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UEMS CONTRIBUTION

to the Consultation Paper by DG Internal Market & Services on the Professional Qualifications Directive
(MARKT.D.4 D(2010))

CONTRIBUTION to EC CONSULTATION PAPER
(MARKT.D.4 D(2010))

EXECUTIVE SUMMARY

The UEMS is a non-governmental organisation representing national associations of medical specialists in the European Union and in associated countries. With a current membership of 35 countries and operating through 37 specialists sections and European boards, the UEMS brings together approximately 1.4 million medical specialists in Europe. With the support of its membership, the UEMS is committed to the promotion of free movement of European medical specialists while ensuring the highest quality of medical care for European citizens.

The UEMS congratulates the European Commission for approaching the challenges faced by the revision of the Directive on the mutual recognition of professional qualifications (2005/36/EC – hereafter "Professional Qualifications Directive") and welcomes this opportunity to contribute its views on issues of importance to its constituency.

Particular attention should be paid to issues relating to:

- Medical education and training - in order to maintain the quality of general standards
- The necessary guarantees of necessary qualifications and fitness to practice of mobile healthcare professionals
- Prevention of deficient access to medical care due to migration of healthcare professionals to areas and countries offering better conditions of work.

While the UEMS is particularly pleased to see the importance of each of these issues acknowledged by the Commission, it is also concerned to bring healthcare professionals, particularly medical specialists, better conditions and improve the profession's ability to maintain sustainable levels of competence.

The UEMS, as a non-governmental organisation aiming to promote the mobility of medical specialists in Europe while guaranteeing the highest level of healthcare standards across Europe, carefully examined this Consultation Paper and carried an extensive consultation of its constituent bodies to elaborate this contribution.

The UEMS has therefore made a certain number of observations and recommendations in regard to the various issues raised in the European Commission's Paper. Additional issues having a direct or indirect impact on these matters were also addressed. The UEMS will now seek adherence to these concerns among the healthcare community and is happy to offer its expert-knowledge to the Commission and other EU decision-makers on the fields identified as its core areas of interest and expertise.

CONTRIBUTION from the EUROPEAN UNION of MEDICAL SPECIALISTS to the CONSULTATION PAPER by DG INTERNAL MARKET & SERVICES on the PROFESSIONAL QUALIFICATIONS DIRECTIVE

INTRODUCTION

The UEMS is a non-governmental organisation representing national associations of medical specialists in the European Union and in associated countries. With a current membership of 35 countries and operating through 37 specialists sections and European boards, the UEMS brings together around 1.4 million medical specialists in Europe. With the support of its membership, the UEMS is committed to the promotion of free movement of European medical specialists while ensuring the highest quality of medical care for European citizens.
The UEMS congratulates the European Commission for launching this public consultation as a first practical step towards the revision of the Professional Qualifications Directive (2005/36/EC) and welcomes this opportunity to contribute its views on an issue of key importance to its constituency. It also welcomes this document as a first step in defining innovations and areas of improvement in the framework of the revision process to come.
In this respect, the UEMS is particularly satisfied that the document focuses on a number of issues presented as priorities for a number of years.
As a whole, the UEMS as an organisation strongly committed to values such as the quality and the safety of healthcare treatment in Europe, calls the European Commission and EU Member States to take the quality of medical education and training at the basis of the quality of healthcare delivered within the EU as a long term responsibility, particularly in the framework of professional mobility underpinned by the PQD.
The UEMS is keen to contribute its professional expert-knowledge on the various issues raised in the Commission's document. In its Strategy Document[1], the UEMS precisely defined its fields of expertise and areas of interest and competence as the following:

- Postgraduate Training (PGT)
- Continuing Medical Education and Professional Development (CME-CPD)[2]
- Quality Assurance (QA) in specialist practice

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[1] See UEMS 2008/05: The UEMS Strategy

[2] *"The UEMS defines CPD as the educative means of updating, developing and enhancing how doctors apply the knowledge, skills and attitudes required in their working lives. The goal of CPD is to improve all aspects of a medical practitioner's performance in his/her work.*
"CPD therefore incorporates the concept of CME, which generally is taken to refer only to expanding the knowledge and skill base required by doctors. While the initial model of continuing education for practitioners focused on CME, an increasing recognition of the many components that contribute to good medical practice has led to CPD being accepted as the more appropriate concept.
"There is a continuum from undergraduate medical education (UGE) through postgraduate training (PGT) to continuing professional development (CPD). CPD forms part of a personal program of life-long learning that every doctor is engaged in from his/her first day at medical school until their retirement from practice." Ref: Basel Declaration – UEMS Policy on CPD (*http://admin.uems.net/uploadedfiles/35.pdf*)
However, for the purpose of this document, the terms "CME-CPD" will be used.

