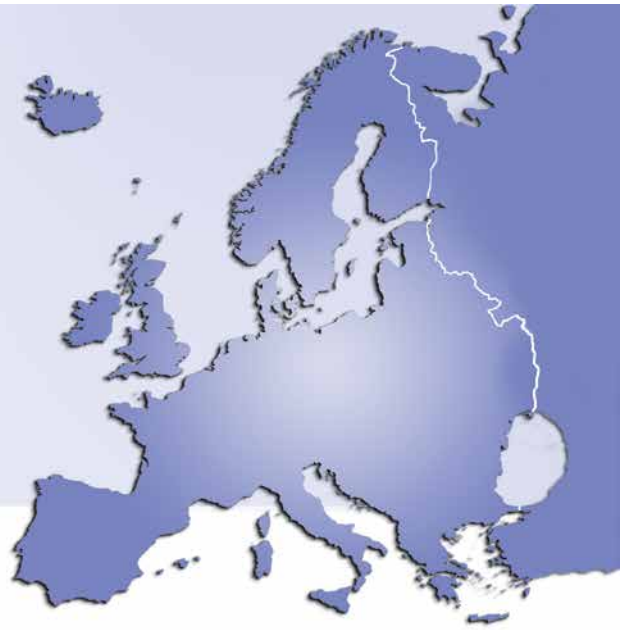
Summer edition I Issue 39

HPCB
Healthcare Professionals Crossing Borders

Crossing Borders Update



Welcome to the summer edition of the Healthcare Professionals Crossing Borders Update. In this edition Professor Martin McKee pens a guest article providing an analysis of our fitness to practise sanctions mapping exercise, the EC host a conference to celebrate the first anniversary of the alert mechanism and European professional card, and we look at the proposed Proportionality Directive.

We also look at recent case law on dental advertising, new standards for pharmacy professionals in the UK and an update on the European working time Directive.

In addition, the European medical organisations voice their views on Brexit and the Portuguese Ordem dos Enfermios discuss the future of nursing education and training across the EU.

Draft Proportionality Directive closely recalls Services Directive

***Rita Baeten**, senior policy analyst, European Social Observatory (OSE)*

Earlier this year, the European Commission proposed a general proportionality assessment on regulation of regulated professions, including health professions. Member states must provide evidence that measures are necessary to protect a public interest objective and that they do not exceed what is necessary to attain this objective. The regulations referred to in the proposal include the following issues: continuous professional development; language knowledge; reserving specific activities for professionals with a particular professional title; rules relating to the organisation of the profession and professional ethics, registration or authorisation schemes and requirements limiting the number of authorisations to practice.

While regulation in the healthcare sector is crucial to guarantee universal access to care and to redress market imperfections, the lack of clarity as to the extent to which a specific approach for health professions regulation could be justified under the proposal, would lead to substantial legal uncertainty.

Continued on next page >

CONTENTS

For further information please contact:
Nicola While, HPCB,
350 Euston Road, London NW1 3JN
Tel: +44 0161 250 6954
Email: hpcb@gmc-uk.org

The requirements to be assessed under the proportionality test closely recall provisions of the initial proposal for a Services Directive, in 2004. Here too member states were obliged to engage in a major screening exercise of their regulation of services, including health services. The application to healthcare was highly controversial and finally led to the exclusion of healthcare from the in 2006 adopted version. It is therefore surprising that a similar proposal now seems ready to pass without much animosity. The European Commission seems to have learnt from its failures with the Services Directive and now has carefully built up the policy process. The proposal now deals with one specific sector (professionals), which reduces the potential for broad protest. Member states' health authorities are in a rather weak position to oppose the Commission's initiative since they are unable to agree on a specific approach for the application of the internal market rules to healthcare. This is mainly because any legal proposal addressing this issue would inevitably encroach upon national powers over the organisation of health systems.

As argued in an OSE Opinion Paper,[1] given the specificity of the healthcare sector, an adapted approach for health professions would be advisable.

1 Baeten R. *Was the exclusion of health care from the Services Directive a pyrrhic victory? A proportionality test on regulation of health professions.* OSE Paper Series, Opinion Paper 18, Brussels, OSE, 2017

Analysis of the HPCB fitness to practise survey

***Prof Martin McKee**, Professor of European Public Health, Research Director European Observatory on Health Systems & Policies, London School of Hygiene and Tropical Medicine*

The right of European citizens to move freely across borders is one of the fundamental pillars of the European Union (EU). From its earliest days, there have been provisions for health professionals to work across borders. Of necessity, this was subject to certain safeguards. Thus, the member states agreed common standards for basic and specialist medical training. Subsequently, similar arrangements were created for other health professionals.

These arrangements worked relatively well at first, but in time, it became clear that there was a need to update them to take account of changing circumstances. First, the standards were based on hours of study rather than the acquisition of defined competences, increasingly seen as the most appropriate means of evaluating training programs. Second, they assume that someone who had qualified at any time in the past remained competent to practice indefinitely, even though there was growing support, in some countries, for regular assessments to ensure continuing competence. Finally, there were a few high-profile cases of professionals who had moved to another member state and whose actions raise questions about their fitness to practice.

As a consequence, a major review was undertaken in 2013 leading to a new directive on professional mobility. It included a number of new provisions, including some that responded to particular concerns about potential risks arising from movement of health professionals. These include the introduction of a proactive alert mechanism, whereby the regulator in each member state notifies those in all other member states about individuals whose fitness to practice is in question.

