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HPCB
Healthcare Professionals Crossing Borders

Crossing Borders Update

Welcome to the July issue of the *Healthcare Professionals Crossing Borders Update*. This edition covers key policy news from the European Union and updates from various European regulators and international network meetings and conferences; the Medical Council Ireland introduces their second report focusing on Health and Wellbeing from the *Your Training Counts* trainee doctor's survey, and the UK's General Medical Council asks for your views on their draft guidance on cosmetic interventions.

Secondary legislation on EPC and FtP alert mechanism published

The final, adopted version of the Implementing Regulation for the European professional card (EPC) and the alert mechanism has been published in the Official Journal of the European Union (EU).

The Implementing Regulation sets out the process that competent authorities will need to follow to grant recognition via an EPC to professionals. Nurses, pharmacists and physiotherapists are in the first stage of the EPC, and will need to implement the Regulation by 18 January 2016. Doctors are expected to be in a second wave of implementation due 2018 at the earliest. Some competent authorities were hoping that the Regulation would provide more clarity around powers a host member state would have to revoke an EPC issued in error by the home state under the temporary & occasional regime. Some had also called for a transition period which would give competent authorities time to adapt their applications processes to the new EPC procedure, and make allowances for the delay in the adoption of the Regulation. Authorities will now work with the European Commission (EC) on the design of the IMI system to ensure that they can effectively process recognition with an EPC.

Member states also have until 18 January 2016 to implement the alert mechanism. The Implementing Regulation explains how the alert mechanism will work, but falls short of defining what decisions should result in an alert leading to some confusion amongst competent authorities about the kind of decisions that should be shared.

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European Union institutional developments

MEP publicly supports medical regulators in RPQ debate

On 6 May MEPs in the European Parliament Internal Market Committee held a debate with the European Commission on the Implementing Regulation governing the European professional card and alert mechanism. Competent authorities briefed MEPs in advance of the debate, and the chair of the committee raised a number of patient safety concerns regarding the EPC and its potential impact on temporary and occasional registration. The chair called for the Commission to outline in writing how these concerns would be mitigated.

EC report on free movement of workers from Croatia

The EC has published a report looking at the free movement of workers from Croatia, focusing on the two years after it joined the EU in July 2013. The report makes assumptions around the movement of Croatian workers in the next five years, predicting that numbers will be be small and unlikely to cause issues in the labour markets of destination member states.

The Accession Treaty for Croatia describes a period of seven years during which member states can choose to apply transitional arrangements for Croatian workers to access their labour markets. In the first two years Croatian workers tended to move to Germany, Austria and Italy.

MEPs call for improvement in patient safety

The European Parliament is taking forward a resolution on improving patient safety. The report calls for full implementation of the EU Recommendations on patient safety, and for healthcare systems to be protected from austerity measures. The resolution highlights:

- the importance of robust data collection systems
- appropriate training of healthcare professionals
- the need for improved reporting systems for adverse events.

It also calls for measures that encourage accurate, blame-free and anonymous reporting by both health professionals and patients.

EC commits to transparent policymaking

In May, the EC announced their 'Better Regulation Agenda', a package of reforms aiming to boost openness and transparency in the European Union (EU) decision-making process.

The EC implemented the first of these measures on the 1 July; the Roadmap or Inception Impact Assessment for any new legislation. This gives stakeholders the opportunity to influence very early on in the policy development cycle, before impact assessment and the related 12 week public consultation is launched. After the adoption of a legislative proposal by the EC, stakeholders will have eight weeks to submit any comments that will be collated and sent to co-legislators to help inform their legislative work. All submissions will be made public. Stakeholders can access these new tools through the Your voice in Europe website.

Other changes affecting healthcare professions is the option for periodic EC evaluations of adopted proposals and the webtool Lighten Your Load. This allows citizens as well as organisations to voice their concerns about any aspects of EU legislation.

The EC will also establish a Regulatory Scrutiny Board (RSB) to scrutinise feedback received on EC impact assessments, major evaluations and fitness checks. The RSB won't have the power to block EC proposals, but if they deem it appropriate, they will be able to call for the EC to publically justify their decisions before they take any work programmes forward.