For the purpose of contributing to the current consultation, the UEMS restricted its comments to this document. However, for a full coverage of all the issues raised, the reader is recommended to also consult the following UEMS policy papers:

- The UEMS Charter on Training of Medical Specialists[1]
- The UEMS Charter on CME[2]
- The UEMS Charter on Quality Assurance in Medical Specialist Practice[3]
- The UEMS Charter on the Visitation of Training Centres[4]
- The UEMS Charter on Continuing Professional Development - Basel Declaration[5]
- The UEMS Declaration on Promoting Good Medical Care[6]
- The UEMS Budapest Declaration on Ensuring the Quality of Medical Care[7]
- The UEMS Policy Statement on Assessments during Postgraduate Medical Training[8]

The views presented in this paper are based on contributions from the UEMS constituent bodies, i.e. National Medical Associations and UEMS Specialist Sections & European Boards, as well as key elements from well established UEMS policy.

List of acronyms used in this contribution:

- **CME:** Continuing Medical Education
- **CPD:** Continuing Professional Development
- **EACCME®:** European Accreditation Council for CME
- **ECAMSQ®:** European Council for the Accreditation of Medical Specialist Qualifications
- **ECMEC®:** European CME Credits
- **PQD:** Professional Qualifications Directive – Directive on the mutual recognition of professional qualifications (2005/36/EC)
- **UEMS:** European Union of Medical Specialists – Union européenne des médecins spécialistes

[1] For the full document, see http://admin.uems.net/uploadedfiles/906.pdf
[2] For the full document, see http://admin.uems.net/uploadedfiles/174.pdf
[3] For the full document, see http://admin.uems.net/uploadedfiles/175.pdf
[4] For the full document, see http://admin.uems.net/uploadedfiles/179.pdf
[5] For the full document, see http://admin.uems.net/uploadedfiles/35.pdf
[6] For the full document, see http://admin.uems.net/uploadedfiles/772.pdf
[7] For the full document, see http://admin.uems.net/uploadedfiles/875.pdf
[8] For the full document, see http://admin.uems.net/uploadedfiles/801.doc

Q1 Citizens' access to information on recognition process

The lack of access to information from citizens should be addressed as a matter of priority.
Potential solutions encompass the creation of a commonly accessible website or hub containing necessary on the different procedures for recognition and the authorisation to practice, including notably the contact details of the host competent authority, the documents needed, the charges, the scope of professional rights and practice in the host Member State, etc.
Contact points already play a valuable role in providing information related to mobility but they should not become responsible for administrative procedures in the framework of the recognition process. Moreover, there should not be intermediaries preventing direct communication between the migrating professional and his-her competent authority, nor additional bureaucracy potentially leading to delays or additional barriers.

Q2 Simplification of current procedures

As far as medical specialists are concerned, migration procedures can be simplified through extending the scope of automatic recognition to new specialties (See also below Q22)
In practice, a professional should receive the confirmation of his-her qualifications in the home Member State and means of verification from other competent authorities should also be provided. However, the questioning of competences of a holder of evidence of formal qualifications issued by a competent authority should take place in exceptional, individually justified cases only.

Q3 Code of conduct for competent authorities

The Code of Conduct for competent authorities is generally seen as a useful tool for guidance in the implementation of the PQD. It is commonly agreed that this tool should be more widely known, both by authorities and the public in general.
When implemented, attention needs to be paid to possible discrepancies with some national provisions relating to administrative procedures. Hence flexibility in the implementation of the PQD should be ensured. This is why this Code of conduct should not be made legally binding as a mandatory application of the Code of Conduct would impede the competent authorities in their flexibility in the recognition process. Nevertheless, Harmonisation, if not unification, of these procedures should remain an objective since this would have a clear added value for citizens in terms of clarity and transparency.
Moreover, it is considered that the denomination "Code of conduct" is very much misleading in an issue affecting regulated professions. Another name for this guidance document should therefore be considered.

