Doctors and the EEC

ROGER BREARLEY

From 19 December 1976 member States of the EEC must recognise each other's medical qualifications—both basic and specialist. So the Commission in Brussels and European medical organisations have been trying to resolve the many potential problems arising from this decision. Mr Roger Brearley has been a representative on the European Union of Medical Specialists for 4 years and is vice-president of its Council of Direction. He is also the BMA's alternate member on the Advisory Committee on Medical Training and serves on the Standing Committee of Doctors of the EEC and the BMA's Committee on the EEC. This paper is an edited version of a report by Mr Brearley which formed an appendix to the report of the Central Committee for Hospital Medical Services to the 1976 National Conference of Hospital Medical Staffs.

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Treaty of Rome, 1958

The principle of free migration stems from the Treaty of Rome. The Treaty aimed to combine the member States into a single trading community by abolishing the economic effects of

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national frontiers. In this way it would benefit populations by helping economic growth and by replacing political rivalries with new economic co-operation and interdependence. Though the Treaty is preoccupied with economics, the Community has also concentrated on developing its social and political facets. The Treaty required the establishment of complete freedom of movement of goods, persons, services, and capital. Employed and self-

employed persons had to be free within 12 years, that is, by 1970, to establish themselves or to take employment in any member State, and to take up residence in order to do so. These rights do not cover employment in the public service or self-employed activities connected with the exercise of official authority. A profession which cannot be legally pursued without a recognised qualification requires special arrangements and these are the subject of Article 57, which requires the Council of Ministers to issue Directives for the mutual recognition of "diplomas, certificates and other evidence of formal qualifications" and for the "co-ordination of the provisions laid down by law, regulation or administrative action in member States concerning the taking up and pursuit of activities as self-employed persons." Article 57.3 also says that "In the case of the medical and allied, and pharmaceutical professions, the progressive abolition of restrictions shall be dependent upon co-ordination of the conditions for their exercise in the various member States."

Is a doctor in an NHS hospital or a general practitioner issuing a prescription a self-employed person exercising official authority? We believe not, but the French are loth to open posts in their public hospitals to foreign doctors and a special Council Statement accompanying the Directives requires member States to take special measures to overcome this problem. Does Article 57.3 mean that the free migration of doctors must be postponed until all member countries have broadly the same system for providing health care? The Belgians fear that if it does not, their country may be flooded with immigrant doctors. It was largely because of this danger that the Council

decided to set up a special Committee of Senior Officials on Public Health.

The final area of uncertainty in this section of the Treaty is where it deals with Provision of Services (*Prestation de Services*). Though medicine is not mentioned except generically as "activities of the professions," the chapter is concerned with the position of individuals established in one country and rendering a service in another. There are further details of the medical aspects in the first Directive.

Mutual recognition of qualifications

The scope of mutual recognition of basic qualifications is defined at the beginning of the First Directive (Article 2): "Each member State shall recognise the diplomas, certificates and other evidence of formal qualifications awarded to nationals of member States by the other member States . . . by giving such qualifications, as far as the right to take up and pursue the self-employed activities of a doctor is concerned, the same effect in its territory as those which the member State itself awards."

This right is also extended explicitly to salaried doctors. Article 3 lists the various national basic qualifications. The entry for the UK reads "a primary qualification granted in the United Kingdom after passing a qualifying examination held by a competent examining body and a certificate of experience granted by that body which give entitlement to registration as a fully registered medical practitioner." Member States—that is, governments—must tell each other and the EEC Commission who the competent authorities are before 19 December 1976, the final date of implementation of the Directives.

In future, mutual recognition will apply only to qualifications based on certain minimum academic standards defined in Article 1 of the Second Directive. Established doctors whose training did not fulfil these requirements will be covered by special transitory arrangements.

WHO IS COVERED?

