



Statement of the German Medical Association

on the Consultation Paper by DG Internal Market and Services on the
Professional Qualifications Directive

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The German Medical Association would like to thank the Commission for providing the opportunity to contribute their experience to this consultation procedure.

The medical profession in Germany welcomes the three challenges brought up for deliberation by the Internal Market and Services Directorate General of the European Commission in the revision of Directive 2005/36/EC on professional qualifications. These challenges “simplification for individual citizens”, “integrating professions into the single market” and “injecting confidence into the system” enjoy the full support of the German medical profession.

Physicians have a special responsibility for their patients. Therefore, these three separate challenges must not be balanced against each other. In particular, integrating professions into the single market and injecting confidence into the system are challenges that could, in our opinion, result in a potential conflict of objectives, which must not be resolved to the detriment of the patients.

Key to the success of the Directive is mutual trust. This trust is, in turn, dependant upon the successful practical implementation of the Directive. The migration of physicians would be facilitated by a revision of the Directive that dispels any doubts that the competent authorities responsible for recognition in the host Member State might still have.

Question 1: Do you have any suggestions for further improving citizen's access to information on the recognition processes for their professional qualification in another Member State?

There is a plethora of information available on professional recognition procedures in the Member States. However, we doubt whether the proposed single information point (Point of Single Contact) could guide a physician wishing to migrate through this abundance of information. To make certain that the information can already be made accessible in the home country, the Internet – a resource that can be used across borders – should be employed as the preferred information medium. This could be accomplished by making use of existing structures to provide interested parties targeted assistance in their search for information and to facilitate their search for the competent authority in the desired host country. The way to ensure this would be to keep continuously updated contact data on the competent authorities available. Likewise, the competent authorities could facilitate access to information by providing their website content in a common European language in addition to their home language.

Question 2: Do you have any suggestions for the simplification of the current recognition procedures? If so, please provide suggestions with supporting evidence.

The current system, particularly the system of automatic recognition, has proven successful. Essentially, the system of automatic recognition allows a physician to obtain quick and unbureaucratic recognition of his or her medical qualifications in the host Member State. Therefore, the revision of Directive 2005/36/EC should focus on readjusting the procedure and strengthening trust in the system.

Based on the experiences of physicians in the recognition of their medical qualifications in accordance with Directive 2005/36/EC, it can be concluded that the practical implementation of the Directive can be optimized. We therefore support the Commission's efforts to simplify the existing system and to enhance trust in the existing regime so that the system of automatic recognition can be extended to other areas in the future.

Suggestions for measures which could simplify the current system of automatic recognition by enhancing it, and thereby increasing trust in the system, may be found in the German Medical Association's answers to questions 22 – 24 of the consultation paper.

Question 3: Should the Code of Conduct become enforceable? Is there a need to amend the contents of the Code of Conduct? Please specify and provide the reasons for your suggestions.

The Code of Conduct should not be made legally binding. The provisions of the Code of Conduct go partly beyond the requirements of the Directive and its framework. This is made clear by the chosen formulation of Article 8 in comparison to that of the Code of Conduct. The same applies to procedural requirements with respect to the handling of an applicant's documents and certificates.

Stricter provisions in the Code of Conduct could obstruct a flexible implementation of the Directive.

Question 4: Do you have any experience of compensation measures? Do you consider that they could have a deterrent effect, for example as regards the three years duration of an adaptation period?

Because of the special responsibility of the medical profession, aptitude tests are a necessary practice needed to allow individuals with deficits access to the profession under the general system of recognition and to ensure the quality of medical treatment. Likewise, this serves to ensure patient safety and strengthen trust in the Directive. No negative effects are known to us.

Question 5: Do you support the idea of developing Europe-wide codes of conduct on aptitude tests or adaptation periods?

The concept of a Europe-wide code of conduct on aptitude tests or adaptation periods developed by competent authorities is not practicable due to the complexity of the individual case constellations. In view of national differences, the development of a code of conduct, even if conceived as a non-binding guideline, also does not appear expedient in our opinion (see also the response to Question 8).

Question 6: Do you see a need to include the case-law on "partial access" into the Directive? Under what conditions could a professional who received "partial access" acquire full access?

