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On 20 September 2011, the CPME Executive Committee adopted the CPME response to the "consultation on the Green Paper 'Modernising the Professional Qualifications Directive'" (CPME 2011/123 EN)

CPME response to the consultation on the Green Paper 'Modernising the Professional Qualifications Directive'

The Standing Committee of European Doctors (CPME) represents medical doctors across Europe and is composed of the most representative National Medical Associations of 27 European countries. CPME aims to promote the highest standards of medical training and medical practice in order to achieve the highest quality of healthcare for all patients in Europe. CPME is also concerned with the promotion of public health, the relationship between patients and doctors, and the free movement of doctors within the EU. CPME also cooperates closely with national medical associations from associated and observer countries, as well as with specialised European medical organisations and international medical associations[1].

CPME warmly welcomes the opportunity to comment on the Green Paper 'Modernising the Professional Qualifications Directive' and believes this consultation to mark a vital step in the review process. Against the background of the positions submitted in reaction to the public consultation2 earlier this year, please find below CPME's responses to the questions set out in the Green Paper.

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?

CPME agrees that the National Competent Authorities (NCAs) would be the primary actors in such a process. CPME is strongly in favour of awarding the competence of issuing the professional card or alternative application to the NCA of the country in which access to the profession was first granted. This however is without prejudice to the host NCA's ultimate responsibility and discretion to grant recognition.
In full awareness of the potential to facilitate mobility by decreasing the need for exchanges of documents, this should however not preclude the NCA of the host Member State from having access to the documents and certificates required for the application dossier upon request. CPME agrees that IMI has the potential to provide a secure and workable platform in the process and supports the dedication of resources to its further development and consolidation.
Given the voluntary nature of the proposal, it must also be carefully considered how the current system of recognition is carried forward and interacts with the additional new system.
CPME has been an active contributor to the discussion on European professional cards, not least within the context of the Commission Steering Group. In order to develop a workable approach to the proposals, it is essential that the practical impact and functionality of an application, as well as its financial implications, are further explored objectively on the basis of the models presented for discussion in the Steering Group.

[1] CPME is registered in the Transparency Register with the ID number 9276943405-41.
[2] 'CPME response to the Public Consultation on the Recognition of Professional Qualifications Directive', adopted on 13 March 2011 (link to document).

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In this context the technical implications and infrastructure necessary to support the implementation of such a proposal should be considered comprehensively, also with a view to future extensions of use to eHealth applications and Member States' actual capacities to provide the necessary facilities. To this end the outcomes of the case studies planned in the framework of the Steering Group should be awaited in order to make an informed decision as to how to proceed. CPME therefore looks forward to the results of these case studies and the recommendations resulting from them.

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).

CPME agrees that the professional card or alternative applications hold great potential to facilitate and accelerate professional mobility by making access to up-to-date information on the professional's qualifications easier and reliable. CPME is in favour of further exploring these opportunities in the framework of the case studies. However, patient safety must be a consideration of equal weight to facilitation and simplification. In this light, the following comments must be made on the options presented, without prejudice to the new processing opportunities under discussion:
Ad a) The regime of prior declaration is essential to the medical profession as a safeguard to ensuring public health and safety. This is acknowledged in the current Directive in Art. 6 and Art. 7(2) as regards pro-forma registration. It must therefore be maintained. Also, the NCA of the host Member State must have the possibility of accessing the documents and certificates required from the NCA who issued the card or alternative application, if found necessary.
Ad b) In the interest of ensuring that the verification of qualifications required for the recognition process can be carried out with the necessary care and to the fullest extent, it does not seem helpful to set out timeframes which are likely to restrict the NCAs in their capacity to fulfil this task to a high standard. While the applicant of course has a valid interest in being informed of the outcome of the procedure within a reasonable period of time, this consideration must not outweigh the far-reaching implications the recognition has, especially in the case of establishment. NCAs must therefore be given sufficient time to handle applications, even with the possible advantages a new mechanism could offer in this process.
Ad c) For cases in which doctors' qualifications cannot benefit from automatic recognition, but have to be analysed under the general system, the arguments set out in ad b) are all the more relevant, as the individual processing of the application potentially requires an even more intensive effort on part of the receiving Member State's NCA.