A doctor who is entitled to practise in one EEC country is not automatically entitled to practise in all the others. To do so he must be a national of a member State and he must hold a basic qualification awarded by a member State. The first requirement arises naturally out of the Treaty of Rome, which the Directives merely implement, since the Treaty was originally conceived as a means to give new rights and benefits to the nationals of member States. To the second requirement there is an exception in favour of Luxembourg, which has no university. The practice of medicine in Europe at the time the Directives were being drafted was otherwise limited by law in each country to nationals holding the national qualifications. So no provision was made for circumstances such as exist in the United Kingdom where many immigrant doctors, though naturalised citizens, hold basic qualifications obtained in other

countries and where neither UK nationality nor a UK qualification have ever been necessary requirements for entry to the *Register*.

Moreover, the Community can ensure that in future the qualifications of the member States conform to its own minimum standards, but there is no means of ensuring this for third countries. Of course, each country is free to accept any qualification it chooses, but qualifications which it is to be *obliged* to accept are limited to those of the other member States. There is, however, nothing to prevent the recognition of other particular qualifications by special reciprocal agreements between governments, and the Directives do not deprive any doctor of any rights held at present.

Specialised medicine

Member States are also required to "recognise the diplomas, certificates and other evidence of formal qualifications in specialised medicine awarded to nationals of member States by the other member States . . . by giving such qualifications the same effect in its territory as those which the member State itself awards." For the UK the qualification and competent body are defined as "certificate of completion of specialist training issued by the competent authority for the purpose." As with the basic qualification, the Government must define the competent authority for the UK and notify this to the Commission and the other governments before the date of implementation of the Directives. The individual specialties recognised in all member States are listed, as are those (36) recognised in two or more member States.

Also, as with basic qualifications, future mutual recognition will depend on the qualifications fulfilling minimal standards defined in Articles 2, 3, and 4 of the Second Directive, but established specialists whose training fell short of these are covered by transitory arrangements.

At present, in the UK the words "giving such qualifications . . . the same effect in its territory as those which the member State itself awards?" have no meaning. In the rest of the EEC they mean allowing the migrant to use the appropriate protected title, and in the UK there are none. Except possibly for accreditation in higher medical and surgical training—still in its infancy—we have nothing answering to the definition of specialist qualification. Such certificates will confer no legal or other rights, though their lack may in future entail disadvantages. In fact, our specialist practice is regulated by three features. Firstly, patients reach the specialist by reference from a general practitioner. Secondly, specialist practice is based on a hospital appointment (which is the principal way in which specialists are identified by the GP). Thirdly, hospital appointments are made by selection with detailed examination of all previous training.

In the original EEC countries patients normally consult specialists directly without reference by a GP (Holland is an exception). Many specialists (most in some specialties) have no hospital appointment, and in offering their services to the public they need a title, limited to those who are properly qualified, indicating their field of practice and the fact that they are duly qualified specialists. These titles are protected by law just as the title registered medical practitioner is in the UK. In the social security systems of medical practice specialist titles have a further meaning, since specialists are paid at a higher rate for a service within their own field than a non specialist would be.

SPECIALTIES COMMON TO TWO BUT NOT ALL COUNTRIES

A doctor qualified in a particular specialty—for example, plastic surgery—moving to a country where that specialty is not recognised, say, Germany, cannot claim to be recognised as a specialist in something which the host country does not recognise. The UK will not have to grant undefined privileges to practitioners of strange and hitherto unknown specialties.

A specialty which is independent in some countries—for example, microbiology or chemical pathology—may be practised in others as part of a broader specialty (as part of clinical biology in France, Belgium, and Italy). A Belgian clinical biologist wishing to practise as a chemical pathologist in Luxembourg or Holland would have to obtain a diploma in chemical pathology acceptable in the host country. But in indicating the necessary training time, the competent authority would have to make allowance for the duration of the studies already completed in chemical pathology. The same would apply in reverse.

Decisions affecting medicine

Council Directives

The First Directive is on mutual recognition of qualifications and the Second is on the co-ordination of legal or similar provisions concerning the activities of doctors; in fact dealing with the definition of acceptable standards of training for basic and specialist qualifications.

