European Board of Intensive Care Medicine

Brussels, 20th September 2011

Dear Mr. Tiedje,

Response to the European Commission consultation on modernising the Professional Qualifications Directive.

The European Board of Intensive Care Medicine (EBICM), the specialty board for ICM within the UEMS, is pleased to provide you with further input to the revision of the Professional Qualifications Directive.

In 2010, the EBICM participated in the evaluation of the Professional Qualifications directive, Directive 2005/36/EC, and asked for a modernization of the system. Subsequently, the EU commission launched the Public Consultation on the Recognition of Professional Qualifications Directive led by DG Internal Market and Services. The EBICM was pleased to also be able to contribute to this important consultation process and welcomed the European Commission's suggestion to modernize the acquis on the recognition of professional qualifications.

The EBICM firmly believes that a modernized system for the recognition of professional qualifications will lead to an improved and more homogeneous level of care, quality and safety for acutely ill patients cared for in EU hospitals, and that it will aid the free movement of health professionals between EU Member states (MS).

We have answered a selection of the questions that we believe are most relevant to the EBICM.

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?

A strengthened cooperation between member states with increased flow and exchange of information using an internal market instrument, such as the existing IMI - easily accessible and safeguarding data protection- can only lead to enhanced trust and patient safety whilst facilitating EU cross-border mobility. It remains imperative that each competent authority can be confident in the processes whereby practicing doctor's credentials can be checked and confirmed in order to satisfy the criteria for fitness to practice at a local level.

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).

A professional card will only aid those specialty areas that already qualify for automatic recognition. The EBICM would like to see the potential use of these administrative cards to expand to include other areas that could be defined by their particular competencies or qualifications, such as Intensive Care Medicine. The EBICM would not be supportive if these efforts misdirect attention away from the specialties not yet qualifying for automatic recognition and for professionals of which who can already have significant delays and problems in moving between member states.

The EBICM sees the introduction of a professional card as an advantage so long as the processes required to check credentials can be completely trusted and do not duplicate administrative efforts elsewhere. The card coupled with an expanded IMI would increase patient safety and thus trust in Health Professionals in case of increased mobility within the EU. Concerns regarding security and interoperability should not be overlooked. A card should not replace the ability of any competent authority to check original papers. The Internal Market Information System (IMI) should become the source for the verification of documents. IMI registration should be compulsory for all competent authorities. This would simplify the process and make it more timely efficient.

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.)

The EBICM is very uncomfortable with the possibility of partial access being introduced for the medical profession. Only those doctors who have had the minimum amount of training, properly accessed and certified, with clear documentation that they achieved the minimum and appropriate competencies should be able to practice in the different fields of medicine. The EBICM believes that the medical profession should be excluded from this amendment to the directive unless the assessment of competencies and qualifications can be introduced to assess any professional’s credentials to practice.

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.)

The EBICM thinks that common platforms have failed in their present format to harmonize compensation measures, so other conditions must be explored, such as the one proposed. It is our strong the opinion that moving towards a "European curricula" is a strategy that should be explored.

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).

The EBICM supports the obligation of Member States to ensure that information on the competent authorities and the required documentation is available through a central online access point. This would render the system more efficient and quick. The most important facet of this would be the openness and transparency of the system enabling the information to be both trustworthy and useful. A single access point that provided all the necessary paperwork and information would be a useful move forward.

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 practice due to a disciplinary sanction? The initiating Member State would be obliged to address each alert to all other Member States.)

The EBICM would support option 2 for an alert mechanism for health professionals within IMI provided that some safeguards are put in place. Indeed, not all Member States manage/measure/sanction fitness to practice in the same way. Nevertheless, non-fitness to practice ***(temporarily or permanently)*** is information that should be shared systematically. Appeal processes and revalidation measures should also be shared.

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.

The EBICM believes strongly that having a good understanding of the local language is a necessary skill in order to be able to practice medicine safety and effectively. This assessment of language needs to be part of the recognition process for specialty status when moving between countries and cannot be left to the employer to resolve. This can, and has, lead to significant problems for individual member states and can be a cause of issues relating to reduced quality and impaired patient safety.

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?

The EBICM welcomes and supports the proposed three-phase approach to modernization. It is vital, however, that the revision process should be performed in a transparent fashion and in close cooperation with the responsible authorities in individual member states that have the expertise to evaluate comparability of competence levels and qualifications across borders.

The EBICM stated clearly in its March 2011 answer that the system for the recognition of professional qualifications is in need of fundamental reform to bring it up to date with current developments in medical specialties and processes. There is a necessity to revise the training subjects in Annex V. The EBICM strongly believes that this would lead to an improved and more homogeneous level of care, a greater quality and safety for acutely ill patients cared for in EU hospitals, and that it would facilitate dramatically the free movement of health professionals between EU Member states (MS).

The EBICM would propose to minimize the importance of a minimum time base for the recognition of training in a certain specialty and favor as the major determinant the assessment of a given set of minimal competencies. In recent years, due to the implications of the European Working Time Directive, trainees' experience and hands-on training has diminished, whilst the minimum training period has remained constant. The result has inevitably been a reduction in the quantity and quality of training with potentially diminished standards of healthcare delivery and reduced levels of patient safety. We believe that healthcare professionals are better described in terms of the level of competencies that are necessary and have been acquired and maintained. The EBICM has already implemented such a concept through the

CoBATrICE project (Competency-Based Training in Intensive Care in Europe, initially funded by the Leonardo de Vinci EU programme) that now constitutes the basis for training in many EU countries.

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?

Regarding the demonstration of the right to exercise one's profession in cases of establishment in another Member State, the EBICM would favor an identical regime for temporary mobility and establishment. The medical tasks stay the same whether the health professional is temporary or established so a different treatment for the two scenarios is meaningless.

Continuous Professional Development (CPD) is of the utmost importance in critical care as the specialty is evolving so quickly. The EBICM already recognizes a European wide Diploma in Intensive Care (EDIC) and can provide 44 modules of continuous professional development (CPD) via the PACT e-based system so that intensivists that want to take the exam can study for it. The EBICM is of the opinion that the question of CPD – crucial to maintain the required competencies for keeping a safe and effective clinical practice - should be addressed more extensively in the Directive. It would encourage professionals in keeping their skills up to date.

Because the EBICM believes in the harmonization of medical training according to the highest standards of care for the benefit of EU citizens, we have actively participated in and contributed to the first pan European pilot test of knowledge assessment set with UEMS, that took place in several European countries.

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.)

The EBICM would agree that Member States should make notifications via the IMI system as soon as new programmes of education and training are approved. They should go through IMI only once they have been checked against the Directive.

4.3. Doctors: Medical Specialists

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.)

The EBICM has concerns that with the expansion in the number of member states, new specialties have to undergo a far more stringent process in order to get into annex V. This has impeded the development of new specialties with a detrimental effect on the development of healthcare and the safety and quality of care thus delivered. The EBICM is thus clearly in favor of this amendment.

With a decrease in this minimum number, the automatic approval of specialist status could be extended to other disciplines not yet described in Annex V of the Directive.
For this group of specialists the decrease in the minimum number of member states could lead to a simplification of migration and would not create new difficulties. In order to further strengthen the automatic approval as an additional step the automatic approval of particular qualifications as e.g. intensive care medicine could be taken into consideration as it is in many member states already uniformly regulated as particular qualification.

The EBICM therefore believes that this would be an opportunity to re-assess the criteria used for obtaining specialty status. In particular it would favor a move away from a time-based criteria to an assessment of competencies and qualifications.

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