



JOINT ROUNDTABLE

'EQUIVALENCE OF TRAINING SKILLS IN THE EU HEALTHCARE WORKFORCE'

13 July 2009

Report

Jeni Bremner (EHMA) welcomed participants, underlining the importance of the topic and aims of the meeting, i.e.

- acquiring a better understanding of the practical issues arising in relation to equivalence of health professionals' qualifications
- addressing ways to overcome barriers and challenges in this field

Martin Else (Royal College of Physicians) then took over the chair, and introduced the format of the meeting and the various speakers.

Setting the scene: the current EU framework

The first speaker, **Pamela Brumter (European Commission, DG MARKT)** informed the meeting on the content and background of the EC Directive (2005/36/EC) on the recognition of professional qualifications, which provides the EU legal framework in this area. As national requirements of professional qualifications may hinder free movement (one of the four Fundamental freedoms enshrined in the Treaty), a legislative framework was deemed necessary by Article 47 of the Treaty. The Directive provides this framework, and is based on recognition of qualifications and on mutual trust, i.e. trust that the professional is sufficiently qualified in his member state of origin to exercise professional activities in other member states.

The Directive specifies two recognition systems applying to health professions, i.e. automatic recognition and a general recognition. Automatic recognition is the most privileged regime. This applies to professional qualifications for which minimum training requirements are harmonised at EU level. For the migrating health professional, this means that his/her training is not checked and that the host member state cannot impose any compensatory measures. The system of general recognition applies if training requirements have not been harmonised at EU level or in certain situations where the automatic recognition cannot be applied. Under this system, the training of the migrating professional is compared with the training requirements of the host member state. In case of substantial differences the host member state can impose compensatory measures. While this regime is less favourable for professionals, mobility and training standards are still guaranteed.

The Directive also stipulates specific minimum training requirements for five health professions. Doctors need a basic medical training of minimum 6 years (equivalent to 5500 hours) of practical and theoretical training provided by, or under the supervision of, a university. Furthermore, training should ensure that a health professional has acquired 'specific knowledge and skills'. Doctors are required to possess adequate knowledge of the sciences on which medicine is based and a good understanding of the scientific methods. This includes the principles of measuring biological functions, the evaluation of scientifically established facts and the analysis of data. Moreover, they must have a sufficient understanding of the structure, functions and behaviour of healthy as well as persons affected by illness, as well as the relations between the state of health and physical and social surroundings of the human being. Adequate knowledge of clinical disciplines and practices, providing a coherent picture of mental and physical diseases, of prophylaxis, diagnosis and therapy and suitable clinical experience in hospitals is also required.

For general practitioners, minimum of 3 years of practical and theoretical training should be followed by at least 6 months of practical training in an approved hospital or general medical practice, in conjunction with other health establishments or structures concerned with general medicine.

In the case of medical specialists, member states are not obliged to join the scheme of automatic recognition but if they do so they have to respect the minimum training duration that has been specified for the 52 specialties. Both automatic recognition as well as the general recognition system can apply, depending on whether the national titles of the Member State of origin and of the host member state are listed in the relevant Annex of the directive. The current Directive lists 52 specialties, for which the minimum training duration is harmonised.

According to the Directive, general care nurses need to have minimum 3 years (the equivalent of 4600 hours) of theoretical and clinical training. For midwives, there are two different scenarios: they need at least 3 years of theoretical and practical study or training as a general care nurse combined with 1,5 years midwife training. Dental practitioners and pharmacists need minimum 5 years of theoretical and practical training; pharmacists also need a 6 months traineeship.

For all the above professions, the Directive stipulates that 'the training shall provide an assurance that the person has acquired specific knowledge and skills'. Moreover, these requirements should be regarded as *minimum* standards: member states can go beyond these.

The requirements in terms of knowledge, skills and content of training for all these professions (except for doctors where the directive does not specify the subjects of the training programme) can be modified by the Commission, however only if adaptation to scientific and technical progress is needed. The required minimum duration of specialist training can also be adapted. The Commission can carry out these modifications under delegated powers. This requires that within a Committee, in which all Member States are represented, the changes can be adopted by qualified majority, however it must be noted that the European Parliament has scrutiny rights. This implies that the Parliament can express its disapproval of measures proposed by the Commission which, in Parliament's opinion, go beyond the implementing powers provided for in the legislation. However, it needs to be borne in mind that for any changes of the minimum training requirements, a legislative procedure by unanimity is required.

Pamela Brumter also referred to requirements in terms of linguistic knowledge. The Directive states that "persons benefiting from the recognition of professional qualifications shall have knowledge of languages necessary for practising the profession in the host Member State."

Language tests are allowed in individual cases; however, one-size-fits-all tests are not allowed.

