
The EFOMP is the umbrella organization for the profession “Medical Physicist / Medical Physics Expert” in Europe. Its membership consists of the national professional organizations of all states in Europe and therefore represents the interests of all European Medical Physicists / Medical Physics Experts.

The definition of the role of Medical Physicists is as follows:

"Medical Physicists will contribute to maintaining and improving the quality, safety and cost-effectiveness of healthcare services through patient-oriented activities requiring expert action, involvement or advice regarding the selection, acceptance, commissioning, quality assurance and optimised clinical use of medical devices and regarding risks from associated physical agents (particularly though not exclusively ionising radiation); all activities will be based on current best evidence or own scientific research when the available evidence is not sufficient"

Medical Physicists apply the above role to many areas of medicine. Medical Physics Experts are defined in European Directives related to ionizing radiation and apply the above role in Diagnostic and Interventional Radiology, Nuclear Medicine and Radiation Oncology.

Below are the consultation questions and our responses.

Question 1: Do you have any comments on the respective roles of the competent authorities in the Member State of departure and the receiving Member State?

Answer 1: The Competent Authorities of the Member State of departure would be in a better position to verify the qualifications of an applicant taking into consideration that these authorities will have a better knowledge of their own educational systems and it would take a shorter time to verify and receive any additional information required from the applicant.

But, as already pointed out in the Green paper, it is rarely obvious or clear who the competent authority is in each member state. Also, the work of the competent authorities in recognising professions is by no means finished and is in many cases still a matter of development.

Question 2: Do you agree that a professional card could have the following effects, depending on the card holder’s objectives?

a) The card holder moves on a temporary basis (temporary mobility):
   - Option 1: the card would make any declaration which Member States can currently require under Article 7 of the Directive redundant.
   - Option 2: the declaration regime is maintained but the card could be presented in place of any accompanying documents.

b) The card holder seeks automatic recognition of his qualifications: presentation of the card would accelerate the recognition procedure (receiving Member State should take a decision within two weeks instead of three months).

c) The card holder seeks recognition of his qualifications which are not subject to automatic recognition (the general system): presentation of the card would accelerate the recognition procedure (receiving Member State would have to take a decision within one month instead of four months).

Answer 2: We agree with the exception of a) Option 1, since this will be redundant if the other option is implemented.

The use of a professional passport is a convenient mechanism to demonstrate competence. This could be a useful vehicle, possibly underpinned through the use of the IMI.
We would consider a) option 2 the most useful, as the aim of professional recognition is ultimately the protection of patients and the general public, the concept of limited requirements to allow for partial access is as far as EFOMP is concerned a non-starter.

Question 3: Do you agree that there would be important advantages to inserting the principle of partial access and specific criteria for its application into the Directive? (Please provide specific reasons for any derogation from the principle.)

Answer 3: Establishment of proper criteria of Knowledge Skills and Competence (KSC) are essential for the protection of the patient and the general public. This is especially important for the Profession of Medical Physics, since we have sub-specialisations within medical physics and a medical physicist specialised for example in Nuclear Medicine medical physics may not be competent to work in Radiotherapy or Radiology medical physics. In the medical Physics profession the currently recognised sub-specialties are Radiotherapy, Nuclear Medicine, Diagnostic and Interventional Radiology, Radiation Protection, Non-ionising Radiation and Physiological Measurements.

Some Medical Physicists may be qualified and competent in more that one of the above sub-specialties but it is very difficult to find a few that are qualified and competent in all the sub-specialties.

The use of the passport would facilitate short term movement.

Question 4: Do you support lowering the current threshold of two-thirds of the Member States to one-third (i.e. nine out of twenty seven Member States) as a condition for the creation of a common platform? Do you agree on the need for an Internal Market test (based on the proportionality principle) to ensure a common platform does not constitute a barrier for service providers from non-participating Member States? (Please give specific arguments for or against this approach.)

Answer 4: As mentioned above, the use of harmonised standards for KSC would by definition constitute a common platform. The number of states would be irrelevant. What would be a problem though is the “lowest common denominator” would become the de-facto common standard.

