The European Union: open to the practising physician?

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ABSTRACT – The European Union (EU) has powers and responsibilities in the area of public health, while the organisation of healthcare facilities remains the concern of member states. However, a series of directives has, since the late 1970s, sought to ensure the right of individual practitioners to travel freely throughout the EU, both to obtain specialist training and to practise in all member states on the same basis as doctors working in the member states where they were first registered. More recently, there has been mutual recognition of completion of specialist training across the EU. A new directive concerning the mobility of medical practitioners across the EU is under discussion.

Key words: CPD, European Union, directive, medical practice, medical specialties, free movement, medical training.

It is often said (and believed by many people, including doctors) that while the European Union (EU) now has competence to legislate in the arena of public health[1,2], everything relating to the organisation of clinical services and medical practice remains solely the concern of the governments of the 15 EU member states[2]. If this was true in the past, it is now becoming increasingly less so, partly because of some recent decisions by the European Court of Justice[3]. However, what is often forgotten is that, while EU public-health competence dates only from 1993, medically qualified practitioners have had the right to practise freely across the whole of the EU (or the European Community as it was then) since the late 1970s.

Key Points

- **Free movement of doctors within the EU has operated since the 1970s**
- **A 1993 directive has introduced specialist recognition across the EU**
- **Medical graduates can seek specialist training anywhere in the EU**
- **Long term professional careers throughout the EU in medical specialties are available**
- **Free movement is not yet available for graduates from UK or French ex-colonies**
- **A new directive is anticipated**

In the UK, we have been used to seeing doctors who qualified in medical schools in Commonwealth countries, or in certain other ex-colonies of Britain, working here. Similarly, doctors who qualified from medical schools in France's ex-colonies were to be found practising in France. Originally, most of the medical schools in Commonwealth countries were set up on a similar basis to those in the UK, operating subject to General Medical Council (GMC) supervision. Following independence of most of the countries in the current Commonwealth, it became necessary for graduates of these medical schools to pass basic examinations in medical knowledge and competence, and in English before being allowed to practise in the UK[4]. The revolutionary change, which began over 20 years ago, was that graduates of medical schools throughout the European Community gained the right to practise freely in the UK and in all other EU member states, without having to pass any additional examinations relating either to medical practice itself or to language ability. This is the reason that so many German, Austrian, Italian, Spanish, Portuguese, etc junior doctors are now employed in UK hospitals.

The first 'Doctors' directives'

One of the first principles of the EU (then the European Community) to be applied in practice was that professional qualifications obtained in any member state should apply in all member states. In the mid-1970s a number of directives concerning some of the more traditional professions were approved (subsequently, a more general system for the mutual recognition of practitioners of other professions was approved; this was generally considered to be less satisfactory than the arrangements already agreed for the first group of professions). Accordingly, by the resolution of the Council of the European Community of 6 June 1974, there was henceforward to be '…mutual recognition of diplomas, certificates and other evidence of formal qualifications…' of medical graduates of all medical schools in the European Community[5]; this was formalised by two directives in 1975[6,7]. An Advisory Council on Medical Training was established[8]; its main task was '…to help to ensure a comparably demanding standard of medical training in the Community, with regard both to basic training and

further training'. It was to do this by '…exchange of comprehensive information as to the training methods and the content, level and structure of theoretical and practical courses provided in the member states; discussion and consultation with the object of developing common approaches to the standard to be attained in the training of doctors and, as appropriate, to the structure and content of such training; keeping under review the adaptation of medical training to developments in medical science and teaching methods'. The Advisory Council was made up of three representatives from each member state: one from the practising profession, one from the medical schools and one from '…the competent authorities of the member states' (eg the GMC). At the same time, a committee of senior officials in public health was set up to identify any difficulties arising from the implementation of the directives, to collect relevant information on arrangements in the member states for provision of general and specialist medical services, and to advise the European Commission on any further measures that might be needed[9]. Yet another Council recommendation, approved on the same day, concerned the admission of nationals of other member states to clinical training posts[10], and a further Council statement[11] clarified the position of clinical doctors who, in certain member states, are employed as civil servants, thereby guaranteeing freedom of movement as professionals for this group as well.

Recognition of specialty training

The next stage of European legislation on the free movement of practising doctors concerned the mutual recognition of specialist training and diplomas. A complex directive was approved on 30 October 1989[12], amending eight previous directives referring to medical doctors, nurses, midwives, dental practitioners and veterinary surgeons. This directive defines how items of specialist terminology in one official language should be translated and defined in others (eg what is to be the official Dutch translation of the English term 'geriatrician'). In places, this directive goes into remarkable detail about what a particular type of specialist professional may do, and about precisely what practical and clinical training is to be '…dispensed under appropriate supervision' (eg 'Performance of episiotomy and initiation into suturing. Initiation shall include theoretical instruction and clinical practice. The practice of suturing includes suturing of the wound following an episiotomy and a simple perineal laceration. This may be in a simulated situation if absolutely necessary')[12]. However, the definitive directive concerning mutual recognition of postgraduate training and diplomas was not finally passed until 1993[13]: this was the directive that was the starting point for the 'Calmanisation' changes in postgraduate medical training in the UK, as the UK legislation underwriting these changes was necessary to implement the directive in the UK.