Q4 Compensation measures

This question relates to the context of the general system. When it comes to the medical profession, compensation measures are applied on a case-by-case basis. However, it is necessary to maintain coherence and adequacy in the implementation of such measures.
Compensation measures will be required only if the criteria from the PQD are met, i.e. when substantial differences or major deficits are detected. Patient Safety remains the key factor to justify such requests in order to ensure that the medical competence is guaranteed in the interest of citizens. It is therefore not considered that these measures would have a deterrent effect to the moving professional.

Q5 EU-wide code of conduct on aptitude tests and adaptation periods

A European consensus on this matter is likely to maintain coherence and thereby avoid imposing additional requirements and creating new barriers.
This process can also potentially bring greater clarity to migrating professionals' on their expectations.
On the contrary, such harmonisation or standardisation process should not lead to a decrease or weakening of requirements towards medical specialists' competence.

Q6 Partial Access

It is widely understood and agreed that this principle can in no way be applicable for the medical profession. Medical organisations were satisfied to note that the ECJ itself confirmed that partial access could only be granted if this was not in conflict with valid public interest reasons. This should though be clarified and enshrined in the revised PQD.

Q7 Mobility of young graduates

Along the general philosophy of free movement and in line with the emerging principle of "knowledge mobility" within the EU, mobility of trainees and young graduates should be allowed throughout the EU without discrimination: admission should be granted under the same conditions as host country's nationals. Mobility at all stages of the medical specialist's career is seen as potentially of great value but further facilitation during the postgraduate training and in the early phases of the professional career is necessary for this mobility to become fully effective and beneficial. Training periods in another country during studies are seen to be useful both from the viewpoint of individual physician and his-her professional development and due to the ever increasing cooperation in the health sector within the EU.
In this respect, further harmonisation in postgraduate medical training curricula proofs to be highly beneficial as it will contribute to realising this principle concretely, with an aim ultimately to introduce a "European postgraduate training internship" recognised in all EU Member States as envisaged previously by EU decision-makers. Reference should be made to the Council Recommendation on clinical training of doctors (16th June 1975)[1] as well as

[1] Council Recommendation of 16 June 1975 on the clinical training of doctors (75/367/EEC)

Article 8 §2 from the former Directive on Doctors' Mobility and the recognition of their diplomas and qualifications (5th April 1993)[1].
Mechanisms of support must also be developed in order to foster the mobility of trainees and young graduates. In a previous contribution to the EC Green Paper on Healthcare Workforce, the UEMS advocated for stronger support be delivered to *"the mobility of healthcare professionals for education and training and/or professional experience purposes. (...) The UEMS strongly supports the idea to establish exchange programmes for doctors based on the Erasmus model. Such "Hippocrates" programmes are likely to be highly beneficial to doctors for the purpose of their PGT and CME-CPD."* [2]
The UEMS is though aware of the difficulty emerging from a lack of training options in certain countries and therefore strongly advocates for greater resources be allocated to this sector at the national level. The development of EU incentives should also be seriously considered, and this potentially in collaboration with other Commission services.
Currently, this situation is not adequately covered under the PQD. Further addressing this issue (e.g. along the lines of previously agreed provisions of Directive 93/16/EEC or Council Recommendations) is likely to alleviate obstacles to mobility.

Q8 Professionals returning to their home Member State

Again this issue highlights the potential for greater harmonisation in postgraduate training and the need for it to be considered and recognised at the national level in order to guarantee an easy return from internships carried abroad. Accreditation of training centres such as already proposed by the UEMS[3] would also proof to be highly beneficial in this regard as it would allow the emergence of a mechanism of automatic recognition of training.
In addition, proper incentives should be put in place in order to avoid a medical brain drain to the detriment of certain countries and regions, and encourage young professionals to follow circular migration circles. This should certainly best be done at the national level and in collaboration with the relevant professional organisations.

The Council notes that in most of the Member States, after university medical training proper, the requirement of clinical training is imposed as being a condition for acquiring the unrestricted right to practise medicine.
As it is considered desirable that the possibility should exist of acquiring such clinical training in Member States other than that in which the candidate underwent his university training, the Council hereby recommends to the Member States that admission to such clinical training posts be afforded to nationals of the other Member States.