In late 2016, Healthcare Professionals Crossing Borders undertook a survey to update what was known about the regulation of health professionals across the EU. They sent a detailed questionnaire to professional regulators in each member state.

Organisations varied in the coverage of professional groups. In most countries, there was a separate regulator for doctors, in some cases also covering dentists. In others, a single organisation regulated all health professionals as in Sweden and Estonia. In some countries, there were separate regulators for nurses and midwives, while in others, they were combined.

Of 35 bodies that responded, 31 regulated those with basic qualifications and 26 regulated those with specialist qualifications. In 21 cases, the regulators registered practitioners for life, while the remainder, registration was time-limited. 31 were responsible for taking action when a complaint was made about a registered practitioner. 29 of these could act in relation to questions of clinical competence or professional conduct at work. All but one would become involved in the event of a criminal investigation but only 24 would take action in relation to concerns about language and communication skills and only 21 with respect to conduct outside of work.

All of those with responsibility for responding to complaints were able to impose temporary suspension of the right to practice and all but 2 could withdraw the right permanently. 25 could restrict what the practitioner could do but only 14 were able to require remedial action, such as further training. 11 were able to impose a financial penalty.

Figure 1 - Do you take action if you receive a complaint about a registered healthcare professional?

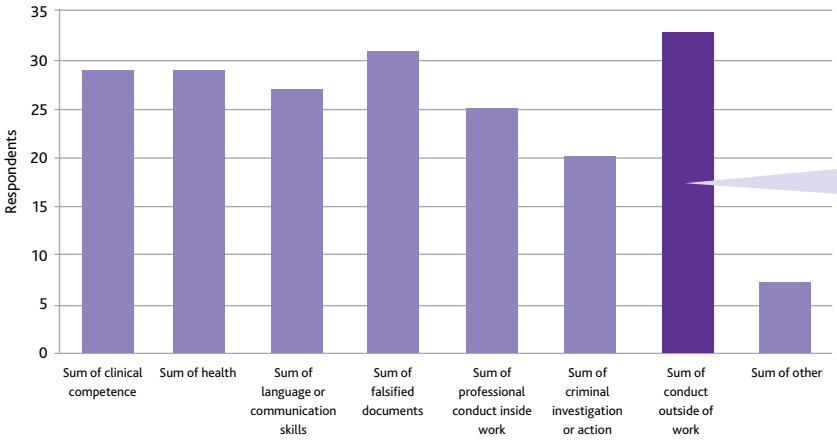
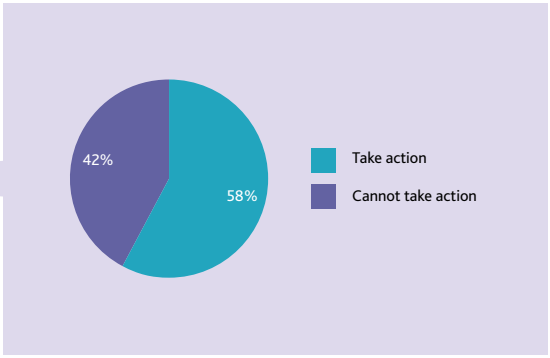


Figure 2 - Respondents that can take action on conduct outside of work



Surprisingly, only 20 reported that they were definitely able to act on information received from a regulator in another jurisdiction, with 10 precluded from doing so. Two did not know if this was possible.

Exchange of information on fitness to practice takes place within the Internal Market Information (IMI) System. Somewhat surprisingly, only 28 of the regulators were registered with the system, allowing them to send and receive alerts. Of these, 22 proactively exchanged information on clinical competence, while 21 exchanged information on professional conduct at work, concerns about the health of the practitioner, falsification of documents, or ongoing criminal investigations. Only 17 shared information on concerns about language or communication skills, with 16 sharing information on conduct outside work.

There was also considerable variation in what would trigger an alert to be sent. Thus, 29 would notify a temporary suspension and 27 the withdrawal of the right to practice. However, only 23 would notify when conditions were imposed on a practitioner and even fewer, 12, would notify when conditions were imposed on the practitioner's scope of practice.

Regulators also differed as to when they would issue an alert, with 10 doing so after any ruling but before an appeal while 18 would only do so after the appeal process had been completed.

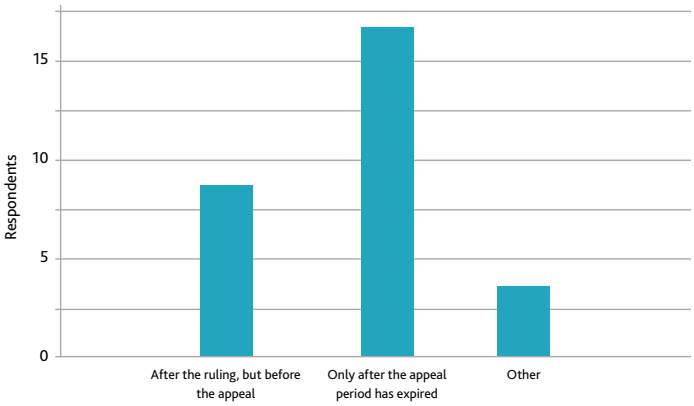
Health professionals moving within Europe are required to obtain a certificate of good standing from the regulator in the member state from which they are coming. All of those responsible for disciplinary issues were also responsible for issuing the certificates. When all would decline to issue a certificate if the practitioner was not entitled to practice, 20 would do so if disciplinary action was pending or being investigated, although 10 would include details of the circumstances. 22 would issue a certificate where the practitioner was subject to restrictions on their right to practice. 17 of them would include details on the certificate of the nature of any restrictions.

