COMMISSION OF THE EUROPEAN COMMUNITIES

Brussels, 09.09.1996
COM(96) 434 final

REPORT FROM THE COMMISSION

ON SPECIFIC TRAINING IN GENERAL MEDICAL PRACTICE PROVIDED FOR BY TITLE IV OF COUNCIL DIRECTIVE 93/16/EEC OF 5 APRIL 1993 TO FACILITATE THE FREE MOVEMENT OF DOCTORS AND THE MUTUAL RECOGNITION OF THEIR DIPLOMAS, CERTIFICATES AND OTHER EVIDENCE OF FORMAL QUALIFICATION

INTRODUCTION

This report relates to the application of Title IV of Council Directive 93/16/EEC of 5 April 1993 to facilitate the free movement of doctors and the mutual recognition of their diplomas, certificates and other evidence of formal qualifications[1].

This Directive (hereinafter referred to as the 'Doctors Directive') constitutes the codification of all the directives adopted between 1975 and 1993 regarding the mutual recognition of doctors qualifications and containing measures designed to facilitate the effective exercise of the right of establishment and the free provision of services as well as those designed to co-ordinate the legislative, regulatory and administrative provisions concerning the activities of doctors. At the time of the consolidation of these directives, it was judged appropriate to incorporate Council Directive 86/457/EEC, of 15 September 1986, relating to specific training in general medicine[2]. It is this Directive which now constitutes Title IV of the Doctors Directive.

Title IV of the Doctors Directive provides that the Commission is to present two reports. Article 33 reads as follows: *"On the basis of experience acquired, and in the light of developments in training in general medical practice, the Commission shall submit to the Council, by 1 January 1996 at the latest, a report on the implementation of Articles 31 and 32."*

Article 40 provides that *"On the basis of experience acquired, and in the light of developments in training in general medical practice, the Commission shall submit to the Council by 1 January 1997 at the latest a report on the implementation of this Title and, if necessary, suitable proposals with a view to appropriate training for every general medical practitioner in order to satisfy requirements of general medical practice."*

During the work conducted within the framework of the Advisory Committee on Medical Training (ACMT) with a view to the preparation of the report envisaged by Article 33, it quickly became obvious that the examination of the content of specific training in general medicine, the minimum requirements of which are contained in Article 31, must be placed in a more general context. This position is supported by the reasoning behind Directive 86/457/EEC, from which it is clear that the introduction of specific training in general medicine must be achieved progressively.

---

1 OJ n° L 165, 07.07.1993, p.1.

2 OJ n° L 267, 19.09.1986, p.26.

According to the sixth recital of that last mentioned directive, the first step required the Member States to establish, in respect of general medicine, specific training, training which at that stage was optional for doctors. The second stage was the requirement for specific training in general medicine for all doctors practising general medicine within national social security schemes. The third step is the presentation of a report to the Council on the developing situation and new proposals with a view to achieving these objectives. In describing these three steps the Commission, in its preparatory documents, (travaux préparatoires), stated, concerning the third step *"regarding the difference from the two first steps, it does not envisage legislative, or regulatory, reform, but provides for reflection before the finalisation of the objectives envisaged, to consider the putting in place of the second step in all the Member States and to determine what role to bestow, within the national medical treatment systems, on doctors with no complimentary training whether as a generalist or specialist".*

The work of the working group of the ACMT resulted in the preparation of a report and recommendations. These recommendations, which are annexed to this document, reveal the numerous aspects examined by the working group.

In the circumstances, the Commission does not consider it appropriate to alter the conclusions of the ACMT but rather to present all the questions already considered in a single report corresponding to the requirements of both Articles 33 and 40 of the Doctors Directive.

This report is above all a consultative document designed to provide input for the dialogue which the Commission wishes to initiate with the institutions, bodies and parties concerned by specific training in general medical practice.

It therefore does not contain any legislative proposal.