General approach to data protection agreed

EU Ministers have agreed a general approach to revising the data protection Regulation. This means there is political agreement on the draft text at member state level and negotiations with the European Parliament can now begin.

First (trilogue) discussions with the European Parliament took place on 24 June 2015 with a view of reaching overall agreement by the end of 2015. The main features of the draft text aim to give data subjects more control over their personal data including:

- easier access
- more detailed information about what happens to their personal data once they decide to share it
- requiring a service provider to immediately remove personal data collected under certain conditions
- a right to portability enabling easier transmission of personal data from one service provider to another

- limiting the use of 'profiling', such as automated processing of personal data to assess personal aspects, such as performance at work, economic situation, health and personal preferences.

The general approach can be read here.

Competition among health care providers: not a blank cheque

Cédric Grolleau, Orde National des Chirurgiens - Dentistes

On 12 June the European Commission independent expert panel on effective ways of investing in health published its final opinion on *Competition among health care providers - Investigating policy options in the European Union*.
The report identifies various conditions across EU member states that need to be considered such as:

- adequate information about provider prices and quality
- the existence of standardised products or services facilitating comparison by patients
- the presence of multiple providers
- the possibility of an easy entry and exit of health care providers.

The expert panel stresses that in addition to economic evaluation, information about quality is of particular importance for competition to improve access to high-quality care.

Such competition is also essential for public authorities looking to improve efficiency in the use of health resources. However the expert panel appears keen to stress that:

"Competition in health care provision will not solve all health system problems and may have adverse effects. Neither economic theory nor empirical evidence support the conclusion that competition should be promoted in all health services".

The expert panel advises repeatedly against policy measures that introduce or increase competition, without a careful prior assessment of the conditions mentioned earlier. Since these vary across the 28 countries, they conclude there is no fixed set of conditions that will ensure competition will improve health system performance.

Recruitment and retention of health workforce: lessons from across Europe

Caroline Hager, Directorate General for Health and Food Safety, European Commission

Many EU countries report difficulties both in retaining and recruiting health staff. Reasons vary between EU countries. It can be due to unattractive jobs, poor management or few opportunities for promotion. In a number of EU countries, the economic crisis has increased the outflow of health professionals – the so-called 'brain drain'. These problems concern us all. Everybody is a patient at some point in their lives and patients deserve access to high quality care from a well-qualified workforce.

The European Commission has published a study on the Recruitment and Retention of the Health Workforce. This report maps strategies for recruiting and retaining health professionals across Europe, and hopes to serve as inspiration for the development of organisational strategies and human resources policies.

The study consists of a review of the literature, eight case studies on recruitment and retention – covering 40 interventions from 21 countries.

It recognises recruitment and retention of health workers as an immediate and urgent problem which needs to be addressed by policy-makers, healthcare managers and healthcare workers.

Recruit & Retain throughout the Health Professional's Working Life: case study topics

1. Attracting young people to healthcare
2. Attracting and retaining GPs to strengthen primary care in underserved areas
3. Providing training, education and research opportunities for a life-long career
4. Attracting nurses through the extension of practice and development of advanced roles
5. Providing good working environments through professional autonomy and worker participation
6. Making the hospital workplace more attractive by improving family-friendly practices
7. Return to practice for healthcare professionals
8. Providing supportive working environments for the ageing workforce

While no "one size fits all" solutions can be found for problems in the recruitment and retention of health workers in Europe, there are a number of success factors that are particularly relevant for specific types of recruitment and retention interventions, and that could help governments and health organisations to attract and retain healthcare staff. These include education opportunities, financial incentives and professional and personal support.

ECJ overturns working time ruling against Ireland

In March 2015 the advocate general of the European Court of Justice (ECJ) published an opinion that found Ireland in breach of the European working time Directive, in relation to the working hours of non-consultant doctors. In a more recent ruling issued this month, the ECJ dismissed the European Commission's infringement proceedings against Ireland due to lack of evidence.

In reply to the Commission's argument that certain training hours of non-consultant doctors are wrongly not considered 'working time', the Court observed that the Commission had not established that during training doctors are required to be physically present at a place determined by the employer and to provide medical care to patients.