This survey is subject to many limitations. Most importantly, responses were only received from a minority of regulators within Europe. However, it is not possible to calculate a precise response rate, because of uncertainty about the role that different bodies undertake. In addition, the information obtained is based on self-reported, and it was not possible to validate it.

Brexit implications

While the existing system is far from perfect, there are at least mechanisms in place that can be built upon and improved. However, these mechanisms form part of the European Single Market and are subject to rulings of the European Court of Justice. Unfortunately, this conflicts with the stated positions of the main political parties at Westminster. If, contrary to widespread expectations, the forthcoming negotiations on Brexit do not collapse rapidly as a result of the UK's lack of understanding and preparedness, it may be possible to salvage something, albeit with the parties reversing their previous positions. If they do not, the UK will fall out of a system that, while imperfect, is beginning to work effectively.

Figure 3 - Do you send an alert before or after a professional can appeal the decision?



EU institutional developments: EPC and alert mechanism, working time Directive, partial access, dental advertising

European Commission conference - First year of operation of the European professional card (EPC) and the alert mechanism

On 15 May, the European Commission hosted a conference in Brussels to look at the first year of operation of the European professional card and the alert mechanism. Representatives from professional bodies and competent authorities from across the EU attended to share their experiences of the two new tools.

Over 2,500 applications for an EPC have been submitted between 18 January 2016 and the end of March 2017, however less than half of all applications result in an EPC being issued.

Profession	Applications submitted
Physiotherapists	999
Nurses	706
Mountain guides	517
Pharmacists	289
Real estate agents	87
Total	**2,598**

Profession	EPCs issued
Physiotherapists	337
Mountain guides	321
Nurses	209
Pharmacists	110
Real estate agents	38
Total	**1,015**

The EC stated that a formal assessment of the EPC will take place later this year which will focus on the lessons learnt from the first year of operation and on the results of the recent stakeholder survey. Only after this has taken place will any recommendation to extend the EPC to other professions emerge.

Over 13,000 alerts have been sent between 18 January 2016 and the end of March 2017.

Alert module	Number of alerts sent
Nurses	7,439
Other health professions	2,965
Doctors	2,894
Education of minors	225
Vets	62
Falsified documents	2
Total	**13,587**

The EC received 181 responses to the recent stakeholder consultation. Nine of the responses came from the UK with the highest number of responses from Romania (61), Poland (29), Ireland and Denmark (12). The responses to the stakeholder consultation highlighted the need to share information on the sanctions imposed by national authorities. The high number of alerts sent by UK authorities was also raised.

The EC confirmed that it was making ongoing improvements to the functionality of the IMI system which will continue over the summer.

Has the alert mechanism made a positive impact in your profession or your competent authority?

We'd like to hear from you about instances where the alert mechanism has improved patient safety in your jurisdiction. Perhaps you have been alerted to a professional practising in our country who was erased in another EU country? Or perhaps it has helped you to identify a professional using a falsified document?

Please let us know of any practical examples (of course omitting personal data) as we're keen to include some real life stories in the next HPCB update.

European working time Directive – interpretative communication

The European Commission has published an interpretative communication on the implementation of the European working time directive.

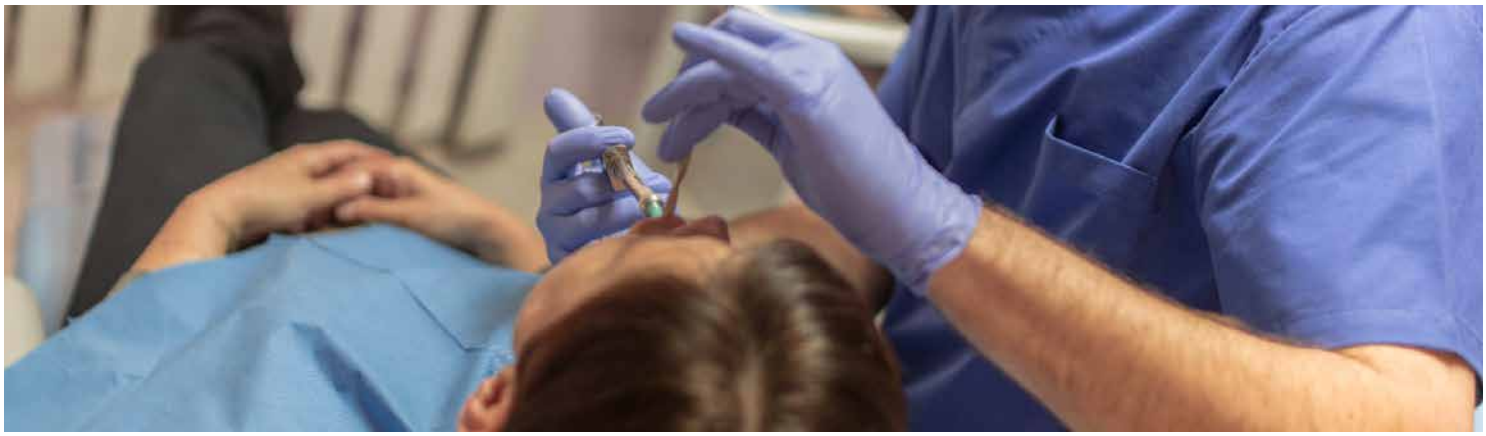
The communication provides guidance on how to interpret various aspects of this directive following recent case law. The aim is to help member states implement the law correctly and avoid further infringements. It contains no proposals for future amendment/legislation.

