directive must better protect patients and introduce a legal duty on competent authorities to securely exchange fitness to practise information with all member states. This should take the form of an IMI 'alert mechanism' similar to the one in place for the Services Directive¹.

29. We have invited the European Commission to consider whether the work undertaken by Healthcare Professionals Crossing Borders (HPCB)² 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.

Question 6: Article 53 of Directive 2005/36/EC requires those benefiting from mobility under the Directive to have a knowledge of languages necessary for practising the profession in the host Member State. Are you content that this requirement has been applied satisfactorily as regards healthcare professionals and ought it to be strengthened?

30. We are committed to making sure that only those doctors who have the necessary language and clinical skills can treat patients in the UK, this includes EEA applicants to the GMC register do not currently need to meet a language requirement before they gain registration. The ability of a professional to communicate effectively in the language of the host member state lies at the heart of good medical practice.

31. We are working closely with the Department of Health (England) and have made good progress in our joint work to identify new ways in which to ensure that the language and clinical skills of all doctors who wish to work in the UK are suitable for their practice. This is a complex area of policy and law but we have a shared commitment to provide further safeguards for patients.

32. We are currently considering a scheme which we believe is proportionate and consistent with the requirements of European law and which will provide greater protection for patients. This scheme would be likely to require a change to UK law

¹ See Articles 29.3 and 32.1 in the Services Directive ([2006/123/EC](#))

² HPCB is an informal network of the European healthcare professional regulators which was established in 2004-2005 by the Dutch and UK Presidencies of the EU. Its purpose is to contribute to patient safety in Europe through effective regulatory collaboration in the context of cross-border healthcare and free movement of healthcare professionals. [The GMC holds the secretariat for HPCB.](#)

and provide a strengthened role for Responsible Officers, who are based in healthcare organisations across the country. They are responsible for evaluating the doctors they employ or contract with and this scheme would enhance their role to make sure that their doctors have the necessary language and clinical skills to give patients safe care.

33. Separately, the GMC has urged 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 all doctors as part of the registration process to ensure that patients are better protected.

Question 7: The Commission refers in its consultation paper to the possible introduction of a European Professional Card. What is your response to this suggestion? Under what conditions would it be helpful for healthcare professionals and patients?

34. We are not convinced that the introduction of a professional card will have the desired effect of improving professional mobility. Instead we are concerned that it may present a risk to patient safety.

35. We do not support the suggestion that a card could become the sole source of information on which regulators should base their recognition decision. A card offering an immediate entry gate for healthcare professionals to practise in another member state could also have serious implications for the integrity of our registration processes and should be discouraged.

36. For example, we have experiences of regulators issuing declarations and certificates in error, confirming that a professional should benefit from recognition of their qualifications when their education and training does not in fact meet the minimum training requirements. We are concerned that similar carelessness could lead to situations where regulators, patients and the public assume that the fitness to practise of a professional is inadvertently confirmed by virtue of a professional being in possession of a card that may have been issued by mistake or may have been withdrawn.

37. A card could also be open to fraud. We doubt that a card without chip and pin technology and robust data underpinning the information on the card will ever be able to provide up to date fitness to practise information.

38. We believe that the most efficient, cost effective and accurate way for patients, the public and employers to check the registration and fitness to practise status of a doctor registered in the UK is through the GMC register. This is updated on a daily basis, is freely available online on the GMC's website, supports the information we exchange on a bilateral basis, and enables patients to make informed choices about the practitioners they consult. An alternative to the card and 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.

39. We also consider that efforts would be better focused on encouraging other European regulators to effectively share information directly. The Commission has invested substantial resources into the IMI system, which already provides a cost

effective tool for the secure information exchange between competent authorities without some of the risks associated with a card system. We therefore believe that efforts should be better targeted at further developing and improving IMI.