[1] Council Directive 93/16/EEC of 5 April 1993 to facilitate the free movement of doctors and the mutual recognition of their diplomas, certificates and other evidence of formal qualifications

2. The host Member State shall, however, take into account, in whole or in part, the training periods completed by the nationals referred to in paragraph 1 and attested by the award of a diploma, certificate or other evidence of formal training by the competent authorities of the Member State of origin or the Member State from which the foreign national comes provided such training periods correspond to those required in the host Member State for the specialized training in question.
It shall also take into account their professional experience, additional training and continuing medical education.

[2] See UEMS 2009/07: UEMS Contribution to the EC Green on EU Workforce for Health
[3] See the UEMS Charter on the Visitation of Training Centres

Q9-10 *irrelevant for medical profession*

Q11-14 EU Professional Card: objectives, added value, features, information an format

It is not clear whether an EU professional card should be introduced or not. This highly varies from the different national situations as well as the perceived potential for real added value in the eyes of competent authorities which can benefit from the IMI system. In this respect, it is obvious that any card must be supported by robust database and security system in order to demonstrate concrete applications reliably.

From the professional perspective, added value can be found in opening and improving access to information in regard to his-her qualifications and mobility procedure (which is currently non-existent via IMI) and/or making communication and exchange of information with competent authorities from his-her home and host Member States faster.

The card can also potentially contribute to increase patients' trust into the service provided as the holder of a card would be supposed to be able to demonstrate the record of his-her competence.

In this regard, an EU professional card can effectively contribute to achieving the objectives of the current consultation, i.e. simplification, integration and confidence. It should be seen as an enabler in addressing mobility in this broader context as it encapsulates these three elements. Furthermore, linking such a card to additional features is likely to foster its acceptance. At the same time, this should be kept simple and also avoid duplication with cards already implemented at the national level. Information to be contained on the card or be made available through the card encompasses: the professional identification and authentication; evidence of his-her fitness to practice (formal qualifications and continuous professional development as well as authorisation to practice and professional standing); and all additional information required in the framework of the recognition procedure. This information should naturally be kept up-to-date and made available to authorities from the other Member States synchronously.

A card aiming at supporting mobility purposes should remain voluntary (i.e. be delivered upon request from the professional). Nevertheless with appropriate standards to ensure transparency and security, a well thought off card has the potential to facilitate, if not replace, the current procedure, particularly in the context of temporary mobility as it would serve as evidence of qualifications and professional standing of its holder.

Before establishing a card though, it is suggested carrying an in-depth impact assessment on the practical, economic, financial and social implications of such a development. In this respect, the UEMS very much welcomes the creation of the Steering Group as an opportunity to look into the feasibility of the card and formulate recommendations as to how this can be achieved. In this respect, the UEMS is convinced that, as a European organisation, it has a role to play in the development of a European card for medical specialists in line with its activities towards harmonisation of medical specialist training at the EU level. Coordination with competent authorities is already ensured in this exercise and can then possibly facilitate the issuing process of EU-harmonised card.

In terms of terminology, the word "card" suffers from bad connotation and should certainly be improved. As stated above, the "card" cannot be considered if the general context of mobility is not addressed in full. The word "card" should therefore rather be seen as a "linguistic vehicle" encompassing the other concepts.

Q15 European curriculum

This concept is of great added value. Such a regime is actually nothing new since several European organisations, among which the UEMS, have been working on the elaboration of European curricula in their respective sectors as a way to achieve in affect training harmonisation. In many of the specialties represented under the UEMS aegis, European examinations or additional “qualifications” have been organised.
Albeit not bearing any legal standing as yet, this regime appears as an additional opportunity to obtain qualifications that would be recognised throughout Europe. European curricula developed by UEMS Specialist Sections & European Boards contribute to set high standards of harmonised medical training to be achieved in the different EU Member States.
This system is currently developing, recognised and taken over by increasingly more EU countries as it emerges from a purely voluntary nature. Ultimately, it is envisaged to build up acceptance from competent authorities towards these curricula in order to get full recognition of their value and/or integrate them into national training programmes.
This is precisely the philosophy underpinning the recent project by the UEMS to establish its European Council for the Accreditation of Medical Specialist Qualifications (ECAMSQ®). Such a project is actually building on and expanding the successful experience from the UEMS with the establishment of the European Accreditation Council for CME (EACCME®) in 2000 to facilitate doctors’ mobility for the purpose of their CME and CPD.
The innovation in introducing European curricula’s within the PQD is mainly two-fold.