Find out more here.

The EC has also published a report on the implementation of the directive across member states. The report concludes that the Directive has for the most part been transposed in both the public and private sectors. However, in some member states, categories of workers are excluded from the scope of the legislation. Compliance among member states with the requirement to treat on-call time as working time is improving, but there are still some issues.

Find out more here.

Partial access to the profession of dentist



***Cédric Grolleau**, FEDCAR/European federation of dental regulators*

Can it be envisaged that a clinical dental technologist should be allowed to have partial access to the profession of dentist?

In a pending case before the European Court of Justice (C-125/16), the European Commission has answered 'yes'. The Advocate General has not been convinced by its arguments.

The litigation refers to a situation where a clinical dental technologist has not been authorised to practice in Malta as his profession does not exist in this host country. Among many other claims, one wonders whether he can be granted a partial access to dentistry in order to practice some acts of his profession.

Partial access is a creation from case-law which introduced last year in the revised Directive on the recognition of professional qualifications; since then it has been heavily discussed whether this partial access applies to health professions benefiting from an automatic regime of recognition in the Directive. Such is not the reading of the Advocate General. His opinion published on 1 June states that: "My reading of that article [on partial access] is therefore that, so far as dental practitioners are concerned, there can only be full access to the activities by virtue of (i) the harmonisation of the conditions of training organised by Directive 2005/36 and (ii) the automatic recognition that follows and from which dental practitioners benefit under that directive." (para.17)

Three reasons are given as justification (para.18):

1. Directive 2005/36 "gives the impression that the professional activities of dental practitioners are reserved" and "are envisaged as a whole".
2. The pursuit of the activities of a dental practitioner requires the possession of specific qualifications cautiously referred in Directive's Annex.
3. Authorising partial access to dentistry "would lead to the creation of a new 'imperfect' category of only partial dental practitioners" which is not allowed in the Directive and in case-law (Vogel case C-35/02).

Provided Directive 2005/36 applies to the unregulated profession of clinical dental technologists, which is unsure, the European judges should deliver their decision by the end of the year and could at last clarify the scope of application of partial access.

Mapping the obstacles to free movement of health data

A newly published report, commissioned by the Estonian government and funded by the EU, looks at issues surrounding free movement of health data across the EU.

Entitled '*Mapping out the obstacles of free movement of electronic health records in the EU in the light of single digital market*', the report explores the challenges and opportunities facing the free movement of health data. It looks in detail at public opinion, and the possibility for patients to access their own health data in Finland, Sweden, Germany, Poland, the UK and across the borders of member states. Where potential obstacles were identified by the report, proposals are made to overcome them. The report concludes that the main barriers for free movement of health data are not information technology or legislation, but rather aspects such as public attitudes, awareness and cooperation.

Supporting the principles of the digital single market, free movement of personal data, and digital innovation to support healthcare is one of the priorities of the current Estonian EU Presidency who hope to reach agreement on a set of broad policy guidelines for eHealth policy and planning for the coming years, in order to accelerate and expand the use of health data across borders.

European medical organisations call to safeguard health in Brexit negotiations

European Council of Medical Orders (CEOM), Standing Committee of European Doctors (CPME), European Junior Doctors Permanent Working Group (EJD), European Federation of Salaried Doctors (FEMS), European Union of General Practitioners (UEMO), European Union of Medical Specialists (UEMS)

With the launch of the 'Brexit' talks this summer, European medical organisations have continued their joint action on safeguarding health in the negotiations. In June 2017, the European Council of Medical Orders (CEOM), the Standing Committee of European Doctors (CPME), the European Junior Doctors Permanent Working Group (EJD), the European Federation of Salaried Doctors (FEMS), the European Union of General Practitioners (UEMO) and the European Union of Medical Specialists (UEMS), in close cooperation with the British Medical Association (BMA) sent a letter to Mr Michel Barnier, former European Commissioner and current chief negotiator for the European Commission for the UK's withdrawal agreement.

The letter builds on previous exchanges and elaborates on the key issues at the heart of the medical professions' appeal: the need to ensure continued free movement of medical professionals, the recognition of professional qualifications for doctors, cooperation and exchange on medical research, and coordination of public health for example on communicable disease and antimicrobial resistance. The letter develops the discussion on professional migration by highlighting the knowledge transfer thus achieved and addresses the special need to find a mode of cooperation for the island of Ireland which safeguards cross-border collaboration on healthcare, including on patient mobility.

In the past weeks, the European Commission has published details on its negotiating guidelines for the Brexit talks on the rights of those EU citizens in the UK and UK citizens in the EU which live in the respective member state at the time of the entry into force of the withdrawal agreement. It is indicated i.a. that for free movement and residency rights, as well as the recognition of professional qualifications the EU is suggesting to maintain the status quo. European medical organisations welcome the Commission's commitment to attain legal certainty for doctors and will continue to provide input to the process.

Confirmation of the legality of national prohibitions of dental advertising

***Cédric Grolleau**, FEDCAR/European federation of dental regulators*

Four lessons can be drawn from a recent European Court of Justice decision rendered on 4 May regarding the Belgian prohibition of professional advertising that is imposed on dentists.

