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UEMS CONTRIBUTION

to the European Commission's Green Paper on Modernising the Professional Qualifications Directive
(COM(2011) 367 final)

CONTRIBUTION to EC GREEN PAPER
(COM(2011) 367 final)

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 has gained 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 EUROPEAN COMMISSION's GREEN PAPER on MODERNISING 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 (http://admin.uems.net/uploadedfiles/984.pdf)

[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)*

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:

- **CA:** Competent authority
- **CME:** Continuing Medical Education
- **CPD:** Continuing Professional Development
- **EACCME®:** European Accreditation Council for CME
- **ECAMSQ®:** European Council for the Accreditation of Medical Specialist Qualifications
- **ECJ:** European Court of Justice
- **ECMEC®:** European CME Credits
- **ECTS:** European Credit Transfer System
- **IMI:** Internal Market Information System
- **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

NEW APPROACHES TO MOBILITY
A EUROPEAN PROFESSIONAL "CARD"

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?*

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).

Introduction

The UEMS supports the Commission's and the Steering Group's efforts in order to develop a "professional card[1]" that would ***facilitate professional mobility*** and ***guarantee greater trust*** in the recognition process. From the UEMS perspective, establishing a "card" should be run in parallel with reinforcing the existing systems of communication (i.e. IMI) as well as enlarging the scope of the information exchange. At the same time, necessary pre-conditions need to be met, particularly in terms of data protection.

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. 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 this respect, any "card" should be issued on a voluntary basis but must be fit both for establishment and temporary mobility.

A "card" in connection with IMI…

Competent authorities from both Member State of departure and the receiving Member State naturally play an essential role in checking doctors credentials, and ultimately their fitness to practice. A stronger focus should be drawn on the responsibility of the Member State of departure and the efficiencies that can be reached from their pro-action in assuring the

[1] 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. acceptance, and should certainly be improved. As stated above, the "card" cannot be considered until the general context of mobility is not addressed in full. In this respect, the word "card" should rather be seen as a ***"linguistic vehicle"*** encompassing the concepts of storage and exchange of data, and improved communication.

credentials and documents of the professional seeking recognition in another Member State. This though should not preclude the central role of the host Member State competent authority in the final decision as regards recognition.

The IMI system should be at the centre of this discussion and is the key tool that is used in the relationship between Member States of departure and that which is receiving the professional.

The main focus of this discussion should remain on the efficient communication between the competent authorities, and how this could assist in the process of automatic recognition. Authentication of documents and verification of professional status are the key components in the automatic recognition of qualifications. The introduction of a professional "card" must respect this process which is already in place and provide all the necessary guarantees against administrative duplication, difficulties with interoperability or fraud. The better utilisation of the IMI system, which could facilitate the mobility and recognition process between competent authorities, should be the key focus for doctors seeking recognition of their qualifications in another Member State.

The potential added value of the "card"

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*** (tokens of professional competence, i.e. e-portfolio with 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.

The "card" can indeed 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.

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.

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.

Technical issues

If the "card" is implemented we would like to see a solution where the "card" would only contain "***static***" information (i.e. identity, date of birth, etc.) which should link with the existing databases where "***dynamic***" information is available.

Data management systems must always be up-to-date, ideally through or derived from IMI. While a full access is restricted to authorised users (i.e. the competent authorities), anyone should be able to request information regarding a professional's fitness to practice through a

public interface. This is likely to contribute to enhancing trust into the system and this is why keeping the information up to date is crucial, particularly in cases of restriction imposed on a professional's license to practice.

Possible "card's" format

As stated above, what can be achieved through improvements to the IMI system could render a physical professional "card" unnecessary for the medical profession. This should be left to the discretion of the CA.

From the responses gathered thus far from the UEMS constituency, it indeed remains unclear whether a physical EU professional "card" should be introduced. 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.

The practical effects of the "card"

The importance of a robust and efficient recognition process is predominantly an issue of patient safety. While timelines to process the professionals request for recognition are important to doctors moving from Member State to Member State, the competent authority of the Member State of departure must be able to operate within a reasonable timeframe whereby it can undertake the necessary comprehensive communication and investigation between the relevant authorities. Meeting these responsibilities should be balanced with the professional's request of recognition. In this context, any "card" that would be introduced should only aim at improving and facilitating the process already in place.