Question 5: Do you know any regulated professions where EU citizens might effectively face such situations? Please explain the profession, the qualifications and for which reasons these situations would not be justifiable.

Answer 5: The Medical Physics Profession is such an example. In a number of Member States (more than 15) it is regulated by law or by an independent Board or a voluntary system by the National Medical Physics Association. They all have their own conditions for registration. This is an obstacle to free movement of medical physicists.

EFOMP in an effort to assist in the removal of this obstacle has set up a scheme with guidelines and recognises the Member States that meet these guidelines and participate in the scheme. This recognition ensures that the same conditions apply. Currently 11 EFOMP National Member Organisations are recognised by EFOMP.

Question 6: Would you support an obligation for Member States to ensure that information on the competent authorities and the required documents for the recognition of professional qualifications is available through a central on line access point in each Member State? Would you support an
obligation to enable online completion of recognition procedures for all professionals? (Please give specific arguments for or against this approach).

Answer 6: Yes. EFOMP would welcome the availability of online information. Online recognition can only mean online application for recognition. This will however only work if a common platform for KSC exist.

It is obvious that such facilitation will ease the procedures for recognition. Such a facility will also provide up to date changes in requirements. It will also facilitate Member States to harmonise their requirements as they can easily see what the other Member States require to recognise a particular profession.

Question 7: Do you agree that the requirement of two years' professional experience in the case of a professional coming from a non-regulating Member State should be lifted in case of consumers crossing borders and not choosing a local professional in the host Member State? Should the host Member State still be entitled to require a prior declaration in this case? (Please give specific arguments for or against this approach.)

Answer 7: First and foremost in the rationale for professional recognition is the protection of the patient and the public. In this context, "two years experience" without defining what was actually done is rather pointless. Experience acquired only makes sense when put against KSC criteria.

Question 8: Do you agree that the notion of "regulated education and training" could encompass all training recognised by a Member State which is relevant to a profession and not only the training which is explicitly geared towards a specific profession? (Please give specific arguments for or against this approach.)

Answer 8: Yes. This is particularly important for the Medical Physics professional since for the health and safety of a patient, a Medical Physicist is also a Health Professional and above and beyond his/her Medical Physics KSC, he/she will require other skills such as communication, ethics, confidentiality, etc., that are not part of the core medical physics education and training.

Question 9: Would you support the deletion of the classification outlined in Article 11 (including Annex II)? (Please give specific arguments for or against this approach.)

Answer 9: No, EFOMP does NOT support the deletion of qualification. This will ultimately lead to the "lowest common denominator" becoming the standard and we do not consider that this would be of benefit to patients or the public.

We would support the amendment of Article 11 to be in line with the eight levels of the Lifelong Learning Qualifications Framework. Professions can then be classified according to these eight levels to ensure the necessary KSC for each profession.

Question 10: If Article 11 of the Directive is deleted, should the four steps outlined above be implemented in a modernised Directive? If you do not support the implementation of all four steps, would any of them be acceptable to you? (Please give specific arguments for or against all or each of the steps.)

Answer 10: EFOMP does not agree with the elimination of Article 11 of the Directive. This defeats the purpose of the directive as a whole since the introduction of compensation measures will restrict the free movement further. The modernisation of the Directive should seek to eliminate compensation measures as much as possible.
With respect to the individual criteria 1-4, we have the following comments:

1. Use of harmonized KSC should facilitate definition of required training.

2. Length of experience is related to the length required to acquire certain competences and skills. Any experience needs to be calibrated against the KSC criteria.

3. Competent Authorities should be in a position to justify their decision. However, regulation serves to protect patients and public and it should be unacceptable if lowest common denominator becomes the de facto standard.

4. Probably better if the code is not mandatory.

**Question 11:** Would you support extending the benefits of the Directive to graduates from academic training who wish to complete a period of remunerated supervised practical experience in the profession abroad? (Please give specific arguments for or against this approach.)