EC confirms: EWTD does not apply to self-employed

An Italian doctor working in Poland has submitted a complaint to the European Commission claiming that Poland is evading the European working time Directive by hiring doctors who have established themselves independently, instead of employing doctors directly via the health service.

In response the EC has confirmed that the rights contained in the Directive do not apply to the self-employed. It falls to national law to regulate the working hours and rest periods of those that do not fall within the scope of the Directive.

European Parliament questions

The European Commission (EC) has responded to a question from an Italian MEP about the legality of the proposed UK Medical Licensing Assessment. It stated that it was aware of the recent proposal to introduce a 'Passport to practise' for all registered doctors in the UK and will closely monitor these debates and consultations to make sure that any new requirements for UK registered doctors are in line with the professional qualifications Directive, and do not discriminate against doctors qualified in other member states.

Daniel Buda MEP (Romania) questioned the EC on what he calls the exodus of doctors from Romania. He stated that the deficit of doctors in Romania is at approximately 40% and that a significant proportion of medical graduates prefer to emigrate due to the low level of wages in the country. He asked whether the EC foresees developing an action plan in order to align salaries in the medical field across Europe. In its answer the EC said that because salaries are a national competence, it will not develop an action plan on this issue.

European Parliament petitions

The European Parliament's petitions committee has considered **a petition** submitted by a Croatian qualified nurse of Serbian nationality who wishes to work in Ireland. The petitioner has been unable to register with the Irish Nursing Board due to the inability of the Croatian authorities to provide the requested explanations on the professional status of nurses trained at vocational secondary level prior to Croatia's accession to the EU. The EC has stated that it is aware of the need to clarify the situation and is currently in the process of investigating the matter with the Croatian Nursing Council.

European networks update

Update from the European Council of Medical Orders

Dr. Nicola D'Autilia, CEOM President

The European Council of Medical Orders (CEOM) brings together European medical orders and independent medical regulatory authorities. Its purpose is to promote the practice of high quality medicine respectful of patients' needs within the EU.

The last CEOM plenary meeting was held in Luxembourg on 12 June 2015. Thirteen medical orders attended the meeting, from Austria, Belgium, Cyprus, France, Greece, Italy, Luxembourg, Portugal, Romania, Slovenia, Spain, Switzerland and the United-Kingdom alongside four guest organisations the Standing Committee of European Doctors (CPME), the European Union of Medical Specialists (UEMS), the INPHET Network, and the Finnish Medical Association.

Several texts were adopted during the Luxembourg plenary meeting: the Statement of the CEOM on the use of mobile health (mHealth) within the European Union, two deontological guidelines on information and advertising and guidelines around the refusal of medical treatment.

The Joint Vienna Declaration on working time was also endorsed by CEOM participants.

Participants had the opportunity to hear and discuss presentations on various topics, such as ethical use of social media by physicians, models of international regulation and national reports on the social determinants of health. The final topic included the work of a panel from Greece on the impact of refugees and irregular crossings on the Greek health system which was followed by a decision to form a CEOM Working Group on refugees.

The work of the SNAPS Working Group on medical demography in the Nordic countries was also presented together with an update on medical demography in Switzerland.

Update on the Joint Action on European Health Workforce Planning and Forecasting

The Joint Action on European Health Workforce Planning and Forecasting (JA EUHWF) is a collaborative project between 30 associated and 60 collaborating partners. Members include most EU member states and health professional federations, the World Health Organisation (WHO), the Organisation for Economic Co-operation and Development (OECD) and the International Organization for Migration (IOM); a full list of those involved can be found on our website.

The aim of the JA EUHWF is to create a platform for collaboration and exchange between member states and stakeholders on the future of the healthcare workforce. The venture is partly funded by the Consumer, Health, Agriculture and Food Executive Agency, and coordinated by the Belgian Federal Public Service of Health.

Second Joint Action Conference in Rome

On 4 and 5 December 2014 over 200 people attended the Joint Action's second conference in Rome. The focus of the conference was health workforce employment, planning methodologies and international recruitment of health personnel. All conference presentations can be found on our website here.

