General Medical Council

Regulating doctors
Ensuring good medical practice

GMC Response
Green Paper on the European Workforce for Health
31 March 2009

Introduction

1. The General Medical Council (GMC) is the independent regulator for doctors in the UK. Our purpose is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine.

2. There are currently over 230,000 doctors on the UK Medical Register. 21,451 (9.2%) of these doctors qualified in other parts of the European Economic Area.

3. The law gives the GMC four main functions:

- keeping up-to-date UK registers of qualified doctors
- fostering good medical practice in the UK
- promoting high standards of medical education in the UK
- dealing firmly and fairly with doctors practising in the UK whose fitness to practise is in doubt.

4. The GMC believes the fundamental purpose of medical regulation is to ensure safety and quality of care for patients. Our approach to regulation is based on the fostering of professionalism. We believe that greater professionalism will drive up clinical standards and contribute to continuous improvement in patient safety. This makes effective regulation a vital component in achieving safe and high quality healthcare for all across Europe.

5. Our purpose is to protect and promote patient safety through effective regulation and ensuring proper standards in the practice of medicine. It is with this remit that we make our comments on the Commission's consultation. Our position as set out in this response, aims to balance the efficient free movement of doctors with the maintenance of patient safety, which should be at the core of any future EU initiative on the European workforce for health.

6. For more information contact Tanja Schubert, European & International Policy Manager, General Medical Council, 350 Euston Road, London, United Kingdom, NW1 3JN. Tel: + 44 20 7189 5346. Email: tschubert@gmc-uk.org

Training of health professionals

7. The GMC is responsible for setting the standards of basic medical education and medical practice in the UK as set out in our 'Tomorrow's Doctors' publication for undergraduate education, and 'The New Doctor' for the training of provisionally registered doctors, and in our suite of professional guidance known as 'Good Medical Practice' (GMP). The maintenance of patient safety must shape medical education and all forms of medical practice. Indeed, it is important to ensure that educational standards are kept under review, are based on objective research and evidence and take into account developments in medical practice.

8. It is also important that professional and ethical standards are developed at the national level in order to take account of cultural and practical considerations. Our professional guidance, GMP has been developed in the context of a wide range of UK stakeholder groups, and is increasingly embedded in health service delivery in the UK.

9. We have produced supporting ethical guidance for UK registered doctors which provides more detail on how to comply with the principles in GMP. Within the Green Paper there is a brief mention of 'management training for health professionals'. The GMC has produced specific guidance on 'Management for doctors'. The booklet is concerned with principles of good practice and is consistent with the principles and ethical standards set by the British Association of Medical Managers, the Institute of Healthcare Management and the Department of Health's Code of Conduct for NHS Managers. All doctors receive copies of our guidance which is also available to the public via our website and on request.

10. We have also been working on developing more innovative ways of presenting our guidance, such as the web-based 'GMP in Action' initiative. This is an interactive web section which brings the GMC's ethical guidance to life. Users can choose what a doctor should do in a series of case studies highlighting how the principles might work in practice. 'GMP in Action' may be a model which other medical regulators in Europe could follow.

11. The freedom that doctors have to practise their profession across Europe is largely derived from the mutual recognition by member states of their basic medical qualifications and certain specialist training. However, it is increasingly important and in line with public expectations that doctors should be able to demonstrate that they remain up to date, and safe to practise throughout their career. This demands evidence beyond the acquisition of basic and specialist qualifications and the development of mechanisms for assuring the current competence of doctors.

12. There should be mechanisms in all member states to enable the regular evaluation of a doctor's practice in order to assure patients that they continue to be competent to practise. The GMC is working on plans to change the way doctors in the UK are regulated to practise medicine, in the form of licensing and revalidation. This will be the single biggest change to medical regulation since the establishment of the GMC 150 years ago.

13. The first change will come in late 2009 when the GMC will introduce licences to practise. All doctors in the UK will be required by law to hold a licence if they wish to exercise the legal privileges currently reserved for registered medical practitioners (such as prescribing medication and signing death certificates). Licences to practise will require periodic renewal. At the end of the first revalidation cycle, the licence to practise will signify that the GMC has received positive affirmation that a doctor remains up to date and fit to practise.

14. All doctors holding a licence to practise will need to participate in revalidation. This means that at regular intervals they will need to collect evidence to demonstrate that they are practising in accordance with the GMC's core guidance, by undergoing an annual workplace appraisal, and participating in an independent process for obtaining feedback from patients (where applicable) and colleagues.

15. The purpose of this new approach is to give patients assurance that licensed doctors are up to date and fit to practise. Revalidation is not only designed to find doctors whose fitness to practise is impaired. It is designed to promote excellence in clinical practice and, through supporting the professional development of doctors, enhance patient safety.

16. Some other regulatory jurisdictions in Europe already have a review process attached to the regular re-licensing of doctors. However, this is usually only based on the collection of the requisite number of continuing medical education training points. Revalidation in the UK will be based on the doctor's actual practice, taking their skills and behaviour into account.