1. It can serve for the introduction of the educational concept of “competence” and thereby address the concept of competence-based training.
2. Seeing the serious concerns arising from the irrelevance of certain provisions on automatic recognition in the Annexes of the PQD (See below), this new option can be seen as a way to complement such inaccuracies.

The UEMS very much welcomes the introduction of the concept of European curriculum by the Commission and sees merits and benefits in further developing it, particularly as a mean to ensure quality in professional mobility.

Q16 Excessive number of regulated professions

The medical profession is (self-)regulated for the essential purpose of guaranteeing patient safety. There is no way this core principle of self-regulation can be challenged.

Q17 Lighter regimes

Lighter regimes of recognition are acceptable but in exceptional cases only. Exemptions from the regular recognition procedures must be considered carefully and should be restricted to cases when doctors accompany their patients abroad and their medical activity remains confined to these patients only. In such cases, a simple declaration only would be necessary.
For such circumstances, the opportunity and potential added value for introducing a European “Card” and developing a European qualification or licensing might be considered.

Q18-20 Temporary provision of services: Declaration regime, prior checks, etc

There is a need to clarify the definition of "temporary or occasional" in order to prevent lack of safety, abuse or lowering of standards in the provision of services. The lack of clear provisions in the PQD causes considerable legal uncertainty and definitely deters potential service providers from making a declaration at all, thus inducing unlawful behaviour and thwarting the PQD's intentions. In this respect, competent authorities should be authorised to request information as regards the duration, frequency, regularity and continuity of the service to be provided.

Additional checks should be permitted in individual, justified cases, i.e. in the case when in relation to an individual, who exercises a profession that may have public health or safety implications, there are indications that this person does not meet the requirements or conceals facts that constitute an obstacle for the safe provision of services in other Member States.

In addition, further clarification is needed as regards the extent to which the PQD does or should apply to the provision of e-Health or Telemedicine services. The PQD is indeed one useful source in order to address the issue of professional standing and authentication. In this regard, the UEMS would like to recall its position that:

> It should be ensured that *"the use of e-Health and other telemedicine services:*
> *(a) adhere to the same professional medical quality and safety standards as those in use for non-electronic healthcare provision.*
> *(b) offer adequate protection to patients, notably through the introduction of appropriate regulatory requirements for practitioners similar to those in use for non-electronic healthcare provision."*[1]

Patients should indeed be protected from unqualified doctors providing temporary services also via Telemedicine. Introducing a system of mandatory declaration to such cases should also be permissible.

Q21 Access to the profession through minimum training harmonisation

Access to the profession via proper training is effective for the medical profession.

Q22 Opportunity to modernise the minimum training requirements and introduce competences

As regards minimum training requirements, there is a need to reflect and be in line with developments of modern medical practice.

The current system which is solely based on duration of training should integrate the concept of competence-based training. At the same time, it is clear that purely replacing one system by the other will create problems and discrepancies consecutive from the various degrees by which educational reforms have been implemented in the Member States. Therefore, a blend of both duration- and competence-based training standards should be worked out.

[1] See UEMS 2008/55: UEMS position on the draft directive on patient's rights in cross-border care

In addition, the work carried out towards harmonisation of specialist training by the profession itself, through the UEMS, must be taken into consideration more seriously. This work essentially encompasses:

- Establishing a European set of competences and other requirements (e.g. log-books, requirements on training centres, visitation programmes, etc);
- Introducing the concept of particular competences (formerly "particular qualifications") to reflect qualifications;
- Ensuring a minimum duration of training for specialties in Annex 5.1.3 of no less than 5 years, and in some cases even 6 years –anything below should be increased and 3-year duration is definitely unacceptable seeing the continuous and rapid development of medicine;
- Revising the general denominations of certain specialties (e.g. "Physiotherapy" vs. "Physical Rehabilitation Medicine")
- Facilitating the introduction of new specialties, notably through:
  - Improving the functioning of the Recognition Committee
  - Lowering the threshold of the minimum number of countries needed from 2/5 to 1/5

  – This is likely to facilitate migration (See also Q1)

As already mentioned, the UEMS, through its ECAMSQ®, ambitions to create a system whereby the knowledge, skills and competence of medical specialists will be assessed, and possibly certified, on the basis of EU-harmonised standards of training. This will be achieved by the integration of such European experiences (e.g. European Exams). In the long run, international accreditation of specialist training by European Boards of UEMS will prove to be highly beneficial.