SECTION 1

Introduction

1.1. This report contains the Commission's submissions in accordance with Article 33 and Article 40 of the Doctors' Directive on:

(a) the implementation of Title IV and in particular Articles 31 and 32 thereof (minimum requirements for specific training for general medical practice);

(b) analyses with a view to achieving further harmonization of the training of general medical practitioners and completing the reform; and

(c) the conclusions to be drawn from experience.

1.2. The report is in five sections. Section 1 contains the introduction and background, Section 2 describes the impact of introducing specific training in general medical practice in all national training systems, Section 3 presents an analysis of possible revision of the Directive, Section 4 outlines the conclusions to be drawn from experience and summarizes the analysis, and Section 5 sets out the final conclusions.

1.3. This report incorporates in particular the recommendations of the Advisory Committee on Medical Training and the recommendations of the European Union of General Practitioners (UEMO) (see section 3).

Background

1.4. Directive 86/457/EEC (now Title IV of the Doctors Directive) provided for specific training in general medical practice and set a clear timetable for its introduction. In 1975 specific training for general medical practitioners existed in some Member States, e.g. the Netherlands and Denmark. However, it was then considered premature to introduce such training throughout the European Community. Title IV was based on the Report and Opinion of the ACMT adopted in March 1979.[3]

1.5. The 1986 provisions were introduced step by step. Member States were required to set up specific training in general medical practice such that the first qualifications on completion of training could be issued by 1 January 1990 (Article 30). It was only on 1 January 1995 that all general medical practitioners

---

[3] ACMT Doc. III/D/697/3/77.

working in the social security systems of Member States were obliged to have Article 30 qualifications (Article 36(1)). Article 40 of the Doctors' Directive envisages that specific training for every general medical practitioner could be introduced as a final step after 1997.

This long lead-in period for specific training in general medical practice was felt to be necessary at the time to prepare the European Community for what was then a new discipline. The idea was to recognize the general medical practitioner's specific role and function within the health care system of Member States. In many Member States general medicine has now become a medical speciality, like other medical specialities listed in Article 5 or Article 7 of the Doctors Directive.

It should be noted in this connection that the ACMT recommended that the Member States recognize general medicine as a specific discipline, on a par with the recognized specialist disciplines (recommendation of March 1979 already mentioned at point 1.4.). It should be remembered that the third step was to make specific training in general medical practice compulsory for all those who practice general medicine. In other words, the basic training envisaged by the Doctors Directive would lead only to a qualification granting entry to specialist training, including specific training in general medicine.

1.6. The staged process was also necessary to allow Member States to adjust their training schemes so as to make provision for the adequate placement of young doctors. In some Member States the concept of general medical practice was not as developed. It is for this reason, that it has been judged necessary to proceed by successive steps. It is considered that the adaptation, notably of an educational nature, will require considerable time.

1.7. Article 31 (3) makes the possession of a formal qualification referred to in Article 3, a condition for the issue of an Article 30 qualification. Article 31 also contains the minimum content, duration and other general criteria for the specific education and training of general medical practitioners.

1.8. In Article 32 a derogation on a temporary basis was provided for those Member States in which training for general medical practice takes place in the context of the provision of services from the surgery of the trainee general practitioner. It was quite clearly envisaged in 1986 that the introduction of the obligations in Articles 31 and 32 would require time, resources and careful preparation of the profession, recipients of health care and the authorities. It was also foreseen that Article 31 would have repercussions for Articles 23 and 24 (minimum criteria for the undergraduate medical education and training and for specialised courses). Thus Article 33 set the review date of 1 January 1996.

SECTION 2

Impact of the introduction of specific training for general medical practice to all national training systems.

2.1. In 1975 the Community scheme for the mutual recognition of medical diplomas included the co-ordination of undergraduate education and training and certain specialist education and training. Other post graduate training courses, which lead to the award of qualifications not specified in either Articles 5 or 7 are not co-ordinated. The rights of free movement of doctors with qualifications in a speciality not specified in the Directive is based on mutual acceptance as set out in Article 8.

