General Medical Council

Regulating doctors
Ensuring good medical practice

Evaluating the Professional Qualifications Directive
Experience reports from competent authorities

The General Medical Council (GMC) is the independent regulator for doctors in the UK and the competent authority responsible for the mutual recognition of medical qualifications in the UK. The GMC believes the fundamental purpose of medical regulation is to ensure safety and quality of care for patients.

The GMC supports the free movement of doctors in the EU and the principle of recognition of professional qualifications; for decades the UK health system has benefited from EU and overseas qualified doctors practising in the UK. Approximately 37% of those doctors on the register gained their primary medical qualification in countries other than the UK.

There are currently over 239,170 doctors on the UK Medical Register. Of those 151,280 (63.3%) received their primary medical qualification in the UK; 22,263 (9.3%) qualified in other parts of the European Economic Area; and 65,627 (27.4%) are international medical graduates (IMGs).

The specific requirements that doctors have to satisfy before being granted entry to the medical register vary depending under which category they fall. UK legislation ensures that are more stringent system of checks is in place for IMGs wishing to join the UK medical register to ensure patient safety is not compromised. Given the higher proportion of IMGs on our register, these checks do not appear to act as a barrier to movement.

Recent events in the UK have highlighted some of the regulatory gaps that have the potential to harm patients and undermine confidence in healthcare. In an environment where health professionals and patients are encouraged to move across member states a risk to patient safety in one member state is potentially a patient safety risk in another member state. It is therefore essential that EEA doctors and healthcare professionals, exercising their rights of free movement, are only granted registration when they are known to be appropriately qualified and fit and safe to practise.

We welcome the opportunity to respond to the European Commission evaluation of Directive 2005/36/EC on the mutual recognition of professional qualification and remain committed to working with the Department of Health (England), devolved administrations, employers and the European institutions to ensure that the free movement of doctors in the EU does not compromise patient safety in Europe.

QUESTIONNAIRE FOR THE MEDICAL PROFESSION

A. Recognition procedure in case of migration on a permanent basis

1. Do you accept applications from EU citizens for the recognition of foreign diplomas sent by email or requests made on line? Under which conditions can they send documents and declarations electronically? What are your experiences in this respect?

In the majority of cases, doctors applying for registration in the UK make an application using our online facility. Since 2009, 85% of applications were made online (5,400). A hard copy application form is available if required.

Applicants are required to submit photocopies of documents to enable us to recognise their European qualifications. They can choose to send these by post or email. Inevitably there can be problems sending information electronically – problems with security, file size etc.

The GMC has concerns about the Code of Conduct[1] as adopted by the European Coordinating Group in April 2010. The Code prevents competent authorities from requiring original and officially translated copies of documentation and from requesting doctors to verify their identity. We understand that these provisions are in line with the outcome of ECJ Case C-298/99[2] which refers to the case of architects but, given the risk to patients and the public that would inevitably arise from a fraudulent recognition and registration, we believe that special provisions should be made for healthcare professionals in line with Recital 6 in the Directive. It states that: "The facilitation of service provision has to be ensured in the context of strict respect for public health and safety and consumer protection".

We believe that original documentation, officially translated copies, and verification of identity of the applicant are essential in the prevention of fraud and identity theft. In our view they do not impose any unnecessary barrier to free movement upon applicants who are appropriately qualified and fit to practise. The GMC has experienced a number of cases of fraud and identity theft. These include:

- Thomas Nassier, who was admitted to the GMC register based on documentation that was subsequently found to be fraudulent. The doctor had never worked in France as a doctor nor had he studied medicine. After investigation we found the qualification documentation, as well as the confirmations (including those from the medical regulatory authority about his good standing), were forgeries.

- Barian Baluchi, a former mini cab driver, stole the identity and documents of a Spanish doctor. He claimed to have trained at Harvard, Colombia, Newcastle and Sussex Universities, and Leeds Medical School but in reality had no medical

[1] Code of conduct as approved by the Group of Coordinators, 30 April 2010
[2] Case C-298/99 Judgment of the Court (Fifth Chamber) of 21 March 2002 - Commission of the European Communities v Italian Republic-Failure by a Member State to fulfil its obligations-Directive 85/384/EEC-Mutual recognition of formal qualifications in architecture-Access to the profession of architect -Article 59 of the EC Treaty.

experience. He worked as a consultant psychiatrist and committed fraud in relation to asylum applications. He was jailed for 10 years.

2. **What is the yearly number of positive and negative decisions of recognition from 2000 to 2009? Please submit specific data for applications for automatic recognition based on diplomas, automatic recognition based on acquired rights (as from 2005), and recognition based on the general system[3]. If available, please provide information on the average duration of the recognition process.**

The GMC has submitted the yearly number of positive and negative decisions to the European Commission through the UK National Coordinator.

It is not possible to provide specific data for applications for automatic recognition based on acquired rights.

The average duration of the recognition process is between 2 and 16 days upon receipt of a complete application.