The full license to practice medicine entitles the holder to unrestricted exercise of the practice of medicine. The case law referred to in the consultation paper on the professional

qualifications Directive of the Internal Market and Services Directorate General does not apply to the medical profession.

Question 7: Do you consider it important to facilitate mobility for graduates who are not yet fully qualified professionals and who seek access to a remunerated traineeship or supervised practice in another Member State? Do you have any suggestions? Please be specific in your reasons.

The migration of medical students is regulated by the "Lisbon Convention" on the recognition of qualifications concerning higher education in the European region.

The amendment of Directive 2005/36/EC for the purpose of facilitating the mobility of graduates of higher education institutions who are not yet fully qualified professionals is not expedient from the perspective of the German medical profession.

Question 8: How should the home Member State proceed in case the professional wishes to return after a supervised practice in another Member State? Please be specific in your reasons.

The sheer number of young physicians who complete part of their training in other EU Member States is a testament to the fact that there are no major constraints, and that the recognition of knowledge, skills and training times acquired in other EU Member States is not a problem.

Question 9: To which extent has the requirement of two years of professional experience become a barrier to accessing a profession where mobility across many Member States in Europe is vital? Please be specific in your reasons.

Because the medical profession is regulated in all Member States, questions 9 and 10 of the consultation paper do not apply to the medical profession.

Question 10: How could the concept of "regulated education" be better used in the interest of consumers? If such education is not specifically geared to a given profession could a minimum list of relevant competences attested by a home Member State be a way forward?

Because the medical profession is regulated in all Member States, questions 9 and 10 of the consultation paper do not apply to the medical profession.

Question 11: What are your views about the objectives of a European professional card? Should such a card speed up the recognition process? Should it increase transparency for consumers and employers? Should it enhance confidence and forge closer cooperation between a home and a host Member State?

A European professional card could accelerate the recognition process, create transparency for all parties involved, and enhance trust and cooperation between Member States. To achieve these objectives, the use of a chip (smart card) is not absolutely essential; however it would be appropriate under certain conditions. In this case, the information relevant to recognition is more important than the bearer of the information (card). This should be addressed in a first step. In order to achieve this, systems which are already in place, such as IMI, should be expanded. The next question is by what mechanism or by which transport route this information should reach the receiver.

Consistent with the principles of appropriateness and proportionality, all considerations regarding the introduction of a European professional card should take into account the existing card systems in the EU Member States in order to avoid duplication resulting from the issuance of another European professional passport in card format. Therefore, confinement to a technical solution that could use existing Member State card systems and could be used by Member States without a professional card appears to be expedient.

In addition to the answers to questions 11 – 14, see also the appendix “Proposal for using a professional card to promote mobility within the European Union.”

Question 12: Do you agree with the proposed features of the card?

The described features of the card are appropriate for achieving the objectives described in Question 11. However, an evaluation is needed to determine whether the proposed features are sufficient. For example, one current cause of dissatisfaction in the recognition of qualifications is the problem of increasing numbers of falsified documents. The validity and authenticity of the card and of the information linked to it or contained on it should therefore be protected by associated digital services. Furthermore, the needs of competent authorities (recognition of qualifications) and consumers (information and trust) should be differentiated. One way to do this would be to design a card system enabling two types of disclosure: "full disclosure" of all legally binding information needed for recognition by the competent authorities and "basic disclosure" of information needed by consumers to determine whether a professional card is currently valid or blocked, that is, whether the card-holder's electronic professional certificates are valid. It would also be desirable that all information required for the recognition of qualifications be accessible via the card so that a professional would not need to submit any other documents (except, perhaps, proof of identity).

We strongly support the concept that the competent authority in the home country should be responsible for issuance of the professional cards. From our point of view, it is obvious that the competent authority issuing the documents should be located in the Member State where access to the profession was first granted or, in the case of physicians, where specialist medical training was completed. However, this raises the question of how and in what form additional training acquired in another Member State or sanctions imposed under professional or criminal law in other Member States can be recorded on the professional card or passport and who is authorised to do so.

Question 13: What information would be essential on the card? How could a timely update of such information be organised?

See appendix "Proposal for using a professional card to promote mobility within the European Union."