Third Joint Action Conference in Varna

The third and final Joint Action Conference will be held in Varna, Bulgaria, in February 2016 – date to be confirmed. The conference agenda will cover mobility of health workforce and will tackle the challenges of major health workforce outflows and dependency on inflows. The second theme of the conference will be the influence of demographic changes on health workforce.

Project progress

JA EUHWF has released a number of official documents this year. These include:

- A report on terminology mapping.
- A review of the WHO Global Code of Practice on the International Recruitment of Health Professionals and how this applies in the EU.
- The User Guidelines on Qualitative Methods in Health Workforce Planning and Forecasting.

All official results of the Joint Action are available on our website.

In addition a *Handbook of Planning Methodologies* looking at seven different health workforce planning systems in Europe will be released this summer. JA EUHWF is running pilot projects in Italy and Portugal to support this work. Feasibility studies in Germany and Romania/Moldova will test several aspects of the handbook providing valuable intelligence for implementation of planning systems in different countries.

For more information, see past newsletter issues available here or contact EUHWForce@health.belgium.be.

The official Joint Action Health Workforce Planning and Forecasting website domain www.euhwforce.eu is undergoing a makeover and has been temporarily replaced with euhwforce.weebly.com. A new, official Joint Action website and domain name is expected to be launched by the end of summer 2015.

Joint Action Health Workforce Planning and Forecasting

Funded by the Health Programme of the European Union

Developments in European regulation

Health and wellbeing of trainee doctors in Ireland

Ailbhe Enright & Simon O'Hare, Medical Council Ireland

On the 30 April 2015 the Irish Medical Council published the second report from the first ever survey of trainee doctors in Ireland, *Your Training Counts*. The report focuses on health and wellbeing of trainee doctors and is based on a survey held in 2014.

Your Training Counts gives a broad and comprehensive insight into the experiences of doctors in training, and is a key component of the Medical Council's role in setting and monitoring standards of medical training. It was launched in early 2014 and received a response rate of over 53% of trainee doctors. To allow for international comparisons the report utilised questions from similar medical education surveys in the UK and the Netherlands.

Findings on the general health, quality of life, and wellbeing of trainees from the survey were extremely valuable. Eight out of ten, or 83% of respondents, rated their general health as being good or better, and two out of ten rated their general health as excellent. Many trainees also reported high levels of work engagement, indicating that they approach their work and training with vigour, dedication and positive absorption despite the many challenges facing the Irish health system.

Other results included:

- Six out of ten of trainee doctors rated their quality of life as being good or better and two out of ten rated it as poor or very poor.
- 21% reported low scores on a rapid assessment of wellbeing tool, which presents a concern for possible mental health and wellbeing difficulties and a potential need for more robust support.
- Those who reported experiencing bullying and undermining also reported poorer health and wellbeing across a number of areas: general health, quality of life, wellbeing, and work engagement.

The report also found that trainees working greater number of hours per week indicated poorer general health, quality of life, and wellbeing. Interestingly, trainees working in hospitals reported poorer quality of life ratings than trainees in GP practices.A third report focusing on career choices, emigration, and retention will be published in the coming months.

The *Your Training Counts 2015* survey is now open for all trainees in Ireland.

New UK standards for podiatric surgery

The UK's Health and Care Professions Council (HCPC) has published new standards for podiatric surgery. These standards have two purposes: they set out our expectations of education providers delivering training in podiatric surgery, and the knowledge, understanding and skills we expect a podiatrist practising podiatric surgery to be able to demonstrate when they complete their training.

The standards were published following a 16 week consultation that included discussions with a range of UK organisations including the College of Podiatry, British Orthopaedic Foot & Ankle Society, NHS Education for Scotland, the British Orthopaedic Association, The Royal College of Surgeons and General Medical Council.