Issues and concerns

The second speaker, **Andrew Goddard** (Royal College of Physicians, UK) focused on issues in relation to the quality and competence of doctors. He provided the results of an internal RCP survey, which suggested that reducing training hours makes doctors feel less well trained in acute medicine. Reducing the number of training hours may look good on paper, but if doctors are there to protect patients, the highest possible standard of care should be strived for. On the whole, the general public in the UK is quite aware of the quality of its doctors and health services: health issues (particularly medical errors and problems with patient safety) are ever present in the UK media – in many cases in a negative sense – and this does not help build confidence in the competence of doctors and the care they provide. The Shipman case is a clear example of this.

Another RCP survey, focusing on the skills of locum middle grade doctors, found that these skills are generally not thought sufficient by colleagues with respect to locums from outside the hospital (so-called external locums), although variations in terms of professional competence exist. Many external locum doctors are from outside the European Economic Area (EEA).

To ensure quality care and competent health professionals, a new system of revalidation of doctors will be introduced in the UK in August. Part of this is an annual appraisal, which should also take account of incidents, patient feedback and complaints. The General Medical Council (GMC) has put together a list of 'key attributes' to be assessed at this annual appraisal. According to the GMC attributes, doctors should:

- Maintain their professional performance
- Apply their knowledge and experience to practice
- Keep clear, accurate and legible records
- Put into effect systems to protect patients and improve care
- Respond to risks to safety
- Protect patients and colleagues from any risk posed by their health
- Communicate effectively
- Work constructively with colleagues and delegate effectively
- Establish and maintain partnerships with patients
- Show respect for patients
- Treat patients and colleagues fairly without discrimination
- Act with honesty and integrity

According to Andrew, the situation regarding language skills is unbalanced: doctors from outside the EEA have to demonstrate their communication skills to the General Medical Council by passing the International English Language Testing System (IELTS) to the required standard. EEA doctors, on the other hand are not required to do so. It was suggested that it is imperative however, that an employer ensures that a candidate has the ability to communicate to the required standard for the post. Whatever method is used to assess this, employers must ensure it is consistent for all candidates.

Andrew concluded by stating that the RCP supports a framework to assess and confirm the skills and competencies of all EU doctors (a 'health skills passport' would be useful), a language standard for all EU doctors for the member state they will work in and a robust mechanism to monitor flow of doctors within Europe.

The final speaker, **Deirdre Daly (European Midwives Association)** focused her presentation on the EC Directive, and more specifically on the pursuit of the professional activities of a midwife and their acquired rights. According to Deirdre, the strength of the Directive lies in its existence, as it attempts to ensure a minimum training standard and specifies access to and duration of training – which protects the various health professions. However, the Directive, which was originally developed some 30 years ago, defined the programme content and structure fit for purpose at that specific time. Meanwhile, the profession of midwifery has altered radically in many respects.

In terms of pre-registration education, many countries have moved beyond the minimum requirements and the content of their midwifery education programmes now includes: research and evidence for practice and the knowledge and skills of critical thinking. There is an emphasis on the autonomous role of the midwife and a focus on competence, continuing training and education as well as professional responsibility and accountability. Training and education has also evolved and there are now different levels of education throughout the EU. Some countries deliver the pre registration education programme at certificate or diploma level whilst many countries deliver the programme at degree level and some countries deliver the programme at master level.

As a consequence of all these changes, the midwifery practice as a whole has evolved considerably, but this is not yet reflected in the Directive.

According to the Directive, minimum requirements may be met for pre-registration programmes. However, the opportunity to practise and maintain these activities varies throughout the member states. A survey focusing on antenatal care in Europe revealed that many midwives report being unable to practice aspects of the activities and that the practice profile has changed. The midwife as an autonomous practitioner experiences limitations in scope of practice, autonomy and decision making skills in many cases. This is partly caused by national legislation which undermines transposition of the Directive. In terms of the acquired rights specific to midwives, the scope of practice varies greatly between Member States and this has implications for the safety and care women receive. There is no means of assessing competence and decision making skills.

In conclusion, Deirdre stated that there are ways and opportunities to strengthen the Directive, e.g. by adding means to monitor (continuing) compliance. Verifying competence in relation to acquired rights is also needed, as specifying the number of years of required training does not say anything about competence and skills: training time is no guarantee for professional competence.

Questions and discussion

In the discussion, chaired by **Martin Else**, the following issues were raised:

- ✓ *The Directive: yes or no?*

Several contributors argued that the Directive should be adapted and not only stipulate training hours; training time alone does not ensure acquisition of the appropriate skills and competence. However, determining and developing the content of the training curricula in the various member states is beyond the remit of the Commission, and the Commission has to be careful not to exceed its mandate. The Directive – developed for the situation 30 years ago - could be modified and improved in line with the current status and technological progress of the health professions. The concept and model on which the Directive was based originally (i.e. hours of training) are decades old and out of date, and recognition of professional qualifications should not only be based on training time but also on competence. As the definition of competence, safety and quality are currently lacking, amending the Directive in this way would have clear benefits for patients' care; revalidation of doctors could be a possible start to the process of improving the Directive.