Firstly, a general and absolute prohibition of any advertising relating to the provision of oral and dental care services is not compatible with the single market's requirements. The communication of professional details (name, qualifications, address, website and telephone number) should at least be possible.

Secondly, a relative prohibition of any advertising relating to the provision of oral and dental care services is compatible with the single market's requirements. Such a prohibition is acceptable given the pursued objective of public health, given the temperance ('proportionality' in euro-jargon) of the prohibition and given the acknowledged need by the EU legislator of professional standards to regulate commercial practices and to regulate commercial on-line communications.

Thirdly, the 'relationship of trust with the patient' and the 'dignity of the profession' are two important objectives of oral public health that are validated by the European judge.

The decision is crystal-clear: "The extensive use of advertising or the selection of aggressive promotional messages, even such as to mislead patients as to the care being offered, by damaging the image of the profession of dentist, by distorting the relationship between dentists and their patients, and by promoting the provision of inappropriate and unnecessary care, may undermine the protection of health and compromise the dignity of the profession of dentist". Because of these objectives, a restriction can be brought to professional advertising as it is currently the case in most European countries.

Fourthly and finally, establishing certain requirements of discretion with regard to signs of dental practices is not prohibited by EU law.

The prohibition of flashy signs and the requirements, made by deontological codes of conduct or by domestic law, of discretion with regard to signs of dental practices is allowed under EU law. The Court has confirmed that, clearly, a public health professional is not a commercial service provider like any other.

Anneleen Van Bossuyt MEP elected chair of the internal market committee

Following the election of Vicky Ford MEP to the UK national parliament, Belgian MEP Anneleen Van Bossuyt has been voted as the new Chair of the IMCO Committee. An MEP since January 2015, she represents the Belgian Nieuw-Vlaamse Alliantie which is part of the European Conservatives and Reformists group.

Recognition of cardiac surgery qualifications in member states

The EC has been questioned about the recognition of cardiac surgery qualifications across the EU. Member states have different kinds of cardiac surgery specialisations. Poland and Italy, for example, have two specialist areas – cardiac surgery and chest surgery (thoracic surgery), while other countries (e.g. the UK and Luxembourg) have just one specialism that incorporates both practices. The Polish translation in Annex V of the RPQ Directive fails to take those differences into account, which is hampering uniform recognition of cardiac surgeons' qualifications in the member states.

In the translation of the directive, the heart-surgery specialism is not given as an equivalent of the English term 'cardio-thoracic surgery'. As a result, Polish thoracic surgeons are treated abroad as being qualified in both cardiac surgery and thoracic surgery (which is not the case), while Polish heart surgeons' qualifications are not recognised at all. Countries which have similar specialism systems to that of Poland (e.g. Italy), but which took the above differences into account do not have the same problems.

In response the EC stated that as the directive does provides definition for the specialisations at EU level, nor regulates which activities can be performed within a particular specialisation, there are indeed some differences amongst the national 'thoracic surgery' specialisations listed in the Annex of the directive.

The EC is working with member states on the inclusion of cardiac surgery into the relevant Annex of the directive. At least twelve member states must notify the EC of their relevant national specialist programmes in cardiac surgery for it to be added. Up to date the EC has only received four national notifications.

Find out more here.

Upfront payment for cross-border healthcare

Irish MEP Mairead McGuinness has asked whether the EC is aware of the problems faced by patients seeking to exercise their rights to cross-border healthcare. The fact that member states require patients to pay for cross-border treatment upfront, then be reimbursed by the member state, means that only the wealthiest can utilise the patients' rights directive, and the poorest are placed at a disadvantage by not being able to access their rights. In response the EC stated that it is aware of the difficulties faced by patients accessing cross-border healthcare in another member state due to required upfront payment to the healthcare provider. It confirmed that the directive foresees that member states may choose to apply the mechanism of financial compensation as provided for by the Regulation on the coordination of social security systems which allows for direct reimbursement in case of, for example, authorised planned treatment abroad.

Find out more here.

Use of conscience clauses in EU law

Polish MEP Agnieszka Kozłowska-Rajewicz has questioned the EC on whether it monitors or regulates those member states that allow doctors and/or other healthcare providers to invoke so-called conscience clauses that permit them not to provide certain medical services for reasons of religion or conscience. In response, the EC confirmed that the use of conscience clauses is an issue regulated at national level and as such, the EC has not assessed and does not plan to carry out any action on the issue.

See more here.

Use of personal health data

Maltese MEP Roberta Metsola has questioned the European Commission on the use of digital technology in healthcare systems, in particular how data will be collected and used, especially in the management of chronic conditions like diabetes. In response, the EC stated that it aims to facilitate the cross-border exchange of health data between member states through the eHealth Digital Service Infrastructure (eHDSI) that is currently being developed by a group of member states. This will support the exchange of patient summaries and ePrescriptions thereby guaranteeing the continuity of healthcare for patients travelling or living outside their member state of origin.

The EC confirmed that health-related data constitute a special category of personal data and that it is generally prohibited to process such data, other than under one of the specified conditions as set out in the data protection rules and in line with all the data protection principles i.e. purpose limitation, data minimisation, storage limitation.

You can see the full question and answer here.

Petition on the non-recognition of a UK qualification

A petition has been submitted by a physiotherapist who obtained a UK qualification via a college in Greece which operates a franchise system with the University of Wales in the UK. The petitioner has been unable to have his qualification recognised by the Greek authorities. The European Commission confirmed that they had received a number of such complaints against the Greek authorities and that the Greek authorities have subsequently committed to process the applications.