- ***Temporary mobility***

  The regime of ***prior declaration is essential*** (Option 2) to the medical profession as a safeguard to ensuring public health and safety. The UEMS therefore believes that the professional "card" must not replace the declaration that doctors providing services on a temporary and occasional basis are currently required to make.

  From a patient safety perspective it's important that the CA knows when a person is working in the health-care sector and that the person is eligible to work in the member state of origin, thus we support option 2. Unless a fully interoperative and secure professional "card" is developed which provides a safe and secure method for storing accompanying documents, it is essential that competent authorities continue to verify the accompanying documents of doctors. The replacement of accompanying documents by the "card" should be the ultimate goal, provided that the information on the "card" is kept up to date by the CA in the Member State of first registration. At least until safety and reliability of the information on the "card" has been demonstrated – f.e. in pilot projects – the CAs should have the possibility to ask for accompanying documents.

- ***Automatic recognition***

  A "card" would probably ***accelerate*** the procedure but it is hard to predict whether a two-week deadline is realistic. The time limit should perhaps be slightly longer since there is nothing that hinders the CA to assess the application faster. It is important that the time-limit should not lead to a situation where the quality of this assessment of the professional qualifications is questioned.

- ***General system***

As mentioned, the time-limit should not lead to a situation where the quality of the assessment of the professional qualifications by the CA might be questioned.

However, extending the scope of the "card" can offer an opportunity to compare specialist training with ***more scrutiny***. The "card" could encompass an e-portfolio with the professional's achievements in terms of knowledge, skills and attitudes. There are multiple advantages to such a system: e.g. ascertained recognition of professional competence; track record of professional training, professional development and experience. This is likely to offer solutions to existing pitfalls in the current procedures (see below).

THE PRINCIPLE OF PARTIAL ACCESS

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.)*

It is widely understood and agreed that this principle can in ***no way be applicable for the medical profession***. Full licence/registration to practice medicine is essential to ensure optimum patient safety and healthcare service delivery in Europe.

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.

RESHAPING COMMON PLATFORMS

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?*

Whilst the concept of common platforms is not directly targeted to regulated professions, the UEMS can see some ***advantages for it to be applied to those specialties which do not enjoy automatic recognition***. The UEMS also regrets that the Green Paper no longer mentions the concept of ***European curriculum which was also seen as of great added value***.

As already mentioned in the UEMS contribution to the EC public consultation in March 2011[1], 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 would again support the introduction of the concept of European curriculum by the Commission as it sees merits and benefits in further developing it, particularly as a mean to ***ensure quality in professional mobility***.

[1] See UEMS 2011/07 UEMS Contribution to the EC Consultation on the Professional Qualifications Directive.

NEW COMMUNICATION TECHNOLOGIES

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?*

As already stated by the UEMS and other professional organisations, the lack of access to information by citizens should be addressed as a matter of priority. The UEMS therefore supports an obligation for Member States to ensure that information on the competent authorities and the required documents for the recognition of professional qualification is available through a ***central online access point*** in each Member State.

Potential solutions encompass the creation of a commonly accessible website or hub containing necessary information 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. Online applications should also be made available through that online platform.

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. Easier access to information must not lead to creating new entities but should rather be organised in the framework of the existing networks.

As suggested above, these improvements must also be considered when looking into the opportunity of introducing a European professional ***"card"***.

OPENING UP THE GENERAL SYSTEM

Question 9: *Would you support the deletion of the classification outlined in Article 11?*
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?*
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?*

Key principles

As the medical profession is regulated in all EU Member States, applicants for recognition only fall in the general system if they are not covered by automatic recognition. In the interests of ensuring that requirements applied to general system recognition processes are coherent with those set out under the automatic recognition regime, the UEMS does not support restricting the CAs' discretion to assess qualifications and require compensation measures as appropriate, as this could potentially lead to situations in which compensation measures undercut minimum requirements in order to adhere to such provisions. Moreover, limiting the ability to require compensation measures might lead to a situation where citizens are mistrusting the recognition procedure.
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.