Question 14: Do you think that the title professional card is appropriate? Would the title professional passport, with its connotation of mobility, be more appropriate?

Both titles "professional card" and "professional passport" are compatible with the objectives of the card. The choice of name should be made based upon those of existing card systems. Should the card be introduced as an additional card distinguishable from existing card systems (e.g. the Electronic Health Card in Germany), the name "professional passport" would be better. This would make it possible to employ the term in Member States that do not have their own professional identification cards and thus would contribute to harmonisation of the usage of the terminology. The card should be introduced as a supplement to existing card systems and thus make use of synergy effects. "Professional card" should be utilised as the general term, and the specific title (e.g. "pharmacist identification card") should be printed on the card.

Question 15: What are your views about introducing the concept of a European curriculum – a kind of 28th regime applicable in addition to national requirements? What conditions could be foreseen for its development?

It should remain the exclusive right of the Member States to specify the structure and content of their basic and speciality medical training programmes. Rather than introducing a European medical training and continuing medical education program in the sense of a 28th regime applicable in addition to the national requirements, the existing system of automatic recognition should be optimised.

Given the differences between the Member States in terms of their systems and contents of specialist medical training, we doubt whether it is either necessary or expedient to specify a common speciality training content which could guarantee high-quality training for the benefit of patient safety. To create more transparency, the contents of the medical training and continuing medical education programmes in the Member States could be made public and published in a common European language (see also the responses to Questions 2 and 23).

Question 16: To what extent is there a risk of fragmenting markets through excessive numbers of regulated professions? Please give illustrative examples for sectors which get more and more fragmented.

The medical profession is regulated. This should not be challenged, in particular, for reasons of patient safety.

Question 17: Should lighter regimes for professionals be developed who accompany consumers to another Member State?

In the case of the medical profession, the definition in the question applies, for example, to sports physicians and ship's physicians. No special regime is required in this case because it is subject to the "state of treatment principle".

Question 18: How could the current declaration regime be simplified, in order to reduce unnecessary burdens? Is it necessary to require a declaration where the essential part of the services is provided online without declaration? Is it necessary to clarify the terms "temporary or occasional" or should the conditions for professionals to seek recognition of qualifications on a permanent basis be simplified?

Because the number of physicians providing services in the territory of another EU country under Title II of Directive 2005/36/EC is currently deemed to be low, it has not been possible to establish robust practice rules for interpretation of the terms "temporary" or "occasional" to date. The European Commission's comments in MARKT D/3415/2006/DE of 10 March 2006 simply repeat the text of Article 5, Paragraph 2. It would seem expedient to further refine the criteria specified in Art. 5, Para. 2 (duration, frequency, regularity and continuity) in the sense of an interpretation guide to be uniformly applied in the Member States. The criteria for assessing the temporary nature of the provision of services should be established according to the consistent case law of the European Court of Justice.

Question 19: Is there a need for retaining a pro-forma registration system?

As medicine is a profession affecting health and safety, a system of prior registration is imperative. Other less restrictive options are not apparent. Only with such a system in place is it possible to monitor EU citizens with regard to the laws on access to and exercise of a profession. The competent authorities would not be able to operate efficiently without registration and thus without knowledge of the provision of services.

The extent to which the registration of the service providers can be reinforced by other legal mechanisms (e.g. assistance from employers or as a pre-employment requirement) is another question.

Question 20: Should Member States reduce the current scope for prior checks of qualifications and accordingly the scope for derogating from the declaration regime?

See response to question 19.

Question 21: Does the current minimum training harmonisation offer a real access to the profession, in particular for nurses, midwives and pharmacists?

Directive 2005/36/EC has made the migration of physicians in Europe substantially easier. Access to professional employment in other Member States of the European Union has been made considerably simpler by the minimum training requirements set out in Article 24 of the Directive. The medical profession provides a prime example of the advantages of automatic recognition with regard to (speciality) designations and the minimum period of speciality training.

Question 22: Do you see a need to modernise the minimum training requirements? Should these requirements also include a limited set of competences? If so what kind of competences should be considered?

As a consequence of medical and technological advances, medical training and continuing professional development are continually subject to adaptation and modernisation. With 27 Member States, it is not feasible for a suitably detailed regulation to be contained within the Directive to reflect these, therefore adaptation and modernisation should remain the responsibility of the Member States.