While some did advocate for the general introduction of obligatory examinations, the culture of formative assessments, such as developed in Scandinavia, also needs to be taken into consideration.[1] At the EU level, European Board's assessments by the UEMS should serve as a role model in this respect.

Q23 Transparency of information on qualifications benefiting from automatic recognition

It is generally agreed that training curricula and requirements should be transparent and available online, albeit such a process is considered as heavy and costly in terms of resources for professional organisations.

At the same time, it is feared that the system of automatic recognition would thereby be undermined as host Member States could be able to check the training of a doctor although he-she benefits in theory from the automatic recognition.

Such a collection would nonetheless be worthwhile for specialties excluded from the scope of automatic recognition, i.e. not listed under Annex 5.1.3.

[1] See UEMS 2006/19: UEMS policy on PGT Assessments

Q24 Notification of new diplomas

The list of qualifications relevant to the medical profession is included in the Annex 5 of the PQD. Cases were identified where discrepancies existed in the definition and provisions of certain specialties further to changes and developments in time. In order to circumvent this problem, it is suggested to provide a list or a database where "historical" information can be found back when needed. This mechanism could for example be integrated into the IMI system.

Moreover, further flexibility and coordination mechanisms between the Member States must be enforced when introducing new diplomas or reforming national education and training systems, and this in order to preserve coherence with the PQD. Again great added value is to be seen by way of harmonisation of training through professional bodies and greater consideration should be dedicated to this work.

In doing so, the frequency of publication of changes within annex of PQD in the EU Official Journal should be increased. A permanent flow of information on current developments should ideally also be provided. Greater accountability should also be provided on the meetings, work and achievements of the Recognition Committee working under the PQD. Mechanisms of notification, and particularly the agreement from other Member States, should also be clarified in order to secure scrutiny in accepting new diplomas proposed by one individual country.

Anyhow, coordination mechanisms or training harmonisation cannot be used in attempting to lower standards of training. Some countries were indeed reported to try reducing their national specialist training programmes as a way to reduce spending but also to prevent migration from their healthcare workforce.

Q25-26 *irrelevant to the medical profession*

Q27 Continuing Professional Development

The UEMS supports that education and training at all stages of the medical life are vital components to sustain doctor's knowledge, skills and professionalism. In this regard, lifelong learning is an essential element of doctors' professional career and practice.[1]

While it recognises the diversity in the domestic regulations towards CME and CPD[2], the UEMS recalls that, in order to be fully effective, CME-CPD should remain voluntary as it is part of the personal ethical obligation for each doctor. Any EU provision on this matter should take full account of this state of play. Also, there should not be any compulsion for revalidation of recertification through CME-CPD. Indeed sanctions were demonstrated to be inefficient and lead to CPD becoming a bureaucratic burden rather than real contributor to improvement of care.

In spite of this, harmonisation of CME-CPD has been worked out through the creation of the EACCME® by the UEMS as a way to allow mobility for the purpose of CME-CPD (notably through the introduction of European CME Credits (ECMEC®) as well as to harmonise and

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[1] See the relevant extracts of the UEMS Contribution to the EC Green Paper on EU Workforce for Health (UEMS 2009/07) reproduced in Annex I to this paper.

[2] See the UEMS publication "CME-CPD in Europe – Development and Structure" (available on request to the UEMS Secretariat)

improve the standards of accreditation at the EU level. These harmonised standards, including the system of ECMEC®, are widely recognised and further enforcement might be considered.
As far as the recognition of qualifications is concerned, CME-CPD might need to be taken into account when considering the professional's fitness to practice. A doctor should be able to prove that he met the requirements of his country of establishment. If not, compensation measures should/could be envisaged. The EU professional "Card" could play a role in this process.