2.2. Until 1 January 1995 a doctor who had successfully completed his undergraduate medical education and possessed a qualification set out in Article 3 had access to general medical practice in a host Member State. Member States were allowed to maintain national requirements for specific, or vocational, training in addition to undergraduate training for the purposes of general medical practice within their own territory, but were obliged to accept migrant doctors from other Member States who did not have specific training in general medical practice who wished to practise as general medical practitioners.

2.3. As from 1 January 1995 all doctors practising within the national social security schemes have to be in possession of an Article 30 qualifications in general medical practice (Article 36(1)). Member States were, of course, entitled to confer acquired rights on practitioners who were regarded as having acquired national rights in the practice of general medical practice. In addition those doctors who were already established in the national security scheme system of a host Member State as general medical practitioners by 31 December 1994 were given the acquired right by virtue of Article 36 (2), second sentence. In certain circumstances Member States may issue a qualification in general medical practice to those who possess another specialist qualification and fulfil Article 35.

2.4. The introduction of specific training for general medical practice had different effects in the various national training schemes. In some Member States general medical practice was placed on the same footing as other specialisations or was treated as a discipline in its own right. In other Member States the transition from treating general medical practice as an area of practice open to a doctor with nothing more than an Article 3 qualification, to the present situation of it having to be treated as a distinct postgraduate discipline in its own right, has not yet taken place. The requirement in Title IV for a minimum period of 2 years of specific training is regarded as a prolongation of undergraduate medical education and training.

2.5. Although an Article 3 diploma is issued at the end of undergraduate medical education and training, as from 1 January 1995 such a diploma does not entitle the holder to access to the medical profession in some Member States. In these States general medical practice is exclusively within the national social security schemes and entry conditions operate to limit the numbers of entrants to further or specialist training places. The combination of the two factors meant that doctors holding an Article 3 diploma who failed to secure training posts either in general medical practice or in other speciality training, found themselves unable to work at all, whereas previously they were able to work in general medical practice until they qualified for entry to a specialist training place.

2.6. Article 36 (1) requires that Member States ensure that every general medical practitioner in the national social security scheme is specifically trained, subject, of course to, acquired rights. The impact of this provision is that Member States must ensure that third country nationals and EU nationals alike, who hold third country qualifications, are specifically trained in accordance with national standards if they are to be authorised for practice under national security schemes.

2.7. Article 36 (5) makes it clear that the requirements in the Directive do not prevent Member States from authorising for general medical practice in accordance with their own rules within the national social security scheme, those with either medical training, or specific training, or both, obtained outside the EU.

2.8. Member States are obliged by Article 37 (2) to recognise an acquired rights certificate (Article 36 (4)) issued by other Member States. If a Member State issues an acquired rights certificate to an EU national practising within its social security scheme, a host Member State is obliged, per se, to recognise it and consider it equivalent within its own territory.

2.9. Article 34 provides for part-time training for general medical practitioners. It was found that part-time training is still relevant. Some Member States' training schemes were experiencing serious difficulty in meeting the requirement that the weekly duration of part-time training may not be less that 60 % of weekly full-time training and that a certain number of full-time training periods should be included.

The provision for part-time training in other specialities specifies that the minimum necessary to ensure the level of quality equivalent to that of full-time training is 50 %.

Member States training programmes for general medical practice often include a component of certain speciality training and certain training programmes for specialisations include periods of general medical practice training.

The different provision for general medical practice training and speciality training results in unnecessary complications.

SECTION 3

Analysis of possible revision of the Directive

3.1. Developments within national training and health care systems and between the recognition systems of Member States necessitated a review at EU level of the quality of education and training and the national arrangements for recognition. In addition, the profession represented at EU level in particular the UEMO[4], the CP[5], the UEMS[6] and PWG[7] put forward initiatives to address the assessment and evaluation of the quality of education and training.

The Commission requested the advice of the ACMT, in order to incorporate the profession's advice on matters affecting quality in medical education and training in the Commission's report under Article 33. The following items / issues in Title IV in Paragraphs 3.2. to 3.9. following have been identified by the profession.