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.)

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The jurisprudence of the ECJ in this area is not applicable to the medical profession, as in light of general interest requirements, only professionals in possession of a full and valid license may practice medicine. CPME calls for the medical profession to be explicitly exempted from any provision in the legislative proposal, which sets out conditions under which partial access to professions can be granted.

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? (Please give specific arguments for or against this approach.)

As the establishment of common platforms only applies to professions falling under the scope of the general system for recognition, this question is not applicable to the medical profession, as the minimum training requirements as set out in Art. 24 and Art. 25 are the sole criteria applicable to medical training. CPME would like to see this explicitly clarified in the corresponding provision.

Question 5: Do you know any regulated professions where EU citizens might effectively face such situations? Please explain the profession, the qualifications and for which reasons these situations would not be justifiable or against this approach.)

As the medical profession is subject to automatic recognition based on minimum training requirements in all MS, this question is not applicable.

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? (Please give specific arguments for or against this approach).

CPME doubts the advantages of establishing a new structure of Single Points of Contact to fulfil this role and favours instead improving the access to information on the existing network. Complete and up-to-date information on these existing contact points must be easily accessible to all interested parties. This information should at a minimum be made available in the relevant national languages and English. While the internet is the medium in which this can be most easily achieved, 'off-line' information must also be made available, so as not to marginalise citizens who do not have access to or skills in internet use. Professional organisations could be helpful in putting potential applicants in touch with the relevant contact points.
Allowing applicants to complete recognition procedures online is indeed a useful simplification. This however should not preclude access to paper-versions of documents and certificates for the respective NCA, if verification thus requires. Moreover, the NCAs should be the sole competent bodies and access points to host online applications for recognition. Also, a parallel system of 'offline' applications must be maintained, in order to provide for applicants who do not have access to or skills in internet use. The standards of data protection must be equally high for both application methods.

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Question 7: Do you agree that the requirement of two years' professional experience in the case of a professional coming from a non-regulating Member State should be lifted in case of consumers crossing borders and not choosing a local professional in the host Member State? Should the host Member State still be entitled to require a prior declaration in this case?
(Please give specific arguments for or against this approach.)

While the rule enshrined in Art. 5(1) of the Directive is not applicable to the medical profession, as this is regulated in all Member States, CPME would like to call for the provisions set out in Art. 5(2) to be further clarified. Temporary mobility has not been defined sufficiently by ECJ jurisprudence, therefore a clarification of the terminology is necessary in order to ensure that the Directive is applied correctly. In light of the discussion framed by questions 1 and 2, and the possible enhanced differentiation between the provisions of Title II and Title III of the Directive, this clarification becomes all the more necessary to ensure legal certainty.

Question 8: Do you agree that the notion of "regulated education and training" could encompass all training recognised by a Member State which is relevant to a profession and not only the training which is explicitly geared towards a specific profession? (Please give specific arguments for or against this approach.)

As the medical profession is bound to minimum training requirements, this is not applicable.

Question 9: Would you support the deletion of the classification outlined in Article 11 (including Annex II)? (Please give specific arguments for or against this approach).

As the minimum qualification requirements for the medical profession are set out in Articles 24 and 25, this question is not applicable.

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? (Please give specific arguments for or against all or each of the steps.)

As the medical profession is regulated in all Member States, applicants for recognition only fall in the general system if they are not covered by the automatic recognition system. In the interests of ensuring that requirements applied to general system recognition processes are coherent with those set out under the automatic recognition regime, CPME does not support restricting the NCAs' 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.

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? (Please give specific arguments for or against this approach.)

