

Migrating Misconduct

A report on an invitational conference:
'EU health care professionals crossing borders'
at the Royal Tropical Institute, Amsterdam
9 and 10 December 2004

The background

A case history

Sometimes misconduct seems to migrate forever. In this case, for example, a medical professional has been guilty of misconduct in several countries over a period of 31 years.

As a foreign student he graduated in medicine in the Netherlands. With this diploma he was recognised in country number 2 as a physician.

In The Netherlands, he was convicted in 1973. Of course, action was taken against him, but the negotiations with foreign authorities took a long time. Meanwhile, he went about his business.

In country number 2 he was convicted too. This time for fraud and theft of narcotics. He returned to the Netherlands and was employed there in preclinical work from 1973 till 1978. He also published a book on anatomy and was immediately charged with plagiarism.

Shortly afterwards, a university handed him a diploma qualifying him as a physician, probably on the strength of a fabricated story. The man left for his home country and started a practice as a gynaecologist. After six months they took away his licence because of significant lack of competence.

In his further career he started a faculty of medicine in an African country and worked in an Arab country as the personal physician of a member of the Royal Family.

In 1994 he began again in Europe where, on the basis of his first registration, he was able to work as a healthcare professional in different professions, moving around as soon as trouble arose.

He is still doing that today.

Introduction

This is only an example of what is happening at the present time and what will continue to happen in the future because of inadequate communication between the countries concerned. The Amsterdam conference 'EU health care professionals crossing borders' was a first step towards solving this communication problem.

The conference was not only a first step, it was also a unique meeting. It was the first time that health care officials – the competent authorities at national and subnational level, registration bodies, inspectorate and supervisory bodies, as well as policy makers who all have the task to carry out exchange of information regarding measures, sanctions or penalties imposed upon a health care professional and are dealing with matters of protection of personal data -- from the member states of the European Economic Area and Switzerland* were together, became acquainted and shared ideas and information. The results of the meeting are recorded on this cd rom, which not only contains this report, but also all presentations, speeches, results of discussions and a Conference Communiqué.

Amsterdam was the first step. The next step will be taken by the British counterparts who have agreed to carry on where this conference left off. This promise guarantees continuity and continuity is the key in this matter as communication *must* improve. European countries must share information in the interests of patients and citizens of all member states and prospective member states of the European Union.

In his welcoming speech, André Knottnerus, President of the Netherlands Health Council, Professor of Primary Health Care and chair of the conference, stressed the fact that the conference was an historic moment. 'It is the first time we come together and we are here to set up an agenda for future action.'

The scope of the problem is framed in the name of the conference, as André Knottnerus explained. 'Crossing Borders refers to two ways of crossing borders: mobility and misbehaviour. The movement of health care professionals – doctors, dentists, pharmacists, G.C. nurses and midwives -- is a positive thing, but it has to be safe. Therefore, we need quality control. Quality control is the responsibility of Health Ministers of course, but they can only control quality if they have up-to-date information at their disposal. Right now, there is a lack of information, because of a lack of communication between European states.

We are facing an intriguing challenge and this conference is a first step to meeting this challenge. We are here together to exchange information. Hence the greatest part of this conference consists of exploratory workshops that aim at taking stock of ideas in the field.

This conference is a first step, an opportunity to get to know each other, to exchange information and to share the problems that each European country faces. We will also exchange information with the US delegation, which will be presenting the American way of dealing with migrating health care professionals and measures for safety.

This is the first time we meet so we cannot expect any clear-cut conclusions. We are here to learn.'

* See enclosed list of contributors and participants.

A working party of experts

Roel Bekker, Secretary General of the Ministry of Health, Welfare and Sport, spoke on behalf of the Minister, Hans Hoogervorst. He not only stressed the importance of the subject of the conference, but also called upon the participants to agree on practical approaches in the follow-up.

‘Patients should never run the risk of being treated by someone who is not qualified or permitted to practise medicine. No matter where, no matter when, patients must have the utmost confidence in the doctor, dentist, nurse, midwife or pharmacist whose services they seek.

I list these specific health care professions because, under various European directives, they are all entitled to automatic recognition of their qualifications and credentials in other member states.

Each country has a duty to ensure that medical staff who, for whatever reason, are not considered fully competent, are unable to cause any harm to healthcare consumers. This will only be possible if the competent authorities of each country inform each other about physicians who migrate, particularly if they have something on their records.