Council Decisions

There are two Decisions, one setting up an Advisory Committee on Medical Training and the other a Committee of Senior Officials on Public Health.

Council Recommendations

One Recommendation concerns Luxembourg doctors holding third country qualifications and the other concerns the clinical training of doctors which favours the possibility of doctors doing their preregistration, post-degree training in another country, if such training is required.

All these documents were signed on 16 June 1975, published in the Official Journal of the European Communities (30 June 1975), and must be implemented not later than 19 December 1976.

The principle has particular relevance to specialties which are combined in some countries and separate in others—such as neurology, psychiatry, and neuropsychiatry—and also in the case of dermatology and venereology, recognised as separate specialties in the UK and Ireland (each with a minimum of four years' training), and dermatovenereology, recognised as a single specialty in the other seven countries (with a minimum training of only three years).

Minimum training times

The articles on minimum training times have caused confusion and misunderstanding, though the wording is clear enough. "Member States . . . shall ensure that the minimum length of the specialised training courses mentioned below may not be less than the following . . ." The specialties are arranged in three groups with minima of five, four, and three years' training. What member States have to do is to recognise one another's existing specialist diplomas. The fact that training may not fall below the minimal times does not mean that the minimal times are everywhere the norm, and still less that anyone who has been training in a specialty in an EEC country for the minimum time can claim the right to be certified as a specialist. Nevertheless, the times to gain a specialist qualification are generally shorter than the times required in Britain to become eligible for appointment to a consultant post in a hospital.

Continental specialists aspiring to a senior hospital post would also expect to undergo many more years of training. Nevertheless, they would not then expect a further certificate comparable to our higher training certificate. So far our specialists have not needed a certificate comparable to the continental specialist diplomas. If they are to migrate within the EEC on terms of equality with their European colleagues, however, they will need one in the future, and a piece of paper stating that they have undergone training for a period equal to the minima laid down in the Directive scarcely fits the requirements ("Certificate of completion of specialist training.") There is another difficulty: Continental doctors normally start their specialist training immediately without general professional training or rotation through other specialties. A trainee in some countries could, for example, spend five years studying and practising urology in the first five years after qualification; a British trainee could not. There is scope here for future harmonisation of training programmes.

Some misconceptions

The following beliefs are prevalent in the UK and all are false.

(1) We are required to introduce specialist qualifications within the UK. This is nowhere laid down.

(2) We are required to keep a register of specialist qualifications. This is not so, and many of the other EEC countries have no national register of specialists. They merely require that *before using the protected title*, a specialist must present his certificate of specialist training for inspection to the authority (often a regional or provincial authority) which governs medical practice in his area.

(3) We shall have to treat European certificates of specialist training as equal to our own. This is true only in their legal effect and, as our own do not and are not likely to have any legal effect, this has no implications. Of course, we are already familiar with many qualifications—foreign and domestic, higher and lower—which are evaluated along with other evidence in choosing candidates for specialist posts. European specialist qualifications would be considered in the same way.

For a doctor seeking to establish himself in independent private specialist practice (not a frequent event) no specialist qualifications are legally required in the UK. The academic standards of European or other specialist qualifications are again irrelevant. It is important to remember that the Directives are not concerned with questions of the scientific equivalence of different qualifications but with the co-ordination of their legal effect.

(4) We must not lower our standards. This is not an error: it is a correct view but it is often erroneously applied. Nothing in the Directives affects how we maintain standards at home and the sense in which European certificates are to be recognised does not influence the question. Nor would the award to UK specialists wishing to practise in Europe of certificates answering to the description "Certificate of completion of specialist training..." and fulfilling the criteria laid down in the Second Directive. There would seem to be no difficulty in distinguishing between "specialist training," fitting a doctor for independent single-handed specialist practice outside hospital, and "higher specialist training," leading to a position of authority in charge of a specialist team in a hospital.