3. **To what extent have the system of automatic recognition and the general system been a success? How do you see the costs and benefits? Specify in particular whether automatic recognition based on diploma, Annex V and the current notification system represent an efficient way to facilitate automatic recognition. Please submit comments for:**

   - **Automatic recognition based on diploma**

Where a doctor has a European qualification that is listed in the Directive, we have some assurance that the training leading to the award of those qualifications meets certain standards.

However, we have recently had an application for registration from a former Sudanese national who obtained British citizenship and had recently qualified in another EEA country. This qualification was listed in the Directive. Although not a requirement for registration for EEA doctors, this doctor elected to sit an exam in the UK, run by the GMC, which is known as the Professional and Linguistic Assessments Board (PLAB). This test is the main route by which international medical graduates demonstrate that they have the necessary skills and knowledge to practise medicine in the UK. Despite three attempts, this doctor failed to pass the exam. This indicates that, although he has a qualification that is listed in the Directive, and therefore is entitled to registration, he does not appear to have the requisite knowledge and skills to practise safely as a fully registered doctor in the UK.

We also have evidence of 83 applicants who have in the past failed our PLAB test and have subsequently gained recognition and registration with the GMC under the Directive after they acquired EC rights or following EU enlargement. We have grave concerns that these doctors although eligible for recognition and registration with the GMC under the Directive, may pose a risk to patient safety.

[3] Please provide this information unless it has already been provided to the Commission in the Database or the implementation reports.

We believe that the current recognition system does not offer competent authorities and patients the assurance that doctor's current knowledge, skills and experience are at the levels required to practise safely. Since 1 January 2009, we have received applications from 29 doctors who have had extensive breaks in their medical practice (some spanning 10 years) and yet automatic right to registration allows them to practise medicine in the UK.

The automatic recognition process also relies on competent authorities only issuing documentation in accordance with the Directive. We have seen examples of certificates issued under Article 23.1 when we have evidence that the applicant has worked outside the EEA since 1996. We have also received certificates that have been issued in compliance with Directive 92/16/EEC when the country in question was not subject to that Directive. This is a cause for concern.

In the majority of cases, automatic recognition based on diploma is successful for applicants, in that their qualification is recognised and they gain registration to practise medicine in the UK.

- **Automatic recognition based on acquired rights**

If an EEA qualification was obtained before the reference date in Annex V and the training does not meet the minimum training requirements, Article 23.1 in the Directive specifies that the applicant can benefit from automatic recognition if they can show, via an attestation from the member state of origin, that they have been effectively and lawfully practising the profession in question for at least three consecutive years during the five years prior to the attestation being issued. However, in some cases, competent authorities, cannot confirm that the doctor has been working for at least three consecutive years during the five years prior to the attestation being issued. This is because the competent authority does not hold information on an applicant's practice. In these cases, the GMC would seek to obtain alternative evidence, such as employment references. We would welcome clarification from the European Commission on whether the competent authority in the member state of origin is obliged to provide the requisite certification, or whether the GMC should continue to accept and require alternative evidence.

Whilst Article 23.1 specifies the total duration of professional experience as three years, this is open to interpretation and may allow for minimal experience (such as part-time work) or experience confined to highly restricted forms of practice. Therefore, it is possible that an applicant, whose training does not meet the minimum training requirements laid out in the Directive, may have acquired rights to recognition and registration based upon working one locum shift per month over a period of three consecutive years during the five years prior to the attestation being issued. This scenario offers competent authorities like the GMC little assurance that applicants can practise safely in the UK.

There are also no provisions in the Directive that allow competent authorities to satisfy themselves that the professional experience certified by the member state of origin has been completed satisfactorily.

- **Recognition based on the general system.**

EEA doctors with European qualifications

The GMC has not experienced any difficulties when dealing with applicants with European qualifications under the general system. In most cases the applicant cannot provide evidence that they hold the accompanying certificate (to their medical qualification) listed in the Directive and instead submit an alternative compliancy letter. The compliancy letters issued by the member state of origin are easy to obtain and make the applications straight forward.

EEA doctors with third country qualifications

The GMC has not experienced any difficulties with the applicant's member states of origin confirming that the applicant's third country qualification has been recognised. This route to registration (under S19A of the Medical Act) presents a simpler application process for the applicant and the GMC. It is easier to obtain the relevant documentation from a competent authority in a member state than it would be for the applicant to provide documentation from overseas.

However, for all general systems cases, we have the same reservations as with acquired rights cases, when it comes to accepting the duration and extent of professional experience as outlined in Article 3.3.

We do not experience many difficulties with applicants undergoing a general systems assessment for specialist or GP recognition.

We are aware that in some cases doctors with EC rights have obtained their primary medical qualification outside of the EEA and have become recognised by another European competent authority before obtaining registration with the GMC. In these situations we are reliant on the rigour of another competent authorities' procedure in awarding recognition and registration in their country. This gives us cause for concern. For example, we are aware of a case involving an applicant who failed the GMC's PLAB test twice before being given registration in another EEA country. By virtue of their recognition in this country, they were eventually given UK registration, under EC rules, and subsequently became the subject of GMC fitness to practise action.

