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HPCB
Healthcare Professionals Crossing Borders

Crossing Borders Update

This update includes articles on EU negotiations on the proposal amending the recognition of professional qualifications Directive; a snapshot of approaches to continuous professional development (CPD) across a number of European healthcare professional regulators; an overview of the IMI Regulation; an update from the European Council of Nursing Regulators Conference; and news from around the world affecting healthcare professional regulation.

CONTENTS

EU institutional developments

Update on the EU negotiations on the proposal amending Directive 2005/36/EC

EUROPEAN PARLIAMENT

In October, the Internal Market and Consumer Protection (IMCO) committee, the lead committee for the recognition of professional qualifications (RPQ) Directive, published around 700 amendments MEPs propose to table to the Directive. The amendments cover a number of issues including the professional card, language assessment, the alert mechanism, partial access, and the use of delegated and implementing acts.

Professional card

The proposed amendments vary widely – some MEPs suggest increasing the timelines for recognition under the professional card, whereas others want to propose benefits for the professional. A number of MEPs have also suggested that the professional card should be tested through pilot projects first before being implemented. The issue of tacit authorisation remains controversial – some MEPs have proposed to delete the principle altogether while others have suggested granting 'temporary authorisation' if competent authorities do not comply with the proposed deadlines.

Language assessment

A number of amendments clarify that language assessment should take place after recognition but before access to the profession and under the supervision of the competent authority, for all healthcare professionals. However, MEPs are divided on whether the costs of language assessments should be borne by the professional or competent authorities.

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Alert mechanism

MEPs are broadly supportive of the alert mechanism but there is still discussion on the type of information that should be exchanged. A number of amendments propose extending the alert mechanism to all health and social care professions, regardless of whether they benefit from automatic recognition or general systems.

Partial access

A number of amendments have been tabled on partial access either to remove the principle from the proposal or limit its application. However, there is general recognition that the principle should not apply to healthcare professionals.

Delegated and implementing acts

Many amendments highlight the role of relevant organisations in the implementation of the professional card, alert mechanism, and minimum training requirements for the sectoral professions.

In parallel to the work in the IMCO committee, on 6 November 2012 the Environment, Public Health and Food Safety (ENVI) committee, the **opinion** committee for the Directive, adopted the opinion by Anja Weisgerber MEP (Germany, EPP). This will now feed into the discussions in IMCO.

Next steps

The compromise amendments will be discussed on 10 January 2013. The vote in IMCO is expected to take place on 23 January 2013.

EUROPEAN COUNCIL

Progress has also been made in the European Council, with a number of working groups taking place under the Cypriot Presidency.

On 1 January 2013, Ireland will take over the Presidency of the European Council. The Presidency is aiming to reach an agreement during its six month mandate and has organised 11 working groups on the topic.

This will be the seventh time that Ireland will take the Council Presidency and it coincides with the 40th anniversary of the country joining the EU.

Midwifery Regulators: Upward or downward harmonisation?

Charlotte Creiser, Conseil National de l'Ordre des Sages-femmes

The **Network of European Midwifery Regulators** (NEMIR) welcomes Bernadette Vergnaud's report on the proposal amending the recognition of professional qualifications Directive. It proposes key enhancements to midwifery training across Europe.

Network of European Midwifery Regulators

The profession is one of the most fragmented professions in Europe. There are considerable differences in the level of study and competencies required in the Directive and the structure of training in some Member States.

The current Directive gives Member States the flexibility to organise midwifery training, which has led to varying practices across Europe. This is further exacerbated by the proposed introduction of the European Credit Transfer and Accumulation System (ECTS) to compare different training programmes. This is why NEMIR proposed amendments to the European Commission's (EC) proposal for MEPs to consider building on some of the suggestions in the Vergnaud report.

However, some IMCO amendments fail to consider the need to harmonise and upgrade standards for entry to the midwifery profession. This has led to some very dynamic exchanges in the Parliament. NEMIR believes it is crucial that entry requirements for midwives are increased from 10 to 12 years in order to reflect recent developments in midwifery practice and to ensure competent authorities and employers have confidence in the system.

