Member states slow to implement updated rules on professional qualifications

In May, the European Commission (EC) published a report into the implementation of the revised Directive on the mutual recognition of professional qualifications. The transposition deadline for the revised Directive was 18 January 2016. The report states that most member states did not complete the transposition by the deadline, with those countries who have a de-centralised structure (for example through federal, regional or provincial laws) facing a higher administrative burden to implement.

The report lists the areas of concern that remain with the implementation and gives an overview of the various infringement procedures that are still ongoing.

Partial access

Unsurprisingly, implementation of the new rules on partial access raised concerns for 12 member states. The Commission has censured countries that imposed a blanket ban on partial access for professions where automatic recognition is in place and also countries that do not clearly inform failed applicants for full registration that the possibility of partial access exists.
Alert mechanism

Concerning implementation of the alert mechanism, the infringement procedures mostly focused on ensuring that member states meet the three-day deadline to send alerts and meet their obligations on data protection, data deletion and information for professionals. A number of member states were requested to provide justification as to why they had sent no or only very few alerts since the mechanism was brought in. In a few instances, the Commission found that the alert mechanism was not implemented at all for specific professions (e.g. education of minors, health professions), for specific cases (e.g. falsified diplomas), or only in parts of a member state’s territory.

The report outlines that member states have reported challenges related to the functioning of the alert mechanism. These included difficulties in meeting the deadline to send alerts, technical feasibilities in managing the high volume of notifications (to filter substantive/relevant alerts), and differences between member states as to when alerts need to be sent (due to different penalty mechanisms). One member state has called on the Commission to tackle the legal effects of alerts on the practice of professional activities at EU level.

European professional card

With regards to the European professional card (EPC), the transposition issues focused mainly on technical and procedural rules including missing or inaccurate specification of deadlines in legislation, and tacit recognition not being provided for in law.

Language controls

Implementation of the new rules on language controls was addressed in infringement proceedings for approximately one third of member states. The enforcement action aims to ensure that only knowledge of one official language by the host member state can be required and the mandatory imposition of language checks is not permitted. Infringement discussions with a number of member states are still ongoing in this area.

Common training principles

Only one agreement on common training principles (a common training test for ski instructors) has been reached since 2016. The report states that it has proven difficult to reach agreement on minimum training standards, even by taking a bottom-up approach. Suggestions from a number of professions could not reach the required thresholds of regulation in member states.

Next steps

A staff working document accompanying the report has been published. This contains detailed data on the content of the infringement proceeding and on the use of the IMI system.

The European Commission’s power to adopt delegated acts in the area of the mutual recognition of professional qualifications has been extended until January 2024. As such it is thought that a full-scale revision of the Directive will not take place, rather the EC will use its delegated power to make updates where necessary.
Minimum training requirements amidst COVID-19

In May, the European Commission published guidance advising member states on the actions they are able to take if they decided to grant early registration to final year medical students or if those students had to graduate without completing their full course due to COVID restrictions.

The guidance clarifies how member states can ensure that the recognition of professional qualifications Directive’s rules on minimum training requirements can be respected in cases where students are not able to complete their training because of disruptions due to the coronavirus crisis.

If the minimum requirements cannot be met, member states can request a derogation from Article 21(6) of the Directive so that students graduating in 2020 could obtain the diploma listed. Article 61 of the Directive provides the possibility to allow for a derogation from specific provisions of the rules for a limited period via the adoption of an implementing act if a member state encounters major difficulties in applying a specific provision. The scope and content of any derogation will depend on the specific circumstances in a given member state.

The derogation would be subject to the condition that the knowledge, skills and competences referred to in the minimum training requirements will be acquired, albeit in part after the diploma has been issued. Diplomas that are issued based on the conditions set out in a derogation would not be eligible for automatic recognition by a host member state until the minimum training requirements have been met. The Commission considers that such diplomas could be identified by issuing a diploma supplement, detailing the parts of the minimum training requirements that are missing. The information in the diploma supplement would help any host member state decide on the recognition and application of possible compensation measures if the doctor wished to get their qualification recognised in another member state before completing the full training.

We understand that one member state is considering using the derogation for certain final year students.

These guidelines complement an earlier set of guidelines to assist member state health authorities in the field of cross-border cooperation which were published in April. Amongst other things, the guidelines state that member states are able to relax their procedures for registering EEA doctors, for example by removing requirements for translations of documents, removing requirements for compensation measures, or applying shorter deadlines for application processing.

EC infringement proceedings

In its regular package of infringement decisions published on 14 May, the European Commission (EC) has sent a reasoned opinion to Belgium and Spain for non-compliance of their national legislation and practice with the Directive on the recognition of professional qualifications. The reasoned opinion to Belgium concerns issues related to non-compliance with EU rules related to harmonised minimum training requirements and the recognition of professional traineeships.

The reasoned opinion sent to Spain concerns non-compliance with the procedure for the mutual recognition of professional qualifications and rules on knowledge of languages. Belgium and Spain have one month from the sending of the reasoned opinions to respond to the arguments put forward by the Commission otherwise the EC may decide to refer the countries to the European Court of Justice.
The WHO Regional Office for Europe, the European Commission, and the European Observatory on Health Systems and Policies have jointly launched the Health System Response Monitor which collects up-to-date information on how countries are responding to the COVID-19 crisis. It focuses primarily on the responses of health systems but also captures wider public health initiatives. The website presents the different ways in which individual countries have responded to the crisis and allows users to create documents comparing up to four countries at a time.

In addition to this, and in an effort to coordinate an EU-wide response to the pandemic, the European Commission launched a COVID-19 Clinical Management Support System providing an online platform for clinicians across Europe to exchange with peers on the management and treatment of the condition. Clinicians can access a dedicated helpdesk managed by the Commission to set up web conferences and exchange with their peers in Europe on possible treatments and on how to handle severe and complex cases.

Minimum training requirements – nurses responsible for general care

In May 2020, the European Commission published the results of the study, Mapping and assessment of developments of one of the sectoral professions under Directive 2005/36/EC - nurse responsible for general care. As reported in previous issues of the HPCB Update, the study aimed to support the assessment of whether or not to propose an adaptation of the minimum training requirements for nurses responsible for general care under Directive 2005/36/EC.

The study mapped the current national requirements in all EU member states, EFTA states and the UK with regard to the effective theoretical and clinical training of nurses responsible for general care, the training subjects included in the national curricula, and the knowledge and skills that students should acquire by such training.