- **Please specify whether there are any specific problems with Annex V.**

We are aware that the Annexes of the Directive are out of date. It would be beneficial if these were updated more frequently (annually as a minimum), with input from the relevant authoritative bodies, and if the dissemination of new versions of the Directive was facilitated in a more structured and timely fashion to all competent authorities either through the national coordinator or via direct communication from the European Commission. It would also be helpful for effective dates to be included as well as historic information. For example for the UK, the specialist qualification was a certificate of completion of specialist training up to 16 January 1996 and certificate of completion of training from 17 January 1996.

4. **Is the general system applied in your country each time the conditions for automatic recognition are not met? Are there major difficulties in the recognition procedure under the general system? Please include any comments you may have on the implementation of compensation measures. Is the migrant given the choice between an aptitude test and an adaptation period or is the choice restricted. Please explain.**

We apply the general system where the conditions for automatic recognition are not met. The GMC has not experienced any major difficulties in the recognition procedure under the general system.

The process involves a comparison of the applicant's training with our national training to check whether there are any substantial differences. In accordance with the Directive, we define 'substantial differences' as major differences with regard to the subjects which are essential for the safe practise, If differences are identified we have three options: we can recognise the qualification; refuse to recognise the qualification; or apply compensation measures, and require the applicant to undertake an aptitude test or an adaptation period.

The GMC sought a derogation to require EEA doctors whose applications fall under the general system to undergo an adaptation period. This period can be of a maximum of three years and the applicant is responsible for payment of costs.

The GMC has not had any cases of applicants requiring compensation measures for basic medicine. However, initial estimates indicate that the financial cost of developing an adaptation period will be high. This will need to cover the services of an expert to assess the applicant's experience, determine the content of the adaptation period required, and decide if the shortfall has been met.

For those applicants undergoing a general systems assessment for specialist or GP recognition, the recommendations made for the adaptation period are very specific and provided in line with the requirements of the relevant curriculum. At the end of our assessment, we provide a clear recommendation to the applicant, the time in which it can be achieved, as well as suggesting what evidence can be provided to the GMC to demonstrate that the requirements have been fulfilled.

From time to time, applicants may not agree with the recommendations. In these cases we invite applicants to supply further evidence to allow us to review the application further.

5. **What is your experience with the recognition procedure for EU citizens with professional qualifications obtained in a third country and already recognised in a first Member State (see Articles 2(2) and 3(3))?**

EEA nationals with an overseas primary medical qualification that has been recognised by a competent authority of another EEA member state (or Switzerland) and have been allowed to work in that country as a doctor for at least three years can be assessed under general systems. This route to registration (under Section 19A of the UK Medical Act) presents a simpler application process for the applicant and for the GMC. It is easier to obtain the relevant documentation from an EEA country than it would be for the applicant to provide documentation from overseas.

However, as already outlined under question 3, we would welcome further clarity about the definition of 'professional experience' which is to be relied upon as the basis for recognition by other member states. This definition is open to interpretation and may allow for minimal experience or experience confined to highly restricted forms of practice. We would also welcome further provisions to enable competent authorities to satisfy themselves that the professional experience certified by the member state of origin has been completed satisfactorily.

We would also welcome further provisions to enable competent authorities to be provided with details of the standard against which the professional qualifications obtained in a third country were recognised in the first member state.

6. Please describe the government structure of the competent authority or authorities in charge of the recognition.

The General Medical Council (GMC) is a statutory body established under the UK *Medical Act 1858*. We are a charity registered with the Charity Commission for England and Wales, and the Office of the Scottish Charity Regulator.

The GMC is the independent regulator of doctors in the UK. We are independent of government, as the dominant provider of healthcare in the UK, free from domination by any single group and publicly accountable for the discharge of our functions. This means that we:

a. put patient safety first

b. support good medical practice

c. promote fairness and equality and value diversity

d. respect the principles of good regulation: proportionality, accountability, consistency, transparency.

Our purpose is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine.[4]

The *Medical Act 1983* sets out our four core functions:

a. keeping up-to-date UK registers of qualified doctors

b. fostering good medical practice in the UK

c. promoting high standards of medical education in the UK

d. dealing firmly and fairly with doctors practising in the UK whose fitness to practise is in doubt.

[4] For more information about the role of the GMC, please see our website at http://www.gmc-uk.org/about/role.asp

The Council[5] is the governing body of the GMC. It is comprised of 24 members, 12 lay and 12 medical, all appointed by the UK's Appointments Commission. Members are appointed for a four year term.

The GMC is responsible for the recognition of primary and specialist medical qualifications – automatic recognition and general system. From April 2010, the General Medical Council (GMC) is the single organisation responsible for the regulation of medical education and training. Until April 2010, the Postgraduate Medical Education and Training Board (PMETB) was the independent regulatory body responsible for postgraduate medical education and training.