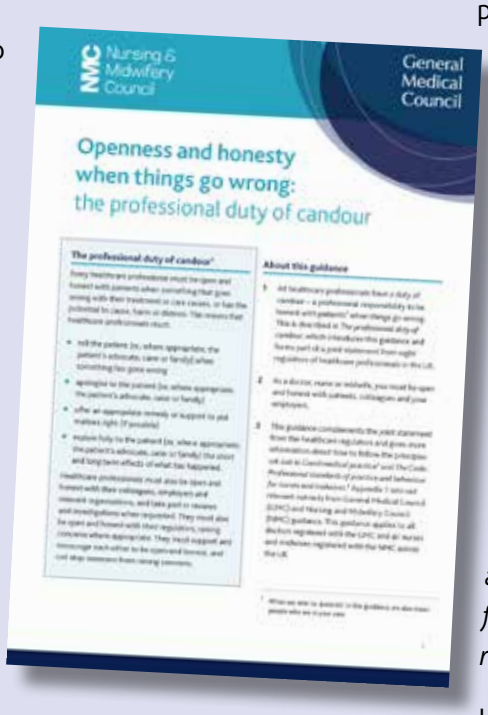
The practice of podiatric surgery is significantly beyond the scope of practice of a chiropodist / podiatrist at entry to the profession. Therefore podiatrists practising podiatric surgery will have to adhere to these standards, in addition to the HCPC's standards of conduct, performance and ethics, standards of continuing professional development and the standards of proficiency which apply to all chiropodists / podiatrists. By annotating the register to indicate those who have completed an approved programme it allows us to strengthen public protection.

Further to the planned annotation to the register, we are now seeking visitors to assist us in approving podiatric surgery training programmes. Visitors are responsible for visiting and assessing existing and proposed education and training programmes delivered by education and training providers. This will enable us to ensure that training programmes meet our new standards for podiatrists practising podiatric surgery.

The full standards can be found here.

UK: Joint Duty of Candour guidance launched

The UK's General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) have jointly launched their new guidance for doctors, nurse and midwives on professional duty of candour. It sets out the standards expected of all doctors, nurses and midwives practising in the UK and aims to help patients understand what to expect.



Under the new guidance doctors, nurses and midwives should:

- Speak to a patient, or those close to them, as soon as possible after they realise something has gone wrong with their care.
- Apologise to the patient - explain what happened, what can be done if they have suffered harm and what will be done to prevent someone else being harmed in the future.
- Use their professional judgement about whether to inform patients about near misses – incidents which have the potential to result in harm but do not.
- Report errors at an early stage so that lessons can be learned quickly, and patients are protected from harm in the future.
- Not try to prevent colleagues or former colleagues from raising concerns about patient safety. Managers must make sure that if people do raise concerns they are protected from unfair criticism, detriment or dismissal.

All healthcare professionals have a duty of candour, a professional responsibility to be honest with people in their care when things go wrong. The overarching guidance for doctors is *Good medical practice*; for nurses and midwives it is *The Code: Standards of conduct, performance and ethics for nurses and midwives*. Both GMP and the Code cover fundamental aspects of a doctor's, nurse's or midwife's role, including working in partnership with patients and treating them with respect.

Niall Dickson, Chief Executive of the General Medical Council, said:

We recognise that things can and do go wrong sometimes. It is what doctors, nurses and midwives do afterwards that matters. If they act in good faith, are open about what has happened and offer an apology this can make a huge difference to the patient and those close to them. We also want to send out a clear message to employers and clinical leaders - none of this will work without an open and honest learning culture, in which staff feel empowered to admit mistakes and raise concerns.

Jackie Smith, Chief Executive of the Nursing and Midwifery Council, said:

We developed this joint guidance to help nurses, midwives and doctors to uphold a common duty of candour that is set out in their professional standards. They often work as part of a team and that should absolutely be our approach as regulators to ensure we are protecting the public. We believe that the public's health is best protected when the healthcare professionals who look after them work in an environment that openly supports them to speak to patients or those who care for them, when things have gone wrong. We can't stop mistakes from happening entirely and we recognise that sometimes things go wrong. The test is how individuals and organisations respond to those instances, and the culture they build as a result.

Consultation on UK guidance for cosmetic intervention

The UK's General Medical Council is consulting on new guidance for doctors offering cosmetic interventions.