Discipline

Medical migration poses new disciplinary problems, which are dealt with in Articles 11 to 15 and the Council Statement about

Quality criteria and training times

Although the minimal training times have attracted much notice, Article 2 of the Second Directive lays down five other important requirements for post-graduate training:

—it shall entail the successful completion of six years' study within the framework of the training course referred to in Article 1;

—it shall comprise theoretical and practical instruction;

—it shall be a full-time course supervised by the competent authorities or bodies;

—it shall be in a university centre, in a teaching hospital or, where appropriate, in a health establishment approved for this purpose by the competent authorities or bodies;

—it shall involve the personal participation of the doctor training to be a specialist in the activity and in the responsibilities of the establishments concerned.

Part-time training may continue as at present where it is necessary for good reasons and has the approval of the national competent authority but the total duration may not be shortened thereby or the standard lowered. The Council of Ministers must review the position after four years.

Article 12. Generally the country of origin is responsible for the discipline of the migrant. Host States knowing of any offences report these to the State of origin for action but host States can take disciplinary action within their own country in connection with offences committed there. There are also provisions for the exchange of certificates of good character or health.

Adaptation and linguistic competence

Governments must see that migrants are told of the health system and laws and the ethical rules in the host State. They *may* set up information centres for this purpose. They must also "see to it" that migrants acquire the necessary linguistic knowledge. No one knows precisely what this means, least of all the official lawyers. Nevertheless, the general interpretation is that it is a measure to help the migrant to establish himself, but it could not mean that the right to practise might depend on passing a language test.

Checking qualifications

Machinery is provided for checking credentials to ensure that they are genuine and also that they testify to courses of study which have fulfilled the criteria of the Second Directive.

Quality criteria and the Advisory Committee on Medical Training

Early drafts of the Directives contained no indications of the minimum requirements of basic medical education beyond its duration (six years, or 5500 hours). Nevertheless, the final text gives a fair outline of the scope of a medical course. It is couched in general and partly subjective terms, however, which could not possibly be enforced or even uniformly interpreted. The missing link is provided by an entirely new measure, the creation by a Council of Ministers decision of an Advisory Committee on Medical Training. The committee's task is "to help to ensure a comparably demanding standard of medical training in the Community, with regard to both basic training and further training." It will do this by exchanging information about medical education; discussion and consultation to develop common approaches to training standards; and continuous review of new developments in medical science and teaching. The committee will pass its conclusions to the Commission and member States; advise on questions referred to it by the Commission; and suggest amendments to the Directives.

CONSTITUTION

The committee's constitution is as follows: three experts from each member State—one from the practising profession, one from the teaching bodies, and one from the competent authorities, each with an alternate. The UK members for the first group have been nominated by the BMA (Dr J C Cameron; alternate Mr R Brearley) for the second by the universities and royal colleges (Professor Sir Hugh Robson; alternate Professor Sir Stanley Clayton), and for the third group by the GMC and the DHSS (Professor J N Walton; alternate Sir John Brotherston). The Committee held its first meeting on 5 May (29 May, p 1354). One of its tasks could be the co-ordination of undergraduate and postgraduate education to enable migration of trainees as well as of fully qualified doctors. The lack of any provision for this is one of the most serious shortcomings of the Treaty of Rome and the Directives.

There is also the Committee of Senior Officials on Public Health which will advise the Commission on difficulties (outside education) which may arise from the implementation of the Directives. It has already met.

Organisation and medical representation

THE EEC

The four principal institutions of the Community are set out in the box on the next page.

The Council and Commission are helped by an advisory body of 144 members drawn from as wide a spectrum of society

as possible in the member States. This is the Economic and Social Committee. The Council is also helped by a Committee of Permanent Representatives (the Ambassadors to the Community), who attend to much of the routine work between ministerial meetings.

In brief, the Commission proposes Community legislation and the Council enacts it. In many matters, the Council is also required by the Treaty to consult with the Economic and Social Committee and with the Assembly. The Commission must also submit an annual report to the Assembly, which may if dissatisfied vote it out of office.

The legal instruments issued by the Council of Ministers include Directives and Decisions (which are binding) and Recommendations (which are not).