It is this exchange of information which is currently lacking. One of the difficulties is that not every member state knows which organization is responsible for collecting this type of information in the other member states. A further complication is that privacy-protection legislation in some countries prevents certain details from being freely exchanged.

These are not problems that can be solved overnight. Therefore, we are primarily concerned with identifying the obstacles and with evaluating the extent of those obstacles.

Acknowledging that a problem exists is always the first step in finding the solution. Also, we must exchange experiences and learn from each other. It would be a waste of time and effort if we all reinvented the wheel!

If we could close this conference with an agreement relating to the appointment of a ‘working party’ of experts, it would be a great step ahead. This working party will spend the next few months elaborating the various proposals to form a practical action plan for each theme discussed here in Amsterdam. The proposals and plans can then be presented during the second half of 2005, by which time the presidency of the European Union will have passed to the United Kingdom.’

An inventory of the European situation

Frits Tjadens, Senior Advisor of the Netherlands Institute for Care and Welfare (NIZW), gave a presentation about an inventory that was made in August this year of the registration and supervision of the five groups of professionals in EEA countries.

Frits Tjadens: 'The aim of the inquiry was to gather information that could help in setting up an on-line data base containing information about health care professionals. * The outcome of the inquiry made clear that Europe is very complex and that we face complex problems. Registrars are often multi-taskers which makes it even harder to co-operate. For instance, in most European countries health care professionals are registered only once. And, because of data protection, information about misconduct is not sent actively. If information is given, it is only on request and always sent by letter, which is quite an old-fashioned way of communicating. Moreover, most of the times, foreigners are not registered in the second country. It is only when they come from a different ethical system that the chances of registration grow.

Because of this complexity, the first idea was that it was important for registrars to find one another and to have a little knowledge about one another available on a website. For this purpose NIZW/IC was requested not only to conduct the research, but also to construct the website where registrars and / or supervisory organisations can find one another: www.nizw.nl/eeahealthpros. But it could go on from here. It might lead to a structural network, with *some* similarities to IAMRA, but with an explicit EEA-wide scope, with a bandwidth of all registrars with links to the sectorial professions (later even to those with connections to the General System health professions, such as paramedical professions and nursing specialists). This, of course is an effort in itself.

There are surprisingly many independent supervisory boards in Europe and they need to start working together. Our inquiry not only showed that communication between registrars is lacking and that information is hardly shared, fortunately it also showed that there is a broadly perceived relevance and a perceived need to work together. Therefore, I urgently call upon everyone in the field to fill out and return the questionnaire that is on the website.

The EEA wide online database is operational right now. In case of foreign health care professionals wishing to perform their profession in the area of your register it provides a website where you can find:

- colleagues with their contact information in 28 other countries;
- information about their system which helps to assess the situation of this professional

It is a first step, a basis for further action.

* Website: www.nizw.nl/eeahealthpros

Awareness of misconduct

Pamela Brumter, head of the unit for regulated professions, Directorate General Internal Market European Commission, stressed the fact that the migration of health care professionals guilty of misconduct is high on the *shared* agenda of the European member states. She also stated that the authorities in 'host' countries are not aware of the misconduct of these professionals in their 'home' countries.

'It is vital that the authorities in charge of implementing and enforcing EU legislation cooperate to ensure that citizens may enjoy their rights but also to secure the protection of patients. The issue of administrative cooperation should be high on the agenda, with the objective that the member states consider it a shared agenda. The Commission is ready to contribute to this work helping to define the objective to be achieved, the type of information to be exchanged as well as the tools needed. Moreover, we could benefit from a recent initiative proposed by the Commission to set up a framework in order to exchange extracts of criminal records upon requests. However, member states must be willing to help each other in the daily application of our directives for such networking to become a reality.

Authorities of member states are simply not aware of the malpractice of the medical professionals that enter their country. This is a serious matter and there is no doubt that appropriate solutions must be found to secure the protection of patients; such solutions should, however, obviously safeguard the fundamental rights of individuals. Current EU Directives stipulate the obligation of the member state of origin to inform the host member state of all "*necessary information regarding measures or disciplinary action of a professional or administrative nature taken in respect of the person concerned or criminal penalties imposed on him when pursuing his profession in the home member state*" (art.12 of dir.93/16 and similar provisions in other sectoral directives). The host member state may also enquire and report back to the home member state in case of doubts and before granting access to the activity.