Notwithstanding this, the current Directive also contains articles which should be adapted in the course of this revision. In Article 24, paragraph 2 it should be made clear that the requirement “at least six years of study or 5,500 hours” is to be understood cumulatively.

The undefined legal terms “adequate knowledge” and “suitable clinical experience” contained in Article 24, paragraph 3 allow considerable room for interpretation. The minimum requirements for training should be formulated more precisely and at least one final examination should be added to the minimum requirements. With regard to speciality medical training, it should be noted that the general minimum requirements contained in Title III, chapter III and Annex V, along with some of the key elements of Article 25, paragraph 2, stipulate a minimum of only three years full-time training for some of the speciality areas set out in Annex V, point 5.1.3

We propose carrying out the necessary modernisation of the minimum requirements, in particular a revision of the minimum periods currently stipulated in the Directive, in order to appropriately convey and secure the key competencies (knowledge, expertise and skills) which are nowadays essential for the adequate provision of care. The minimum period of speciality training should, as a rule, amount to 5 years.

A listing of individual competencies is, from our point of view, unnecessary. Due to the differences in the systems of speciality training between the Member States it would not be possible to define in detail the contents of speciality training along with a uniform standard. Setting out a common definition of the contents of basic speciality training (common trunk) at the European level would, in our view, also not be expedient.

An assessment of the regulations on continuing professional development may be found in our response to question 27.

Question 23: Should a Member State be obliged to be more transparent and to provide more information to the other Member States about future qualifications which benefit from automatic recognition?

The current regime of automatic recognition, which has proven successful in recent years, should be made more transparent. Member States could contribute to more transparency in the system by making information on the content of medical training and specialisation accessible to the public, for example via electronic platforms.

Question 24: Should the current scheme for notifying new diplomas be overhauled? Should such notifications be made at a much earlier stage? Please be specific in your reasons.

The current scheme for notifying new diplomas has overall been proved successful. However, the system must be able to react faster and more flexibly to changes at a national level, as well as possible current mistakes. As automatic recognition cannot take place until notification has been completed, it appears, in our opinion, necessary to increase the frequency with which changes to Directive 2005/36/EC concerning the recognition of professional qualifications (Annex V) are published. It would also make sense to list the previous titles of those speciality designations where there has been a change of title over the years under the relevant category in order to generate more transparency in the recognition process with respect to current and former titles.

Question 25: Do you see a need for modernising this regime on automatic recognition, notably the list of activities listed in Annex IV?

As Annex IV of Directive 2005/36/EC does not concern the medical profession, it is not possible for us to answer this question.

Question 26: Do you see a need for shortening the number of years of professional experience necessary to qualify for automatic recognition?

As Annex IV of Directive 2005/36/EC does not concern the medical profession, it is not possible for us to answer this question.

Question 27: Do you see a need for taking more account of continuing professional development at EU level? If yes, how could this need be reflected in the Directive?

Although the provisions for continuing professional development (CPD) in the Directive are formulated in a general terms, they are adequate. We do not consider it necessary to take

any further account of continuing professional development in the provisions of the Directive than is already the case. On the contrary, an obligation to provide evidence of CPD, which would prevent automatic recognition in cases where the CPD requirements of the country of origin have not been fulfilled, could inhibit the freedom of movement, freedom to set up practice and free provision of services. We also doubt whether such an obligation is permissible from a legal point of view at all. Ultimately, it is about the (automatic) recognition of formal qualifications of training in order to be able to practice a profession in another Member State. Evidence of CPD is not, however, evidence of formal qualifications and could, if necessary, be taken into consideration only in terms of the framework of the general system.

An obligation on the part of Member States to create regulations on CPD requirements, and thereby on medical practice, where not already in existence, should not, in our view, be the aim in the revision of the Directive. Continuing professional development is an integral part of medical practice, and CPD obligations are already a reality in many Member States. As CPD is already anchored in national law, we do not foresee any added value in a parallel regulation in the form of the Directive.

Question 28: Would the extension of IMI to the professions outside the scope of the Services Directive create more confidence between Member States? Should the extension of the mandatory use of IMI include a proactive alert mechanism for cases where such a mechanism currently does not apply, notably health professions?