B. Temporary mobility (of a self-employed or an employed worker)

7. Are EU citizens interested in using the provisions for exercising their professional activities on a temporary and occasional basis in your Member State? How many citizens used this new system in 2008 and 2009 (per month, per year) [6]?

Under temporary and occasional provisions the rules that apply are more flexible compared to recognition on a permanent basis mainly because there is no requirement for evidence of good standing or a registration fee.

The GMC has not experienced any difficulties in this area. However, we are concerned that before granting temporary registration, we cannot perform our standard fitness to practise checks. We believe that members of the public have a right to expect that the protection afforded to them by the regulatory system should be the same regardless of whether the doctor practises in the United Kingdom temporarily or permanently. We would wish to require them to provide the same information as other applicants, i.e. asking the applicant to complete a fitness to practise declaration, which enables us to follow-up any issues in relation to potential impairment. There is anecdotal evidence to suggest that Section 18 is seen as a 'back door route' to gaining registration. This could seriously undermine confidence in the provision of public health services. In our view, Title II of the Directive should be amended to provide guarantees for the safety of patients and include separate provisions for those professionals who have contact with patients.

In 2008, we received 49 applications from European doctors requiring temporary registration. We granted 38 of these applications.

In 2009, we received 68 applications and 46 were granted.

[5] For more information on the Council of the GMC, please see our website at http://www.gmc-uk.org/about/council.asp

[6] Please provide this information unless it has already been provided to the Commission in the Database or the implementation reports.

8. How are the provisions of Directive 2005/36/EC concerning temporary mobility applied by the competent authorities in practice taking into account the relevant provisions of the Code of Conduct? For instance:

- **How is the "legal establishment" criteria foreseen by Article 5(1) (a) interpreted in practice? What conditions does a migrant need to fulfil in his home Member State in order to be able to provide services?**

To benefit from temporary mobility, the applicant must be legally established in one of the EEA countries, i.e. they meet all the conditions for practising that profession in the host member state and are not prohibited from practising that profession either permanently or temporarily.

A visiting practitioner who proposes to provide occasional medical services for the first time in the UK is entitled to registration if they provide the following documents:

1. A written declaration that:

   a. States the practitioner's wish to provide occasional medical services, and

   b. Contains details of the insurance cover, or other means of personal or collective protection, that the practitioner has with regard to professional liability.

2. If the practitioner is a national of a relevant European state, proof of nationality in the form of a passport or ID card. If the practitioner is not a national of a relevant European State, proof of the Community right by virtue of which the practitioner is an exempt person.

3. A European recognised medical qualification that is listed in Annex V of the Directive. In addition to this, where the visiting practitioner proposes to provide any services as a general practitioner or a specialist medical practitioner, they must provide the European recognised qualifications which entitle them to provide those services in their home state.

4. A certificate, dated within the last 12 months, issued by a competent authority in the practitioner's home State confirming that:

   a. The practitioner is lawfully established in medical practice in that state, and

   b. The practitioner is not prohibited either on a permanent or temporary basis from practising as a medical practitioner there.

An applicant who has previously held temporary registration may apply again. They are entitled to further periods of registration if they provide new declarations (as detailed in paragraph 1.a and 1.b above) and a certificate as described in paragraph 4.

The conditions a migrant needs to fulfil in the UK in order to be registered with a licence to practise and thus able to provide services and be legally established are as follows:

a. They need to provide evidence of having completed a primary medical qualification and the requisite training obtained while provisionally registered. This is normally evidenced by a degree certificate and a certificate of experience, as detailed in Annex V of the Directive.

b. Their fitness to practise is not impaired.

c. They have to pay a registration fee on application and then continue to pay their annual retention fee.

To remain on the register, and therefore legally established, doctors have to maintain an effective address. Whilst registered, doctors are also bound by Good Medical Practise. Serious or persistent departure from which may lead to action being taken against their registration through our fitness to practise procedures

- **How are the "temporary and occasional basis" criteria foreseen by Article 5.2 interpreted in practice? Do Member States assess duration, frequency, regularity and continuity of an activity and if so according to which criteria?**

Most new applicants when making initial enquiries about temporary and occasional registration, voluntarily state their intentions. To date, in nearly all cases, applications could be clearly defined as 'temporary and occasional'. The majority of doctors require this type of registration to allow them to participate in highly specialised surgical procedures or training. The duration of their stay typically ranges from a couple of days to a week.

With regard to renewals, we make registration decisions on a case by case basis as it is not always clear in what circumstances a renewal would be considered temporary and occasional. While we have had no difficulties to date, it is possible that applicants may attempt to use this route to registration because we can only undertake limited fitness to practise checks and no registration fee is payable.

The term 'temporary and occasional' is ambiguous and we would welcome further clarification from the European Commission about the length of time envisaged by the use of this terminology.

9. Why is a prior declaration system necessary? What do competent authorities do with the information received? Are other possibilities conceivable? Do you have any cases – and if yes how many - whereby doctors sent the declaration after the provision of services has taken place.