The modalities for the implementation of these provisions have been left to the initiative of each member state with the results that some (very few indeed) have notified to all member states the measures of various kinds that have been taken against professionals, sometimes without knowing if this person had the intention of moving and where to. Other member states have not gone so far as to proactively provide information if not requested to do so.

Our work now is only the start of a process for setting up cooperation networks; be assured that the Commission will actively contribute to these discussions.'

An interactive conference

During the two day conference, not only presentations and speeches were given, but there also were three rounds of parallel working-groups on the first day and three rounds of parallel presentations on the second day. During the working-groups and the presentations, the colleagues of competent authorities were expected to discuss the subjects and themes that were presented to them. Through this interactivity, the participants of the conference had the opportunity to get to know each other and to gain insight in each others problems. Also, the basic idea of this approach was to activate the network of competent authorities, facilitating future cooperation.

The explorations of the first day programme aimed at taking stock of diverging ideas in the field and were not meant to achieve clear-cut final conclusions. The programme for the second day, however, was intended to reach conclusions that brought participants closer to a future solution.

The first day working-groups discussed the following themes:

- a) organisational issues;*
- b) security issues and*
- c) registration and definition of misconduct.*

Each working-group had a leader and a rapporteur. Together, they presented the feedback from the workinggroups and processed the input into new questions for the following groups.

The three parallel presentations on the day two presented examples of information exchange and registration in the U.K., the U.S.A. and Germany. The goal of these presentations was to learn from other countries and other systems and to determine what elements could work in Europe and what not.

Sessions round 1

Organisational issues: data exchange procedures

Questions:

- How often (in a year) do you – as competent authority - transmit or receive data (on professional misconduct) according to the article(s) in the relevant Sectoral EC-directive?
- To and from which Member States mainly? (Is there a pattern?)
- Do exchanges (procedures) also occur at national level – who are the other stakeholders - -Do you inform other (sub)national authorities
- Do you use some standard format or data-set?
- Do you transmit pro-actively – or (only) on request – why?
- What media are used in transmitting – phone, fax e-mail – other?
- How are the data recorded, stored and updated
- What kind of action stems from this data – by whom?
- Do you monitor and (regularly) check the quality and currency of the data; are there corrective procedures
- Are there specific procedural differences between the (five) health care professions in your country?

- Do you (sometimes) review existing procedures – do you have suggestions for improving current practice?

Outcome of the working-groups

- Make it a registration requirement in host country for HP to give consent to competent authority in the country of origin to disclose information.
- Refuse to register migrant HP in the event of ongoing investigation.
- Hard to make new EU rules on sharing information. Therefore need to share best practice with others.
- A step-by-step solution is needed, not a single overall solution.
- Solutions need to be pragmatic and proportionate, but focussed on patient safety.
- Draft Directive on qualifications will require information sharing.
- Having a full list of competent authorities will help to solve the problem of who to contact when regulation is on a regional rather than national basis.
- Proactive notification by States of misconduct findings to all other countries not seen as a feasible solution. It's up to the receiving country to seek notification, or get consent from the HP to seek information from country of origin. But active notification is feasible if you know where the HP has gone.
- Each regulator displays on its own website the names of professionals it has taken action against.

Sessions round 2

Security issues: protection of personal data

Questions

- Is there national legislation on data protection?
- Has Directive 95/46 been implemented – if not (new MSs) so what?
- Is the content of national privacy legislation the same or different from Directive 95/46?
- Does national legislation exist restricting the data-protection rights and obligations to safeguard “breaches of ethics for regulated professions”?
- Are there any (other) national constraints on disclosure of information?
- Do you apply a protocol or (model) code of conduct on data processing?
- Which competent authority is responsible for protection of personal data?
- Is there a difference in data protection in viewing a person as a human individual or as a professional?
- What rules for access and authorisation are used?
- When and how is the data-subject involved (information given; consent asked)?
- What are the disclosure policies; for specific authorities; for the public at large?
- Do you disclose aggregated (non-personal) data and information?

Outcome of the working-groups

- Overwhelming view that there is an obligation to share information. The sectoral Directives already make provisions for this, though vague in some places. New Directives on services and qualifications will improve the situation. States often fail to exploit the full provisions of the Directives available to them.