The extension of IMI and better cooperation between the competent authorities could improve confidence in the existing system of recognition, particularly with respect to automatic recognition. Cooperation between competent authorities using IMI has the potential to speed up processes of recognition in target countries by simplifying the proper assessment of applicants' documentation, above all in cases where reasonable doubts arise, in that supplementary documentation or verification may be directly requested from the competent authority of the country of origin.

Currently, IMI does not allow for optimal cooperation between competent authorities. In particular, it is not possible to follow the optimal procedure as envisaged in the code of conduct endorsed by the coordination group, due partly to missing answers and partly to those which are submitted by the competent authorities of countries of origin after the deadline (see response to question 3). The schema for enquiries directed at the competent authorities of home countries currently envisaged for IMI is too inflexible and should be revised.

A revision of the existing IMI could, in terms of patient safety, incorporate the extension of an early warning system for medical personnel. In addition, it should be investigated whether IMI could also be utilised by the issuing authorities in countries of origin to send documentation directly to the competent authorities in the target country. In this way, IMI could not only simplify and speed up the process of recognition of qualifications, but would also contribute to increasing patient safety by reducing the risk of recognition based on falsified documentation.

Question 29: In which cases should an alert obligation be triggered?

A potential early warning system for healthcare professions must take into account the data protection regulations of Member States. Taking into account the principle of the presumption of innocence, a common understanding must be found concerning when, what, how and to whom information may be passed on. Information on legal, disciplinary and punitive sanctions could then be passed on proactively and on request, providing that the new location at which the physician is practising is known.

Question 30: Have you encountered any major problems with the current language regime as foreseen in the Directive?

Sufficient knowledge of the national language(s) is a necessary prerequisite for cultivating a relationship of trust between patients and physicians. As such, it makes an essential contribution to patient safety. In addition, proven language abilities help to prevent communication difficulties between physicians which can have serious consequences for patients.

As it cannot be ruled out that insufficient language skills lead to negative consequences for patients, it is the view of the medical profession in Germany that a protective mechanism must be put in place. Language skills are a prerequisite for every physician before being granted authorisation to practise. As part of the revision of the Directive it could be assessed to what extent Article 53 can be developed as an additional requirement for recognition.

The special status of the patient-physician relationship must be protected; therefore it must be left up to the discretion of every Member State to determine the level of language skills required. At the same time, the level of language knowledge required must be justified and appropriate in order to allow the migration of physicians. In order to further facilitate the migration of physicians within the EU, there should be various means by which they can prove their language skills. In addition, information about the level of language competency required and the forms of acceptable proof must be made available to physicians who wish to migrate (see response to question 1).

Appendix: Proposal for using a professional card to promote mobility within the European Union

Facilitating cross-border professional practice in the EU is one of the foremost goals of the Internal Market and Services Directorate General. As a result the Directorate General has discussed the idea of a professional card. The following represents a proposal on the extent to which current forms of identification already in use in Member States, in this case the German physician's professional card, may be used to provide the necessary information and documentation to enable professional practice in another Member State. The proposal is based on the following key points:

- It should be possible for national cards, where necessary with modifications, to remain in use. Hence, the functionality of a professional card is supposed to be integrated into existing national cards. The discussed introduction of an EU professional card should not lead to additional cards on the level of member states.
- The administrative procedures necessary for compiling the proof of professional qualifications remain the responsibility of the national authorities of the home country. This means less bureaucracy for the migrating professional and a shorter process of recognition.
- The competencies already existing within Member States are retained.
- The professional card for physicians is also used to improve patient safety.
- Member States which do not currently use professional cards can introduce these at low cost for migrating physicians. It is also possible to forgo professional cards altogether as the principle of supplying the necessary information and documentation also works without a card.
- Existing information systems such as IMI are incorporated and utilised.

In cases involving cross-border professional practice, two different types of information required by receiving countries must be taken into account. This results in the following two scenarios for the application of the professional card:

- A.** Basic enquiry: private individuals or organisations (e.g. employers, patients, pharmacists) enquiring about the validity of professional qualifications (membership of the medical profession).
- B.** Qualified enquiry: a competent authority enquiring about the existence of the necessary requirements for professional practice and the qualifications (speciality training) of a physician in another EU Member State.