In the meantime, midwifery regulatory authorities continue to meet to exchange good practices in the area. The next NEMIR Policy Working Group will take place in early 2013 and the annual Summit of European Midwifery Regulators will be in June 2013.

European Network of Medical Competent Authorities (ENMCA) publishes briefing on RPQ amendments

The **European Network of Medical Competent Authorities (ENMCA)** has produced a **briefing** on proposed amendments from the IMCO Committee.

ENMCA welcomes that the draft report and proposed amendments take into consideration many of the specificities of healthcare professionals, in particular doctors, and the need to enhance patient safety while promoting professional mobility.

Medical competent authorities call for the deadlines under the professional card to be extended and support the proposal to remove the principle of tacit authorisation.

ENMCA also stresses that language must be assessed by competent authorities after recognition but before access to the profession for all doctors and that the alert mechanism should be extended to the exchange of intelligence about individuals that try to register with fake diplomas or false identities.

The Alliance of UK Health Regulators in Europe (AURE) publishes views on European Parliament RPQ reports

AURE has produced a **briefing** in response to the European Parliament (EP) reports on the proposal to amend the professional qualifications Directive.

AURE brings together 9 of the health and social care regulators (competent authorities) in the UK to work collaboratively on European issues affecting patient and client safety.

AURE members call on the EP to ensure that the professional card is appropriately piloted before implementation and supports IMCO's suggestion to allow competent authorities to introduce additional controls on automatic recognition professionals who are out of practice.

Key developments in continuing professional development (CPD)

The EC's proposal to amend the RPQ Directive includes a requirement on Member States to be more transparent about their arrangements for CPD. This reflects a growing number of calls from European organisations and stakeholders to share good practices in the area, with the aim of promoting high standards for healthcare professionals. In this section of the newsletter, we hear from different healthcare organisations across Europe on their approaches to competence assurance and recent key developments in this area.

UK: NEW CPD PROPOSALS FOR DENTISTS

Claire Herbert, Head of Revalidation, General Dental Council (UK)

The General Dental Council (GDC) has recently opened a consultation on its proposals for CPD for all the dental professionals it regulates.

Our new proposals build upon the last 10 years of mandatory CPD for dentists in the UK. They refocus our requirements firmly upon quality and impact of CPD for a new era. At the heart of these developments is a responsibility to assure patients and the public of the on-going fitness to practise of all those dental professionals we regulate. Patient safety is at the core.

We propose to introduce a scheme that links the requirement to keep up to date, through CPD, with GDC annual re-registration. We also want to ensure that CPD is directed towards our expectations – of knowledge, skill, communication, behaviours – by introducing high level CPD outcomes that relate to our standards of practice. We also propose to instil a reflective approach to maintaining our standards by requiring that all our registrants hold and maintain a personal development plan.

We believe our proposals will continue to embed CPD in the life of dental professionals and make it a cornerstone for supporting dental professionals to meet our standards.

To find out more about our CPD proposals, please visit our website. The consultation closes on 31 January 2013.

IRELAND: MAINTAINING COMPETENCE, MAINTAINING TRUST – APPROACH TO CPD FOR DOCTORS

Grainne Behan, Professional Competence Section, Medical Council (Ireland)

Since May 2011, it has been a legal obligation for registered doctors in Ireland to maintain professional competence.

Doctors practising in Ireland are required to enrol in professional competence schemes operated by recognised medical postgraduate training bodies in Ireland under arrangement with the Medical Council. These schemes support doctors to maintain competence in line with the Medical Council's **'Standards for Maintenance of Professional Competence'**.

The Medical Council oversees doctors to ensure maintenance of professional competence through its monitoring and audit procedures.

Each year, as doctors apply to retain registration with the Medical Council, they make a declaration that professional competence is being maintained. The Medical Council then requests that a sample of doctors participate in audit. Selected doctors submit documentation to the Medical Council to evidence their declaration. This documentation, known as a Statement of Participation, is provided by the medical postgraduate training body operating the professional competence scheme with which the doctor is enrolled. It sets out the types and amounts of activities which they have reported as having completed. Doctors are required to submit evidence to the medical postgraduate training body operating the professional competence scheme to support claims of reported activities.