Postgraduate training in general medical practice

3.2. The 21st recital to the Directive reads as follows: "whereas it is immaterial whether this training in general medical practice is received as part of, or separately from, basic medical training as laid down nationally". Experience appears to suggest that the Doctors Directive could be revised to provide that specific training in general medical practice may not begin before the education common for all doctors is completed and should begin at the same point as other specialist training begins.

So that the future doctor is made aware of the main forms in which medicine may be practised and can make an informed choice of career, thought should be given to the possibility of including a new provision specifying that appropriate exposure to general medical practice should be mandatory in undergraduate medical training.

---

4 European Union of General Practitioners

5 Standing Committee of European Doctors

6 European Union of Specialist Medical Practitioners

7 Permanent Working Group of Junior Hospital Doctors

Duration and Design of General Medical Practice Training Programmes

3.3. Article 31(1)(b) provides that the training shall be a full-time course lasting at least two years and shall be supervised by competent authorities or bodies. The UEMO proposal that the course leading to qualifications in general medical practice should be a full-time course lasting at least three years has been endorsed by the ACMT, though this would be a problem for some Member States and is probably not feasible in the coming years. Other Member States would need a longer transitional period to increase the length of the training period because such an extension would have significant budgetary implications.

The requirement that general medical practice training must be supervised by competent authorities could perhaps be strengthened by making provision for these competent authorities or bodies to do so with the involvement of general medical practitioners throughout the period of training.

It is proposed in some quarters that the clinical nature of training for general medical practice should be emphasized and that at least 12 months be spent in an approved general medical practice or comparable setting. For financial reasons, such a requirement should be phased in over a period of years. This does not prevent those countries who wish to extend the minimum 12-month period to an 18-month period from doing so.

Article 32

3.4. The provision in Article 32 which makes temporary provision for training by experience in the surgery of the trainee has no time limit. It seems appropriate to examine with the Member States if this derogation should be maintained.

Part-time Training

3.5. With regard to part-time training, consideration should be given to the possibility of requiring that the minimum time commitment for those in part-time training for general medical practice should be 50 % of full-time training so that the requirements in general medical practice are in line with the provisions for part-time training in other specialities. The third indent of Article 34(1) (part-time training to include a certain number of full-time training periods) should in that case be deleted, so as to make the provisions relating to part-time training the same for all postgraduate courses. Part-time training offers certain advantages, and in particular the possibility of increasing the number of training opportunities since these are dependent on the number of places.

Assessment and evaluation of Training Programmes

3.6. It is recommended to the Member States that a statement of intent relating to good practice be introduced in the assessment and quality control of programmes for specific training and education for general medical practice.

Induction Training

3.7. Thought could usefully be given to the desirability of inserting a carefully worded provision, with adequate safeguards to ensure that there is no discrimination, on the organization of induction training for migrants if this is found to be necessary in individual cases.

Adequate resource for Training Programmes

3.8. Consideration should be given to the possibility of adding a provision on the need to provide resources which are commensurate with the objectives, design, supervision and evaluation of specific training for general medical practitioners. The provision in Article 31(1)(d), which is currently the basis for the remuneration of trainees, should be more explicit. It would probably be appropriate, for example, to introduce a point (e) equating the position of a doctor following specific training in general medicine with that of a doctor following specialist medical training, at least for a significant part of the training.

Specific Training for every general medical practitioner

3.9. The profession are of the view that it is appropriate to introduce specific training for every general medical practitioner immediately. It is not appropriate to maintain the possibility of practising medicine without training as a specialist and without specific training in general medicine. Indeed there is little understanding as to what training conditions will be maintained according to whether or not the practice takes place within the context of a social security system. Apart from this theoretical incoherence, one can reasonably conclude that it does not constitute a practical necessity. Finally, the appropriateness of such an approach is certainly confirmed if the view of patients is taken into account. The experience in Member States is that there is no justification for a further delay as envisaged in Article 40.

"Euro certificates"

3.10. It appears that some Member States have designated an Article 30 qualification, which is evidence of the minimum requirements set out in Article 31 but which have no currency within the national social security schemes of these Member States.