Section 18 of the Medical Act, with reference to Schedule 2A, makes provision for registering visiting EEA practitioners from relevant European states so that they can provide medical services in the UK on a temporary and occasional basis. To ensure patient safety, we verify the applicant's qualification before they start the temporary provision of services.

Prior to December 2007, in exceptional cases, doctors could supply the documentation required for temporary and provisional registration after the services have been rendered. Declarations had to be provided as soon as possible and no later than 15 days after the provision of the service. These cases were rare.

The practice allowing retrospective submissions was ceased in 2007. Since then, there have been no cases of declarations submitted after the provision of services.

We believe that the prior declaration system is essential to patient safety and effective regulation of the profession.

10. Do you charge any fee in case Article 7, § 4 applies?

We have not received any applications where Article 7(4) applies. It would, however, be our intention to charge a fee in these cases.

C Minimum training requirements

11. To what extent are the common minimum training requirements for specialists and general practitioners set out in Title III Chapter III of Directive 2005/36/EC and as defined in Annex V in line with scientific progress and professional needs? Furthermore, are the knowledge and skills required by the Directive still relevant and up to date? Please specify. What about the conditions relating to the duration of training? Do you have many specialties training, which have a common trunk. If yes, please specify which ones.

The minimum times for training set out in the Directive are useful, but the lack of overall consistency of approach between member states means that the level of assurance that states can draw from the training obtained by migrants is limited. We have an example of a specialist who gained recognition in the UK under the Directive but subsequently found they required a further four years of experience to gain employment as a specialist consultant in the NHS in the UK. All GMC approved curricula are required to state and demonstrate achievement of the EU minimum time requirements, where applicable. All approved curricula have to make the time period expected explicit and reflected in the programmes delivered.

There is no obvious rationale why some specialties do not have a minimum time requirement.

There are 61 specialties and 34 subspecialties recognised in the UK. Of the 61 specialties, eight have a common surgical trunk; 29 have a common medical trunk; 33 have an option to undertake an acute care common trunk; six of the psychiatric specialties have a common psychiatry trunk. There is no universal common trunk covering all specialties. Other developments for a common trunk are in progress.

12. To what extent are the common minimum requirements for training set out in Title III Chapter III of Directive 2005/36/EC in line with scientific progress and professional needs in the last ten years? Are the knowledge and skills outlined in Article 24.3 still relevant and up to date? Please specify. What about the conditions relating to the duration of training?

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.

The specific requirements of article 24.3 of the Directive remain relevant and up to date. However, in many respects they are so broadly drawn and general that they are of limited practical value in providing assurance for other member states about the standards of medical education and training of migrants. At the same time, their focus on time served in training rather than the outcomes of training has imposed constraints which have impeded us in developing undergraduate medical education in line with the UK's needs.

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 we cannot be assured of the quality of education elsewhere, not least given the very general nature of the standards on curriculum content and delivery required in the Directive, and the lack of information about how those standards are quality assured. In addition, comparability is largely based on length of training rather than training content or the range of competencies that medical education develops. The overall result is a climate in which competent authorities cannot have full confidence in each other's medical training and education.

In addition, the scope of medical practice can differ between member states. What is routine treatment or procedure for a General Practitioner in the UK, for example, may not be within the normal scope of a doctor trained from another EEA country. Moreover, in some member states graduates may have strong theoretical training but less clinical experience than is deemed desirable in other member states. This can give rise to a patient safety risk where the expectations placed upon a doctor working in one jurisdiction, but trained in another, are not met.

In our view, 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 views of competent authorities can be made available to the Commission.

We believe 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 should be used as a basis from which to develop the minimum training requirements. These should be developed in terms of learning outcomes rather than inputs (hours and length of study).

The current emphasis on inputs in terms of hours and duration of study has meant that the UK has encountered constraints in developing undergraduate medical education and training in line with the UK's needs. This is not helped by the fact that although the Directive is quite clear that training should comprise 5,500 hours or six years' training, there have been attempts in some quarters to impose a much more restrictive interpretation on what the Directive requires.

13. The Directive is based on mutual trust between Member States. To what extent is such trust actually achieved? Are training programmes accredited in your country? Does accreditation of a training program in another Member State enhance trust or is it not relevant?

The GMC is responsible for the regulation of medical education and training in the UK. Our responsibilities are divided into three areas; undergraduate education, postgraduate education, and continued practice.

This function provides assurance to the public on the quality of medical education and training doctors receive throughout their careers. This contributes to the overall standard of care that doctors provide.

Undergraduate medical education
We have a statutory duty to set the standards and outcomes for undergraduate medical education in the UK. These are outlined in *Tomorrow's Doctors* 2009. *Tomorrow's Doctors* sets the framework within which medical schools must plan their curricula. Students must meet all the outcomes within it before they graduate.