If the Medical Council identifies that a doctor is failing, ceasing or refusing to cooperate with the legal duty to maintain professional competence, it can commence disciplinary action which may result in sanction or removal from the register.

These monitoring and auditing processes are designed to be straightforward and to support the confidence of the public, the profession and other stakeholders in professional competence arrangements. They provide an opportunity for doctors to demonstrate that they are fulfilling their legal duty, are keeping their knowledge and skills up-to-date, and are committed to ensuring the care they provide is safe, personal and clinically sound. In this way, maintenance of professional competence supports maintenance of trust between the public and the medical profession.

FRANCE: CPD FOR PHARMACISTS

Patrick Fortuit, Vice-President of the French Chamber of Pharmacists

In France, continuous training has been mandatory for pharmacists for years, but the concept of CPD was introduced into law in July 2009. It is now compulsory for all healthcare professionals regardless of their type and location of practice, and is defined by the following objectives:

- the evaluation of professional practices;
- the improvement of knowledge;
- the enhancement of the quality and safety of treatment; and
- the incorporation of public health priorities and the medically managed control of healthcare expenditures.

From 2013, pharmacists will have to take part in an annual or multi-annual CPD programme offered by a registered CPD organisation. The Chamber of Pharmacists will be responsible for overseeing the individual annual CPD obligation of pharmacists.

The programmes offered must correspond to national or regional guidelines and must be based on methodology and procedures that have been approved by the Higher Healthcare Authority (Haute Autorité de Santé).

We are currently in an implementation phase and the system should be fully operational in 2013.

UK: REVALIDATION INTRODUCED FOR DOCTORS

General Medical Council, UK

General Medical Council

Regulating doctors
Ensuring good medical practice

On 3 December 2012, **revalidation** – a system of regular checks on doctors to ensure they are fit to treat patients – came into force for all licensed doctors in the UK.

The GMC will run the new system of checks and means the UK's 230,000 licensed doctors are now legally required to regularly show they are keeping up to date and are fit to practise.

The new system is based on an annual appraisal, which is based on our core standards and guidance for doctors *Good Medical Practice*, and the information doctors will collect about their practice, including CPD activity, feedback from patients, doctors, nurses and other colleagues. The GMC has published advice on the type of **supporting information** doctors will have to provide and guidance on **CPD** which aims to assist doctors in planning, carrying out and evaluating their professional development.

Revalidation is part of a wider system of measures designed to promote improvements in safety and quality in UK healthcare, and is intended to ensure that all medical practice is conducted within a governed system.

All doctors who hold a licence to practise will need to revalidate, usually every five years. Doctors who work wholly outside the UK do not need a licence to practise and can choose to hold GMC registration without a licence. This allows doctors to show to employers, overseas regulators and others that they remain in good standing with the GMC. Doctors can apply to have their licence restored if they return to practise in the UK. However, doctors who hold registration without a licence cannot undertake any form of medical practice within the UK for which a licence is required.

The GMC expects to revalidate the majority of licensed doctors by March 2016, with medical leaders expected to go first.

Nursing regulators work together to improve patient safety

Professor Theodoros Koutroubas, FEPI Senior Policy Adviser

fepi

On the 5-6 November 2012, the **European Council of Nursing Regulators** (FEPI) organised an international conference in Croatia, to discuss the challenges nurses are currently facing in the context of the economic crisis and the revision of the RPQ Directive.

Held in Split, the event brought together representatives from regulatory bodies of nursing from all over Europe and the USA, who shared their national experiences and debated potential joint actions.

Representatives from the European institutions and the government of the Republic of Croatia were invited to address the conference. Ms. Phil Prendergast MEP (Ireland, ALDE), updated participants on the progress of negotiations on the RPQ Directive proposal, discussing notably the article which provides for 12 years of general education as a compulsory condition for entering a nursing programme – a core issue for all FEPI members.