Trainees' Mobility

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. At the same time, any country cannot refuse to recognise a traineeship on the sole ground that it was conducted in another Member State.
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)
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 practice medicine.
As it is considered desirable that the possibility should exist of acquiring such clinical training in

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. From a purely workforce planning perspective, increased competition for intern places might also impede on national medical graduates' access to internships in their country.

Mutual reciprocity of entitlements and rights of access for internships in other EU/EAA Member States must therefore be ensured. In parallel, 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 or any other EU legislation. 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. It though remains unclear whether the PQD is the appropriate legal instrument to do so.

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 (http://admin.uems.net/uploadedfiles/1280.pdf)

THE INTERNAL MARKET INFORMATION SYSTEM
EXPLOITING THE POTENTIAL OF IMI

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.)

Our answer is:

➔ ***Option 2: Introducing the wider and more rigorous alert legally enshrined 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 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 envisaged.

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. This should also be the case when sanctions are obsolete and the health professional therefore no longer is a risk for the patient safety. It is essential that the alert mechanism both benefits patient safety and at the same time does not restrict the free mobility for persons who no longer are a threat to patient safety.

There have been some recent high profile cases of physicians migrating to other Member States after sanctions and disciplinary action have been recorded. Public health and safety is paramount for the recognition of qualifications for physicians. As physicians qualify for automatic recognition, it should also be an automatic function that other Member States are notified if a health professional is no longer permitted to practice due to disciplinary action.

One, albeit rare, situation that has not been considered in this process is if a doctor is struck off the home country register for something not acceptable or against medical practice in the home country, but may be acceptable in another jurisdiction. This situation, while rare, may arise given the diversity amongst medical systems throughout the EU and should be considered by the Commission.

It is therefore essential that ***specific conditions*** for the use of the alert mechanism are determined. Member States must be familiar with the use of disciplinary sanctions in the other Member States, including information on which basis the sanctions are given and whether it is permanent or temporary sanctions and when they expire.

Any alert mechanism to be introduced must also strictly comply with ***data protection*** regulations. Provisions to this end must take account of the on-going review of the EU data protection legislation and ensure the highest possible standards. Adherence to these high standards for issuing alerts must be enforced in all Member States.

It is also agreed to expand the scope of IMI but, as stated above, there is a need to ***overcome the lack of transparency for professionals***. Access to information by individual professionals should be made possible, possibly through the European professional “card”.
The above regulatory requirements should apply to electronic as well as traditional healthcare. EU Member States should ensure that the providers of e-Health and other telemedicine services adhere to the same quality and safety standards as those in use in non-electronic healthcare provision; and that they offer adequate protection to patients through the application of regulatory requirements for telemedicine practitioners, wherever their location, identical to those in use for non-electronic healthcare provision.

LANGUAGE REQUIREMENTS

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.

Preliminary comment

Patient care and treatment requires adequate language skills from health care professionals. This is fundamental as regards communication and patient safety.

It should be noted that it is important for health professionals to be able to engage with their co-workers and their wider professional environment to ensure they are able to communicate appropriately regarding patients and the system that they operate within. Health professionals who have direct contact with patients and who benefit from automatic recognition need to ensure that their language skills are proficient to a level where exchange with patients allows for mutual understanding. Otherwise, complications from misunderstandings often resulting in a lack of comprehension can result in adverse medical outcomes. To be able to successfully interact with patients, physicians particularly need to have a capacity to adequately communicate with patients not only for reasons of patient safety, but to reinforce the trust that is fundamental to the doctor/patient relationship.

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.

Therefore, our answer is:

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

A balance needs to be achieved to ensure that competent authorities are not (directly or indirectly) using language testing as a discriminatory tool. As stated above, the Member States ability to demand sufficient language skills must be proportionate to the language skills needed to carry out the profession.

If the language requirements in the directive are increased, discussions should take place regarding financing of the language courses that the health professional has to undertake. If each professional has to pay for the courses, mobility might decrease.

Possible ways of addressing this issue should be explored through the ***Code of Conduct***: on a European level, clarifications should be made with regard to the content of the Code of

Conduct also in relation to the responsibilities of the various stakeholders with regard to the communication skills of a moving doctor. A clarification of the content of the Code of Conduct would enlarge the awareness of the responsibility of the migrating European doctor, the competent authority and the employer as to ensuring that the EU-doctor possess the necessary skills – including language skills, that are a necessity for the doctor being able to perform his profession with “due care and conscientiousness“. It should be noted, though, that the Code of Conduct is not legally binding.