However, it was argued that it would be wise not to dispose of the Directive completely at this stage. Without the Directive and the specified recognition systems there would be no framework at all – and this would make the situation more difficult.

There was generally consensus that it would be useful to gather evidence on concrete cases demonstrating shortcomings of the Directive and on the concrete barriers to transposition at national level. In other words, an evidence-based discussion on the way forward, outlining the gaps and priorities, would be a welcome step, also to the Commission. More evidence is needed, for example on non-compliance, on the actual migration of health care professionals and on parallel national legislation (reference was made to the profession of midwife) which can go against the spirit and undermine transposition of the Directive: there is a tension between the EU's objective to put in place an internal market and guaranteeing freedom of movement on the one side and the fact that legislation on health systems and health care provision falls strictly within national competence on the other. Some member states are restrictive and inflexible in their interpretation of the Directive.

The Directive is set to be evaluated in 2012, and evidence gathered on where the problems are and recommendations for solutions could feed into this evaluation. As other areas of legislation also impact on health care provision and qualifications, and as the EU can require adaptations of other legislative measures, it might be worthwhile to also look beyond the Directive and ensure mutually supportive legislation.

✓ *Gathering evidence: role of stakeholders and their organisations:*

Good systems are needed for high quality patient care and patient safety. Stakeholder organizations should be involved in the development of these systems and can support positive change by providing exhaustive descriptions of the roles of the various health professions. As it stands, there is too little engagement from professionals' organizations and commissions to ensure alignment with the evolution of the health professions and ensuring the maximum benefit of the Directive.

Developing a better understanding of what progress could look like might lead to required change. Furthermore, there is a role for professional organizations to provide information to the relevant stakeholders on recognition of qualifications, as it seems to be difficult to obtain information on these topics. The situation will become even more complicated with increasing erosion of the dividing line between health and social care professionals.

✓ *Automatic recognition:*

While automatic recognition is described as the most favourable regime for migrating health professionals, questions were raised about how 'automatic' this recognition is in reality. It is meant 'automatic' in terms of recognition. The competent authorities of the host Member States are not authorized to impose any compensatory measures (adaptation period or aptitude test). However, 'automatic' does not mean that the process is automatic. A doctor must send a request for recognition of his professional qualifications to the competent authorities of the host Member States and he must include certain specific documents. Annex VII of Directive 2005/36/EC lists the documents that can be asked for by the host Member State, such as the diploma, proof of nationality; proof of not being banned from the profession, proof of good mental health and a range of other documents and records.

✓ *Language issues:*

Language can be tested by employers. However, the language used in an interview is not the same language used in a situation with a patient. In many cases, language testing

focuses on academic language rather than on 'communicative' language in a professional situation. Questions were raised on whether language proficiency could not be part of the job description to ensure that candidates are competent to communicate with patients and colleagues.

✓ *Recognition of internship:*

Internship for doctors after the basic medical training is not standard across Europe. But it is taken into account when determining whether the overall duration of medical training in a specific Member State is in compliance with the minimum training requirements of the directive.

✓ *Take into account the Bologna and Copenhagen processes*

From an educational and training curricula perspective, the Bologna and Copenhagen processes should not be forgotten. It needs to be better understood how these processes have an impact on training and skills development and what the interface and overlap between the two processes are.

✓ *The locum survey*

It has to be recognized that there are many locums with good professional skills. However, the general level of competence is not satisfactory. It was also asked which qualifications this locum staff held. It was said that most of the locum staff hold neither a specialist nor a general medical practice qualification. It was pointed out that the same issues apply to agency nurses.

The RCP locum survey interviewed registrars and trainers and based its conclusions on the views of these two stakeholder groups. It might be interesting to repeat this exercise with patients, as there may be a gap in perception and experience between the various stakeholders.

Next steps

It is clear that there is an evidence gap that needs to be filled, and that the Commission would be open to having a discussion on the functioning of the current framework. In other words, a practical evidence base needs to be developed on the current situation and existing gaps, identifying where progress needs to be made.

It is also evident that these issues are not only relevant to northern EU member states; the situation in southern member states also needs to be addressed.

Several participants expressed their willingness to become actively involved with building an evidence base and gathering information, as well as with helping to assemble and synthesize the information. This meeting should be viewed as a first step; initiatives could be taken to reconvene in the autumn to decide on concrete steps forward.