The Directive is a specific instrument of EU law, the role of which must be seen as complementary to other legislation regulating the free movement of Union citizens, e.g. Articles 18 and 21 TFEU as well as secondary legislation such as Directive 2004/38/EC. While CPME strongly encourages the facilitation of mobility for graduates in supervised practice, the Directive would not seem the appropriate instrument in which to set out provisions to this end. This is especially relevant to the medical profession, as automatic recognition uses the system of an exhaustive list of professional titles supported by the evidence of the

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corresponding formal qualifications certifying successful completion of professional training, with the aim of enabling the provision of services or establishment. Extending the scope of the Directive to cases for which this system is not applicable and the aim of which is not coherent with the Directive's objectives would therefore not be supported by CPME.

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.)**

In the interest of patient safety it is of high importance to be able to communicate restrictions to a doctor's license to practice between NCAs reliably and quickly. CPME therefore supports the establishment of a proactive alert mechanism centred on the NCAs. Once a competent body has imposed sanctions on a healthcare professional restricting his or her right to practice, this restriction must be communicated by the NCA of the Member State in which the restriction was imposed to the NCAs of the Member States which have recognised his or her qualifications, so as to effectively prevent the healthcare professional in question from practising without the NCAs' knowledge of possible restrictions. IMI, by functioning as a central node at EU level, could offer the appropriate tool to effect the transmission of this alert, in so far as all relevant NCAs are connected to it and have the capacity to follow up and link alert data to future applications for recognition. Expirations of restrictions on the right to practice could also be communicated thus. In addition, an attestation of the right to practice the profession in the home Member State, as discussed under Question 15, would offer a complementary safeguard. The Directive should set out an exhaustive list of cases which trigger an alert and define timeframes and obligations for action.
As to the content and format of an alert, it must respect the principle of presumption of innocence as well as the right to effective remedy, and consequently apply only to restrictions for which legal proceedings have been concluded. In addition an alert must 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 that highest possible standards. Adherence to these high standards for issuing alerts must be enforced in all Member States.

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.**

CPME agrees that doctors must have language skills relevant to safely practice their medical competencies. While the level of skills is dependent on the specific context in which the individual doctor works, it is important to ensure that the doctor in question is able to communicate and interact not only with patients, but also the regulatory, administrative, commercial and professional infrastructure in which he or she practices. In light of new healthcare delivery models facilitated by eHealth and telemedicine, it is also no longer suitable to limit a definition of medical practice to direct patient contact.

In order to ensure patient safety, the Directive could set out certain general criteria of language skills which are then subject to verification by the relevant NCA according to the national and/or specific context in

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question. Limiting the opportunity to verify language skills to one-off testing is however not supported, as employers' discretion to ensure all necessary professional language skills are acquired should not be restricted. To develop a provision which neither poses a disproportionate burden on the migrating professional nor makes the recognition of qualifications under the Directive's provisions dependant on the outcome of the language tests, it should be explored what options could decouple recognition of qualifications from the right to exercise the profession in the host Member State.

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?

CPME would like to preface its responses to the Questions 14 and 16 pertaining to the regulation of minimum training requirements with the acknowledgment of the existence of differing opinions within its membership as to the approach to the regulation of the minimum training requirements as well their duration as set out in the Directive.
CPME underlines the necessity of maintaining an approach based a) on the minimum training requirements as set out the Directive in Articles 24 and 25 and b) the Member States' competence to define the specific content of training. Member States, through their respective competent bodies, should remain the sole regulators of the details of training beyond the Directive's current provisions, as the modernisation and adaption of these contents can best be implemented at this level.
However, in order to ensure a common high standard of medical training at European level and thus safeguard Patient Safety and high standards of quality of care all over Europe, CPME recognises the need to further ensure that qualifications included in the Directive are genuinely comparable between Member States. A discussion among professional bodies and NCAs on the content of training programmes, preferably based on an audit of specialist medical qualifications across Europe, could be encouraged with a view to levelling differences between Member States, but without prejudice to their competence to define the content of programmes. Preferably this process would lead to on-going discussion and review of minimum training requirements between Member States. Against this background, as regards specialised medicine, CPME supports an amendment to the minimum periods for training set out in Annex V 5.1.3 and referred to in Art.25(2) of the Directive to stipulate a minimum duration of ideally no less than five years, as a rule, for specialist medical training courses. In addition to the clarification endorsed in the response to question 16, CPME furthermore reaffirms the need to specify the terms 'adequate knowledge' and 'suitable clinical experience', as used in Art. 24(3).
While the mechanism enshrined in Art. 58 of the Directive was an appropriate tool to effect up-dates to the Directive, CPME would welcome a clarification of how this mechanism will translate into the new Comitology framework as set out in Art. 290 TFEU. In this context, CPME strongly calls for a formalised consultation of an expert committee comprising representative bodies of the medical profession to be established and enforced. The NCAs could offer valuable expertise in this regard. Decisions taken through this mechanism, as well as the actors involved, should be subject to the greatest possible measure of transparency.