Croat Deputy Minister of Health, Mr. Marijan Cesarik, underlined the importance of nursing education and patient safety for the government of the soon-to-become newest EU Member State. From the EC's side, DG Research officer, Mr. Grzegorz Ambroziewicz, updated the audience on the cooperation projects between hospitals, regional authorities and NGOs.

At the end of three very active sessions, the conference adopted a **Final Statement**, reiterating its support for nursing competencies, CPD, ethical codes and respect for cultural and linguistic diversity within the Single Market.

Concluding the two successful working days, FEPI President, Ms. Dragica Simunec confirmed the intention of nursing regulators to continue working together towards a patient-centred healthcare with the involvement of all stakeholders.

New IMI Regulation now in force

The new Regulation on administrative cooperation through the Internal Market Information System (the 'IMI Regulation'), came into force on 4 December 2012. IMI is currently used for a number of policy areas including the RPQ Directive and Services Directive. This regulation does not change the way IMI operates, but consolidates its legal framework and also paves the way for expansion of IMI to additional policy areas.

Consolidation of the data processing rules

The Regulation maintains the current period of data retention of six months but specifies that this is renewable to a maximum of 18 months, if this is specified in the corresponding EU Directive or Regulation. In addition, the Regulation stipulates that blocked data must be automatically deleted three years after the formal closure of the administrative cooperation procedure.

Regarding data processing, the Regulation clarifies that personal data may only be collected and used for initial information purposes, such as the recognition of a diploma, and in line with the protection of confidentiality required under EU law. Individuals are also allowed to have access to the information on the IMI system upon request and have the right to correct the information or ask for it to be deleted. This is in line with the proposals in the amended Directive on the recognition of professional qualifications.

Expansion of IMI to other policy areas

The Regulation includes a procedure for extending the coverage of the IMI to new policy areas. Under this procedure, the Commission may carry out pilot projects before deciding whether to extend the IMI to a specific area. From 2013, IMI will also be used for information exchange for cooperation in cross-border healthcare in relation to the Patient's Rights Directive.

Use of IMI to exchange personal data with third countries

Where international agreements are concluded between the EU and third countries that cover IMI policy areas, the Regulation allows the inclusion of these countries on the IMI system for the purposes of administrative cooperation provided that they have an adequate level of protection of personal data in accordance with Directive 95/46/EC.

Key developments in the reform of Europe's Data Protection rules

In January 2012, the EC presented a new proposal designed to reform the EU data protection rules. This consisted of a **Regulation on the protection of individuals with regard to the processing of personal data and on the free movement of such data**, and replaces the existing Directive 95/45/EC on data protection.

The rapporteur for the Regulation, Jan Philippe Albrecht MEP (Germany, Greens/EFA) has produced three working documents on the proposal. He has also signalled his intention to achieve an agreement on the package with the Council in 2013. Key priorities for the rapporteur include:

- Clarity regarding the definitions of 'personal data' and 'data subject' as they determine the scope and application of the safeguards contained in the Regulation to the various types of processing of personal data.
- Clarification of 'anonymity' to ensure the scope of the Regulation is clear and well-defined.
- Consistency across the EU. The rapporteur has called for the number of provisions to be decided by implementing/delegated acts to be limited.

On 9-10 October 2012, the lead committee on the proposal, the Civil Liberties, Justice and Home Affairs (LIBE) committee held an inter-parliamentary committee meeting on the reform of the EU Data Protection framework. The European Data Protection Supervisor, Peter Hustinx, called for the powers of the Commission to be limited and clarified.

The UK House of Commons Justice committee has also produced an opinion on the proposal. The committee comments that the Regulation is too prescriptive and does not allow enough flexibility for Member States. Committee members noted that in its present form, the Regulation will not 'produce a proportionate, practicable, affordable or effective system of data protection in the EU'.