17. Medical Revalidation in the UK could become a model of good practice for medical regulators across the European Union. We believe all regulatory jurisdictions should develop similar approaches to provide assurance to patients, the public, and other regulators of doctors' continued competence to practise.

The GMC believes that professional and ethical standards for high quality medical practice must be developed at national level and have patient safety at their heart.

We call on the European Commission to incorporate the requirement for regulators to develop national or regional systems of regular performance enhancement and assessment into a more robust legal framework for the free movement of doctors in Europe.

Mobility of health workers within the EU

18. 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. We believe therefore that the European Community needs to play a role in addressing patient safety concerns and in some cases must develop appropriate legislative responses.

19. We strongly believe that European legislative initiatives are required in the following areas:

Legal Duty to Exchange Information

20. For some time, the GMC, individually and through the Alliance of UK Healthcare Regulators on Europe (AURE), has called on the European Commission to impose a legal duty on professional healthcare regulators to share registration and disciplinary information. Although most doctors are highly competent individuals there will always be a small minority who exploit free movement rules to evade regulatory control in their home country, and who could present a serious risk to patients. Regulators must be proactively alerted to those practitioners whose registration has been restricted or removed and who may seek registration elsewhere or simultaneously hold registration in another jurisdiction(s). Without a legal duty to exchange information impaired practitioners could move from one Member state to another going undetected until patient safety is compromised.

21. The diversity of domestic approaches to the implementation of privacy legislation throughout Europe means that public safety concerns, for some regulators, might be secondary to maintaining the doctors right to privacy. Therefore the most effective way of ensuring information is exchanged, including on a proactive basis, is through establishing a legal duty in European legislation.

22. In 2007 the European Parliament agreed with us on the need to establish a legal duty on information exchange. The Parliament called for this in both the 'resolution of 15 March 2007 on Community action on the provision of cross-border healthcare' and in the 'resolution of 23 May 2007 on the impact and consequences of the exclusion of health services from the Directive on services in the internal market (2006/2275(INI))'.

23. More recently, the need to establish a legal duty to share registration and disciplinary information was supported by the Employment and Social Affairs Committee (on 4 March 2009)[1] and the Internal Market and Consumer Protection Committee (on 10 March 2009)[2] in their opinion reports on the proposed Directive on the application of patients' rights in cross border healthcare in Europe. Once again we call on the European Commission to propose a legal duty on competent authorities to exchange information both proactively and reactively.

We call on the European Commission to propose the establishment of a legal duty upon national and regional authorities to reactively and proactively exchange regulatory information about doctors in the interests of patient and public safety.

[1] Amendment 88, opinion of the Committee on Employment and Social Affairs on the proposal for a directive of the European Parliament and of the Council on the application of patients' rights in cross-border healthcare.

[2] Amendment 35, opinion of the Internal Market and Consumer Protection Committee on the proposal for a European Parliament and Council directive on the application of patients' rights in cross-border healthcare

Language competence

24. In providing high quality and safe care, doctors must be able to communicate effectively with their patients, and other members of the healthcare team. They must ensure informed consent is acquired before the commencement of treatment. Assessing a doctor's language proficiency is often dismissed as a matter for employers, not regulators. This does not consider the fact that many doctors are independent practitioners.

25. Directive 2005/36/EC currently states that "persons benefiting from the recognition of professional qualifications shall have a knowledge of languages necessary for practising the profession in the host Member State" [3].

26. The European Commission has provided a guide to Language Knowledge dated 9 November 2006[4]. From this guide we understand that if linguistic knowledge is to be assessed, "it may be assessed after the recognition is granted (regardless of whether recognition is granted on an automatic basis, after a comparison of the training of the migrant with the national relevant requirements or even after the migrant has successfully undergone a compensatory measure). The wording of Article 53 *("persons benefiting from the recognition of professional qualifications…"*) supports this interpretation. The assessment of linguistic knowledge cannot be used to check, in any way, the substantial qualifications of the migrating professional." The guide also states that "although language tests are not excluded, they can neither be used systematically nor in a standardised form".

27. This rule does not currently permit regulators to satisfy themselves about a doctor's language proficiency prior to granting recognition. As in the UK there is no distinction between recognition and registration we are almost invariably unable to assess language competence at the point of registration/recognition. We are also prevented from adopting a general requirement to prove competence and cannot specify the standard of acceptable competence.

28. This current situation is profoundly at odds with the pursuit of safe and high quality healthcare. Indeed, we have examples of fitness to practise cases brought before the GMC where the lack of English language competence has been a factor contributing to the impairment of EEA trained doctors.

29. The current legal framework provides a situation where the entitlement and ease with which a doctor can gain registration and take up practice in another EEA Member state is given higher priority than the entitlement of the patient to be treated safely. This may present a risk to patient safety. European legislation must be amended to allow healthcare regulators across Europe to establish, at the point of registration, that a doctor has the level of language proficiency necessary to practice safely.

We call on the European Commission to enable regulators to test the language competence of all EEA graduates.

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[3] Article 53, Directive 2005/36/EC.