- Most agreed that information sharing is best carried out on request from the host member state, rather than proactively. The information should be provided to the host state. It is up to the host state to decide what to do with it.
- Information should also be provided when the professional moves or is known to be practising in another member state. Some took the view that general circulation of information to all member states might be disproportionate.
- The Council has put forward a new proposal for the exchange of information in relation to criminal convictions. The system will be based on requests for information and will not be proactive.
- Pending cases: these were very difficult to address and there were a range of views expressed. There was unease about the reporting of cases that were under investigation or pending appeal, where no final verdict had been given. Concern that professionals were innocent until finally proven guilty. However, against this, some countries had provision for imposing interim suspensions on professionals where allegations were particularly serious while the case was investigated further. These interim suspensions could be disclosed, even if there might be problems disclosing the reasons behind it. It is important for the host state to have early warning. This would help with the rehabilitation of the professional (especially if the problem was health related) as well as public protection. There was also concern about the possibility of individual's voluntarily deregistering and fleeing jurisdictions to avoid sanctions. How should that information be communicated, if at all?
- There was agreement that the most important view to take was that of the patient and the public. What do they want? Protect the patient, not the professional.
- Some expressed the view that sanctions no longer in force should not be disclosable since there would no longer be restrictions of the professional's practice. Others felt that past history should be included in the register, but that information should not be published for privacy reasons. Also, a distinction should be made between public and registrars information.
- How to convey information? Various options: a single central database was one idea. A central European clearing house for disseminating information was another. But most argued for reliance on the use of certificates of good standing communicated between competent authorities when the professional moves (and not relying on professionals to carry such certificates themselves because of the risk of ID fraud etc). Competent authorities should avail themselves of the use of electronic technology to communicate information and not rely on paper certificates.

Sessions round 3

Definitions: identification and registration of data on professional misconduct

Questions

- Which authority in your country is responsible for observing and recording cases of (alleged) misconduct? National and/or regional.
- If different legal systems are prevailing: disciplinary, administrative, civil, criminal – does this result in differences in identification and registration?
- Do relevant differences exist between (the five) health care professions?
- What kind of final decisions on sanctions will be registered – which will not; is this regulated by some law?
- Do you do anything with (the knowledge) of not-registered sanctions?
- Which “degrees of severity” do you distinguish?

- How long will a sanction “stick” to a person or be kept in registration? Do these terms differ per profession?
- Where (by whom) are these sanctions laid down or registered?
- Are current cases or pending verdicts being recorded in your national system?
- Do you “use” information on pending cases coming from other competent authorities?
- Is a standard or working definition of “professional misconduct” being used?

Outcome of the working-groups

- Not everyone is fully aware of the extent of the tools available to them. In this regard, some felt that there should be information in the Directives which explicitly states who all of the different competent authorities are.
- Others felt that it was less important to seek extra legal provisions of this kind, than to emphasize co-operation and collaboration between member States.
- Some felt it would be better to have a single point of contact in each State which would be able to advise other States of who the relevant competent authorities are.
- There was general agreement that further harmonization of procedures and definitions was desirable. However, this should be based around minimum requirements and broad, general principles, rather than full harmonization. More important was flexibility, transparency and better collaboration between States. Any wish for harmonization should not undermine or interfere with national systems.
- Everyone agreed that it was more important to have a system that was pragmatic and workable than to strive for a system that was 100% perfect but not achievable.

The chairs’ impressions

1. Organisational issues:

Adriaan Duivesteijn: ‘Do we need a European standard? We certainly need a minimal set.’

Menno van Leeuwen: ‘The need is felt to have one single point of reference in each country.’

2. Security issues:

Hanna Pava: ‘To know the competent authorities is the most important issue.’

Peter Hustinx: ‘Exchange of data should be proportional and precise.’

3. Definitions:

Martin Staniforth: ‘There is no common definition of professional misconduct. How to define the broad domain of misconduct?’

Herbert Plokker: ‘Full harmonisation is not the best way to go. Information should be shared on request.’

The learning experience

As was stressed by several speakers, the conference aimed at getting to know each other and learning from each other. Therefore, part of the conference programme consisted of presentations and discussions about the way countries tackle the registration of medical professionals.* The three countries that presented their systems of registering medical professionals were:

-the USA, which has a federal system linked to state systems;

-the U.K., which has a national system with international links to e.g. the Commonwealth and
-FRGermany, which has a national system build up as a combination of the system within the länder of the FRG countries.

Participants viewed these systems in the light of their national experiences and judge them on their feasibility as a starting point for an exchange system within Europe. The overall objective of these workshops was to specify the practical problems and positive experiences.

What can we learn from the registration system of the United States?