We run a quality assurance programme for UK medical schools delivering the undergraduate programme to ensure they are meeting the standards in *Tomorrow's Doctors*. We hold a list of universities that can award a UK medical degree and have the power to remove universities from that list if standards are not met.

Postgraduate medical education
Following the merger of the Postgraduate Medical Education and Training Board (PMETB) with the GMC on 1 April 2010, we also have statutory responsibility for:

a. Setting the standards and requirements for postgraduate medical education and training. This includes the Foundation Programme, which is a two-year period of generic training completed prior to commencing specialty training.

b. Ensuring that the standards and requirements we set are met (including the standards for curricula and assessment systems).

c. Developing and promoting postgraduate medical education and training in the UK.

Our core responsibilities for postgraduate medical education also include the prospective approval of training posts and programmes that lead to the award of a Certificate of Completion of Training (CCT) that is necessary to work in the NHS as a

GP or NHS consultant, and approving specialty training curricula and assessment systems.

Following the merger with PMETB, the GMC has also become the competent authority to approve and decommission subspecialties in the UK.

Continued practice
The GMC's role in education also covers continued practice for doctors. We publish Guidance on Continuing Professional Development, which sets out the principles on which continuing professional development should be based, and the roles of the relevant organisations involved in its delivery and quality assurance.

Quality assurance
We operate three quality assurance processes – quality assurance of basic medical education (QABME), quality assurance of the foundation programme (QAFP), and the Quality Framework (QF).

- QABME is the system we use to ensure that the 32 medical schools in the UK are meeting the standards and outcomes for undergraduate medical education set out in *Tomorrow's Doctors*.

- QAFP is a quality assurance mechanism that monitors whether the Standards for Training for the Foundation Programme contained within *The New Doctor*, are being met.

- QF links together all the GMC's quality assurance of specialty including GP training. The aim of the QF is to measure quality of training, using a range of evidence, against our published standards and requirements, and then to promote and maintain improvement.

Following PMETB's merger with the GMC, which has brought responsibility for the quality assurance of the whole of medical education and training under the auspices of the GMC, work is underway to integrate the quality assurance of the Foundation Programme and specialty including GP training.

We believe that trust only comes from knowledge in each other's legal systems, education systems and the quality assurance processes applied to those systems. A recent study commissioned by the European Parliament Internal Market Committee suggested that regular meetings between the National Contact Points in the various member states would facilitate cooperation across and between member states and the EU institutions and improve trust. Whilst we do not doubt that cooperation and further meetings between National Contact Points may be beneficial, we believe that the emphasis should be on the establishment of better cooperation between competent authorities as this is where the expertise and knowledge of professional regulation and recognition of qualifications lies. This, more than networking between Contact Points, would help facilitate the implementation of the Directive.

In light of the GMC's extended education responsibilities, we are keen to learn from our colleagues across Europe, about the challenges and issues they face in regulating medical education and training. Following some work we carried out in

2009, the GMC is planning to host a meeting of interested parties on 13 October to discuss issues related to:

- Undergraduate standards and quality assurance
- Postgraduate standards and quality assurance
- The education and training aspects of Directive 2005/36/EC, and its upcoming review
- The Bologna Process.

We envisage this meeting to be an opportunity to share perspectives on how different countries respond to these issues and to improve mutual understanding of our education system and the regulation of it.

14. To what extent are the existing Directive provisions (see recital 39 and Article 22(b) on continuous professional development (continuous training) adequate? Is continuous training mandatory in your country and what are the exact conditions?

The GMC is working on plans to change the way doctors in the UK are regulated to practise medicine. All doctors in the UK are required by law to hold a licence to practise if they wish to undertake certain activities, for example holding certain posts, prescribing medicines and signing statutory certificates. In future, licences to practise will require periodic renewal (referred to as 'revalidation'). This means doctors must undertake the periodic renewal of their licence by demonstrating that they continue to be up to date and fit to practise. We anticipate that the new arrangements will come into force around 2013.

To revalidate, doctors will need to collect evidence about their practice which shows how they are complying with the professional standards set by the GMC. The information required will vary depending on the nature of the doctor's practice, but will include material such as audit data, outcome data, and evidence of participation in appropriate Continuing Professional Development (CPD).

We do not believe that revalidation should set prescriptive requirements for CPD in terms of structured packages of learning delivered by accredited providers. Our professional guidance, *Good Medical Practice* requires doctors to keep their 'knowledge and skills up to date' and 'regularly take part in educational activities that maintain and further develop [their] competence and performance'. To support doctors and those appraising them we have identified core principles[7] that should guide doctors in their CPD activity.

We have recently completed a public consultation on our proposals for revalidation and are currently analysing the results. These will be available in October 2010.

[7] To view the GMC's guidance on CPD, visit: http://www.gmc-uk.org/education/continuing_professional_development/cpd_guidance.asp

The Directive as it currently stands does not allow competent authorities to assure themselves that the doctors and healthcare professionals they register have kept their skills and competence up to date since the award of their professional qualifications. We do not consider that the Directive should impose minimum CPD or revalidation requirements of the kind used in relation to medical education and training for the purposes of mutual recognition. However, the inability of member states to obtain assurance of an individual's continuing fitness to practise at the point at which they register or licence a doctor to practise inevitably weakens the level of confidence that competent authorities can have in the competence and fitness to practise of doctors entering the host state.