It found that inter-/multidisciplinary theories are already sufficiently covered in the Directive and that more emphasis could be given on some topics already mentioned in the Directive (such as person-centred care theories, management theories applied to nursing, and evidence-based practice) considering the apparent importance of these subjects across the countries. It also noted that some of the topics identified in at least 16 countries seem not to be covered in the Directive such as eHealth and healthcare/nursing methods.

Having identified the potential gaps in the Directive with regard to generally acknowledged advancements across the countries covered by the study, the conclusions recommend updating Article 31(6) on knowledge and skills and point 5.2.1 of Annex V. The full recommendations can be read in the final report.
A group of 18 pan-European healthcare stakeholders have published a statement highlighting the importance of addressing health issues as part of the agreement on the future relationship between the EU and the UK.

The statement highlights that coronavirus has exacerbated and exposed the vulnerability of health, health systems and societies and that whilst EU/UK negotiations have reached a critical point, health issues are still largely absent from the negotiators’ agenda.

The group of healthcare stakeholders has called upon EU and UK decision makers to reach agreement on:

- **Public health** – close coordination in public health and wellbeing, including data sharing and early warning systems, to ensure maximum preparedness to tackle health threats

- **Patient safety** – compatible regulatory frameworks for the manufacture, inspection and licensing of medicines and medical equipment such as ventilators and PPE, enabling rapid release onto the market and guaranteeing high safety standards

- **Uninterrupted supply of medicines and medical devices** – maximum possible cooperation in import and export of medicines and medical supplies across UK/EU borders to minimise delays in products reaching patients

- **Citizens’ rights to treatment** – EU and UK citizens to continue to benefit from reciprocal rights to healthcare, ensuring simple and safe access to treatment when working, living or travelling at affordable cost

- **Furthering medical research and innovation** – continued UK-EU collaboration in research programmes and clinical trials, including sharing patient data and information to speed up new treatments, improve patients’ options and maintain Europe’s R&D framework and reputation as an attractive destination for investments into cutting-edge research.

**Brexit transition period**

The UK Government has rejected the opportunity to extend the Brexit transition period for a further two years. In declining to submit a request for an extension by the deadline stated in the Withdrawal Agreement of 1 July, the UK Government has confirmed that the current transition period will end on 31 December 2020. Information on what this might mean for the recognition of professional qualifications can be found on the EC website.
Freedom of movement

Herbert Dorfmann MEP (Italy) has questioned the European Commission about the situation of an Italian doctor who is being prevented from sitting a specialty training exam in Bavaria. In order to sit the final examination for the supplementary training in sports medicine, the prospective examinee is required to be a member of the Bavarian Medical Association. The Italian citizen concerned completed his specialist training as a general practitioner and supplementary training in sports medicine in Munich and was a member of the Bavarian Medical Association during his training. The doctor, who now practices medicine in Italy, is not being allowed to sit the final examination in sports medicine on the grounds that he has to be a member of the State Medical Association. Temporary membership is not possible.

In response, the EC stated that as a general rule, doctors established in Germany have to be members of a State Chamber of Physicians (Landesärztekammer) in the region where they are established. However, the EC stated that it appears the doctor does not intend to make use of either the freedom of movement of workers or of establishment in Germany, he solely requests access to finalise training in a professional organisation of which he is not member anymore. As such the EC is not able to comment on a specific, individual case.

Nursing shortages across Europe

Nicolás González Casares MEP and Dolors Montserrat MEP (Spain) have questioned the EC about a series of studies which show that the EU is suffering from a shortage of nursing staff. They stated that the EU average for nursing staff per 1,000 inhabitants currently stands at 8.8 but the figure is actually far lower in many countries. In view of this situation they have questioned whether the Commission believes that healthcare authorities in the member states should ensure their medical facilities have enough nursing staff to be sure the medical care and attention required can be safely guaranteed.

In response, the EC stated that it supports national authorities to address challenges they face in the area and to share experience and learn from each other. One example has been the funding of a Joint Action on Health Workforce Planning and Forecasting followed by the establishment of the health-workforce planning and forecasting expert network (SEPEN) facilitating the exchange of expertise and the provision of tailor-made advice to member states.

Physiotherapy entry in MRPQ Directive

Sirpa Pietikäinen MEP (Finland) has questioned the European Commission about the incorrect use of the name ‘physiotherapy’ in Annex V of the recognition of professional qualifications Directive, which contains a list of medical specialisations and their title in each country. This Annex includes physical medicine under the title of ‘physiotherapy’. According to the profession, it should be listed as ‘physical and rehabilitation medicine’ in order to differentiate it from the paramedical profession of physiotherapy.
In response, the EC stated that most of the diplomas under the generic title ‘physiotherapy’ currently indicate a name similar to ‘physical and rehabilitation medicine’ and that it is up to member states to decide on the titles to their education and diplomas according to their preferences. The Commission has consulted member states as regards the designation of the category in Annex V and no member state has expressed a need to amend the generic name of this category.

Ramona Strugariu MEP (Romania) has questioned the EC about the delay in reporting on the upskilling programme put in place to support Romanian nurses to meet the requirements of the MRPQ Directive. After Romania acceded to the EU, nurses who had completed their training at nursing college before 2010 found they did not meet the minimum conditions for recognition of their professional qualification. Under the 2003 amended Directive, Romanian general nurses were given the possibility of following a special upskilling programme to supplement their vocational training in line with the minimum requirements of the Directive.

In response, the EC stated that the long-awaited report was published in May 2020 and that a substantial number of students have now successfully completed the upskilling programme. No member state has objected to Romania’s proposal that the graduates benefit from automatic recognition in the future. When assessing applications from those Romanian nurses under the non-automatic recognition regime, the competent authorities of the host member states are advised to consider the completion of the upgrading programme as evidence of additional skills and knowledge acquired to fill the gaps in training.

European Networks

Medical organisations condemn violence against professionals

Following reports of cases of violence, discrimination and exclusion that healthcare professionals across Europe have been facing because of the fear they will spread coronavirus, European medical organisations have condemned the stigma that professionals dealing with infected patients are facing on a daily basis, both inside and outside the workplace. They have stated that this behaviour poses a huge risk to the physical and psychological health of physicians and other health professionals.

The organisations have called on European governments and health authorities to achieve a zero-tolerance policy for violence against healthcare staff, to provide them with a safe working environment and adequate personal protective equipment while they are on the front line, and to deploy all necessary means to protect the physical and psychological integrity of healthcare professionals during this pandemic and beyond.
CEOM: teleconsultation during COVID-19

Dr. Jean-François RAULT, Secretary-General, CEOM European Council of Medical Orders, Belgium

The European Council of Medical Orders (CEOM) conducted a survey of national teleconsultation practice in European countries during the COVID-19 pandemic. The main objective was to map best practices undertaken to support doctors’ vital work while protecting their health during the COVID-19 response. Twelve countries across Europe responded including: Cyprus, Estonia, Germany, Greece, Italy, Luxembourg, the Netherlands, Portugal, Spain, Sweden, Switzerland and the United Kingdom.