An Article 30 qualification issued to an EU national will not give that national access to general medical practice within the social security scheme of that Member State.

A higher national qualification (not identified by those States for the purposes of Title IV of the Directive) gives the holder access to general medical practice within those national schemes.

The Article 30 qualifications issued by those States therefore serve only one purpose - export - that is they provide access to practice within social security schemes of other Member States.

3.11. This situation is incompatible with the scheme set out by the Directive which relies on completion of national training programmes which are relevant within the national health care schemes.

Infraction proceedings under Article 169 of the Treaty against one Member State resulted in it changing its rules.

Firstly this type of implementation contravenes the principle of reciprocity on which the Community scheme of mutual recognition is founded.

Secondly, nationals of other Member States may wish to take advantage of the shorter, and less demanding, training programme in order to achieve a certificate which would then give them access to the profession at home.

Thirdly, where a Member State has already set for its own purposes a higher standard of training, having designated a lower level qualification as the Article 30 qualification it has no interest in raising the Community standards above the minimum which is set in the Directive. That State may rely on the technical provision in the Directive to deny access to general medical practice within their territory to those who hold Article 30 qualifications from other Member States but have the advantage of sending its own practitioners with that lower national level qualification to other Member States.

3.12. This development has been already been the subject of discussion within the ACMT. Minimum harmonisation imposes a common denominator for all Member States but allows higher national standards which encourages and fosters progress within the context of the EU system of automatic mutual recognition. The impetus for upward revision is necessary to respond to the dynamic needs of medicine. The progress in standards for training programmes which have been achieved since 1975 will be undermined if individual Member States have no self interest in setting higher standards in the Doctors' Directive.

Trainee doctors

3.13. EU rules for the mutual recognition of medical qualifications have been in place for 20 years. Community programmes such as Socrates (previously Erasmus) for the mobility of university students, co-operation and information networks like the European Credit Transfer System (ECTS), information on study programmes and national education systems by the NARIC network and improvement in language learning through LINGUA programme have all contributed to greater mobility of the student and trainee doctor.

3.14. The natural evolution of these measures calls for specific provision for facilitating the movement of trainee doctors. Council Recommendation 75/367/EEC[8] urged Member States to accept trainees during their clinical training periods.

Since then the jurisprudence of the European Court of Justice[9] has made it clear that any training (including university) which leads to a professional qualification affects free movement of persons and is therefore protected by the non discrimination principle of Community law. Access to training posts therefore must be open to EU nationals on the same terms as to nationals of the host State. This is a requirement which is not respected.

3.15. Further, in many Member States training for general medical practitioners and of other specialities takes place by involvement of the trainee in the professional activity. He is remunerated for this service element in his training. Notwithstanding that the service element is part of training it is also employment and EU principles prohibit any discriminatory practices either in relation to access to employment or in relation to the conditions of employment.

3.16. Trainee doctors are still experiencing barriers when applying for training posts in other Member States. Even where posts have been offered and accepted, national authorities are reluctant to process applications for several reasons including for those within the national training schemes. This is an area which should be studied with a view to developing proposals to include the principles contained in Council Recommendation 75/367/EEC as binding measures in the context of the trainee in general medical practice and specialists.

---

8 OJ n° L 167 30.6.1975.

9 Gravier Case 83/293 [1989] E.C.R. 593
Kraus Case 19/92 [1993] E.C.R. 1

Article 5

3.17. If specific training in general medicine is actually considered by all the Member States as a medical specialisation, on the same basis as the others listed in this Article, then this Article should be adapted to reflect this.

SECTION 4: CONSEQUENTIALS AND SYNOPSIS OF PROPOSALS

Amalgamated, Augmented and Strengthened common provisions for postgraduate education and training

4.1. Paragraphs 1.7., 2.4. and 2.5. above indicate clearly that for EU purposes an Article 30 qualification is in the same category as qualifications in specialisations referred to in Article 5. Paragraphs 2.9., 3.2., 3.13. - 3.16. also explain that trainees, be they general medical practitioner or specialist, are subject to similar conditions. The minimum conditions for training specified in Articles 24 and 31 should be examined for the purposes of reinforcing the minimum conditions. It is desirable to amalgamate both these Articles as they share common aims and contain common provisions.