Q28-29 Alert mechanism through IMI

The IMI system bears the potential for rapid, efficient and reliable exchange of information between competent authorities. In this regard, alert mechanisms through the IMI should be provided.
However, any alert obligation should be limited to cases when sanctions of disciplinary or criminal nature or other kinds of lawful decisions impose constraints on the entitlement to practice the profession in the Member State (i.e. suspension or deprivation of licence) or limit the scope of professional activities, that a doctor or dentist is entitled to perform.
It is also agreed to expand the scope of IMI but there is a need to overcome the lack of transparency for professionals. Access to information by individual professionals should be made possible, possibly through a European professional card (See Q11-14)

Q 30 Language Testing

Patient care and treatment requires adequate language skills from health care professionals. This is fundamental as regards communication and patient safety. This component is key to doctors' fitness to practice in many respects and should therefore be subject to appropriate checks if deemed necessary, possibly by means of professional deontology, and which should not be part of the recognition process.
However, the required language skills depend on the speciality and physician´s tasks. It should be left up to the Member States to determine the level of language skills required in this respect. There is also considerable doubt that any EU-enforced regime of systematic and/or obligatory language testing would bring any added value. This would entail creating a new bureaucratic "monster" at EU level which is not likely to bring real added value or efficacy.
Should language tests be needed, clarity should though be made on the level of responsibility for carrying this out. Attention should also be paid on "formally certified levels of language skills" since these may appear insufficient depending on the context in which healthcare is provided.

CONCLUDING REMARKS

By and large, the UEMS welcomes all initiatives directed at ensuring professional mobility, provided that the necessary conditions are met in order to guarantee sufficient levels of quality of care and patient safety. Professional mobility has always been a major component of medical specialists' professional life. The UEMS is committed to this principle, as long as genuine training standards are respected and the quality of care is thereby preserved.

This is why the UEMS calls for the necessary revision of the PQD to update the provisions on medical specialist training in regard to standards of modern medicine; and introduce the concept of competence-based education and training, and namely include the notion of particular competences.

Support should also be allocated in order to make mobility of professionals, young graduates and trainees highly beneficial. The idea to start an "Hippocrates" exchange programme was also suggested as a means to support mobility for training purposes.

The UEMS supports that Education and Training at all stages of the medical life are vital components to sustain doctor's knowledge, skills and professionalism. This is with this philosophy in mind that the UEMS established the EACCME® and is currently launching a sister project, namely the ECAMSQ® aiming at the harmonisation of assessment and certification of medical competence at the EU level. The UEMS looks forward to continuing close cooperation with the Commission and other EU decision makers in order to ensure that high standards of medical training for all European doctors are achieved at all stages of their lives.

***** END *****

ANNEX I

UEMS CONTRIBUTION TO THE EC GREEN PAPER ON EU WORKFORCE FOR HEALTH

(UEMS 2009/07 – p.14-16)

WHAT WOULD HEALTHCARE PROFESSIONALS BE WITHOUT PROPER EDUCATION AND TRAINING?

Education and Training at all stages of the medical life: key components to sustain doctors' knowledge, skills and professionalism

Education and training are vital components in creating a modern, efficient health workforce. Investment must be channelled into activities increasing the quality of training for medical students and trainees at both undergraduate and postgraduate level throughout the EU. Lifelong learning and continuous professional development (CPD) must be enshrined in the EU health workforce in order to ensure that doctors have up-to-date professional skills and are knowledgeable about the latest treatments and developments in medical technology.

Undergraduate medical studies

As regards undergraduate education, the Bologna Process is relevant when considering education and training in the context of creating a modern, efficient health workforce. Whilst welcoming the Bologna Process as an opportunity to improve quality assurance and promote mobility of EU students, the UEMS is concerned that it may have particular undesired impacts on medical education in some of the Member States. The introduction of a harmonised three cycle system presents specific problems for medical education with impacts on workforce planning and the flexibility of the medical degree. It may also have financial implications for medical students and could lead to the fragmentation of learning. The UEMS does not want the Bologna Process to result in a potentially fragmented medical degree which may challenge the integrity of the final medical qualification.

Postgraduate Training

As already mentioned, the UEMS has been active in developing harmonised standards for postgraduate training in each of the medical specialties. This harmonisation was summarised in the UEMS Charter on Specialist Training[1]. The UEMS is eager to achieve endorsement by

[1] *See notably the UEMS Charter on Training of Medical Specialists in the European Community*

and within Member States of the training curricula it developed at the European level. These training programmes precisely aim at harmonising training to the highest standard and thereby ensure the highest qualification and fitness to practice for those doctors and medical specialists moving across borders. Raising professional qualifications improves the quality of health outcomes and ensures patient safety. On the contrary, lack of harmonisation in training of medical doctors is likely to result in significant differences and potential discrepancies in healthcare standards across Europe.