The outcome of the survey shows a shift toward teleconsultation across Europe, however, some differences have been identified particularly when it comes to medical procedures that can or cannot be conducted via teleconsultation and the technology available.

National medical associations that had a wide usage of teleconsultation explained that there was continuity of the usual physical consultations remotely during the pandemic. This is due to the fact that in most of these countries, teleconsultation was already a general practice and digital tools already existed (Germany, Netherlands, Luxembourg, Switzerland, UK). Most of these associations provided guidance on how to properly conduct remote consultation in line with medical ethics. Some variations might exist where teleconsultation might be coupled with certain conditions depending on the country, for example: the doctor should have already consulted the patient physically (Luxembourg) or teleconsultation should be followed by a physical consultation (Switzerland). During the COVID-19 pandemic, Estonia relaxed rules to allow the first consultation to be done remotely, and not just the follow-up as before the pandemic. In Switzerland for certain medical conditions, a clinical examination could be conducted via teleconsultation and a second appointment, blood test or examination can be requested with the physical presence of the doctor.

National medical associations who authorised limited teleconsultation explain that its use could not be made universal, especially in cases of serious illnesses (Greece, Portugal, Italy). The use of teleconsultation has been limited to COVID-19 patients, the supply of certificates for sick leave, prescriptions, simple diagnoses and patient monitoring (Cyprus, Italy, Spain). However, teleconsultation has showed its limits, in Spain and Italy teleconsultation was mandatory in cases where COVID-19 infection was suspected in order to protect doctors, however, the move was criticised as it didn’t allow for further examination to check the patients’ status in regard to COVID-19.

Have you put in place exemptions on national level for a wider use of teleconsultation following the COVID-19 pandemic?

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Regarding the technology used to conduct teleconsultations, most countries used traditional communications tools and wide-spread applications such as telephone, Zoom, Skype and WhatsApp. In some countries like the Netherlands, Switzerland and Luxembourg, national medical associations supported the use of specialised and secure eHealth applications that were developed in compliance with European regulations including GDPR and national legislation. When it comes to the respect of medical confidentiality, it was widely considered that teleconsultation is a medical procedure and therefore traditional confidentiality obligations apply.

About CEOM: The purpose of the CEOM is to promote within the European Union and the European Free Trade Association the practice of high-quality medicine respectful of patients’ needs. CEOM brings together the Medical Councils and the independent medical regulatory authorities of European Union member states and the European Free Trade Association responsible for either ethics and professional conduct, registration or licensing procedures, disciplinary matters regarding physicians, recognition of qualifications and levels of specialty, authorisation to practice and setting of professional standards. CEOM is the leading medical organisation in Europe addressing the issue of violence in healthcare settings.

European competent authorities’ pandemic response

In June, the European Network of Medical Competent Authorities (ENMCA) met virtually to discuss the impact of COVID-19 on their work and the regulatory responses taken to combat its impact. The meeting brought together 50 representatives from 25 medical competent authorities across Europe.

The meeting covered issues such as the impact of COVID on registration, revalidation and education & training. A representative from the European Commission presented the EC’s guidance on assisting competent authorities through the crisis.
NMC: COVID-19 regulatory changes

Christian Beaumont, Policy Manager, Nursing and Midwifery Council, UK

The COVID-19 pandemic has presented an unprecedented challenge for the health and social care sector. In tackling this virus, the nurses, midwives and nursing associates on our register have demonstrated exceptional skill, perseverance and bravery.

This article highlights some of the actions we have taken to support this workforce during the crisis in line with the three pillars of our corporate strategy: regulate, support, and influence.

Regulate

In March, we were given emergency powers to create a temporary register. This allows us to temporarily register fit, proper and suitably experienced people. We identified three groups of people for temporary registration. As of the end of June, 14,241 nurses and midwives have become temporary registrants.

We also introduced Emergency Education Programme Standards. These give universities who teach nursing and midwifery courses increased flexibility, to enable students to progress on their programmes while supporting the workforce. Approximately 35,000 students have taken up the option of an extended clinical placement so far.

We have also given all registrants due to revalidate from March to June 2020 a three-month extension. This is to ensure that they have the time they need to prepare their applications. Registrants due to revalidate in July or August will be able to request a three-month extension.

Support

Since the beginning of the pandemic we have increased our advice and information for our registrants and our stakeholders. This includes a joint statement with ten other regulators on how we will continue to regulate during the pandemic. We have used a range of media to reach as wide an audience as possible, responding to issues that are important to our registrants and stakeholders, such as personal protective equipment as well as how to support advanced care planning including the use of non-resuscitation orders.

Influence

We have worked closely with a wide range of stakeholders in order to achieve consensus on the changes described above and to support decision-making across all four UK nations. We have used our data and analysis to highlight (and, where appropriate, act on) areas of concern, including the disproportionate impact of COVID-19 on people from Black, Asian and minority ethnic backgrounds.
Regulate, support, influence – NMC 5 year strategy

Matthew McClelland, Director of Strategy and Insight, Nursing and Midwifery Council, UK

The NMC wants to see safe, effective and kind nursing and midwifery that improves everyone’s health and wellbeing. That’s why we spent last year developing an ambitious new strategy for 2020–2025.

We asked the professionals on our register, the public, our colleagues and our partners in health and social care to help shape this strategy. Thousands of people shared their views, either online or at special events.

The strategy confirms that our purpose is to promote and uphold the highest professional standards in nursing and midwifery, to protect the public and to inspire confidence in the professions. It also clarifies our roles to regulate, support and influence.

Regulate

First, we promote high professional standards for nurses and midwives across the UK and for nursing associates in England. Secondly, we maintain the register of professionals eligible to practise. Thirdly, we step in to investigate when care goes wrong – something that affects less than one percent of professionals.

Support

To regulate well, we support our professions and the public. We create resources and guidance that are useful throughout people’s careers, helping them to deliver our standards in practice and address new challenges. We also support people involved in our investigations and we’re increasing our visibility, so people feel engaged and empowered to shape our work.

Influence

Regulating and supporting our professions allows us to influence health and social care. We share intelligence from our regulatory activities and work with our partners to support workforce planning and sector-wide decision making. We use our voice to speak up for a healthy and inclusive working environment for our professions.

