



European Commission Green Paper on Modernising the Professional Qualifications Directive

Response from the Royal College of Surgeons of England

Key points:

- The goal of the Directive in healthcare should be to ensure the highest standard of patient safety and service quality in the context of removing mobility barriers for professionals between member states in the European Union.
- As such, the College is encouraged by the timely aims of the Green Paper to clarify and update the content of the Directive and its practical application.
- Broadly, we are cautious of proposals to relax requirements within the Directive, and would instead recommend that the Commission and Member States focus on how to satisfy existing requirements of the recognition process more swiftly and efficiently.

Consultation questions:

In our response below we focus on the questions of particular relevance to the surgical profession, considering specifically the impact of any proposed amendments on the safety and wellbeing of patients receiving treatment in the EU which the College considers to be of fundamental importance.

Questions 1 and 2 – Roles of competent authorities and the Professional Card

Competent authorities in the host country should at all times retain the ability to verify an individual's qualifications pre-registration, so as to maintain the standards and integrity of the register.

Therefore there are several aspects of the proposed Professional Card which we believe require close attention. We are concerned about issues of data ownership, the interface of the Card with the existing datasets, and the potential for fraud (quality assurance of the information on the Card). We fear that as the information on the Card would still have to be checked by the relevant competent authority, it would become an extra administrative hurdle with no value to the individual or the assessing authority. Current arrangements are working well in the UK with the competent authorities responsible for assurance of the qualifications, as evidenced by the proportion of EU doctors on the General Medical Council's register (currently around 10%).

Question 3 – Partial access to a profession

On the grounds of patient safety – a valid public interest – we would urge the Commission to put in place derogation for the health sector regarding partial access. An individual who is not able to meet the required standards in the maximum allowable adaptation period as currently defined

must not be granted access to the health professions to any extent, with the accompanying possibility of access to patients and other vulnerable groups.

Question 7 Temporary mobility requirements regarding consumers crossing borders

We suggest retaining the current criteria for two years professional experience plus declaration requirements for healthcare professionals so as to maintain consistent standards and safeguarding of patients across temporary/establishing categories of professional mobility. This is because once on the medical register there is no restriction as to the nationality of patients that a professional can provide services for.

Question 12 – IMI alert mechanisms

We strongly support option 2, whereby all Member States receive notification if a health professional is no longer able to practise due to disciplinary sanction.

Question 13 – Language requirements

Competent authorities must retain the ability to satisfy minimum fitness-to-practise criteria (which includes communication and language skills) in order to maintain the integrity of the medical register. Employers are then ultimately responsible for ensuring clinical and communicative competence of the professional for the specific role in which they are employed. These principles must be maintained in the Directive to ensure patient safety.

We therefore consider the system as currently exists (automatic recognition for doctors) to be safe only when the individuals are employed via a properly constituted appointments process, as there is the opportunity at the interview to assess language and communication skills as well as the critical clinical competencies required for the job. The College has major reservations about the ability to assess these skills in registered individuals who are employed by agencies and utilised in a locum or temporary capacity, and believe that this lack of stringency compromises patient safety.

Given that we make a distinction between general language skills and those required for specific employment, we are not satisfied with the concept of a 'one off' test as it would prohibit an employer from assessing a candidate's full suitability for a job if a language assessment has already been undertaken by the Competent Authority.

We also disagree with the principle of limiting language testing to only those health professionals with whom direct contact with patients is anticipated, as we believe this compromises safety for two reasons. Firstly, there is no practical mechanism to stop people working directly with patients once they are on the medical register. Secondly, this limitation takes no account of the importance of other essential communication skills required to ensure patient safety in healthcare – such as the ability to converse with colleagues, write clear notes, and contact patients indirectly (for example over the telephone) etc.

Question 14 – A phased approach to modernisation

We support the proposed move towards acknowledging and incorporating competencies, but do not believe that the timescales proposed are feasible given the scale of the challenge in clarifying required competencies and assessing equivalence/standards etc. This process must occur with full engagement of the professions throughout, and is likely to take a considerable period of time.

Question 15 – CPD

The College welcomes recognition that the lack of CPD stipulation is a gap in the Directive. We believe that this revision of the Directive is an opportunity to require that CPD is mandatory in all member states – whilst allowing development of CPD standards on a national basis to allow them to most usefully complement and reflect the professional practice in that member state. There

are however implications to explore and resolve regarding movement of professionals between Member States with significantly different CPD standards and requirements.

Question 16 – Minimum training requirements

We support strongly retaining the two eligibility options of either 5500 minimum training hours or six minimum training years to allow all doctors the opportunity of EU mobility (for example, those who have undertaken UK graduate training programmes that incorporate 5500 hours of training in four years with proven effectiveness).

Question 18 – Doctors: New Medical Specialties

We do not believe there is sufficient reason to amend the current requirements of two fifths of Member States in order to declare a new Medical Specialty.

Question 19 – Doctors: Partial training exemptions

Whilst the College recognises that it is undesirable for doctors to have to duplicate training already undertaken when switching to a different specialism, there would have to be robust systems in place to confirm validity and equivalency of previous training before a partial exemption is granted – particularly if that previous training was undertaken in another Member State. This would be a complex process and may prove too great a challenge to address under the Directive.

It is also important to emphasise that whilst the College accepts that there could be a case for partial training exemptions, we do not accept that there is a case for any partial access to the health professions.

September 2011