[4] MARKT D/15748/2006-EN

Healthcare Professionals Crossing Borders

30. The regulatory implications of increased cross border mobility of health professionals and patients make it vital for the Commission to engage closely with national and regional regulators.

31. In this context and at the initiative of the Dutch and UK governments during their EU Presidencies in 2004 and 2005, healthcare regulators have been working collaboratively within the Healthcare Processionals Crossing Borders (HPCB) initiative. This is now led by the GMC on behalf of the European regulators and focuses on regulatory collaboration and cooperation, particularly in relation to information exchange. At present HPCB is the only European level forum that brings together competent authorities from all regulated health professions across the EEA.

32. At the end of 2007 HPCB adopted a collaborative voluntary work programme, the Portugal Agreement, which focuses on three strands of activity: identifying shared principles of regulation; transparent and accessible healthcare regulation; and competence assurance of European healthcare professionals.

33. We call on the European Commission to work closely with HPCB to further the work of the initiative and for the Commission to support the on-going collaboration between regulators (competent authorities) at EU level.

Data and research to support decision-making

34. In order to maintain effective modern medical regulation - regulation that is responsive to the changing nature of healthcare, the medical profession, patient and public expectations and demands - it must be founded on a robust evidence-base. The GMC is committed to undertaking high-quality research to inform the development of our regulatory policies and procedures and contribute to the fulfilment of our statutory public protection role. For more information visit: http://www.gmc-uk.org/about/research/research_commissioned.asp.

35. We believe there are a number of research opportunities related to professional mobility that could be filled by European Commission funded research, particularly in the following areas:

Comparability of EEA medical training and practice

36. 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 ‘equivalent’, as set out in Directive 2005/36/EC on the recognition of professional qualifications, that a doctor can exercise their right of free movement within the EEA. However, this comparability is largely based on length of training rather than training content or the range of competencies that medical education develops. This mismatch could give rise to a serious patient safety risk where the expectations placed upon a doctor working in one jurisdiction but trained in another are not met.

37. Similarly, the scope of medical practice can differ between member states. What is routine treatment or procedure for General Practitioners in the UK, for example, may not be within the normal scope of a doctor from another EEA country. A number of recent GMC Fitness to Practise cases, when EEA trained doctors have had their registration removed or restricted, have demonstrated that there might be a mismatch between member states.

38. The European Commission should urgently undertake a thorough 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 revise recognition of professional qualifications legislation and to develop policies that reduce the risk that practitioners appear more qualified for certain posts than they are in practice, with the consequential risk to patient safety.

Migrant doctors

39. The European Commission should conduct a study into medical migration as a basis from which to understand the impact and contribution of migrant doctors to healthcare in Europe. There are currently over 20,000 EEA trained medical graduates registered to practise in the UK. A significant number of European doctors seeking to work abroad choose the United Kingdom as a destination on either a permanent or a temporary basis.

40. At present there is limited Europe-wide data about levels and patterns of doctor migration; the extent to which doctors are simultaneously registered in more than one jurisdiction; and the number of doctors registered as temporary service providers in a host(s) Member state. It is quite clear that levels of professional mobility within the EEA far exceed current or likely future levels of patient mobility and it is vital that policies relating to cross-border healthcare and doctor mobility are informed by the true extent of professional mobility and the impact this has on patient care, healthcare systems, and quality and safety of healthcare.

Professional Impairment

41. The European Commission should carry out research into the extent of impairment experienced by EEA trained medical graduates, including from the UK. Most EEA trained doctors, whether working in their home Member state or another EEA country, are highly skilled professionals who make an immense contribution to the health and well-being of European citizens. However, it is inevitable that some doctors will, for a range of reasons, fall short of the standards that are expected of them and become a potential risk to patient safety. In the context of European free movement of doctors and cross-border healthcare that risk is not only domestic but Europe-wide.

42. The real extent of medical practitioner impairment within the EEA is unknown and research into this as a basis from which the European Commission, national authorities and medical regulators can develop appropriate policies and procedures would make a significant contribution to patient safety and workforce training in Europe in the context of cross-border healthcare.

We call on the European Commission to deliver a programme of research in the context of professional mobility including in the area of comparability of EEA medical training and practice; doctor migration and patterns of mobility; and professional impairment.

The impact of new technology

43. The provision of telemedicine raises challenges in relation to the regulation of cross-border healthcare and patients' access to redress if treatment goes wrong. We believe that should be no ambiguity as to where regulatory responsibility in any case of cross border healthcare. In particularly complex situations, such as e-health, where neither the patients or professional physically moves, there must be clarity as to who holds regulatory responsibility.

44. The GMC cannot hold regulatory responsibility for doctors who are not on the UK Medical Register. It must be the responsibility of contracting bodies to assure themselves that any e-health contractors are registered and qualified in the country from which they are practise.

We call on the European Commission to ensure that those contracting e-health services from providers and professionals in other member states shall ensure they are appropriately regulated and qualified and that they have demonstrated, via the relevant competent authority, that they are fit to practise and to provide e-health services.