These roles inform five strategic themes for the next five years:
1. Improvement and innovation
2. Proactive support for our professions
3. A more visible and informed regulator
4. Engaging and empowering the public, professionals and partners
5. Insight and influence.

The strategy sets out our priorities for each theme, including where we want to be by 2025. To keep up to speed as we deliver our commitments, follow us on Twitter, Facebook or sign up to our newsletters.

General Pharmaceutical Council strategy

The General Pharmaceutical Council (UK) has launched their 2020-2025 strategic plan, outlining their focus for the next five years to meet their 10-year vision. Centred around developments in health and social care integration, medicine delivery, ‘person-centred’ care and the impact of public health challenges, the GPhC strategy addresses future changes to pharmacy and pharmacy regulation.

Working across five priority areas, the strategy works to:
- Deliver adaptable standards frameworks to meet evolving public and professional need
- Deliver effective, consistent and fair regulation
- Drive improvements in care by updating education and training regulation
- Move towards proactive and proportionate regulation
- Enhance capability and infrastructure

The Council’s strategic aims highlight renewed focus on their key principles of collaboration, learning and professionalism to ensure their regulation is person-centred, proportionate and effective.

“During the current COVID-19 pandemic, our focus is on ensuring patients and the public continue to receive safe and effective care... Both our Vision and Strategic Plan, while developed prior to the pandemic, have helped guide our response to COVID-19 and will continue to direct our work in the future. We wanted to publish them now to underline our commitment to high quality independent pharmacy regulation and to outline the regulatory and operational measures we will undertake to help us achieve our vision”

Nigel Clarke, General Pharmaceutical Council Chair
HCPC: a different way of working

Katherine Timms, Head of Policy and Standards, Health & Care Professions Council, UK

COVID-19 has required us to be more responsive than ever, challenging us to revaluate what it means to regulate.

At the start of the COVID-19 crisis HCPC moved to homeworking, requiring us to reduce our reliance on post, to move more to electronic document sharing, and to undertake virtual hearings and education visits.

Temporary registration

Making sure we weren’t a barrier to increasing the workforce to meet demand, whilst ensuring those returning didn’t pose a risk to the public, was a fine line. We relied on our existing frameworks to ensure those who were on the temporary register would be safe and we tailored our fitness to practise processes to ensure they could be swiftly removed from the register if any concerns were raised.

Support and guidance

Registrants initially asked us about PPE, adapting practice, managing risk and raising concerns, but more recently we’ve seen a shift to consideration of resuming private practice and community services. Our COVID-19 hub responds to FAQs across all stakeholders and is a source of standards specific guidance in light of COVID-19. Our COVID-19 information sheets address each of the 10 overarching standards of conduct, performance and ethics.

In acknowledgment of the pressures on our registrants, we also decided to pause some of our processes to avoid any additional burdens on them, for example CPD audits.

Risks

We are now considering the future of the temporary register. If closed too early, there could be consequences if there are further COVID-19 peaks. However, extended use beyond what is necessary presents regulatory risks; there are less regulatory controls and formal processes to safeguard registrants. Those practising on the full register may also be discouraged by the ongoing temporary registration of a workforce who do not pay fees and are not subject to the usual regulatory processes including CPD.

We are working with the NHS and Governments across the four countries to ensure we clearly understand all the risks and take appropriate action to mitigate them.

The future

Looking to the future, there are many questions we need to answer; how has the pandemic changed the public’s expectation of our professions and their regulators? What can we learn from this experience? How can we harness our learning to continue to improve public protection? This is an exciting set of questions to work through and we believe, collectively as regulators, we can find the answers and be better regulators for it.
CORU: international activities during COVID-19

Margaret Hynds O’Flanagan, Head of Recognition, CORU, Ireland

CORU, the Health and Social Care Professionals Council, is Ireland’s only multi-profession regulator. In 2020 we are still evolving and establishing new registers. At this point in time we have registers open for social workers, radiographers and radiation therapists, dietitians, dispensing opticians, medical scientists, occupational therapists, optometrists, physiotherapists, and speech and language therapists.

Some 10% of our registrants hold a nationality other than Irish and we recognise circa 750 qualifications awarded outside the state annually. Applicants for the recognition of professional qualifications come from all over the world; the top six countries of qualification for CORU applicants are the United Kingdom, the Philippines, India, Nigeria, Zimbabwe, and South Africa. CORU works to actively engage with our colleagues in other countries and to provide the best possible service to applicants.

When it started to become clear that COVID-19 would evolve into a global pandemic we trialled working from home for one team to iron out any problems while we still had support in the office to resolve issues. A week later the entire organisation was working from home, many with laptops repurposed from supporting on-site functions in the organisation. Our legislation requires that Registration Boards hold a meeting to make decisions on qualification recognition. We had been trialling video meetings to address time sensitive decision making in the nine months preceding the outbreak of the pandemic so moving all of our business to our online meeting system was not as challenging as it could have been.

To ensure we met our deadlines for decision making, and to ensure that available and eligible professionals could enter the health service without undue delay, we increased the number of assessors, the frequency of decision-making meetings for key professions and delivered online training for new assessors and Registration Board members. In this way we managed to maintain our standards and requirements while progressing applicants as quickly as possible.

One unexpected advantage of the current situation has been the enhancement of our connections with other regulators internationally to address difficulties encountered by applicants in completing their applications in changed circumstances and to address queries from educational institutions overseas. The pandemic has given us an opportunity to consider alternative approaches and methods of working without lowering standards. After a short break to focus on the transition to remote working, the new environment has also prompted the speeding up of work to implement and roll out a new online application system to replace the existing blended system which uses soft copy submissions and hard copy documents in the post.

In addition to Registration Boards, all of our other functions have now moved, or are moving, online including Council and Committee meetings, appeal hearings, training and stakeholder engagement work and all executive functions. There has been no break in service and processes are being completed within the usual timeframes.

Council of Europe: Bioethics Committee webinars

The Council of Europe’s Committee on Bioethics have been running webinars and publishing material to support shared consideration of ethical issues arising out of the pandemic. More information including recordings of the Committee’s most recent webinars on public health and human rights can be found here.
COVID-19: CPME members share doctors’ point of view

Sarada Das, Deputy Secretary General, Standing Committee of European Doctors (CPME), Belgium

The COVID-19 pandemic made health headline news. To highlight the doctors’ point of view on the pandemic, CPME has compiled an extensive collection of status reports from national medical associations. These address the availability of human and technical resources, testing and treatment protocols and the impact on doctors’ health and practice. A first analysis confirms that a large majority of countries do not have a medical workforce large enough to deal with such events. Existing workforce shortages for example in Bulgaria and Ireland, became even more acute. Elsewhere, it was only the relatively low numbers of infections that prevented problems. Where doctors were in quarantine or on sick leave, the available workforce further contracted, in Malta by up to 10%. In Hungary, a third of all doctors and nurses were excluded from frontline practice as a protective measure due to their age.