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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? (Please give specific arguments for or against this approach.)Is there a need for the Directive to address the question of continuing professional development more extensively?

CPME acknowledges this incongruence between the requirements for accessing another Member State to provide services and for the purposes of establishment. In the interest of legal certainty and ultimately of patient safety, an amendment to Annex VII to explicitly require an attestation that the applicant has the right to exercise the profession in the home Member State, such as the 'certificate of current professional status', would be supported by CPME.
CPME welcomes the Commission's commitment to the topic of CPD. The speed of changes in the field of medical science, professional practice and international cooperation necessitate stringent rules on the obligations on professionals regarding CPD. CPME supports the Directive's provisions set out in Art. 22 in their current form and refers to the competence of the Member States to provide for CPD requirements. As full licenses can only be held by professionals adhering to national CPD requirements, any restriction to the license would be communicated between NCAs at the time of application for recognition.

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? (Please give specific arguments for or against this approach.)

CPME is in favour of revising the wording of the provision in order to avoid any ambiguities and clarify that the requirement of 'at least six years of study or 5500 hours' is to apply cumulatively. In the interests of clarity, it should also be explicitly stated what the equivalent requirement for part-time training is. Whereas the cumulative application of the minimum training requirements of six years and 5500 hours should be the rule, exceptions from this rule should be accommodated for existing programmes which provide 5500 hours of study in less than six years, e.g. 'fast track' programmes and programmes which recognise relevant competencies acquired earlier, e.g. graduate entry programmes. In any case, exceptions from the rule should only be considered if an independent body reporting to the Commission can confirm that the programme is sufficiently quality assured and compatible with the minimum training requirements as set out in the Directive.

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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?
(Please give specific arguments for or against this approach.)

CPME agrees that the notification of titles should be accelerated so as not to prevent professionals' mobility and would support an explicit provision obliging Member States to notify the Commission as soon as the programme has been approved and, if relevant, accredited at national level. To complement this, CPME also calls for the frequency of publication new titles in the Official Journal to be increased. To this end, CPME would support the introduction of mandatory timeframes to Art.7 in order to clarify both the Member States' and the Commission's obligations.
CPME very much favours improving the transparency of and access to national education and training programmes and would support the creation of a public platform through which information on the content is made available. Codifying this practice, including the Member States' tasks, could encourage a meaningful implementation of such a platform. Identifying national bodies responsible for carrying out this task and monitoring coherence between the Directive's requirements and the programmes could facilitate the exchange between NCAs.

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? (Please give specific arguments for or against this approach.)

In the context of provisions on medical specialities, CPME reaffirms its call for family medicine to be recognised as a speciality on equal terms with all other medical specialities. This amendment to the current provisions, which is widely supported by National Medical Associations and European Medical Organisations, most importantly the European Union of General Practitioners (UEMO), has been a long-standing position within CPME, as demonstrated in a series of adopted policies[3]. The differentiation between the treatment of family medicine and other specialities upheld within the Directive is an anachronism which does not adequately reflect the reality of professional practice. In light of the overall objective of the review process to modernise the *acquis*, the division within the section governing the medical profession should be abolished and family medicine should be subjected to the same provisions as the other medical specialities.