The proposed new guidance applies to doctors offering both surgical and non-surgical interventions and follows Sir Bruce Keogh's review, which concluded that patients need better protection in this area. As a result we want to clarify, for both doctors and patients, what constitutes good practice and to highlight aspects of practice where doctors should take particular care.

The draft guidance says that doctors must:

- Be open and honest with patients and not trivialise the risks involved.
- Give patients enough time and information before they

decide whether to have a cosmetic procedure and allow them time to 'cool off'.

- Ask patients to tell them how they have been affected by a cosmetic procedure, both physically and psychologically, and check whether they are satisfied with the outcome.
- Take particular care when working with children and young people – they should not target people under 18 through their marketing and they should seek additional advice from professionals whose expertise is in treating young people.
- Seek their patient's consent themselves rather than delegate it.
- Market their services responsibly; they should not make unjustifiable claims about the results they can achieve and they should not use promotional tactics that encourage people to make ill-considered decisions. For example, procedures given away as a prize.

The consultation is open until 1 September. For more information and to respond, please follow this link.

New UK requirements for chiropractors with overseas qualifications

Neil Johnson, General Chiropractic Council

The General Chiropractic Council (GCC) regulates chiropractors in the UK, Isle of Man and Gibraltar, and patient protection is at the heart of the GCC's activities. When a new chiropractor applies to join our register, we need to be sure that patients can be confident that the new chiropractor has the skills, knowledge, health and character to practise the profession safely and effectively.

Most applicants for registration come from the UK or another EU country, so it is relatively easy for us to ensure that they are of good character and that they meet our educational requirements. However, things get a little more challenging if an applicant for registration is from further afield. To ensure that standards of public protection are upheld, chiropractors without a UK or EU qualification are required to take our Test of Competence (TOC) before they can join our register and practise in the UK.

General Chiropractic Council

We have recently changed the format of the TOC. The new format pays particular attention to ensuring that applicants actively engage with the standards of good practice that are set out in our Code of Practice and Standard of Proficiency (CoP and SoP). Making sure that chiropractors understand our CoP and SoP is particularly important since it means that chiropractors comprehend how chiropractic treatment is provided in the UK and the requirements that, if successful, they will be subject to, during their career in the UK.

An applicant's understanding of the CoP and SoP, and their need to use it as the basis of their practice in the UK, is assessed in an *Evidence of Practice Questionnaire* that they must submit. The questionnaire asks for case studies of patients (along with anonymised patient records) that they have already treated in their career, and how the applicant would comply with the requirements of the CoP and SoP in situations that they have previously encountered during their career. This is then assessed during an interview where the applicant is further questioned on their understanding of our requirements and how they would apply them in a practical situation.

More information about the new TOC can be found here.

Pan-European standards for osteopathy

For the first time a consensus on pan-European standards of osteopathic education, training and practice has been reached.

The European Standard on Osteopathic Healthcare Provision, issued by the European standards body the European Committee for Standardisation (CEN), provides a benchmark of the level of healthcare that should be provided to patients throughout Europe when it comes to osteopathic diagnosis, treatment and care. Osteopaths must complete relevant education and training to a required standard as well as following continuing professional development. In addition scientific rigour and evidence-informed practice are an important part of an osteopath's approach to patient treatment and case management.

This new European standard does not supersede the national legislation already existing in eight European countries (including the UK, France, Finland, Iceland, Lichtenstein, Malta and Switzerland), where osteopathy is regulated. For those countries without regulation, it does provide a valuable tool, for example to develop greater consistency among education and training institutions in terms of the quality and scope of programmes delivered, provide a quality mark for associations and voluntary registers to show patients and the wider public that their members have met a recognised standard, and raise patient/public awareness and understanding of osteopathic practice.

As an organisation, CEN is made up of national standardisation bodies. 18 CEN member countries voted in favour, with one against, during the final vote of the European Standard on Osteopathic Healthcare Provision. If compared to a similar voting system, like the EU institutions', the Standard received a 'weighted percentage approving' of 96.8% – the threshold is 71%.