The 'right to be forgotten'

Healthcare regulators have raised concerns over the principle of the 'right to be forgotten' and the impact this may have on the type of information they are allowed to store and share in the interest of patient safety. On this issue, the proposal includes a derogation which allows organisations to retain relevant information for reasons of public interest.

Next steps

The LIBE committee will present its draft report on 17/18 December 2012, with the deadline for amendments set for 24 January 2013. A preliminary vote on the key issues is expected to take place in Spring 2013. The EC intends to reach an agreement on the text during the Irish Presidency.

Working Time Directive: where now?

Kate Ling, NHS European Office

As HPCB went to press, it appeared that negotiations between the social partners have broken down and it looks unlikely that an agreement will be reached. The European Commission now has to decide whether or not to present another initiative.

The Working Time Directive (Directive 2003/88/EC) is key topic of debate across European healthcare. Without wishing to turn the clock back to the days of excessively long working hours, it has become apparent that court judgements interpreting this well-intentioned piece of legislation – which sets limits on working hours and prescribes minimum periods of rest and leave – go way beyond the original purpose of the Directive, which is to stop over-tired workers harming themselves or others. Health service planning and patient care has, in some circumstances, suffered as a result.

Attempts to reform the Directive foundered in 2009 due to stalemate between the European Council and Parliament. The European Commission has tried a new approach by inviting the social partners (organisations representing employers and trade unions at European level) to negotiate changes to the Directive. This process, known as 'social dialogue' is a provision (Article 155) in the Lisbon Treaty which enables agreements on employment-related issues reached by the social partners to become legislation. Negotiations do not involve external parties such as Member States, and any agreement reached by this method may only be accepted or rejected (but not amended) by the Council. Legislation implemented in this way by Council decision does not go through the European Parliament at all.

Negotiations began in December 2011 and the deadline

for reaching agreement is 31 December 2012, though it is possible this could be extended slightly if a successful conclusion looks likely.

The NHS Confederation is a UK member of CEEP, the social partner representing public sector employers, and is represented in Brussels by the NHS European Office. Our involvement is a vital part of the process as the negotiators need to listen to people 'on the ground' in Member States who can say what the impact of suggested changes would be in their country and/or sector.

As the negotiations are pan-European and cross-sectoral, members of the negotiating teams are drawn from a wide range of the EU27 member countries and from all sectors of the economy, both public and private. It's a very complex task therefore to try to reach a compromise that would work equally well whether applied to a shop worker in Estonia, a nurse or engineer in Germany or a doctor in the UK.

Later this month it will be apparent whether or not an agreement will be reached. If there is no agreement between the social partners, the EC will have to go back to the drawing board and bring forward a new proposal for a revised Directive – and the whole process will start all over again!

French Medical Council produces guidelines for e-health

Dr. Jacques Lucas, French Medical Council Vice President, General Delegate for health information systems

In November 2012, the French Medical Council organised a **symposium** focusing on ethical considerations for healthcare professionals in the use of e-health. Participants recognised the importance of e-health and its' unquestionable added value in healthcare services and in particular, the medical profession.

As the practice of e-health continues to develop, the French Medical Council has published the following key principles, which are designed to ensure the appropriate and ethical use of the service:

- E-health must be developed in accordance with the principles of medical ethics, with particular emphasis on confidentiality. The relationship between the doctor and patient should remain the key basis of medical practice.
- It is important that e-health services provide continuity of care and that technology is able to provide health professionals with the required level of support.
- E-health requires coordinated involvement of doctors and other health professionals at the regional, national and European level, and integrated sustainable IT systems.

The guidelines note that e-health, particularly telemedicine, can facilitate access to high quality healthcare, specifically in remote areas and for elderly or less mobile patients. The EU has strongly advocated this principle during 2012, the European Year for Active Ageing and Solidarity between Generations.

The French Medical Council has called for the creation of a French National e-health strategic council which would bring together organisations and health professionals involved in e-health practice, to ensure patients remain at the centre of e-health engagement.

General Medical Council notes record number of complaints against doctors

Kathryn Thomas, General Medical Council, UK

In September 2012, the GMC published its second edition of **The state of medical education and practice**, a report which presents a profile of the medical profession over the last year and outlines challenges for the future.