This is why the UEMS will soon be launching the European Accreditation Council for Postgraduate Training (EACPGT). This platform will aim at achieving this grass-root deployment of harmonised training programmes through an increased collaboration between the UEMS Specialist Sections and European Boards and the national authorities in charge of this issue. The particular aspects of training which will be dealt with encompass the whole spectrum of doctors' professional life after graduation:

- Knowledge: to be assessed mainly by MCQs
- Skills: to be evaluated by different techniques, among which "DOPS" (direct observation of practical skills) and other techniques of assessment[1]
- Professionalism: encompass publications, research activities and participation to CME-CPD

Faced with the need to achieve concrete outcomes in this regard, the UEMS is keen to initiate and run this project and calls on the Commission and Member States to support its efforts in getting adherence from all partner organisations and relevant bodies or authorities.

Continuing Medical Education and Professional Development, the physicians' commitment to lifelong learning

The model proposed for the EACPGT is based on an existing platform established by the UEMS in 2000 for the purpose of granting European accreditation to CME-CPD activities targeted at doctors, the European Accreditation Council for Continuing Medical Education (EACCME). This mechanism bridges the national accreditation authorities of European countries and the UEMS Sections and Boards in order to:

- assess and certify the quality of CME-CPD events
- allow participants to these events to get the recognition of the CME CPD gained in another country once back home

The UEMS was encouraged to gain recognition of this initiative from the European Commission[2] and looks forward to continuing close cooperation with the Commission and Parliament to ensure that high standards of CME-CPD for all European doctors are achieved. The EACCME has indeed proven to be a beneficial mechanism to allow European doctors to move across countries in order to more easily benefit from international CME-CPD which is of high quality thanks to the transfer of CME credits. The EACCME thereby also allows doctors to access updates in medicine and human science which are of relevance to their clinical work.

(*http://admin.uems.net/uploadedfiles/906.pdf*)

[1] *See also the UEMS Policy Statement on Assessments during Postgraduate Medical Training* (*http://admin.uems.net/uploadedfiles/801.doc*)

[2] *http://admin.uems.net/uploadedfiles/1050.pdf*

The lifelong knowledge and skill renewal: an ethical commitment

The opportunity to compel doctors to undergo CME-CPD on a regular basis is often debated in various circles, including within the medical profession itself. As there is no evidence that making CME-CPD compulsory is likely to improve health outcomes, the UEMS considers that CME-CPD are part of the ethical and moral obligation of each individual medical specialist and should therefore remain a voluntary responsibility[1]. Different kinds of incentives have been developed at the national levels to encourage or oblige doctors to follow CME-CPD. The various national situations have been extensively presented and detailed within the UEMS publication "CME-CPD in Europe – Development and Structure"[2].

General recommendations from the medical profession

The UEMS generally supports the CPD consensus statement which was signed by the European medical organisations in 2006[3] and encourages the European Commission to incorporate the key elements of this statement in any future legislation on the EU health workforce. Sufficient time, adequate learning and professional environment as well as appropriate funding for CME-CPD of physicians must notably be ensured by the health care system, especially when it comes to the CME-CPD requirements which are implemented by legislative acts. Incentives and rewards should be provided both to physicians-learners as well as to trainers or mentors.
Furthermore, the UEMS welcomes all suggestions aiming to increase training capacities across Europe but is also concerned with the quality of medical schools, teaching hospitals and training centres. For that purpose, the UEMS has developed guidance and criteria for the visitation of training centres. The UEMS has already managed to increase standards in certain centres thanks to this Charter and is keen to share its documents and expert-knowledge with the European Commission for greater action in this regard.

(...)

At the same, the UEMS insists that the medical profession remains the driver in defining its own training needs. To that end, greater support and recognition from responsible authorities is needed. Grass-root implementation of training programmes is also sought from Member States in order to achieve a wide implementation of these across Europe. As already mentioned, the UEMS considers this can be achieved through the establishment of its EACPGT and reiterates its request for support from the European Commission and the Member States in getting adherence from all partner organisations and relevant bodies or authorities.

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[1] See UEMS Charters on CME (http://admin.uems.net/uploadedfiles/174.pdf) and CPD (http://admin.uems.net/uploadedfiles/35.pdf)
[2] The full printed publication is available upon request. For an insight see http://admin.uems.net/uploadedfiles/1029.pdf
[3] For the full text of the Consensus Statement, see http://admin.uems.net/uploadedfiles/803.pdf