The proposal does **not** envisage transporting the relevant necessary information on the professional card itself. Rather, it foresees each card as carrying a unique registration number which may be used to access the necessary information mentioned in scenarios A and B.

A number according to the specifications of the "logical identification number of the card" as defined in chapter 3.5.4 (Resolution 190) can serve as the registration number. In addition, the integrated circuit card serial number (ICCSN) can be built into electronic cards according to the above mentioned specifications. The 20 digit registration number is compiled

according to professional sector, country, issuing authority, ID number corresponding to EN1867:1997 and is internationally interpretable¹.

The registration number is changed when a professional card expires so that each new card receives a new registration number. This is the prerequisite for a card being blocked if it is lost.

A. Basic enquiry

Issuing authorities provide information services at a national and/or federal level. If professional cards are reported as lost or stolen, or if the licence to practice is revoked, the issuing authority will block the card. Information about the validity of a professional card, and therefore on whether the proper requirements for professional practice according to the standards of the country of origin have been met, may be accessed via a web portal using the registration number. Private individuals or organisations (e.g. employers, patients, pharmacists) are therefore in a position to easily check the validity of professional membership. This serves to increase patient safety.

A request for information would be carried out via an EU-wide web portal which would access the information services of the national issuing authorities. The professional card serves as a visual identity card (photo), and as the bearer of the registration number. Information services respond to enquiries concerning registration numbers by confirming whether a professional card is valid or has been blocked, and provide the first and last name of the cardholder. In this way, the security requirements of visual / technical attributes of the card can be significantly reduced. Even a registration number printed onto a piece of paper would be sufficient. It would, however, have to be clarified whether the enquiry about first and last names by information services following the entry of a registration number is in line with national and European data protection legislation.

B. Qualified enquiry

In this scenario the professional card also serves as a visual identity card (photo) and as the bearer of the registration number. The IMI System, which has established itself as the central platform for the exchange of information between the competent authorities of Member States, is used for supplying all information necessary for the recognition of qualifications and speciality diplomas. Upon expressing a wish to migrate, all the necessary documents and information related to an applicant are made available through IMI by the competent authority in the home country. This information is then accessed by authorised bodies in the receiving country using the registration number printed on the professional card. This would not take place via a web portal, but rather within the framework of IMI via the interfaces already in existence at the competent authorities of the Member States. This direct exchange between competent authorities within the home and host country has the advantage for migrating physicians that the first step in the process of recognition, consolidating the necessary documents, may be started earlier and in the home member state, thus reducing the period of time taken for qualifications to be recognised. In addition, direct communication between competent authorities reduces the risk of recognition based on falsified documents.

¹ For instance, the registration number 80 276 00108 0104567890 can be assigned to a German physician's identity card: according to [EN1867:1997] the *Major Industry Identifier* (MII) of the health sector is 80, while other sectors have a different MII. 276 is the ISO3166-Code for Germany, 00108 is the *Issuer Identifier* for the German Medical Association, 010 is the code of the issuing Schleswig Holstein state chamber of physicians. An employer or a patient could enter the aforementioned registration number in a common European web portal for the validation of professional cards. The web portal would then automatically identify the issuing authority of the card, enquire about the validity of the card and inform the enquiring authority about the result.

Conclusion

The proposal is in line with the objective of the Internal Market and Services Directorate General to achieve increased mobility of EU citizens with the lowest possible input of resources at Member State and EU level.

No Member State is forced to introduce professional cards for their citizens. Professional cards already existing in Member States or within specific professions could remain in use with minimal alternations.

At the centre of the proposal is the plan for a clearly assignable registration number for migrating professionals. This could be implemented using a professional card or another certified document which confirms professional status and also contains the registration number.

In countries, or for professional groups, which do not currently use professional cards, a certified document confirming professional status and containing the registration number would also be sufficient in this scenario.

References:

Resolution 190

Decision No 190 of 18 June 2003 concerning the technical specifications of the European health insurance card (2003/752/EC)

<http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2003:276:0004:0018:EN:PDF>

(EN1867 : 1997)

Machine readable cards. Health care applications. Numbering system and registration procedure for issuer identifiers