It is important that the migrating EU-doctor has easy access to information on which skills are required in order to work within his or her specialty, and in that connection how the doctor can obtain or prove having these skills. Skills are in this context everything but strictly professional qualifications.

MODERNISING AUTOMATIC RECOGNITION

The three-phase approach to modernisation

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?

The UEMS has some concerns with the three-phase approach, in particular the use of delegated acts to update training competences and to develop sets of competences. Changes to such an integral part of the recognition procedure should be open to full democratic scrutiny and should ensure the full participation of relevant experts including competent authorities, professional organisations and universities.
The three proposed phases are also intricately linked. The issue of minimum training periods (phase one) is closely linked to the issue of ECTS (phase three). A comprehensive review of the Directive encompasses actions under all three phases. The UEMS strongly advocates for phases two and three to be anchored into the initial review of the Directive in order to ensure that they do not drop from the Commission's agenda.
The UEMS agrees with an approach centred on the Member States as holding the competence to determine the content of training. However, in view of ensuring a common high standard of medical training at European level, and thus ensuring patient safety and standard of care of high quality all over Europe, Member States and the respective competent bodies and professional organisations should try together to elaborate minimum training requirements through involvement and exchange with all partners. In order to ensure the necessary expertise for developing a realistic and sustainable provision, the UEMS strongly calls for a ***formalised consultation of an expert committee***, comprising European representative bodies of the medical profession, to be established, who would be tasked with carrying out the development process (See below on the ACMT). Since the differences at national level are to date rather diverse, an in-depth study and mapping would need to be prepared in support of any such process of developing common minimum training requirements. Therefore a setting of timeframes for the completion of this process can only be considered at a later point in the process.

Increasing confidence: Clarifying the status of professionals

Establishment vs. Mobility: gap in the directive

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? Is there a need for the Directive to address the question of continuing professional development more extensively?*

Doctors should always demonstrate to the host Member State that they have the right to exercise their profession in the home Member State, be it through a certificate of good standing or by acknowledgement by their competent authority. 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.***

It is a ***moral and ethical obligation*** for doctors to engage in CPD activities. Currently, Member States have different CPD arrangements, some leading to recertification or relicensing whilst others must meet defined CPD criteria to ensure they keep their professional registration. However there remain Member States with no such CPD activity requirements for doctors. Once doctors move to the new Member State, they will then have to meet the CPD requirements laid down in the host Member State, whatever the requirements may be.

A recommended standard could be explored by the Commission. However, while it recognises the diversity in the domestic regulations towards CME and CPD , 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 or 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 addition, additional problems would evolve if a requirement for CPD is laid out in the Directive. A suitable standard would have to be established in each country for doctors to engage in, or support given for them to achieve an appropriate standard in neighbouring countries. This may present significant resource challenges for those countries that do have CPD arrangements in place. Doctors already understand their moral obligation to engage in CPD activities and generally make an effort to ensure they fulfil this obligation.

Increasing confidence: Clarifying minimum training requirements for doctors

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?*

The UEMS strongly believes that basing a decision on fitness to practise solely on the length of time individuals have trained rather than on the skills they have acquired is not appropriate for the continued development of a modern healthcare system. Competent authorities must be able to satisfy themselves that a doctor possesses all of the necessary clinical skills in order to undertake their job successfully. ***Minimum training periods must be coupled with a comprehensive set of training outcomes in order to demonstrate the competence of individual doctors.***

The current Directive is quite clear that training should comprise 5,500 hours or six years' training. Despite this, there have been attempts to impose a much more restrictive interpretation on what the Directive requires.

It is essential for a certain number of countries that the current wording is maintained in order to maintain flexible systems which encompass intensive graduate-entry medical programmes. Any changes to the current wording would constrain these Member States and will have serious implications for those doctors that have already successfully qualified from the many graduate-entry programmes available in Europe.

Several studies have confirmed that the intensive graduate entry programmes are as robust as traditional programmes[1]; the UEMS therefore sees no need to alter the current system. This change would only be needed if the Commission was aware of a Member State that awards a medical degree to students who have followed a six year course with very low hours. If this was the case then the degree would be awarded following a long but incomplete (or rushed) course. The UEMS believes that the number of hours of quality training is important but sees no reason why they should forcibly take place over a six year period.