4.2. With the increased size of the EU such a guarantee can only be achieved if the provisions enable an objective structure that is transparent and that can be enforced directly in the Member States. The amalgamated provisions may include statements of good practice and policy objectives of training but must be underpinned by provision for adequate resources and transparency.

4.3. Clearly defined bodies responsible for the supervision, co-ordination and regulation of education and training programmes should be identified by each Member State. The exact scope and function of those bodies must be published.

4.4. The training programmes should be defined with precise detail concerning duration and structure. They should be assessed and accredited based on training syllabuses and a range of training methods. In order to ensure that high standards are achieved and maintained, defined scientific evaluation methods of trainees, training posts and programmes should be incorporated. Trainees should be engaged in accredited training programmes so as to ensure a balance between the educational and service elements in the posts.

4.5. Trainers should be adequately prepared for their role and should be assessed and monitored.

4.6. The ACMT should be called upon to develop examples of good practice for successful postgraduate training.

4.7. General medical practice qualifications are postgraduate qualifications common to all Member States.

It follows that the Article 30 qualifications should be included in Article 5 as general medical practice qualifications are postgraduate qualifications common to all Member States.

SECTION 5: CONCLUSION

5.1. The Doctors Directive is a Community measure which respects the principle of subsidiarity. It lays down a framework to ensure the automatic recognition of qualifications.

It seeks to guarantee the host Member State that the qualifications which it is obliged to accept for access to the medical profession within its territory, is evidence of at least a minimum (in most cases it may be of a higher) standard of training. The form of the guarantee on the other hand, provides scope for national particularities and allows for national training needs. That framework has stood the test of time and responds to the needs of the enlarged EU which needs the flexibility to adjust to EU standards and methods.

5.2. Moreover the complexities of medical education and training require clearer guidelines for the achievement of enforceable guarantees of the quality of training.

5.3. Objective rules which are transparent and directly applicable are necessary to achieve the goal of quality. Mutual trust is based on guarantees of the quality of training. The Doctors Directive has provided the foundations for quality and trust. It is necessary to strengthen and develop these foundations, in particular along the lines set out in this report.

ANNEX

RECOMMENDATIONS OF THE ACMT:

The ACMT makes the following recommendations:

1. A properly trained, well resourced cohort of General Practitioners will in future play an increasingly important part in the organisation and development of an increasingly scientifically based, cost effective, health care system and that perception should be reflected throughout medical training both at undergraduate and post graduate level.

2. It is important to establish, as a priority, the on-going involvement by General Practitioners, both from an academic back ground and active general practice, in the organisation/development/administration and evaluation of General Practitioner training programmes.

3. There should be mandatory and adequate exposure of all medical students at undergraduate level to general practice.

4. Specific training for general practice should commence only after the completion of basic medical training, the end point of which needs clearer definition.

5. As conditions permit, the minimum duration of specific training for general practice should be three years.

6. The part of training carried out in general practice or comparable settings should be extended from six months to one year and as conditions permit should be further extended to eighteen months.

7. The facility enabling practitioners to train in their own surgeries should be terminated.

8. The provisions in respect of part-time training should be amended and brought into line with those of all other specialities, i.e. minimum of 50 % of full time training and the requirement for periods of full time training to be abolished.

9. Induction training for doctors travelling from one EU country to another be introduced where necessary and efforts made to facilitate exchange both among established General Practitioners, trainees, trainers and academic departments.

10. Specific training be made mandatory for all general practitioners.

ISSN 0254-1475

COM(96) 434 final

DOCUMENTS

EN 10 04

Catalogue number : CB-CO-96-436-EN-C

ISBN 92-78-08570-7

Office for Official Publications of the European Communities

L-2985 Luxembourg