**Answer 11:** Yes. However, this assumes that there is a certain harmonisation of academic qualifications.

To be recognised as a Qualified Clinical Medical Physicist you must undergo a period of around two years of on the job training to gain the necessary competence to practice without supervision. Some small Member States may not have the infrastructure to provide the full competence that a Medical Physicist requires to practice its profession in any Member State. Effectively if train only in his home state he will be restricted to practice his profession in his state only in a limited capacity. Having his/her clinical training in a facility of another Member State that provides the latest state of the art modalities and even better in a number of different facilities in a number of Member States, would assist in achieving competence at the highest possible level.

**Question 12:** Which of the two options for the introduction of an alert mechanism for health professionals within the IMI system do you prefer?

**Option 1:** Extending the alert mechanism as foreseen under the Services Directive to all professionals, including health professionals? The initiating Member State would decide to which other Member States the alert should be addressed.

**Option 2:** Introducing the wider and more rigorous alert obligation for Member States to immediately alert all other Member States if a health professional is no longer allowed to practise due to a disciplinary sanction? The initiating Member State would be obliged to address each alert to all other Member States.

**Answer 12:** If a Health Professional is suctioned and is not allowed to practise any longer then this should be known to all Member States, therefore Option 2 is the obvious preference. However, this of course only works if registration is mandatory across Europe.

**Question 13:** Which of the two options outlines above do you prefer?

**Option 1:** Clarifying the existing rules in the Code of Conduct;

**Option 2:** Amending the Directive itself with regard to health professionals having direct contact with patients and benefiting from automatic recognition.

**Answer 13:** Option 1. Language skills are only one component of much broader communication skills required to function in a profession. This should be taken into account. It is inconceivable that language skills cannot but be taken into account. Simple example in UK and Ireland, “morning, half nine” equals 9.30 am. This would be in Netherlands “half tien” or half ten. It is easy to see how understanding the language might not mean that the correct time is communicated!
Question 14: Would you support a three-phase approach to modernisation of the minimum training requirements under the Directive consisting of the following phases:

- the first phase to review the foundations, notably the minimum training periods, and preparing the institutional framework for further adaptations, as part of the modernisation of the Directive in 2011-2012;

- the second phase (2013-2014) to build on the reviewed foundations, including, where necessary, the revision of training subjects and initial work on adding competences using the new institutional framework; and

- the third phase (post-2014) to address the issue of ECTS credits using the new institutional framework?

Answer 14: Yes, however, ECTS assumes that all training is performed in academic institutions. This is not necessarily so.

Question 15: Once professionals seek establishment in a Member State other than that in which they acquired their qualifications, they should demonstrate to the host Member State that they have the right to exercise their profession in the home Member State. This principle applies in the case of temporary mobility. Should it be extended to cases where a professional wishes to establish himself? (Please give specific arguments for or against this approach). Is there a need for the Directive to address the question of continuing professional development more extensively?

Answer 15: This is where the passport would come into its own. We do not feel that it is possible to make a distinction between short term work and permanent residency (again, focus should be on protection of patients and public).

The competence required to practice a profession change with time as the profession advances with increasing scientific knowledge and therefore the professional should need to demonstrate that he/she have the necessary skills and competence to continue to practice their profession. Therefore Continuous Professional Development (CPD) should be a tool to be used to assess the competence of a professional to maintain its professional recognition. The directive should address the question of continuing professional development more extensively.

Question 16: Would you support clarifying the minimum training requirements for doctors, nurses and midwives to state that the conditions relating to the minimum years of training and the minimum hours of training apply cumulatively? (Please give specific arguments for or against this approach.)

Answer 16: The competence required to practice a profession should not be based on the number of years or any period of time that a professional undertakes training but he/she must demonstrate that they have achieve the necessary competence related to a harmonized list of KSC. This can be demonstrated for example by the number of procedures that have been successfully completed by the trainee under supervision.

Question 17: Do you agree that Member States should make notifications as soon as a new program of education and training is approved? Would you support an obligation for Member States to submit a report to the Commission on the compliance of each programme of education and training leading to the acquisition of a title notified to the Commission with the Directive?
Should Member States designate a national compliance function for this purpose? (Please give specific arguments for or against this approach.)