The European Commission states that it intends to explore the use of the European Credit Transfer System (ECTS) in the third phase of the revision of the Directive post-2014. This may present a solution to the issue of ensuring that all medical students study for enough hours to satisfy training outcomes. Until further work is undertaken on ECTS, it is imperative that the current wording remains.

[1] Comparing the performance of graduate-entry and school-leaver medical students, Medical Education, Volume 44, Issue 7 (June 2010); Graduate entry to medical school? Testing some assumptions, Medical Education, Volume 38, Issue 7 (July 2010); Preparedness for hospital practice amongst graduates of a problem-based, graduate-entry medical programme, The Medical Journal of Australia (2003).

Increasing confidence: Ensuring better compliance at national level

Notification of national education and training programmes

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?*

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. Member States should be obliged to notify the Commission of all new programmes of education or training. This is vitally important to the progression of the professions in the EU. Currently, there are large discrepancies between education degrees and training programs. 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. A periodic review of criteria for automatic recognition should be introduced to ensure that the Directive keeps up with developments in the field of medical education. 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.

Doctors: Medical Specialists

Criteria for automatic recognition: Lowering the threshold of Member States

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?

As stated in the UEMS contribution to the EC public consultation on the PQD, it would be appropriate to ***extend the scope of automatic recognition*** for medical specialties, particularly through lowering the minimum threshold of Member States.
The Fourth ACMT Report already referenced recommends that official EU recognition be granted to up to 20 medical specialities (admittedly when the rules were that such could happen if the specialty existed as an independent specialty in 2 or more Member States). Reducing the threshold from two-fifths to one-third will permit the long overdue recognition of several other well established specialities.
In reality, as big a challenge in the recognition of 'new' specialties is not the just proportion of Member States that recognise the speciality, but the ***tortuous ill-understood process required for speciality recognition***. As stated in our response to Question 17, Member States should be obliged to report recognised specialities using a much simpler common procedure than the one currently in use.

Partial exemptions in specialist training programmes

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?

As outlined in the Commission's discussion paper there is, with careful scrutiny and adjudication, ***merit in allowing partial exemptions for some specialities*** which as the paper puts it have 'grown out of internal medicine or general surgery'. But this must be done with due care recognising that advancing medical knowledge and the growing understanding and complexities of diseases has led to the emergence of new specialities and clinical skills with their corresponding postgraduate training programmes.
Accordingly while the Directive should be modernised to allow partial exemption from the full training in second specialisation, it would be ***difficult to map out the combinations*** of specialties and second specialties and what extent of exemptions would be appropriate. The condition for granting partial exemption should be that the medical competences, acquired in connection with a partial completed specialist training programme, are equivalent to the medical competences in that specialist training program the partial exemption is granted. It is vital that, if transferable competencies between specialties are implemented, the over arching principles should be that the training has been assessed as satisfactory in the previous programme and that assessment is of competencies and experience and not just of experience or length of training.
This process will require to be adjudicated according to a non-automatic procedure, e.g. upon by an ***agreed expert committee on a specialty by specialty basis*** ; and justified transparently for the benefit of ensuring a proportionate use of the exemptions.

Pharmacists

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?*

While it would not be appropriate for the UEMS to comment on the activities of pharmacists, if an expansion of activities was to be discussed, it should be done so in consultation with that of the medical profession to ensure that ***patient safety, continuity and quality of care*** are paramount, and the patient remains at the centre of any discussion.
In essence, should other healthcare professionals' scope of activity be expanded in the future, this should comply with the ***European Definition of the Medical Act*** as adopted by the UEMS in April 2009[1].