See the petition here.

Regulation of osteopathy across Europe

Italian MEP Rosa D'Amato has questioned the EC on whether it has plans to regulate osteopathy across the EU. At the moment, the profession of osteopath has no legal status or single, harmonised training framework across Europe. In response, the EC stated that the directive on the recognition of professional qualifications does not oblige member states to regulate professions, but solely provides that in cases where a profession is regulated in a host member state, this state recognises education, training and work experience from other member states. As there is no harmonisation on the profession of osteopathy in Europe, member states are free to determine which activities they reserve for this profession.

Find out more here.

European medical regulators discuss proportionality directive

The European Network of Medical Competent Authorities (ENMCA) met in early May in Tallinn, Estonia to discuss a range of European issue affecting competent authorities. Hosted by the Estonia Health Board, the meeting was also attended by officials from DG GROW and DG SANTE who presented on the draft proportionality directive which is currently being debated in the European Parliament, as well as the issue of cross-border eHealth and ePrescribing. The next meeting will take place on 20 November and will be hosted in the Netherlands by the Ministry of Health, Welfare and Sport.

European Specialist Nurses Organisations summit *Francoise Charnay-Sonnek, President*

Brussels, 30 November - 1 December 2017

We are pleased to announce that ESNO Summit will take place in Brussels on 30 November - 1 December 2017.

We can observe a changing health care environment. Healthcare demand is rising and medical specialists alone cannot respond to it - the population is getting older, health is more complex with comorbidities to take into account. The development of higher medical technologies and more sophisticated treatments require nurse specialists in advanced practice roles at master and post master level.

We move more and more from a hospital care setting to a home, community, outpatient care setting with the development of ambulatory surgery, oral therapy, the hospital care setting dedicated to acute care and home/ community care to the follow up, long term care. This necessitates a review of our organisations where nurse specialists have a crucial role to play.

Our second summit will address this topic and will explore with you how specialist nurses can respond to this very challenging issue. This event is unique in Europe, gathering all European nurse specialists under the same roof. A place to exchange and get to know each other and you can be sure that you will go home with a luggage full of new perspectives, knowledge, networking.

With our members, I will be very happy to welcome you on 30 November in Brussels; make it happen and come!

Find out more.

Could you host a HPCB conference?

HPCB
Healthcare Professionals Crossing Borders

The HPCB network is run by volunteers who contribute to the newsletter and who use their experience in EU matters to input into policy recommendations. HPCB conferences are useful occasions to bring together healthcare competent authorities to share experiences and to learn from best practise examples from across the professions and across Europe.

However they can only take place if competent authorities volunteer to host them. The last HPCB conference took place in London in October 2016 and we are keen to hold another conference in 2018.

If your competent authority is interested in hosting a 2018 HPCB conference, please contact the HPCB secretariat for an informal chat.

General Pharmaceutical Council launches new standards for pharmacy professionals

The General Pharmaceutical Council (UK) has introduced new standards for pharmacy professionals, which all pharmacists and pharmacy technicians in Great Britain must meet. The standards describe how safe and effective care is delivered through person-centred professionalism, and replace the standards of conduct, ethics and performance.

The new standards have been reduced from 57 to nine, with examples under each one to illustrate how they might apply in practice. In this way, the standards rely less on detailed guidance and more on the knowledge, skills and judgement of pharmacy professionals.

The standards reflect the feedback heard from more than 2,700 pharmacy professionals and organisations, members of the public and other stakeholder about what is important in receiving safe and effective care; what it means to be a professional; and what will uphold public trust in pharmacy. They are a statement of what people expect from pharmacy professionals, and also what pharmacy professionals have told us they expect of themselves and their colleagues.

Key themes emphasised in the standards include: person-centred care; demonstrating leadership; and greater accountability on the part of pharmacy professionals.

The GPhC has developed a host of resources to support the new standards, including a new interactive app for Apple, Android and Windows devices to make it easy for pharmacy professionals to access the standards, guidance and resources on smartphones and tablets. The GPhC standards app is now available to download from app stores and the resources can also be accessed on the GPhC website.

Duncan Rudkin, Chief Executive and Registrar for the GPhC said:

"These new standards will empower pharmacy professionals in using their skills, expertise and professionalism to provide safe and effective care. As well, the standards can help people using pharmacy services understand what they can expect from pharmacy professionals.

"All pharmacy professionals should now consider how to embed the standards in their practice, and should apply the standards whenever they are making professional judgements. We hope the standards will also act as a springboard for discussions about professionalism and person-centred care across pharmacy."

Overhauling nursing education in the UK

***Anne Trotter** - Assistant Director, Education and Standards, NMC*

The Nursing and Midwifery Council (NMC) UK has announced proposals to radically overhaul pre-registration nursing standards and introduce a new education framework for the delivery of nursing and midwifery education and training in the UK.

As part of its consultation, which will run until 12 September 2017, the NMC is asking healthcare professionals, patients and the public to share their views on proposals to help shape the future of nursing education.

Over the past eighteen months the regulator has worked with nurses at all levels as well as students, educators, other healthcare professionals, patients groups to develop proposed new standards of proficiency that reflect what we the public will need from tomorrow's nurse.

Jackie Smith, Chief Executive and Registrar of the NMC, said: "The health and care landscape is changing at an unprecedented rate and nurses and midwives are being asked to undertake more complex roles than ever before. In the coming years many thousands of nurses and midwives will join our register, delivering care to millions of people. Our standards must ensure that they are able to work in ways that are not only fit for today, but also for the future."