Answer 17: Yes. This is particularly important for the case of new professional titles. These new professions should be recognised before the first graduates come on the market, otherwise the new graduates will not have a chance to practice their profession in another Member State as soon as they graduate.

Question 18: Do you agree that the threshold of the minimum number of Member States where the medical speciality exists should be lowered from two-fifths to one-third? (Please give specific arguments for or against this approach.)

Answer 18: Although this question is not directly relevant to Medical Physics we agree that the threshold should be lowered as this will give the incentives to new Medical Doctors to specialised in new and emerging specialties.

Question 19: Do you agree that the modernisation of the Directive could be an opportunity for Member States for granting partial exemptions if part of the training has been already completed in the context of another specialist training programme? If yes, are there any conditions that should be fulfilled in order to benefit from a partial exemption? (Please give specific arguments for or against this approach.)

Answer 19: Yes, again only if standard and harmonised KSC are agreed and introduced. This parallels the same situation for Medical Physics where to gain specialisation in one area you need a minimum of two years training. To gain specialisation in a second area is the same although most of the training may be the same. Efforts are made to recognise the common elements of the first training that are applicable to the second training of specialisation.

Question 20: Which of the options outlined above do you prefer?

Option 1: Maintaining the requirement of ten years of general school education

Option 2: Increasing the requirement of ten years to twelve years of general school education

Answer 20: Although this question is not relevant to Medical Physics we support Option 2, since the competence required to practice nursing today are much more advance than in the past and a high background of general education will give the necessary foundations to acquire the necessary KSC more easily and successfully in the shortest time possible after the start of the Nursing training.

Question 21: Do you agree that the list of pharmacists’ activities should be expanded? Do you support the suggestion to add the requirement of six months training, as outlined above? Do you support the deletion of Article 21(4) of the Directive? (Please give specific arguments for or against this approach.)

Answer 21: Although this question is not relevant to Medical Physics we support the addition for the requirement of six months training as the activities of the pharmacists are expanding beyond the traditional pharmaceutical dispensing.

We do not have an opinion for the second part of the question.
Question 22: Which of the two options outlined above do you prefer?

Option 1: Maintaining the current requirement of at least four years academic training?

Option 2: Complementing the current requirement of a minimum four-year academic training by a requirement of two years of professional practice. As an alternative option, architects would also qualify for automatic recognition after completing a five-year academic programme, complemented by at least one year of professional practice.

Answer 22: We do not have an opinion for question 22.

Question 23: Which of the following options do you prefer?

Option 1: Immediate modernisation through replacing the ISIC classification of 1958 by the ISIC classification of 2008?

Option 2: Immediate modernisation through replacing Annex IV by the common vocabulary used in the area of public procurement?

Option 3: Immediate modernisation through replacing Annex IV by the ISCO nomenclature as last revised by 2008?

Option 4: Modernisation in two phases: confirming in a modernised Directive that automatic recognition continues to apply for activities related to crafts, trade and industry activities. The related activities continue to be as set out in Annex IV until 2014, date by which a new list of activities should be established by a delegated act. The list of activities should be based on one of the classifications presented under options 1, 2 or 3.

Answer 23: We do not have an opinion for question 23.

Question 24: Do you consider it necessary to make adjustments to the treatment of EU citizens holding third country qualifications under the Directive, for example by reducing the three years rule in Article 3 (3)? Would you welcome such adjustment also for third country nationals, including those falling under the European Neighbourhood Policy, who benefit from an equal treatment clause under relevant European legislation? (Please give specific arguments for or against this approach.)

Answer 24: Yes. In certain areas, and Medical Physics is an example, there are shortages within Europe and such adjustments for third country nationals will benefit the European citizens.

Key in this is the definition of “effective” experience. This is the first place where this qualification is placed on experience. This can only be done when a harmonized set of KSC have been agreed on. If these do not exist then the concept of “effective experience” is meaningless.