Emergency remedies abound. Several countries accelerated medical students’ access to practice, either on a voluntary basis as in Greece or by law as in Germany. Calls to retired doctors to re-join the workforce or to become a reserve were effective for example in Italy, France, and the Netherlands. Sweden has reallocated doctors to different workplaces, while in Cyprus, doctors from the private sector are assisting in public hospitals. From Spain, it is reported that doctors are supporting their colleagues across specialties. Among those countries not experiencing shortages, Norway reports that doctors have travelled to Italy to support their local colleagues.

These encouraging signs of solidarity and resilience must now guide future pandemic preparedness. Doctors and other health professionals coped with unknown adversities to continue the best possible care for their patients. No mention of these efforts can be complete without remembering those doctors and other health professionals who have died of COVID-19. Their deaths are a sad reminder of the danger and real risks the health workforce faces every day. It is therefore imperative that the medical profession is involved in the evaluation of lessons learnt to ensure the pandemic preparedness is fit for practice. European doctors are ready to share their experience.

Cross-border cooperation between dental regulators in Luxembourg and Germany

Michel Pasdzierny, Chair, Regional Dental Council of Grand Est, France

The absence of a coordinated national response to COVID-19 did not prevent or hamper longstanding relationships between borders, but it did hamper professionals’ access to PPE, such are the lessons learned from the crisis.

From the start of the crisis in March 2020, the local Dental Council of Moselle responded to the call from the neighbouring Luxembourg Medical College to share information on the French situation. The exchange was useful and conclusions were quickly shared, as closures of dental clinics followed in Luxembourg too, along with the domestic organisation of emergency care and the drafting of on-call dentists on a voluntary basis.

On another part of the German border, the situation was uneven: if communications with the Saarland Council became impossible (it is only indirectly that the County Council learns about the Saarland situation, for example the maintenance of open dental surgeries and open prosthetic laboratories), cross-border relations with the Baden-Württemberg Council were fruitful - Dr N.Engel, responsible for European affairs transmitted the new ISO quality standards as well as the protocols established by the Karlsruhe Academy headed by Professor W. Walther and D. Hellmann for the dental practices adapted to COVID-19 (certification of clinics, team structure, possible and prohibited treatments and the typology of patients at risk). This information enabled the Grand-Est region to plan for the easing of restrictions in May.

In parallel to this cooperation between border regulators, one can regret that many French practitioners living close to the border and using their usual German suppliers of dental equipment were refused delivery of PPE without any explanation - the cross-border movement of goods was hampered at a time when the Grand Est was a particularly impacted region. Lessons are taught for future crisis.
Many, but interestingly not all, FEDCAR members recommended or forced practitioners to close their practices, sometimes at the request of the government and sometimes even ahead of it. On 15 March the New York Times reported in an article entitled The Workers Who Face the Greatest Coronavirus Risk, a diagram wherein dentists were most at risk to be affected.

Many dental regulators assisted in establishing local and national systems for emergency oral health care in order to:

- refer patients
- receive and treat patients in emergency situations
- relieve pressure on public hospital services
- assist and encourage dental professionals to volunteer in response to the pandemic.

In mid-April PPE for dental practitioners was still not sufficiently available for the profession. Only in May were deliveries of PPE that had been ordered through the Joint Public Procurement signed by EU member states on 17 March started.

Communication with patients was undertaken on a regular basis by some members (see examples in Ireland or Spain).

Though cross-border cooperation was encouraged by the EU Commission, the movement of patients or dental practitioners has not been reported. Cooperation mainly concerned the exchange of information on dental practice’s updated quality standards and new protocols which were apparently more needed.

Early on, the European Centre for Disease Prevention and Control published Infection prevention and control in dentistry for member states and in April these were enhanced by further recommendations. Dental regulators published, updated and shared guidelines regarding infection prevention and control to ensure that patients received appropriate care and that dental practitioners and employees had the best environment to provide safe care and advice. This exchange of information was in parallel to the Joint European Roadmap towards lifting COVID-19 containment measures. This updating of quality standards was initiated in cooperation with academics, professional bodies and regulators.
EFPA psychologists support hub

Sabine Steyaert, Director, European Federation of Psychologists Associations, Belgium

The COVID-19 outbreak is a major public health issue across Europe and the world. EFPA, as the European umbrella organisation for psychologists would like to share some guidelines and possible actions for psychologists to take in its member associations.

The EFPA Support Hub gives a single point of access to psychology resources for psychologists to use. The resources cover supporting individuals, families, local and national communities, and supporting psychologists in their own professional practice. The content is mainly in the language of the country concerned. Links to the World Health Organisation (WHO and WHO Europe), European Centre for Disease Prevention and Control (ECDC) and country government guidance are also included.

BIG-register: responding to COVID-19

Vivianne Habets, Senior advisor, BIG register, Netherlands

The two most important actions taken by the Ministry of Health, Welfare and Sport in relation to the BIG-register and COVID-19 are:

1. Allowing former registered nurses and doctors to temporarily return to work without renewing registration

The work of medical doctors and nurses is crucial in caring for patients and helping to combat the virus in the Netherlands. Therefore, our Ministry of Health, Welfare and Sport made it temporarily possible for medical doctors, specialists and nurses whose registration had expired after 1 January 2018 to return to work in the healthcare sector under certain conditions without re-registering. There are some important conditions, for example, this does not apply to healthcare professionals with a disciplinary sanction or any other limitation on their registration or licence to practice.

2. Postponing the obligation of re-registration

Registration with the BIG-register aims to promote quality healthcare in the Netherlands and to protect the users of healthcare services against unauthorised healthcare providers. Registration is temporary, with healthcare professionals obliged to renew their registration every five years after obtaining their qualification. Re-registration is possible if the healthcare professional has recent and relevant work experience in the provision of individual health care.

Following the outbreak of COVID-19, the BIG-register decided to suspend the obligation of re-registration for all registered healthcare professionals until further notice. This action prevents healthcare professionals losing their registration allowing them to continue to work as healthcare professionals and to support the national effort. When the situation allows the obligation of re-registration will apply again.