Betsy Ranslow, MS, Senior Associate for External Relations, Practitioner Data Banks Branch of the HRSA, presented the American approach to registering medical professionals. The U.S. has two Federal Data Banks:

1. National Practitioner Data Bank (NPDB)
2. Healthcare Integrity and Protection Data Bank (HIPDB)**

Both data banks can be consulted by means of the Internet. The US Data Banks get approximately 100,000 queries per week. Reports cannot be removed from data banks unless illegally reported. Of course, the access to the data banks is restricted:

- Hospitals *must* query by Law
- Others may query:
 - Health Plans
 - Licensing Boards
 - Professional Societies
 - State and Federal Health Care Agencies
 - State and Federal Law Enforcement Agencies (with limitations)

-Practitioners may query themselves.

Remarks during the discussion:

We are not a federal state (yet). We deal with different countries, laws, languages etc. which makes communication more complicated.

The U.S. approach offers useful ideas, like a central electronic databank, registration via internet: quick and easy electronic databank with mandatory data elements. Also, the payment system: a databank funded entirely by queering fees.

There is a lot to be learned from the U.S. system. For instance, is there a need for 2 databanks; preferably one databank. Access should be limited: the public/patients should have no access and misconduct database should separated from the general registration.

* Detailed surveys of the presentations and discussions are enclosed.

** See www.npdb-hipdb.com for more information

The learning experience

What can we learn from the registration system of Germany?*

Susann Katelhön, Head of Section, Department of Foreign Affairs, German Medical Association, presented the German approach to registering medical professionals.

‘All working physicians in Germany are obligatory members of the Medical Chamber of Physicians in the state they are living or working. Germany has a total of 17 State Medical Chambers in 16 Federal States. The German Medical Association is the federation of all State Medical Chambers. All doctors in private practice are compulsory members of one of the total of 24 Associations of Statutory Health Insurance Physicians, which are headed by the German Association of Office based Physicians.’

The exchange of information is restricted.

Code of conduct:

- Censuring reported to supervisory authority
- Entry in the file of the competent medical chamber
- Forwarding the files in case of move
- Report to the licensing authority in case of declared unworthiness to practice
- Information to a third party only when members of the chamber are concerned

Contract law:

- Reprimands, fines and suspension are registered regionally
- Suspensions are recorded in the Federal Register
- Information to the licensing committee in case of withdrawal of the licence
- Under certain circumstances, information to the supervisory authority
- Information of medical chamber only if involved

Remarks during the discussion:

Germany has a very complicated system. The German system seems to have similar problems the EU faces on this matter. It is the EU in itself.

The system only registers doctors, not nurses or other medical professionals.

Remarks from Per Haugum, chair of the workshop on the German approach:

First of all it must be up to the home country to decide how to organise professional and academic recognition of qualifications in the health care system. Secondly, there is a need for more transparency in the different countries systems so that it is easier for host countries to receive the necessary information from the home country about an HP seeking professional recognition in the host country. This could be arranged by having *one competent authority* in each country. If it is not possible to establish a system with a single competent authority, at least for each profession, it should be a goal to have a system in

each country with *one contact point* where the host country can get adequate information about how to get in touch with the competent authority in the home country (or in the other countries where the applicant has been working as a health care professional).

There is a need for a common definition of what a *certificate of good standing* is, and what kind of information it should contain. There is also a need for standardising the certificate of good standing and looking into ways of creating an efficient infrastructure for exchanging certificates of good standing between the competent authorities.

There is a need for a common definition of the term *misconduct*. This can be done by exchanging information about what kind of acts are considered misconduct in each country.

There is a need for more *exchange of information* between the countries about how the system in each country works. This information could be used for *benchmarking* so that each country can learn from *best practices*.

The learning experience

What can we learn from the registration system of the United Kingdom?*

Dr. Brian Keighly of the U.K. General Medical Council and Marc Seale of the Health Professional Council presented the English approach to registering medical professionals.

Dr. Brian Keighly (GMC):

The General Medical Council

- Discloses to any enquirer details of current sanctions against a doctor's registration.
- Discloses to any enquirer historical information (including previous sanctions) that is already in the public domain.
- All findings of serious professional misconduct, even where no sanction has been imposed, are a matter of public record and will be disclosed to all enquirers.

Two Models for Information Exchange

- Model 1: the provision of information in response to a request for data.
- Model 2: the routine proactive provision of information on decisions concerning doctors' fitness to practise.