Because the Council of Ministers is composed of government representatives it speaks only to governments, and there is no official way in which the representative organisations of European doctors can enter into formal communication with it at Community level. On the other hand, there is nothing to stop each national medical association from maintaining contact with its own Minister and Health Department in the home country, and all do so. Official contact at Community level is, however, possible with the Commission, and European medical opinion has undoubtedly contributed substantially to shaping the ultimate form of the Directives.

MEDICAL REPRESENTATION IN EUROPE

There are three principal representative organisations of doctors in the EEC and those which have exerted the greatest influence on the Commission over the years. Firstly, the Standing Committee of Doctors of the EEC, which represents all doctors. Secondly, UEMS (European Union of Medical Specialists), which represents specialists.* Thirdly, the UEMO (European Union of General Practitioners), which represents general practitioners.*

The Standing Committee was founded in 1959 and comprises the member organisations of the World Medical Association in the member States of the EEC (originally six, now nine). These are the national medical associations—for the UK, the BMA. The decision-making body is the Plenary Assembly or its smaller form, the meeting of Heads of Delegations, and lately meetings of these two bodies have alternated at six-monthly intervals. The Presidency and Secretariat of the Standing Committee rotate every three years among the member organisations. At present these are held until the end of this year by the UK (Mr Walpole Lewin, President; Dr Derek Stevenson, secretary general; and Dr E Grey-Turner, deputy secretary general).

As well as the national delegations and the officers, meetings are attended by the liaison officers of BMA, UEMS, UEMO, and any other recognised organisation. In the plenary sessions, national delegations (maximum six delegates, six alternates, and six advisers) are required to be constituted so as to be representative of the medical profession of their respective countries.

Besides the Plenary Assembly, the Standing Committee has several special commissions—for example, jurists, hospital doctors, professional training, salaried doctors. Their recommendations are reported to the Plenary Assembly by their chairmen. Similarly, the recommendations of the UEMS and UEMO are reported by the liaison officers. These can then be sent to the European Commission, backed up by regular personal contact between the Standing Committees' officers and the officers of the Commission.

Specialist sections

The European Union of Medical Specialists (UEMS) was founded in 1958 and the constituent bodies are the national

medical organisations representing specialists (one organisation per country); for the UK, the BMA. The governing body is the Council of Direction, which meets twice a year and is composed of two members per country. The present UK members are Mr R Brearley, nominated by the Central Committee for Hospital Medical Services (also a vice-president), and Dr P Emerson, proposed by and representing the Joint Consultants Committee but technically also delegated by the BMA. In addition, there are 21 monospecialist sections covering the main specialties or specialty groupings. Each comprises two members per country doubly sanctioned by their national body representing all specialists and the national organisation representing the individual specialty. For the UK this means the BMA and the royal colleges, the latter actually providing the nominations.

The proposals of the monospecialist sections are reported to the meetings of the UEMS Council of Direction, which transmits them to the European Commission through the Standing Committee of Doctors. The monospecialist sections have done important work and contributed largely to the formulation of those parts of the Directives concerned with specialist training. Lately, while the Directives were in draft, some sections have not been active, but now, with the establishment of the Commission's Advisory Committee on Medical Training, there will be a renewed call for an authoritative European voice on monospecialist questions and it will again be open to the UEMS monospecialist sections to establish themselves in this role.

UK BODIES DEALING WITH EUROPEAN MEDICAL MATTERS

The main body within the BMA concerned with EEC affairs is its Committee on the EEC. This was set up in 1972, when British entry into the Community was finally negotiated. It was conceived as a joint body, the terms of reference being "To examine the implications for the medical profession of entry by the United Kingdom into the EEC and to discuss them with the DHSS, the GMC, and other authorities concerned with a view to evolving a common policy." Besides the Chief Officers of the BMA and one representative from each of the main BMA committees, including the CCHMS and the GMSC, outside

European Economic Community

There are four principal institutions of the Community:

(1) The *Assembly* (or European Parliament) at present comprises 198 delegated members of the national parliaments on a roughly proportional basis.