BIG-register: applications from EEA countries

Seniz Sari, Senior advisor, BIG-register, Netherlands

At the onset of the restrictions due to COVID-19, the BIG-register expected a drop in applications from other EEA countries. After analysing the numbers, we have seen no significant drop in the number of EEA applicants. With the increased need for healthcare professionals during the pandemic, we are continuing to handle these applications with priority. We are aware of the difficulties applicants may face in obtaining the required documents for registration and in those cases we try to contact the foreign competent authority for the necessary information using the IMI system.
Standards of proficiency consultation

The UK Health and Care Professions Council (HCPC) is seeking views on proposed changes to the standards of proficiency for each of the 15 professions they regulate. These standards set out what the Council considers necessary for safe and effective practice, and describe what professionals must know, understand and be able to do at the time they apply to join the register.

HCPC have proposed changes to both the generic and profession-specific standards, following engagement and feedback from stakeholders last year. The consultation is open until 30 October and further details can be found here.

Pharmaceutical Society of Ireland pandemic response

Úna Ní Chárthaigh, Communications and Engagement Executive, Pharmaceutical Society of Ireland, Ireland

At the PSI, the pharmacy regulator in Ireland, we have been working on our response to COVID-19 since February. We have observed extensive collaborative efforts from our own team as we adapted to new ways of working and we are part of shared initiatives and vital cooperation with external organisations. We are part of a national community pharmacy contingency planning forum and this multi-stakeholder group considers the ongoing COVID-19 challenges and changes for community pharmacy services.

While we initially suspended some of our regulatory activities, we have largely resumed these or have plans in place for resumption in the interest of all those we serve and regulate. We have focussed on keeping our registrants updated with the public health information they need to continue their roles safely and effectively, and to keep them informed about the work we are doing.

Some of our regulatory activities include:

- Coordination with the Department of Health to facilitate legislative change allowing a temporary restoration process for former registrants to support public health efforts. We also assisted with amendments to regulations relating to prescription and supply requirements. To aid pharmacists and prescribers with those changes, we published joint guidance with the Medical Council and Health Service Executive.
- Collaboration with the Health Service Executive to publish guidance about safe delivery of medicines to homes for patients, volunteers and pharmacies and to develop guidance on business continuity planning for community pharmacies to ensure pharmacy was addressed in infection prevention and control advice.
- Amending our statutory rules to provide a flexible and pragmatic approach during the pandemic, including the option for registered pharmacies to temporarily defer registration fees and to provide flexibility in the duration of the final eight-month placement for students completing a Master’s in Pharmacy, if needed.
- Developing new operational standards and an assessment framework to apply across PSI registered pharmacies to assist with challenges faced by the pandemic and guidance on providing pharmacy and medicines services, including appropriate infection prevention and control measures, on an ongoing basis.
- Engaging with the national immunisation office to ensure pharmacists and pharmacies can appropriately support national efforts to increase vaccination uptake across our population this winter.

More information and documents are available on the PSI website or for further information feel free to contact us at info@psi.ie.
The GMC is the UK-wide regulator for doctors. We work to protect patient safety and support medical education and practice across the UK. We do this by working with doctors, employers, educators, patients and other key stakeholders in the four countries of the UK’s health services.

This article sets out the main regulatory actions that we took in response to the COVID-19 pandemic over the past few months.

**Temporary registration**

In an emergency the UK Secretary of State for Health can activate a part of our legislation and ask us to grant temporary registration to certain groups of suitable people to supplement doctor numbers and provide cover in a range of roles. The Government triggered these powers on 25 March.

Between 26 March and 3 April, we granted temporary registration to over 34,000 doctors using our emergency powers. A range of exclusions were applied to these groups and some were not granted temporary registration, for example if they had an open fitness to practise case or sanction against them or if they had previously failed a GMC revalidation assessment.

Doctors had the option to opt-out of temporary registration if they didn’t want to re-join the register and at the end of the emergency period their temporary registration will automatically be withdrawn.

The GMC also brought forward the window for the annual provisional registration of final year medical graduates. Students were asked to apply to the GMC for their provisional registration, which was only granted once their medical school had confirmed their graduation.

In terms of education, we agreed to accelerate our processes to enable the continued progression of trainees whilst continuing to maintain standards. We worked with colleges and other educational bodies to enable the approval of changes to assessments that allow social distancing.

**Supporting doctors**

We created a [COVID-19 ethical hub](#) on our website to answer frequently asked questions about coronavirus and how we’re supporting doctors. It covers issues such as wellbeing, working safely, consent, remote consultations, confidentiality and end of life care.

One of the issues that we were asked about was PPE and whether doctors can refuse to treat patients if they don’t feel they have adequate PPE. We were clear that doctors should use PPE in line with the most up to date guidance issued by the four UK health departments. We also published guidance setting out the key principles of working safely during the pandemic.

In terms of fitness to practise, we published a [joint statement](#) with other UK health regulators setting out how we would regulate during this unprecedented period. This made clear that where a concern is raised about a registered professional, it would always be considered on the specific facts of the case, taking into account the environment in which the professional is working. We would also take account of any relevant information about resource, guidelines or protocols in place at the time.

Finally, we have deferred the revalidation date for doctors who were due to revalidate any time before 16 March 2021 by one year. We made this decision to support the health service to prioritise clinical care for patients during the coronavirus pandemic.

Looking to the immediate future we’re re-prioritising our work – deciding which projects need to be paused and which are still relevant in a potential post-pandemic world. We are currently in the process of developing our next corporate strategy which will run from 2021-25 and we are looking at how to ensure our priorities are still appropriate in light of the COVID-19 pandemic.
Josh Niderost, Senior Policy and Public Affairs Officer, Council of Deans of Health, UK

Students across the UK played a crucial role in supporting the NHS through undertaking practice hours contributing to learning outcomes and to the national pandemic response. The Nursing and Midwifery Council (NMC) introduced new emergency standards to enable finalist students in their last six months to move fully into practice. Other third year and second year students are spending 80% of their time in practice and 20% in online theory learning. Students in practice will still benefit from protected learning time. First year students are not in clinical placement currently but continuing their academic learning virtually. Over 26,000 nursing students opted-in to support practice in England.

These essential changes will have long-term implications for healthcare education. Not all students who were able to be deployed were needed, as thankfully the peak of COVID-19 cases was less than projected. Placement capacity will continue to be an issue; it is affected by service reconfiguration, planning for any future peak, and the need to grow the number of nurses to meet the needs of the NHS Long Term Plan and Government commitments. Universities are also responding to the challenge of delivering education online or face-to-face in a socially distanced way.