The process of amending Annex V must be carried out with the greatest possible transparency, the preconditions of which should be provided for in the Directive. CPME calls for increasing the transparency of the process of amendments to Annex V and a clarification on the roles and obligations of the different actors involved in these procedures. Under the condition that the process of amending Annex V is carried

[3] CPME policies affirming this position include: 'Reaction of CPME and its associated independent organisations on the proposal on the recognition of professional qualifications', adopted on 18 June 2002 (link to policy) ; 'CPME endorsement of the UEMO statements on GP/Family medicine as a medical speciality', adopted on 7 November 2003 (links to policy); 'CPME endorsement of the UEMO declaration on training for general practice/family medicine in Europe', adopted on 11 September 2004 (link to policy) ; 'CPME response to letter from the Presidents of the Nordic Medical Associations on Family Medicine', adopted on 27 November 2010 (link to policy).

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out with the greatest possible transparency, in the interests of legal certainty and equal treatment of medical specialities under the Directive, and underlining voluntary nature of the provision, CPME supports the lowering of the threshold of the number of Member States in which a medical speciality must exist in order for it to benefit from automatic recognition and be included in Annex V. In no way, however, can this amendment prejudice the minimum requirements set out in Art. 25.

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? (Please give specific arguments for or against this approach.)

In order to remove obstacles to professional development, CPME could support an introduction of partial exemptions to medical specialist training. These would however have to be subject to a non-automatic procedure, seeing each application for exemption assessed on a case-by-case basis and justified transparently for the benefit of ensuring a proportionate use of the exemptions.

Question 20: Which of the options outlined above do you prefer?
- **Option 1: Maintaining the requirement of ten years of general school education**
- **Option 2: Increasing the requirement of ten years to twelve years of general school education**

This question is not applicable to the medical profession.

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? (Please give specific arguments for or against this approach.)

This question is not applicable to the medical profession.

Question 22: Which of the two options outlined above do you prefer?
- **Option 1: Maintaining the current requirement of at least four years academic training?**
- **Option 2: Complementing the current requirement of a minimum four-year academic training by a requirement of two years of professional practice. As an alternative option, architects would also qualify for automatic recognition after completing a five-year academic programme, complemented by at least one year of professional practice.**

This question is not applicable to the medical profession.

Question 23: Which of the following options do you prefer?
- **Option 1: Immediate modernisation through replacing the ISIC classification of 1958 by the ISIC classification of 2008?**
- **Option 2: Immediate modernisation through replacing Annex IV by the common vocabulary used in the area of public procurement?**
- **Option 3: Immediate modernisation through replacing Annex IV by the ISCO nomenclature as last revised by 2008?**
- **Option 4: Modernisation in two phases: confirming in a modernised Directive that automatic recognition continues to apply for activities related to crafts, trade and industry activities. The**

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related activities continue to be as set out in Annex IV until 2014, date by which a new list of activities should be established by a delegated act. The list of activities should be based on one of the classifications presented under options 1, 2 or 3.

This question is not applicable to the medical profession.

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? (Please give specific arguments for or against this approach.)

Concerning the treatment of third country diplomas under the Directive, CPME underlines the fundamental importance of ensuring patient safety, in the interest of which requirements as to professional qualifications for the medical profession must not be lowered below the current thresholds[4]. CPME therefore cannot support amendments to Art. 3(3) which aim to decrease the number of years of professional experience required for the recognition of third country diplomas.
The question of the position of third country nationals must be considered separately.

As regards a possible extension of the personal scope of the Directive, CPME would not support such an amendment, due to the implications of such a 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. 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.

[4] In this context, CPME would like to refer to the "CPME Statement on the assessment of International Medical Graduates from outside the EEA", adopted on 13 June 2009 (link to policy).

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