Find out more here.

The future of nursing education and training across the EU: university pathway

***Ana Fonseca**, President of the Board of Nursing of the Ordem dos Enfermeiros (Portuguese Order of Nurses)*

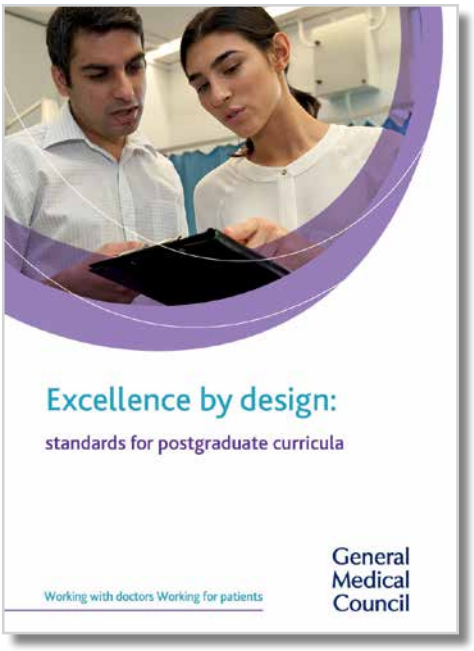
***Rui Gonçalves**, President of the Board of Nursing of the Regional Section of Centre of Ordem dos Enfermeiros (Portuguese Order of Nurses)*

The academic and technical-scientific progress of nursing in the European area is not only associated with socioeconomic development. There has been, for many decades, a global demand for nurses to access different academic degrees and professional degrees. The emergence of regulatory associations has also provided important subsidies to enhance the quality of education, training and the quality and safety of care provided to the population. In the European area nursing education and training is covered by differing frameworks, for example a university course lasting between 3 and 5 years or specialist nursing colleges with courses lasting between 3 and 4 years.

The integration of nursing education into higher education (university system) in many countries has introduced changes that have given nursing a new position in health systems. The reform of nursing education and training systems, with its harmonisation in the European area, would bring an increase in visibility and internationalisation of education and health organisations, placing them all on the same level of scientific development allowing the coexistence of degree, master and doctoral programmes in nursing at the same institution. This would be, without a doubt, one of the main instruments in the reform processes of educational networks and advanced training through participation in collaborative programs in the context of the European area.

There is no doubt that any change produces frustrations and expectations. The integration of nursing education and training in the university system would bring the recognition that entry into university would be the only alternative to ensure the success of the systems' reform and to the health organisations.

It is in this line of action that the Ordem dos Enfermeiros believes that, in the European area, the harmonisation of the length of educational programmes, the academic degree awarded and the typology of the higher education institution, where the cycle of studies takes place, can strengthen the European identity of nurses and nursing. In the same alignment, the development of a competitive knowledge society at global level and the development of the single labour market would be easily achievable.



GMC unveils new standards to boost flexibility of doctors' training

The General medical Council (GMC) UK has published new standards to make postgraduate training more flexible for doctors.

The standards, detailed in a new document called 'Excellence by design: standards for postgraduate curricula', provide a framework for the approval and provision of postgraduate medical education and training across the UK.

Medical colleges and faculties will update all 103 existing postgraduate medical curricula against the GMC's new standards, with a target to complete the process by 2020. The GMC, which oversees medical education and training in each of the four UK countries, will approve each curriculum before it's delivered to doctors.

The launch follows the publication, in March, of the GMC's flexible training review, which identified several problems with the way postgraduate training is currently developed and organised. Trainees face barriers when they want to switch specialty and training cannot adapt quickly to the changing needs of patients.

The GMC's new standards shift the focus of postgraduate training towards helping doctors achieve high-level learning outcomes. Integral to the new standards for postgraduate curricula is the new Generic professional capabilities (GPC) framework.

This covers the broader areas of professional practice, such as communication and team working, necessary for doctors to provide high quality care.

Plan to replace Medical Council India with new regulator faces further delay

The National Institution for Transforming India's (NITI Aayog) proposal for replacing the Medical Council of India (MCI) with a National Medical Commission (NMC) seems to be facing further delay after the group of ministers appointed to review the proposal have asked NITI Aayog to look at further international evidence and make "appropriate changes" to the draft proposal. The proposal calls for the establishment of a new organisation, the NMC, to regulate medial education in India.

Health practitioners accused of sexual misconduct to lose right to work with chaperone

Health professionals being investigated for sexual misconduct will no longer be allowed to continue working accompanied by a chaperone in Australia. The Australian Health Practitioner Regulation Agency (AHPRA) and Medical Board of Australia (MBA) commissioned an independent review of the use of chaperones which found there were better ways to keep patients safe whilst a practitioner was under investigation.

NCCPA publishes statistical profile of physician assistants

Fifty years after the first three physician assistants (PAs) graduated from Duke University in North Carolina, certified PAs are key providers in the US healthcare delivery system, practicing medicine and surgery in every state, specialty and clinical setting. The most comprehensive data available has just been published by the National Commission on the Certification of Physician Assistants (NCCPA) in their 2016 Statistical Profile of Certified Physician Assistants. The report provides information on current physician assistant distribution, demographics and specialty and clinical settings in the United States.