The standards are expected to come into force in early 2016. For more information contact the Forum for Osteopathic Regulation in Europe at: foresecretariat@osteopathy.org.uk

Safe, high-quality and compassionate care in England

Since April 2015 the Care Quality Commission (CQC) – the independent systems regulator of health and adult social care in England – has been given increased powers to make sure that people receive the best care possible at all times. The changes have come about from new regulations called the fundamental standards, which are more focused and clearer about the care that people should expect to receive at all times.

There are also new requirements for providers, such as NHS trusts and general practices, on being open about mistakes when they happen (called the 'duty of candour') and on making sure directors and their equivalents are 'fit and proper'. The new regulations also include a requirement for providers to prominently display their CQC ratings on their websites, as well as at premises, public entrances and waiting areas of care services. The CQC can judge a provider to be Outstanding, Good, Requires Improvement or Inadequate

The CQC is responsible for making sure providers meet these requirements. It does this through its expert-led inspections, which are based on what matters most to people who use services – are they safe, caring, effective, responsive to people's needs and well-led.

When the CQC finds that people are not receiving – or are at risk of not receiving – the high standard of care that it expects and that they deserve, it holds providers to account to make the required improvements. It does this by using its new enforcement policy – a key part of this gives the CQC the ability to prosecute providers for poor care without having to issue a warning notice first. The new policy allows the CQC to act quickly in response to the seriousness of the concern. In addition to this, CQC can place services – or recommend that services be placed – into 'special measures'. Where care is judged to be inadequate, it is essential that the service improves quickly. The CQC has designed its 'special measures' regime to make sure there is a timely and coordinated response to this.

For further information, please visit www.cqc.org.uk or follow the CQC on Twitter: @CareQualityComm.

Systems regulation in the UK is devolved. In Northern Ireland responsibility falls to the Regulation and Quality Improvement Authority, in Wales it is covered by both the Care and Social Services Inspectorate Wales and Healthcare Inspectorate Wales and for Scotland Healthcare Improvement Scotland.

Around the world

AHPRA research into smarter use of data

The Australian Health Practitioner Regulation Agency (AHPRA) and the National Boards are working with the University of Melbourne to investigate how to use their data to prevent harm. Since 2010, Australian law requires health practitioners, employers and education providers across the 14 health professions to report all notifiable conduct to AHPRA. Notifiable conduct is defined broadly to cover practising while intoxicated, sexual misconduct, or placing the public at risk through impairment or a departure from accepted standards.

A three-year research project, headed by physician and health lawyer Dr Marie Bismark, will use intelligence from notifications to create a dataset. Researchers then plan on using this to identify 'hotspots of risk', i.e. groups of practitioners receiving a disproportionate share of notifications.

Supreme court says Canadians have right to die

In February this year the Supreme Court of Canada unanimously ruled that mentally competent, consenting adults who have intolerable physical or psychological suffering from a severe and incurable medical condition have the right to a doctor's help to die. The illness does not have to be terminal.

The case (Carter v. Canada) was brought to the Supreme Court by a civil rights group on behalf of two women, both with degenerative diseases who have since passed away.

The decision takes effect in 12 months, and the Canadian government has until then to rewrite its law on assisted suicide. If it does not, the current law will be struck down. Commentators point out that some physicians are conscientiously opposed to physician assisted dying, and though the Supreme Court of Canada acknowledged their right to refuse, some doctors are afraid that this will force them to participate.

Investigation unveils broken Indian medical education system

Reuters Investigates has published a report stating that Indian's medical education system is fraudulent and unprofessional.

The investigation found that one sixth of the country's 398 medical schools have been accused of cheating, and that in some cases professors, lectures, clinical training, and basic sanitation were missing from medical schools. Accreditation of schools and regulatory inspections were also found to be corrupt, involving the recruitment of fake doctors to elude inspectors and paying or exploiting local villagers to pose as patients.

Report from the 8th meeting of the Latin American Forum of Medical Entities

On 3 to 6 June the Latin American Forum of Medical Entities (FIEM) held its eigth meeting in Santiago de Compostela, Spain. FIEM meets once a year and brings together over 20 Spanish and Portuguese speaking countries and represents more than half a million doctors. It provides a forum for organisations to meet and exchange views on the organisation, management and regulation of the medical profession.