Registration

The number of doctors on the UK register has continued to grow and, for the first time, the number of female doctors has passed the 100,000 mark. The report highlighted that changing lifestyles and expectations of and from doctors means that the need for flexible working and training is becoming increasingly important.

Doctors who qualified outside of the UK continue to make up a third of the register. However, there are changes in the countries from which doctors come to the UK to practise, which appear to have been shaped by external factors. From 2010 to 2011, there were some notable increases in the number of doctors from Greece and Spain joining the UK medical register, which could be linked to the economic climate in their countries.

Fitness to Practise

The report highlights that complaints against doctors have reached a record high, as the number of complaints to the GMC has increased by 23% from 7,153 in 2010 to 8,781 in 2011 – continuing a pattern which has been rising since 2007. As in the past, most complaints in the last year have come from members of the public – and although many are not about matters which call into question a doctor's fitness to practise, some are serious and require a full investigation. This increase is not necessarily evidence that standards are declining. In some cases, complaints have risen because of improved clinical governance systems and greater patient empowerment.

Barriers to good medical practice

The report also explores possible barriers and enablers to good medical practice and identifies areas where there is a need for further debate and action. The report calls for better understanding of the environments in which doctors work and train, and the way this context can impact on standards of practice. It also stresses the need to ensure doctors have tailored support to help them overcome the challenges they face at different stages of their career and provide more guidance and advice.

Changes to social work regulation in England

Mark Potter, Stakeholder Communications Manager, Health and Care Professions Council

Social workers in England have a new regulator following the abolition of the General Social Care Council (GSCC).

On 1 August 2012 the regulation of social workers in England* transferred from the GSCC to the renamed **Health and Care Professions Council** (HCPC), now responsible for their regulation alongside health and psychological professionals from fifteen other professions. The GSCC received significant government subsidy whilst the HCPC is funded solely by fees from the professionals it regulates.

The transfer came about as a result of a government decision in 2010 as part of a wider programme to cut costs across the public sector. The transfer of 88,000 social workers to the HCPC will save the UK government approximately £10m each year.

As a multi-profession regulator of over 300,000 individuals HCPC takes care to ensure that each profession is treated equally, operating under the same rules and regulations, whilst recognising the unique aspects of each profession. For example, each profession shares the same standards of conduct, performance and ethics (behaviour) whilst retaining its own standards of proficiency (competency). This allows it to run efficient processes and keep costs down.

Since the transfer, HCPC has been working with the social care sector to ensure that every social worker on its Register renews their registration, 86.9% had done so by 30 November.

Social workers who have qualified outside of the UK can now apply to the HCPC for registration on a permanent (establishment) or temporary basis.

* Social care regulation is a devolved matter in the UK with separate regulators for England (HCPC), Scotland (SSSC), Wales (CCW) and Northern Ireland (NISCC). A **memorandum of understanding** (MoU) was recently signed by all four regulators to put reciprocal arrangements in place.

The Professional Standards Authority for Health and Social Care, UK

Douglas Bilton, Research and Knowledge Manager, Professional Standards Authority for Health and Social Care

From December 2012, the Council for Healthcare Regulatory Excellence (CHRE) in the UK has taken on new responsibilities and a new name – the **Professional Standards Authority for Health and Social Care**.

We had already started to publish documents in our new name, such as our recent Standards for board members and members of Clinical Commissioning Group governing bodies in the NHS in England. However, from this month everything we do will be in our new identity as the Authority.

The work that we did as CHRE will continue – annually reviewing the performance of the nine statutory regulators of health professionals in the UK and of social workers in England; reviewing all of their final fitness to practise decisions; auditing their early stage fitness to practise decisions; policy development and advice, and research.

However, with our new name come new responsibilities and functions, as set out in the Health and Social Care Act 2012.

We have launched an accreditation scheme for organisations which operate voluntary registers for people working in health and social care occupations which are not subject to statutory regulation. These organisations can apply to us for accreditation, which will be granted if they meet the standards we set.