The COVID-19 pandemic has forced the sector to reflect on the potential future of healthcare professional regulation, particularly in the context of Brexit. The Directive on the recognition of professional qualifications requires nursing and midwifery programmes to include 4,600 hours of theory and practice learning. A competency-based approach rather than the pure measurement of hours is an important lesson to take forward. Programme length has already been flexed slightly to ensure students are not delayed in completion. There should also be more scope for simulation and virtual placements that would count for practice hours, especially for shielding students. Competencies and not hours alone should take prominence as we move back toward normal.
At the end of December 2019, the Ordem dos Enfermeiros (Portuguese Order of Nurses) began to follow closely the information about COVID-19. With the declaration of a state of emergency in Portugal which profoundly changed our daily life, we quickly agreed on the importance of monitoring and supporting nurses. The Strategic Crisis Office COVID-19 was immediately created, allowing the Order to respond in a timely manner to the large number of requests received. With the sense of public service that the moment demanded, but without giving an inch to our commitment to nurses and patients, we collaborated with the Ministry of Health and with health authorities, to identify problems that came from the field and to actively search for solutions.

We created a nurses’ pouch for the SNS 24 Line to immediately reinforce the intensive care units of the country. Equally, upon direct request, the Order has collaborated in the strengthening of nurses in numerous healthcare structures, public, private and social. We also created the Mental Health Helpline provided by specialists in mental health and psychiatric nursing and we created the COVID-19 website collating up-to-date useful information.

The Order has been meeting with the Ministry of Health, participating in the elaboration and revision of technical documents, identifying not only the need to make normative adjustments but also to raise the problems that nurses have been facing. In collaboration with higher education institutions in nursing and with the Ministry, we have been working on solutions that will allow students in the 4th Year of their nursing degree, to complete their training and quickly enter the job market without harming the quality, demand and rigour in nursing education.

With the de-COVID phase slowly underway, there are still many nurses living away from their own families to take care of others. Everything is beginning to return, but we need to be aware that the immediate future will be crucial for nurses.

Strength and unity are necessary to recognise and appreciate the nursing profession in Portugal in the coming months or it will be a missed opportunity. Recognition of the need to enhance the capacities and competencies of nurses, in particular nurse specialists or holders of advanced competencies, whilst autotomising their practice in specific areas is essential.

We have no doubt and have been witnessing the serious commitment of the Government and health authorities in this fight. In these times of plague, which unfortunately will not end tomorrow, it is necessary to seriously assess the importance of nurses and provide them with complete protection and conditions to practice with dignity and security and the same must happen with all other health professionals.
Around the world

US: waiving licence requirements in response to COVID-19

As part of the response to COVID-19 in the US, many states have allowed physicians and other healthcare professionals to practice across state lines as long as they have a medical license in at least one state. The Federation of State Medical Boards (FSMB) are providing information that can be used to verify licenses and credentials for physicians and other healthcare professionals wishing to practice across state lines to treat patients in areas heavily impacted by the COVID-19 virus.

Through the FSMB’s Physician Data Center (PDC), states are able to verify licensure information and disciplinary history for the more than 1 million licensed physicians and physician assistants in the United States. The PDC is continuously updated and is the most comprehensive repository of physician licensure information in the country. A full list of the states waiving licence requirements can be read here.

Pakistan Medical and Dental Council reinstated

Following the dissolution of the Pakistan Medical and Dental Council (PMDC) being declared void and Islamabad’s High Court ruling in March upholding its restoration, the PMDC has re-opened its doors. Since the ruling, the Supreme Court of Pakistan has established an eleven-member board to run the Council. In the first few weeks of opening, the Council processed over 5,000 certificates of registration and received 5,500 new applications. The immediate priority for the Council is to continue to process and issue provisional registration certificates for newly qualified doctors.

AHPRA: professional wellbeing

With the current challenges and pressures facing healthcare practitioners since the onset of the COVID-19 pandemic, AHPRA's Taking Care podcast explores insights from the front line and current challenges in the system. This episode shares personal and professional insights, challenges practitioners are facing in the current situation and the increased pressure and anxiety in the current climate. Health practitioner wellbeing in the pandemic era and beyond episode explores strategies for looking after wellbeing, the Pandemic Kindness Movement as a source of information and connection to the local community and what kindness and wellbeing mean both now and going forward.

Assessments of patient safety culture in OECD countries

While healthcare quality has been improving on average in OECD members countries, patient safety remains a central priority for policy makers and health care leaders. A body of growing research has found that patient safety culture is associated with numerous positive outcomes, including improved health outcomes, improved patient experience, and organisational productivity and staff satisfaction. The Assessments of patient safety culture in OECD countries report finds that measurement of patient safety culture is prevalent across OECD countries, though the application, purpose, and tools vary. It suggests that international learning and benchmarking could have significant potential for better understanding and improvement of patient safety and health care quality.
Jamaica calls for improved regulation

Following recent revelations that only a third of Jamaica’s private hospitals are certified by authorities, there have been calls for increased regulation and more transparent oversight. Although registration for private hospitals is a requirement under the Nursing Homes Registration Act 1934, many have long resisted regulation. Many hospitals state they are unaware of the requirements under the act, specifically that the onus lies with the institution to apply to the Ministry of Health and Wellness for registration.

To address these concerns, the Government is looking to enforce immediate compliance under Section 16 of the Public Health Act. The move allows authorities to perform inspections and to start the process of registration without an application from individual institutions and have since called for the immediate inspection of 17 private hospitals.

The Ministry, who are responsible for enforcing the Nursing Homes Registration Act, has acknowledged weaknesses in the legislative framework, notably that specialised private hospitals are not fully captured under the Act and as such are working to pass the Health Facilities Act into law to govern private hospitals. Calls have also been made for Parliament to pass legislation establishing an independent Medical Facilities Standards Authority to oversee the health system.

As it stands, registration under the Nursing Homes Registration Act is valid for two years and confirms that an institution has met minimum standards for operating procedures, equipment, patient management, hospital environment and staffing through inspection and review.

Medical Council of India telemedicine guidelines

The Medical Council of India has issued guidelines enabling registered medical practitioners to provide healthcare using telemedicine. Previously without regulation or legal framework, the guidelines seek to clarify the country’s stance on providing remote consultations and care. Now formally a part of the Code of Medical Ethics, the guidelines have been included as an amendment to the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations 2020.

As per the guidelines, registered professionals may use any telemedicine tool suitable for carrying out technology-based patient consultation including WhatsApp, Facebook Messenger, Skype, email, phone and video conferencing platforms, except where telemedicine would not be in the patient’s best interest. In instances where the doctor needs to conduct an examination in order to make a diagnosis, video consultation should be recommended, and in cases of emergency patients should be advised to seek care in person however this can be waived if telemedicine is the only option to seek care. The guidelines clearly state that telemedicine cannot be used to conduct remote surgical or invasive procedures and that professionals cannot insist on telemedicine consultations or solicit patients for telemedicine through advertising or inducements. The Telemedicine Practice Guidelines further outline healthcare professionals responsibility around verifying identity, obtaining consent, prescribing remotely, managing patient records, charging fees, protecting data privacy and professional ethics.

The Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations 2020 was approved by government and has been in effect from 25 March 2020.
As healthcare systems and regulatory authorities around the world react to COVID-19, the use of telemedicine is emerging as an important part of the response in countries where face-to-face contact has been significantly restricted. Despite medicine being a regulated profession, telemedicine itself hasn’t always been and doesn’t necessarily fit neatly within traditional areas of law and regulation. A recent article by Hogan Lovells explores some of the regulatory challenges countries and bodies face in governing international remote medical services to ensure patient safety.

Regulate remote care – often, the absence of law or regulation in a country does not mean the practice of telemedicine is not covered by the existing regulatory framework or codes of conduct. Having clear provisions within existing frameworks or passing new legislation detailed enough to address the varied circumstances where professionals may provide remote care, including instances of physicians outside the country providing remote services into the country, would provide much needed clarity.

Define medical practice – the definition and scope of medical practice, including the registration and licensing of physicians, varies from country to country and in some cases including Canada and the US, within the country itself. As such, clearly defining what constitutes the practice of medicine within the country, whether that includes diagnosis, consultation or prescribing, would help support and enforce regulation including fitness to practice frameworks.

Define telemedicine – many countries do not have a clear definition under the law of what telemedicine is or includes.

A clear legal definition that is applicable and enforceable, outlining exactly what telemedicine is and what its practice covers again would support its regulation.

Clarify registration and licensure requirements – when considering international remote healthcare, the question of whether and how licensing rules apply to doctors not resident in the country is one of the most challenging aspects. Registration and licensing are not only professional duties but legal and ethical ones. Being clear on the registration and licensing requirements of foreign physicians practicing telemedicine and of the consequences on their ability to practice medicine should they violate the rules would not only support clear regulation but would support its enforcement across boarders.

Ensure patient consent and data privacy - with the complexities of some physicians treating patients and consulting with professionals remotely across country borders, the need to protect patient data including sensitive personal data and medical information, and to obtain express consent is all the more pertinent and all the more complex when considering the transfer of data across countries. Having clear guidelines around consent and defined laws around data privacy and sharing as per GDPR in Europe would ensure the practice of telemedicine to support the COVID-19 pandemic is focussed around protecting patients.

This article has been adapted from a Hogan Lovells article originally published on 9 March 2020. A link to this can be found here.
WHO State of the world’s nursing

The World Health Organisation has published its first State of the world’s nursing 2020: investing in education, jobs and leadership report. Published during the International Year of the Nurse and Midwife, the report explores the global nursing workforce and opportunities to further its role in healthcare.

Focussed around three central pillars of education, employment and leadership, the report makes the case for investment to progress WHO Sustainable Development Goals and Universal Health Coverage in order to:

- Address the projected 5.7 million nursing shortfall by 2030 in Africa, South East Asia and the East Mediterranean by increasing nursing graduates by 8% each year and improving capacity to employ and retain those nurses, with calls for countries to increase funding for education and employment

- Strengthen capacity for health workforce data collection across the 27.9 million global nursing workforce through the implementation of a national system and the collection of labour statistics and nursing data from governments, regulators and providers to guide policy and investment

- Support leadership in order to strengthen the workforce by embedding senior nurses in governments across the world to drive the collection of data and guide health policy and the establishment of nursing leadership programmes

- Allow nurses to work to their full scope of practice by expanding nurse-led models of care across primary care and garnering support for advanced practice roles

- Create an inclusive system for those within the nursing workforce by addressing the gender pay gap, informing nursing policy and creating flexible working environments for a workforce that is predominantly female

ECFMG medical school accreditation requirement moved to 2024

As reported in earlier issues, the Educational Commission for Foreign Medical Graduates (ECFMG) has previously announced that applicants for certification will be required to be a student or graduate of a medical school that is appropriately accredited from 2023. More specifically, the medical school must be accredited by an agency recognised by the World Federation for Medical Education (WFME). To date, 21 accrediting agencies have received WFME recognition, with many others in process. However, in recognition of the fact that many countries have been forced to suspend or limit their accreditation efforts due to COVID-19, ECFMG have moved the implementation of the requirement to 2024.

Links to the full report and executive summary, WHO Sustainable Development Goals and Universal Health Coverage can be accessed here.
ECFMG COVID-19 response: maintaining standards in a rapidly changing environment

Lisa Cover, MHA - Senior Vice President, Business Development and Operations and Tracy Gill, MLA - Assistant Vice President, Credentialing Services and Business Development, ECFMG Educational Commission for Foreign Medical Graduates, United States

How do you maintain the integrity of your standards while also meeting the challenges posed by the COVID-19 world of remote work? The Educational Commission for Foreign Medical Graduates (ECFMG) quickly adapted its credential verification processes earlier this year in response to the COVID-19 global pandemic. Certification by ECFMG is required for international medical graduates (IMGs) to enter post-graduate training in the United States. In addition, ECFMG works with medical regulatory authorities around the world to primary source verify the credentials of their IMG candidates. In 2018 alone, ECFMG verified more than 60,000 credentials from over 170 countries.

COVID-19 has challenged us to rapidly innovate in collaboration with medical schools and regulatory authorities across the globe as they have transitioned to working remotely. Once the scope of the pandemic became apparent, we proactively contacted institutions to see if they were experiencing difficulties and formed an internal team to monitor institution closures, postal delays, and other issues that could impact our verification processes. We also implemented a communications campaign to institutions to encourage them to begin using our online portal or email to verify credentials, rather than mail. We moved toward using email as much as possible to communicate with institutions, given a verified email address could be identified.

To accommodate staff working from home, we adapted our verification process to enable institutions to verify credentials without the need to print and scan paper forms, such as through fillable PDF forms or through emails, along with a photo (taken by cell phone) of the official’s signature along with the date. Between our online portal and email processes, the number of institutions around the world that we now send credentials to electronically increased from 1,900 to 3,000 between February and May. Since some schools were unable to provide final transcripts or diplomas, we also issued interim ECFMG certificates when needed.

By keeping our standards flexible yet rigorous, we have been able to continue our operations and provide a high level of service to our applicants and clients while still upholding the integrity of our certification and primary source verification processes.
Newsletters and Updates

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If you would like to contribute to the next Crossing Borders Update please send an outline of your proposal to the HPCB secretariat.