At the most recent meeting, the following issues were considered:

- the *Iberoamerican Charter of Medical Ethics* – a guide to good practice in social networks
- a declaration on gender violence as a determinant of health in women
- the role of doctors in private health management and public administration
- social protection and insurance
- trafficking and organ trading
- a drug policy statement: medicalisation of life and social aspects of clinical medicine.

Niall Dickson, Chairman of the International Association of Medical Regulatory Authorities (IAMRA) and Chief Executive and Registrar of the General Medical Council, spoke at the meeting about the work of IAMRA and building an international regulatory community.

Outcomes of the meeting can be found here.

FSMB 2014 census of US physicians

The Federation of State Medical Boards (FSMB) has released its latest census of actively licensed physicians in the United States. The census reviews data received in 2014 by the FSMB from the nation's state medical and osteopathic boards about the current supply of actively licensed physicians in the United States and the District of Columbia.

The information offers a current snapshot of the health care workforce, including the number, gender, age, American Board of Medical Specialties (ABMS) certification and location by state of all physicians with an active license to practice medicine.

Key findings of the 2014 Census include:

- An increase of 4% in the total population of licensed physicians (916,264) since 2012.
- On average the nation added 12,168 more licensed physicians annually than it lost between 2012 and 2014.
- The average physician is now older and still predominantly male, yet increasingly female at entry level.
- The number of actively licensed physicians who graduated from international medical schools, particularly those in the Caribbean region, is growing at a rapid rate.

The findings will be published later this year in the *Journal of Medical Regulation*.

Upcoming events

2015

26 – 29 August 2015
Association for Dental Education in Europe (ADEE) Annual Meeting: Communication and Interaction in Dentistry
Szeged, Hungary

1 – 4 September 2015
AMCOA – Africa Annual conference
Mombasa, Kenya

5 – 9 September 2015
An International Association for Medical Education AMEE Conference
Glasgow, United Kingdom

16 September 2015
International Society of Dental Regulators (ISDR)
3rd International Conference of Dental Regulators
Boston, USA

17–19 September 2015
Council on Licensure, Enforcement & Regulation (CLEAR)
Annual Educational Conference
Boston, USA

29 – 30 October 2015
International Association Medical Regulatory Authorities (IAMRA) Revalidation Symposium
Montreal, Canada

4 – 6 November 2015
Canadian Association of Midwives Annual Conference
Montreal, Canada

19 – 21 November 2015
10th European Quality Assurance Forum (EQAF)
London, UK

27 November 2015
European Council of Medical Orders (CEOM) meeting
San Remo, Italy

Autumn/Winter 2015
Data protection trilogue meeting

November/December 2015 (tbc)
European Network of Medical Competent Authorities (ENMCA) meeting
Brussels, Belgium

2016

18 January 2016
Implementation deadline for the recognition of professional qualifications Directive

February 2016
Final, Joint Action on European Health Workforce Planning and Forecasting Conference
Varna, Bulgaria

Newsletters

Association for Dental Education in Europe (ADEE)
Volume 11, Issue 1, April 2015

CORU
E-newsletter

DG MARKT
E-newsletter

French Order of Doctors
Issue 70, June 2015

General Chiropractic Council
E-newsletter May, 2015

General Dental Council
E-newsletter

General Medical Council
GMC News

Health-EU
E-newsletter

Health and Care Professions Council
Issue 59, June 2015

IAMRA
E-newsletter

IMCO
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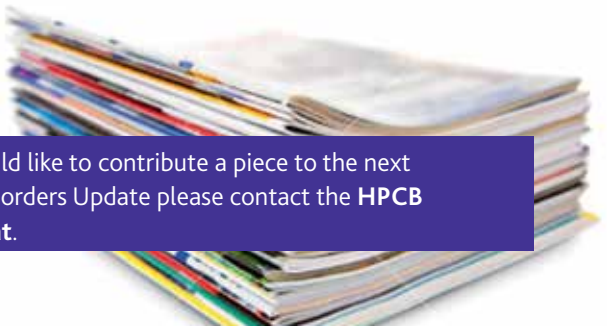
Medical Council Ireland
E-newsletter

Nursing and Midwifery Council
E-newsletter



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