European Commission Green Paper on Modernising the Professional Qualifications Directive

1. I write with regard to the European Commission Green Paper on Modernising the Professional Qualifications Directive.

2. The Royal College of General Practitioners is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 42,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. We are an independent professional body with enormous expertise in patient–centred generalist clinical care. Through our General Practice Foundation, established by the RCGP in 2009, we maintain close links with other professionals working in General Practice, such as practice managers, nurses and physician assistants.

3. The College is keenly interested in the outcome of this Green Paper. We are committed in this as elsewhere to developing and maintaining the highest standards of general practice, and in particular to the prioritisation of patient safety at all times. As you will know, mobility of healthcare professionals has been a matter of particular attention for UK general practice in the light of the tragic case of Dr Ubani.
4. Please see, attached as an annex to this response, the advice we sent to Primary Care Organisations (PCOs) in the UK in December 2008 on the subject of ‘Admitting GPs from Outside the UK to Primary Care Lists’, which demonstrates our ongoing engagement with issues around the mobility of healthcare professionals.

5. We are concerned that the proposals in the Green Paper, as they stand, do not go far enough to recognise that different parts of the EU use specialities differently to deliver their health systems. The UK uses general practitioners as a recognised specialty with an exit exam (MRCGP) to provide a wide range of competencies to patients for whom they are a first point of contact and where many patients are provided with all care for both acute and chronic conditions. This is supported by highly sophisticated teams and computerised records, but the actual work of GPs is less supervised than in hospital settings. This context explains much of our concern about the generic mobility of medical professionals in the EU, where in many countries general practice is not a medical specialty and does not require the same range and depth of competencies as UK GPs provide.

6. We note the section within Annex V of the 2005 directive specifically for general practitioners (5.1.4), who are treated differently from “specialised doctors” (5.1.3). This seems to perpetuate the historically lower status of general practice which is now completely inappropriate, given the highly skilled, high risk nature of primary medical care. It is well time that European general practitioners were treated as medical specialists in their own right, which would allow more stringent qualifications to underpin safer free movement. Arguably, the UK has one of the best systems of specialty training for general practice in the world with a lengthy and detailed curriculum and a demanding licensing exam on the completion of training. And yet, this does not translate into specialty status at the European level, arguably because of a lack of political will on the part of successive UK governments and because the procedures laid down in Article 26 of the directive are overly bureaucratic.

7. A relatively recent position paper from the European Union of General Practitioners on the Evaluation of the Directive\(^1\) calls for the recognition of general practice as a specialty across Europe, the introduction of quality criteria for training rather than a simple time requirement, standards to be set for continuing medical education in

general practice, and the language requirements for migrant doctors to be much more clearly defined. Adoption of these recommendations would address many of our difficulties with the Directive and this Green Paper.

8. We have addressed below specific areas of the Green Paper, where relevant to our expertise:

2.1 The European Professional Card

For the reasons already discussed – that general practice, in the absence of cross-European specialty status, is context-dependent – we do not believe that a European Professional Card will be of use for our profession. Even with a card that provides information about qualifications in the country of origin, it will still be necessary for the regulatory authorities in the host nation to check that the professional meets their training requirements.

2.2 The principle of partial access

It is not clear from the Green Paper whether the principle of partial access is intended to apply to the medical profession, but we are clear that it must not do so. The GP curriculum in particular is amongst the most complex and intensive, and to attempt evaluation of the equivalence of a professional's qualifications and experience in order to facilitate partial access would be an excessively bureaucratic exercise and undoubtedly harmful to the needs of patient safety.

2.3 Reshaping common platforms

Before lowering eligibility criteria, there needs to be rigorous comparison of the outcomes of training and competencies achieved in the different member states and a process to ensure that the regulatory authorities in member state countries are satisfied with the equivalence.

3.1 Access to information and e-government

We would support in principle the implementation of central online access points to facilitate health professionals collating the necessary documentation – though urge caution as ever with regards to the track record of major IT projects that often don't deliver as anticipated.
3.4.2 Alert mechanism for health professions

We would support implementation of a rigorous alert obligation (as described in Option 2) 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. This is clearly necessary in the interests of patient safety, and a pre-requisite for Member States to have confidence in the Professional Qualifications Directive.

3.5 Language requirements

This is a key part of the College’s concerns with regards to the Professional Qualifications Directive. General Practice in the UK is very much centred on the GP-patient consultation and the ability to communicate effectively is essential to the provision of safe and high quality care. Language has standard, colloquial, local, cultural, contextual and technical components, all of which play a necessary part in the role of the GP – and difficulty with any of these mean that a professional will struggle. A standard language test may not identify all such problems.