D. Administrative cooperation

15. To which extent does administrative cooperation, as outlined in Articles 8, 50, and 56 of the Directive, simplify procedures for the migrant professionals?

Administrative cooperation enables the GMC to exchange information directly with other competent authorities. The exchange can take place without the doctor's involvement. Although this is mainly done for security reasons, it also minimises the number of requests for information that we make to the doctor and makes the process simpler for the applicant.

16. Is the competent authority in your country registered with IMI? Under which circumstances does your competent authority use IMI? If not registered, why not and what would be the conditions for changing this situation?

The GMC is registered with IMI. We use IMI in cases of justified doubts. IMI enables us to get answers and obtain information from competent authorities who would not normally respond to routine correspondence. However, as registration with IMI is not mandatory, sometimes we find it difficult to receive replies to our requests and therefore to verify compliance with the Directive.

It would be beneficial if registration with IMI was mandatory for competent authorities, if IMI was more widely used, and regulators responded within the relevant timescales. It would be helpful to allow users to follow up when a response is not received within the timelines stated. It would also be helpful if there was a reporting facility to allow users to track how many requests are made and the timeline for responding – on both incoming and outgoing requests. IMI also has some limitations given that many organisations, such as medical schools or organisations responsible for investigating and taking regulatory action against doctors, are not linked to it.

The IMI system might benefit from the use of a more sophisticated translation tool such as Google Translate as automatically translated questions are problematic, particularly when legal and regulatory terms are used.

Improving the extent to which competent authorities proactively share disciplinary information should be a priority to ensure that competent authorities can take effective action under their own fitness to practise rules if a doctor is registered in more than one jurisdiction. Existing differences in data protection and privacy

legislation in other EEA countries pose a challenge and a potential threat to patient safety. We believe that having a secure means to exchange information when regulatory action is taken against a doctor's registration has the potential to improve significantly the information that competent authorities will be prepared to share.

We strongly suggest that the European Commission strengths the legal basis for IMI so that the system can be used for the proactive sharing of information. IMI could provide a secure password protected tool for the effective sharing of information and enable those competent authorities not currently able to exchange information, due to domestic privacy legislation, to do this more effectively. The Services Directive (Directive 2006/123/EC) currently provides for such sharing of information, via an alert mechanism provided by IMI (Article 29 and Article 32). We believe that similar provisions should be included in a revised 2005/36/EC Directive.

17. How could a professional card (see Recital 32 of the Directive) facilitate recognition of professional qualifications and provision of temporary services? Under which conditions could it be issued by professional associations?

The Directive refers to the possible introduction at European level of professional identity cards. At first sight the development of a European card for health professionals appears a useful tool to facilitate the free movement of healthcare professionals throughout the EEA. Considered more deeply, however, such a card brings with it some potential risks.

We believe that there must be clarity about the problems that such a card seeks to solve. In recent years, various aims for a proposed card have been stated, such as the harmonisation of existing card-based record/identification systems, the facilitation of exchange of information between regulators, and the identification of healthcare professionals for employers.

A card that serves only as a basic photo identity card, rather than a secure chip card containing electronically readable data, is open to fraud and forgery and could present a serious risk to patient safety.

Whilst the card could in principle store further information we believe that the IMI system already provides a cost effective tool for the secure information exchange between competent authorities and that it will be essential to avoid duplication. IMI provides for improved regulatory information exchange between competent authorities without some of the risks potentially brought about by a card system.

A professional card containing microchip-based data would need to be interoperable across all regulatory jurisdictions of the EEA. Information would need to be uploaded effectively and efficiently on the card and would need to be readable in a format and language accessible and understandable by every competent authority. As some professionals will be simultaneously registered in more than one jurisdiction it would also need to be usable by more than one competent authority concurrently. This is to ensure a complete record of the professional is provided and to avoid the risk that professionals only use their 'clean' card to obtain registration as a basis from which to secure employment.

The information being suggested as the basis of the European professional card is already held by competent authorities. Any additional source of this data arguably presents a level of duplication and additional regulatory burden and could become a disproportionate and costly response to the challenge of effective information exchange between competent authorities.

We also believe that efforts in the short term would be better focused on supporting competent authorities to share information directly and more effectively and enabling them to make the information they hold publicly available.

The GMC has a web-based searchable list of registration and disciplinary information freely available on its website. In the UK this not only supports the information that competent authorities exchange on a bilateral basis but also enables patients to make more informed choices about the practitioners they consult or may choose to consult. A positive way of improving transparency would be for European level cooperation to promote similar publicly available web-based information.

The GMC will continue to consider the implications of a professional card but remains cautious about the introduction of such an initiative at European level on basis of proportionality and costs.