Third county qualifications

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?*

The current policy of competent authorities who recognise the professional qualifications of the individual moving advising that the applicant be considered under the general system if their qualifications have been gained in a 'third' country is ***currently adequate***. Three years experience within Europe is a considerable timeframe to enable a professional assessment of the individual and their qualifications.
Given that the principle for recognising the qualifications of a person looks at the qualifications of the individual, the citizenship of the person is not the question, but the quality and experience of the individual in performing the activities of the profession, which is often a result of their quality of training. The three-year rule, along with the current arrangements for recognising qualifications are adequate and provide reasonable safeguards particularly when looking at areas of patient safety. ***No change is required to this area of the directive, provided that the procedures remain of high quality and transparent.***
The UEMS also opposes such an amendment, due to the implications of the proposed change. For one, the existence of Member State opt-outs which affect the legislation mentioned would translate into a fragmentation of implementation of the Directive and diminish its import on the Single Market, introducing an element of ***'registration shopping'*** where third country nationals undertake their primary registration in a member state that has less stringent checks on qualifications. Additionally, in certain cases the application of the Directive's provisions to non-EU nationals would also necessitate a careful consideration of issues such as ethical recruitment and brain drain, which could not be adequately dealt with within the Directive. The maintenance of the current scope therefore seems the most appropriate way forward.

[1] See UEMS 2009/14 European Definition of the Medical Act (http://admin.uems.net/uploadedfiles/1306.pdf)

General comment: Why "minimum" training requirements are not fit for purpose…

The Advisory Committee on Medical Training

Currently minimum training conditions, to ensure that certain levels of medical education and training have been achieved for qualifications to be recognised, are laid down for doctors in Annex V of the Directive. It remains the UEMS view that the text in this Annex needs to be amended and updated to reflect current medical and education principles already agreed in EU publications since 1997, i.e. the ***Fourth Advisory Committee on Medical Training (ACMT) Report***[1].

This publication – the work of EU competent authorities, academic medical representatives and the practising medical profession – defines the responsibilities of training institutions, trainers and trainees. It highlights the importance of quality medical training including defined educational target outcomes and the required competencies that would form part of the overall assessment and evaluation all medical training programmes.

It is remarkable that these fundamental educational principles remain to be incorporated into the revised Directive, at least so far as the medical profession is concerned, though we suspect have equal applicability to other healthcare professions.

Through its work and initiatives, the UEMS aims to re-establish this consultative body in order to provide decision-makers with accurate and updated evidence as regards medical education and training in Europe.

Overcoming discrepancies in training standards

While minimum training requirements have been laid down in the current version of the PQD, ***the UEMS supports a dual approach of minimum training time and competencies to ensure a much more balanced approach to medical training in Member States.***

Currently, there can be significant discrepancies in training standards. A ***comprehensive review*** must therefore be undertaken to best devise a course of action to ensure that the harmonisation of training standards can be achieved. Such a change would decrease the currently quite high discrepancies that exist between Member States when it comes to the length of the education programs.

The demands in the Directive should be ***combined between time and out-come based*** and in the long run harmonised with the system for ECTS. The complexity in the national programmes for specialist education is likely to increase in the future. In this context, it is important that the requirements on doctors with specialist qualifications (article 25) can change when the demands on health professionals in the health care system is increased. This aspect is crucial in order to keep a high confidence for the system for automatic recognition. Increasing the minimum duration of education to ***5 years*** for doctors with specialist education (article 25) is thus of major importance.

There does however need to be a respect for national delivery of training programmes. An agreed common trunk of basic medical training should be delivered to ensure the standard of training is of the highest quality throughout Member States. Better communication between relevant actors in each Member State with their counterparts in other Member States should assist in reducing the current discrepancies that have been identified. By learning from each other, a higher standard can be achieved, and the Commission should encourage and

[1] See XV/E/8306/3/96-EN – European Commission, Directorate General XV, Brussels, 15 January 1997.

possibly facilitate this function. However, it should be up to national competent authorities delivering training to maintain their autonomy.

Key priorities

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

1. 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.
2. 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 (e.g. Anaesthesiology);
    - Revising the general ***denominations*** of certain specialties (e.g. Changing "Physiotherapy" into "Physical Rehabilitation Medicine"; Merging "Radiology" and "Diagnostic Radiology" into one main specialty of "Radiology"; Clarifying the requirements for the specialty of "Oro-Maxillo-Facial Surgery")
    - 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 as this is likely to facilitate migration.

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. At the EU level, European Board's assessments by the UEMS should serve as a role model in this respect.

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 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

[1] See notably the UEMS Charter on Training of Medical Specialists in the European Community (http://admin.uems.net/uploadedfiles/906.pdf)

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.

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

[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

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.

[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