Currently it is the responsibility of the employer to ensure that health professionals have adequate language and communication skills. Therefore it is currently possible for a health professional to be accepted on the medical register without these skills being assessed. As stated, good language and communication skills are essential to work safely in general practice in the UK, so there should be an assessment of communication skills, and this should take place prior to registration.

Good language and communication skills are also required for those health professionals who may not have direct patient contact but nonetheless need to be able to communicate effectively with work colleagues.

4.2.2 Clarifying minimum training periods for doctors, nurses and midwives

General practice training in the UK is competency rather than purely time-based, so this issue may be a diversion from our point of view. That said, we would not particularly support changing this aspect of the Directive – the current wording allows for shorter graduate training programmes, and to change it could potentially disadvantage current graduates who may wish to work in other member states in the future.
4.3 Re: allowing transfer of relevant training/experience between specialties

Medical postgraduate training in the UK, including that for general practice, is very structured and competency based. In other countries training may be time based. Before transfer of relevant training and experience is considered, the outcomes of training and competences need to be equivalent. In the context of the mere 3 years of GP postgraduate training in the UK, even more tightly structured than other specialties, it is not possible to accommodate equivalence in this way.

Anecdotally, one of our respondents who has five years experience of recruiting medical professionals in Europe noted considerable difficulty in comparing qualifications that were superficially similar – for example, encountering someone with a CCT in ophthalmology who had only performed a handful of cataract procedures, or a ‘GP gynaecology’ with a CCT in general practice but who in reality was only doing smear tests, ultrasounds and pipettes, and none of the other activities that we would consider part of general practice.

It is not viable to attempt to map different health care systems, different needs, different expectations, different service delivery models, different languages, different cultures and fundamentally different specialties to the GP curriculum to create effectively an accelerated route to qualification in UK general practice. To do so is likely to result in short term workforce solutions where inadequately prepared professionals can be placed in the most demanding and challenging environments – only to be blamed later for not doing a very good job.

9. As described above (paragraph 7) adoption of the UEMO recommendations would go a long way to addressing these concerns. In the interim, it is vital for the protection of patients and the maintenance of standards in healthcare, particularly general practice, that the professional regulator (the GMC in the UK’s case – please see their recent press release ‘Better support needed for doctors entering UK practice’\(^2\)) be enabled to extend conditional registration to incoming professionals, subject to an assessment of additional training (including language) needs and completion of a tailored induction programme. At present this is left to the discretion (and funding) of PCOs, with the outcomes that patients are placed avoidably at risk.

10. We gratefully acknowledge the contributions of members of the College’s International Committee and colleagues in COGPED in formulating this response.

Yours sincerely

Professor Amanda Howe MA Med MD FRCGP
Honorary Secretary of Council
ADMITTING GPs FROM OUTSIDE THE UK TO PRIMARY CARE LISTS -

ADVICE TO PRIMARY CARE ORGANISATIONS

Summary

This advice is for the staff in primary care organisations (PCOs) in all four countries of the UK who are responsible for admitting GPs who trained and qualified outside the UK to Primary Medical Performers Lists (Lists).

Whilst most doctors admitted to Lists are clinically and linguistically competent, the RCGP is concerned about the threat to patients posed by the minority who may not be. Some incoming GPs will need to improve their knowledge of the English language, some will need help to become familiar with the NHS; others will have worked in healthcare systems where they have had limited or no exposure to certain types of patients and conditions. A minority may be more generally deficient in clinical knowledge and skills.

The RCGP regards PCOs, which are responsible for checking carefully all those applying for Lists, as crucial in the upholding of high standards in general practice and therefore in the safeguarding of patients.

This advice is intended to support PCOs in deciding whether or not to admit an applicant to a List. The RCGP recommends that PCOs work with postgraduate deaneries in providing tailored assessment and induction to incoming GPs to ensure that they are competent and safe to practise.

This advice was produced in consultation with NCAS.

Background

A GP admitted to a Performers List is deemed to be fit to work unsupervised in NHS general practice in both ‘in hours’ and ‘out of hours’, locum work and as a principal or non principal in any part of the UK.

General practice is shaped to a very great extent by its context - societal, cultural and organisational - and those who train in general practice in the UK are required, through robust assessment processes, to demonstrate that they have highly developed clinical and communication skills and a detailed knowledge and understanding of the extended role of the GP in today’s NHS. There are examples of general practice in other countries that are similar to UK practice. However, given the contextual issues, it may well be the case that many aspects of UK general practice will be unfamiliar to those

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3 Unless there are conditions on their inclusion
who have only trained and/or worked elsewhere. Some healthcare systems have a closed list system; in others GPs don’t treat women or children; the UK style gatekeeper system is not replicated throughout the world; some have very limited primary healthcare teams and many do not undertake appraisals, audit and other quality management processes; many GPs outside the UK work in a salaried capacity only and do not necessarily undertake the sort of business and financial management familiar to UK GPs.