We have a new role in the appointments that are made to the regulatory bodies' governing councils (excluding the Pharmaceutical Society of Northern Ireland). While the regulators themselves manage the appointments process on behalf of the Privy Council, and any appointment will be the Privy Council's decision, we advise the Privy Council about the process the regulator has used.

Finally, since August 2012 we have had oversight of the regulation of social workers in England, when responsibility for the regulation of that group transferred to the Health and Care Professions Council (formerly the Health Professions Council), which now regulates a total of 16 groups. The regulation of social workers in the other countries of the UK remains the responsibility of the Scottish Social Services Council, the Care Council for Wales, and the Northern Ireland Social Care Council.

EP questions

International recruitment of nurses

Nuno Melo MEP (Portugal, EPP) has noted that as a result of an increase in the emigration of Portuguese nurses, a number of international recruitment agencies are targeting the country.

Some nurses have allegedly been the subject of dubious recruitment practices and contracts lacking transparency. The Commission has responded to Mr Melo's question advising that they are aware of the situation in Portugal although it lacks comprehensive information on the mobility of healthcare professionals.

MEP highlights shortage of rural practitioners

Franck Proust MEP (France, EPP) has asked the Commission if it plans to address the shortage of rural medical practitioners in the EU, highlighting France as an example. Mr Maros Šefčovič, Commissioner for inter-institutional relations and administration, advised that demographic change and an ageing health workforce could lead to a shortage of about 1 million health professionals by 2020. He notes that in April 2012 the Commission adopted an Action Plan for the EU health workforce, which aims to focus action on three core areas: to improve health workforce planning, to better anticipate future skills needs and to stimulate the exchange of good practice on the recruitment and retention of health professionals.

Around the world

International Association of Medical Regulatory Authorities (IAMRA) 2012 conference

Medical regulatory authorities from across the globe met in Ottawa, Canada, in October 2012 for a four day conference to share experiences and challenges in assuring and promoting good medical practice. It brought together just under 300 representatives from 33 countries. Sessions focused on the licensing/registration, quality assurance and fitness to practise of doctors and presentations can be found on the website. The next biennal conference will be hosted in London in 2014 the week beginning 8 September 2014.

Limits on working hours may lead to lower confidence among trainees in the US

A study has found that restrictions on the amount of hours trainee doctors can work has helped to decrease fatigue but may also have impacted on their confidence to make clinical decisions and decreased satisfaction with their educational experience. In 2003, an 80 hour limit was introduced for medical trainees, as an effort to improve patient safety and end the 120 hour work weeks that had become common during training.

Initiating discussions about revalidation

The Medical Board of Australia has announced it will formally open the discussion on revalidation in Australia. The Board will produce an initial discussion paper in 2013 and will consult with stakeholders as the process develops.

World Medical Journal publishes article on worldwide medical regulation

The World Medical Journal has published the results of a survey which looks at the differences between healthcare professional regulation across the world. The report recognises the diversity of current system of regulations and the challenges that could pose in terms of harmonisation of systems.

Upcoming events

1 January 2013
Irish Presidency of the Council of the EU

10 January 2013
IMCO debate on RPQ compromise amendments

14 January 2013
Council working group on RPQ

23 January 2013
Adoption of IMCO report on RPQ Directive

February/March 2013
ENMCA meeting, Dublin, Ireland

March/April 2013
Orientation vote on data protection Regulation in LIBE

June 2013
Annual Summit of European Midwifery Regulatorsk

Recently published regulators' newsletters

- **French Order of Doctors newsletter**
- **Eurohealth**
- **IAMRA e-News**
- **CORU Newsletter**
- **NMC Review**
  Nursing and Midwifery Council
- **GDC update**
  General Dental Council
- **HCPC newsletter**
  Health & care profession council
- **GMC Student news**
  General Medical Council
- **GMC News**
  General Medical Council

If you would like to contribute a piece to the next Crossing Borders Update please contact the **HPCB secretariat**.