(2) The *Council* (of Ministers) represents governments and comprises one representative per country. The identity of the Ministers changes according to the subject under discussion (agriculture, transport, etc) but the foreign Ministers are the principal national representatives. The Health Ministers met together for the first time when the Medical Directives were agreed on 16 June 1975. Meetings of prime ministers, often referred to as summit meetings, have recently been spoken of as the European Council, a name apt to be confused with the Council of Europe, which is a non-EEC intergovernmental organisation.

(3) The *Commission* is a body of 13 commissioners, nominated by governments but sworn to impartiality and heading a large international civil service.

(4) The *Court of Justice* comprises nine judges, who interpret the Community law embodied in the Treaties and subsidiary documents and see that it is carried out.

*The correct titles are the Union Européenne des Médecine Spécialistes and the Union Européenne des Médecins Omnipraticiens.

bodies represented include the Joint Consultants Committee, Royal College of General Practitioners, and Medical Women's Federation. There are also observers from the GMC, DHSS, Scottish Home and Health Department, Royal College of Nursing, British Dental Association, Irish Medical Association, and councils for postgraduate medical education.

Initially the committee was chaired by Mr Walpole Lewin and the feeling of common endeavour and mutual trust which quickly developed, especially between the Government's representatives and those of the profession at large, and the sense of close contact with the negotiating bodies in Brussels have fully vindicated the original conception. The same good relations have continued (since 1974) under the subsequent chairmanship of Dr Alan Rowe.

In addition, there is a smaller BMA/EEC Working Group without representatives and observers from outside organisations, whose function is "To consider, in conjunction with the standing committees of the Association, the medicopolitical implications of EEC membership with a view to the formulation and correlation of BMA policy, and to report to the Council."

Lastly, to keep the main committees informed and advised on EEC affairs, small working groups have been set up by the CCHMS, General Medical Services Committee, and Hospital Junior Staffs Committee.

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TALKING POINT

Realities of private medical care*

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Private medical care is often depicted by its political opponents as available only to the rich and damaging to the NHS. This is totally out of keeping with the truth and the practical realities of private medical care are worth stating.

Aneurin Bevan once said that if everyone could afford private medical care then there would be no need for a National Health Service—and this self-apparent truth seems to have been forgotten recently by those who are keen to "finish his work." The crux of his statement rests in what "could afford" means, for it clearly means different things to different people.

Classifying disease

If we classify diseases on this basis there are three broad categories (see table). Everyone can afford to treat the conditions in category 1 and few people would wish to see the State system concerned with self-medication, for which doctors are rarely consulted. At the other end of the scale few people can afford the expensive treatment and care of the category 3 disorders.

Category of diseases

Category	Definition	Examples
1	Diseases that everyone can afford to treat themselves	Headaches, colds, simple constipation
2	Intermediate diseases	Most medical and surgical conditions
3	Diseases that no one can afford to treat themselves	Renal failure, haemophilia, long-term care for mental incapacity

Controversy rages, however, in the intermediate category, which accounts for a large volume of the work of the NHS and is an area where the NHS fails to give a uniformly satisfactory service, witnessed by waiting times and waiting lists.

If a finite amount of capital is available from Government sources then the greater the proportion of the intermediate category that is financed from individuals the more will be available for the category 3 diseases and the category 2 diseases for those unable or unwilling to provide for themselves. The

recent consultative document¹ makes it clear that there will be little Government money available in the next few years for category 2 and standards will decline unless alternative provision is sought.

Financial provision for private medical care

Statistical evidence in the private sector is difficult to obtain but most people who seek private care do so through one of the provident associations. Figure 1 sets out the cost of such provision and compares the cost with other non-essential items of life today. The insurance cover quoted is on the highest

FIG 1—Comparison of annual cost of private care provision with some non-essential items.

*This paper is based on a talk given to an IPC conference on 29 April under the auspices of the Campaign for Independence in Medicine.