The difficulty of ensuring common standards across a diversity of healthcare systems has increased with the recent increase in EU Member States. Little is known in the UK about the GP training programmes of other countries.

Many PCOs are already working with postgraduate deaneries to offer incoming GPs tailored training. Deaneries report that a significant minority fail one or more deanery-administered learning needs assessments and that some have been referred either to the General Medical Council because they are considered to be a threat to patient safety or to NCAS for additional support and/or assessment.

The legal framework and guidance governing Lists

All those wishing to work in NHS general practice must be included in a Performers List. Entry and removal from Lists is governed by regulations in each country of the UK.⁴

EU nationals

A pre-requisite to entry to a List is inclusion in the GMC’s GPs Register. An EU Directive⁵ facilitating the free movement of EU nationals gives GPs qualified within the EU automatic right of entry to the Register if they have either a certificate of specific training in general practice or an acquired right to practise from their own Member State⁶. They do not need an evaluation by the GMC or PMETB, nor do they need to have any familiarity with the NHS.⁷,⁸

Non-EU nationals

In contrast, GPs who do not have an enforceable EU right (usually referred to as International Medical Graduates) must satisfactorily complete GMC-determined assessments of their language and clinical

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⁴ NHS (Performers Lists) (England) Regulations, SI 2004, 585; The Health and Personal Social Services (Primary Medical Services Performers Lists) Regulations (Northern Ireland), SI 2004, 149; NHS (Performers Lists) (Wales) Regulations SI 2004, 1020; NHS (Primary Medical Services Performers Lists) (Scotland) Regulations

⁵ EEC Directive 2005/36/EC

⁶ With the exception of Bulgaria and Romania. The European Commission has not yet confirmed that it is satisfied that their training programmes meet minimum EU requirements

⁷ In certain, limited circumstances the GMC may ask an EU qualified applicant to take an aptitude test

⁸ Once on the GMC Register, all doctors are subject to the same arrangements for remaining on the Register. In time, all will be required to revalidate
skills and be awarded a PMETB Certificate confirming Eligibility for General Practice Registration (CEGPR) before being admitted to the GMC’s GPs Register.

Responsibilities of PCOs

Performers List Regulations give PCOs responsibility for determining the suitability of applicants based on the information they supply, for example references. Advice issued by the Department of Health (England and Wales) stresses the duty on PCOs to be sure that those admitted to Lists are competent and safe. It includes the following:

‘Protection of patients should be the overriding consideration when considering whether a performer should be admitted to a list....’

A review of the Performers List Regulations undertaken during 2008 by the Department of Health (England) contains the following recommendation:

‘There should be a formal NHS induction process to help new performers settle into local health economies. This would be tailored to the needs of the individual but would typically cover both local and (for those who had not previously worked in primary care in the UK) national elements. There should be an emphasis, in appropriate cases, on developing English language and communication skills.’

RCGP advice to PCOs

The RCGP advises PCOs that if they cannot be certain that an applicant for a List meets all the following criteria, patient safety could be compromised and further information on the applicant should be sought:

i) The applicant can demonstrate a knowledge of English which, in the interests of the applicant and of patients, is necessary for performing primary medical services;
ii) The applicant is familiar with primary care in the NHS;
iii) The applicant has worked in a healthcare system which has exposed him/her to the generality of patients and conditions routinely managed by GPs in the NHS.

Postgraduate Deanery assessment and induction programmes

The RCGP advises that compliance with these criteria should be assessed, on behalf of the PCO, by the local postgraduate deanery which is the organisation responsible for training doctors after they leave medical school to the level required for a licence to work as a GP. Deaneries are experienced in

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9 A small minority of this group will not have been required by the PMETB to undertake any form of training and assessment in NHS general practice


making assessments of educational need and, resources permitting, can provide tailored assessment and induction programmes. Deanery assessments will include an assessment of competence in the English language.

Postgraduate deaneries have recently agreed and published a UK-wide process for assessing the learning needs of incoming EU GPs and others and have developed a standardised model of training for these GPs. The RCGP hopes that PCOs will, in the context of a robust clinical governance framework, implement systems for referring to deaneries incoming doctors who do not meet all the criteria listed above.

Further information

- RCGP Certification 020 3170 8230/ certification@rcgp.org.uk
- The local postgraduate deanery http://www.cogped.org.uk/contacts

RCGP

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