Some of the key findings from the report include:

- Over 70% of PAs work in specialties outside primary care, including in highly technical surgical specialties, emergency medicine and hospital medicine
- A shift from the early years when the profession consisting of former military medics was all male to a population of certified PAs that is now 67% female
- The states with the largest number of PAs are New York, California, Texas, Pennsylvania and Florida. However, three of the top five states with the largest number of PAs per capita are Alaska, South Dakota, and Montana, indicating that Certified PAs often fill the void for healthcare in rural areas
- Certified PAs earn an average salary of over $104,000 with the highest paid to those in pathology, dermatology, surgical subspecialties and critical care medicine.

The National Commission on Certification of Physician Assistants (NCCPA) is the only certifying organisation for physician assistants (PAs) in the United States. The PA-C credential is awarded by NCCPA to PAs who fulfil certification, certification maintenance and recertification requirements. There are more than 115,500 certified PAs in the US today.

You can read the report here.

MCI directs doctors to use generic names in prescriptions or face punishment

The Medical Council of India (MCI) has issued a public notice to all doctors ordering them to prescribe drugs only by generic names. The MCI stated that the state medical boards will take disciplinary action against any doctor that fails to comply with the ruling, potentially resulting in a suspension from the medical register. The Prime Minister has stated that the government is contemplating introducing a law making it compulsory for doctors to prescribe drugs by generic names against the existing practice of writing brand names in prescriptions.

AHPRA appoints review of speciality medical college IMG assessments

The Australian Health Practitioner Regulation Agency (AHPRA) has appointed Deloitte Access Economics to review specialist medical colleges' performance in relation to assessments of international medical graduates (IMGs).

Specialist colleges have previously been appointed to assess the training, assessment, experience, recent practice and continuing professional development completed by a specialist IMG to determine whether they can practise at a level comparable to the standard expected of an Australian trained specialist starting in the same field of practice. This is commonly known as the 'specialist pathway'.

The review will examine each college's current performance against benchmarks for the specialist pathway set by the Medical Board of Australia (MBA). It will review the extent to which college processes align with the MBA's Good Practice Guidelines for the specialist international medical graduate assessment process. These guidelines define good practice in the assessment of specialist IMGs, including in relation to:

- How colleges assess comparability
- College committee structures
- Interview and assessment procedures and processes
- Fees, and appeals processes

The review will also consider whether elements of the current specialist IMG assessment process can be improved, evaluate current performance benchmarks and recommend methods for future monitoring of colleges' performance. It is expected that a final report will be ready in early 2018.

IAMRA launches data sharing pilot

IAMRA
INTERNATIONAL ASSOCIATION OF MEDICAL REGULATORY AUTHORITIES

The International Association of Medical Regulatory Authorities (IAMRA) has this month launched the pilot testing of a system that will allow for the proactive sharing of licensing and disciplinary information among IAMRA's members (of which there are over 100 from 47 different jurisdictions).

IAMRA has received requests over the years from members wishing to disseminate information about individuals attempting to register with fraudulent documents or who have been disciplined in one jurisdiction and are thought likely to seek registration in another. In response to these requests, IAMRA, through the Physician Information Exchange (PIE) Working Group, has been working hard to develop a mechanism that allows such data sharing to occur.

The first phase of pilot testing the new alert system is now underway with participation from the Australian Healthcare Practitioner Regulation Agency (AHPRA), the Federation of State Medical Boards (FSMB), and the General Medical Council in the UK (GMC). Once the initial phase of testing is completed, the pilot will be expanded to include a wider group of organisations. It is hoped that the system will be available for use by all IAMRA members by 2018.

US medical regulators adopt new policy on team based regulation

The Federation of State Medical Boards (FSMB) has produced a resource outlining emerging best practice for state medical boards seeking to increase cooperation and collaboration among health professional regulatory boards.

In April 2015, the FSMB convened a workgroup on team-based regulation to identify and recommend best practice models and strategies for achieving greater cooperation and collaboration among health professional boards in carrying out their shared responsibility to protect the public.

The new policy, adopted by the FSMB in April 2017, recommends that:

- State medical boards should be authorised and encouraged, within their jurisdictions and where appropriate, to:
  - conduct joint investigations with other health professional licensing boards
  - share investigatory data with other health professional licensing boards
  - create or develop processes to facilitate communication and collaboration among professional licensing boards and their representatives
- State medical boards should work with other health professional licensing boards to streamline their complaints processes so it is easier for those patients who have been harmed or subjected to professional misconduct in a team-based setting to file a complaint.

Upcoming events

21–25 August
Association of Medical Councils of Africa Scientific Conference, Cape Town, South Africa

26–30 August
Association for Medical Education in Europe 2017
Helsinki, Finland

04–06 October
20th European Health Forum Gastein (EHFG)
Bad Hofgastein, Austria

05–06 October
IAMRA Continued Competency Symposium
London, UK

16-17 November
5th CLEAR International Congress
Melbourne, Australia

20 November
18th ENMCA meeting
The Hague, Netherlands

December (tbc)
CEOM meeting

Newsletters

Health and Care Professions Council (UK)

Nursing and Midwifery Council (UK)

European Federation of Nurses

European Federation of Dental Regulators eNews

General Dental Council (UK)

General Chiropractic Council

European Commission DG GROW

Eurohealth

IAMRA newsletter

European Parliament internal market committee newsletter

Association for Dental Education in Europe

Professional Standards Authority (UK) newsletter

General Pharmaceutical Council (UK)

European Social Network

Association for Dental Education in Europe (ADEE)

EC Health newsletter

French Order of Doctors

General Medical Council (UK)

CORU (Ireland)

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