18. Are you alerted by other Member States in case of disciplinary action or criminal sanctions taken or any other serious, specific circumstances which are likely to have consequences for the pursuit of activities under this Directive? How do you share this information? Could more be done in this respect?

Our Fitness to Practise Directorate discloses details of all disciplinary action proactively to other competent authorities. This is done by email via our monthly decisions circular and sent to nearly every regulator worldwide. The circular includes details of all doctors who have been subject to fitness to practise proceedings and sanctions (conditions attached to their registration, erasures, suspensions etc).

In addition to this, after a fitness to practise hearing is concluded, we write to the regulator in the country where the doctor originally graduated, the regulator in the country where the doctor currently resides and, if known, the country to where the doctor has moved.

We also have agreements in place governing electronic exchange of Certificates of Good Standing / Certificates of Current Professional Status with a limited number of competent authorities and are a signatory to the Healthcare Professionals Crossing Borders Memorandum of Understanding on case-by-case and proactive information sharing[8].

[8] Healthcare Professionals Crossing Borders (HPCB) is an informal partnership of professional healthcare regulators in Europe, established to work collaboratively on a range of regulatory issues. The 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. For more information about the HPCB MoU, see: http://www.hpcb.eu/activities/information_sharing.asp

Only a small number of European countries proactively notify us of disciplinary decisions taken, most notably Ireland, Norway, and Sweden. We receive less than six notifications per year. We understand that different data protection regimes prevent some countries from sharing information but we believe that it essential that fitness to practise information is shared to ensure that patient safety is not comprised.

When alerts are received, we check to see if the doctor is registered. If the doctor is registered with the GMC they would enter our Fitness to Practise procedures. Our rules allow us to rely on the decision from other regulatory bodies as conclusive evidence of the relevant facts so we would not need to reinvestigate. However, based on those facts, we would make our own decision on whether the doctor is impaired and what sanction on the doctor's UK registration would be appropriate. For example, we may be referred a determination from another regulatory body which has imposed a major sanction in relation to a doctor. The country in question may consider the actions of that doctor a serious matter. We would accept the determination by the body as evidence of the facts but we may choose to impose a different sanction based on the fact that we treat the issue differently in the UK.

If the doctor is not registered, we make a record of the information we receive in case the doctor makes an application for registration with us in the future.

To ensure patient protection across Europe we have for some time called for legal duty on competent authorities to share information effectively and proactively when regulatory action is taken against a doctor's registration.

It would also be helpful to identify which organisations in the member states are responsible for taking action against a doctor's registration (suspensions, conditions, warnings, erasures) when their fitness to practise is impaired. Our experience shows that in many countries recognition and fitness to practise functions are carried out by separate organisations, sometimes at regional and local level. This provides confusion and potentially a risk to patient safety, especially if information about a doctor's fitness to practise is not communicated effectively and efficiently to the relevant organisation(s). For the IMI alert mechanism to be effective, it would be essential that all organisations responsible for recognition, registration and fitness to practise are registered on IMI.

E. Other observations

19. How and when are the necessary language skills of migrants checked after recognition of the professional qualifications? Are you aware of any complaints (especially from patients/clients/employers) about insufficient language skills of migrants?

Currently, EEA applicants to the GMC register do not need to pass a language assessment.

Whilst we recognise the Directive's reference to language knowledge, the provision proves to be problematic. It is unclear whether article 53 enables competent authorities to assess the level of language proficiency of migrants at the point of registration. It remains our view that the ability of the professional to communicate

effectively in the language of the host member state should be a prerequisite for registration and that we should be able to assess the knowledge of language where appropriate. We understand that a test may be applied in cases of doubt – as long as it is proportionate, appropriate, and not systematic.

According to *Good Medical Practice*, doctors must be able to communicate effectively with their patients, other member of their healthcare team and colleagues in the healthcare system. If they are to provide high quality and safe care and ensure informed consent is acquired before treatment, effective communication is essential regardless of where they practise.

We have examples of fitness to practise cases brought before the GMC where the lack of English language competence has been identified as a concern. These cases indicate that it is not sufficient for employers to assess the language competence of EEA trained doctors. We believe that language provisions for doctors in the Directive should be strengthened to ensure that competent authorities are allowed to check the language knowledge of applicants at the point of registration to ensure patient safety is not compromised.

20. Does the application of Article 30 raise any specific problems?

We receive no more than five applications per month. Generally they do not raise any problems. It is surprising, however, that this provision still exists. Providing an automatic right to someone who qualified before 1994, without any subsequent check on their capability for practice, seems to be at odds with patient safety.

We have come across the following scenario a few times – where a member state has awarded a GP qualification that is listed in the Directive *and* has issued the doctor with an Article 30 letter. A doctor who has a Directive compliant qualification does not have an acquired right. We have to contact the member states that issued the documents to determine why they have been issued an Article 30 letter which can take time. The result is always that the letter was issued incorrectly (often in place of an Article 28).

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