This 1993 directive firstly defines in European law the recognised basic medical qualifications throughout all the member states of the EU. Secondly, it identifies, also in European law, the nature of specialist registration in each member state (in the UK 'certificate of completion of specialist training (CCST) issued by the competent authority recognised for this purpose'). Thirdly, it lists the specialties recognised in all member states; practitioners in these specialties holding the appropriate certificate should be able to practise as specialists throughout the EU (all the 'routine' medical specialties recognised in the UK are in this group). Fourthly, it lists specialties recognised in two or more member states; similar rights would apply to certified specialists moving between these member states, but doctors from other member states (where their specialties are not recognised) wishing to practise in these specialties in member states where they are recognised would normally have to receive appropriate specialist certification in one of the member states where the specialty is recognised. Fifthly, it stipulates minimum acceptable lengths of training in different specialties in order to achieve specialist certification; for most medical specialties (eg cardiology, gastroenterology, rheumatology, therapeutic medicine, occupational medicine, immunology, dermatology, venereology, geriatrics, renal diseases, infectious diseases, public health medicine, paediatrics, chest diseases and neurology) this period is 4 years, but for haematology, endocrinology and allergology, 3 years is deemed to be sufficient, with 5 years being required for internal (general) medicine. The rest of the directive seeks to ensure equality of treatment for applicants for medical posts from all EU member states.

Future developments

In May 2001, the European Commission issued a consultation document on issues that may be included in a future draft directive[14]. This document starts by reviewing the current position and existing mandates for reform. It then poses a number of questions in the context of a new initiative being considered by the European Commission, the strategic objectives of which would be to:

- simplify and consolidate the existing rules and procedures
- improve procedures to allow for more numerous and more flexible ways of extending possibilities for more automatic recognition between member states
- identify, in the context of new technology, developing national training programmes etc, more flexible ways of ensuring the application of meaningful and up-to-date standards
- increase liberalisation of the provision of services
- improve and extend arrangements for providing advice, aid and support to applicants for recognition and to would-be migrants.

The document then poses eight questions to explore the perceived relevance and practicality of measures that might be used to achieve these broad strategic aims. The consultation period relating to this document ended on 28 September 2001, and firm proposals from the European Commission, following this consultation, are awaited.

One clear current injustice could be corrected by the legislation that should follow any new draft directive: the original

legislation permits free movement only for doctors qualifying within EU member states. This excludes graduates of medical schools in other Commonwealth countries and in other ex-colonies, not only of Britain but also of France; clearly it is appropriate and just (if such doctors are registered, for example, as specialists in the UK or France) that the same right to practise throughout the EU should be extended to these doctors.

In 1997 the RCP Council asked the European Commission to investigate ways of ensuring that doctors whose practice has been restricted in one way or another in one member state are similarly restricted from practising freely in other member states[15]; definitive legislation in this area is still awaited.

The current situation

The current situation can, therefore, be summarised as follows:

- any medical practitioner qualifying in an EU medical school may practise anywhere in the EU
- any specialist with a CCST may practise as a specialist in any member state where his or her specialty is recognised
- any EU medical graduate may be accepted for specialist training in any member state where such specialist training is provided
- employers may not discriminate in favour of graduates or specialists from one member state over those from any other.

However, although legally the way may be open for EU-trained physicians to practise anywhere in the EU, other barriers (especially cultural ones) remain. Although there are no language barriers in a legal sense, in practical terms it is clearly essential for most clinical posts that successful applicants should be able to communicate effectively in the local language, both verbally and in writing, with both patients and professional colleagues. Moreover, doctors must learn how to apply for posts and how to operate effectively within them, in the context of the local health service cultures; these vary considerably between Helsinki and Estoril, and between Athens and Glasgow. It is hardly surprising that more doctors who qualified elsewhere in the EU are presently employed in NHS posts than there are UK-trained doctors working in other EU centres, because English has become the international language with which most successful professional people are fairly conversant, while the British are notoriously incompetent in using French or German (or other EU languages) effectively.

For those British doctors who are proficient in French or German, there are clearly some attractive training opportunities in several major medical centres on the continent, and there are, of course, some positions (usually in the Netherlands and Sweden) where it may be possible to practise, at least in the short-term, in English. Moreover, when language has been learned and cultural differences absorbed, long-term professional careers in medical specialties throughout the EU are available for those who look for them.

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