Future approach (developing):

- Each doctor to have a unique registration number pre-fixed with an international code.
- Any certificate of good standing (cgs) issued to a migrating doctor would show the doctor's unique ID number and the international pre-fix of the issuing body.
- Any cgs would also show the unique ID number and international pre-fix of any other jurisdictions where the doctor has previously worked.
- Ability to track doctors' regulatory history from country to country.
- Regulators able to target their sharing of information to where it is most useful.

Marc Seale (HPC):

9 UK Regulators of Healthcare Professionals:

General Chiropractic Council
General Dental Council
General Medical Council
General Optical Council
General Osteopathic Council
Health Professions Council
Nursing and Midwifery Council
Pharmaceutical Society of NI
Royal Pharmaceutical Society of GB

Five Integrated processes:

Approve programmes for entry to register

Set Standards

-Education & Training

-Proficiency

-Conduct, Performance, & Ethics

-CPD

Operate a Register

Continuing Professional Development

Intervene if registrants Fitness to Practise may be below standard

International Migration

450 + applications per month

25% EEA

Detection of "Problem" international registrants

-Export -Letter of Good Standing

-Imports -Cooperation with international regulators

Global not EEA problem

-Language driven?

Who to talk to?

Scale of Problem:

191 countries

200+ States, Regions, Departments Provinces

Regulators, government, professional bodies

35+ professions

Remarks during the discussions:

We don't have the resources to check all the information. You rely on the information that has been submitted.

In Switzerland the data protection offices would never approve a similar system.

ID-number for doctors and other professions is good idea.

NPC online information very interesting- can also share information up to date.

The exposure of data is much too elaborate.

This is extremely useful.

* See www.hpc-uk.org/worldwide/index.html for more information.

Final remarks

In his final remarks, **André Knottnerus, chair of the conference**, again called upon the participants to join the Working Party and to participate in its activities by registering via the contact e-mail address of the Working Party: gordon.spence@dh.gsi.gov.uk.

Remarks from Pamela Brumter:

‘The Working Party could be set up to carry out the work required, elaborating on the findings of this Conference and using the material produced by the enquiry which should be added to by contributions from national authorities.

The Commission is also committed to taking an active part in such a group; in my view, the Dutch Ministry of Health because of its investment in the issue and the enquiry launched, should be part of this Party as well as our British colleagues, who have already signalled their interest in these matters and who will take over the Presidency in the second half of 2005. It goes without saying that in view of the importance of this work other participation would be needed, to ensure a balanced view and better outcome.

The working methods should be kept as light as possible via electronic means; if need be meetings could be organised in Brussels or in another capital.

In any case, the CSP would also provide the forum for reporting to all member states and seek their views on the way forward. The process should allow for the presentation of options which can be decided upon when the new directive has been adopted.

When decisions have been taken as to which way to go, the time will then be ripe to seek means of putting the “future” system (s) in place.’

Remarks from Martin Staniforth:

‘For the U.K. this conference is very well timed, for this subject is high on our agenda, which is a shared agenda. This conference is a unique opportunity to share ideas, to learn about the legislation of other countries and to work together. We must continue to work together, for sharing information is an important issue.

Protecting the patients’ safety is the key. We hope to achieve practical results within twelve months, work with stakeholders and map the wide range of bodies that are involved in Europe and in Switzerland.’

Future strategy

It is agreed that a Working Party will be set up. The conference called for participation in the activities of the Working Party by registering via the contact e-mail address of the Working Party: gordon.spence@dh.gsi.gov.uk.

The Working Party is committed to the following action points.

- To create a network of competent registers with the aim of defining the necessary information to be provided and the means by which the exchange of information could be organised.
- To develop efficient mechanisms of administrative co-operation. More in particular, models for a certificate for good standing. Agreement on such non-obligatory but recommended models and their translation into the twenty languages of the European Union.

Finally, the conference participants expressed their willingness to continue activities after this conference and to cooperate with the Luxembourg and United Kingdom presidencies to come. The conference participants appreciated the important contributions of these two presidencies.

The 'Crossing Borders' conference laid the foundations for better cooperation and information exchange regarding the registration and supervision of medical practitioners. Amsterdam showed what London will reap in the second half of 2005.

More information

All presentations, speeches, feedback forms and results of discussions are included on this cdrom. This cdrom also contains a Conference Communiqué.

The Hague, 2 Februari 2005

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