Evaluation of the Professional Qualifications Directive 2005/36/EC

Experience reports from national authorities with regard to doctors

Evaluating the Professional Qualifications Directive
Experience reports from competent authorities

POSSIBLE QUESTIONNAIRE FOR EACH SECTORAL PROFESSION

A. RECOGNITION PROCEDURE IN CASE OF MIGRATION ON A PERMANENT BASIS

1. Do you accept applications from EU citizens for the recognition of foreign diplomas sent by email or requests made on line? Under which conditions can they send documents and declarations electronically? What are your experiences in this respect?

2. What is the yearly number of positive and negative decisions of recognition from 2000 to 2009? Please submit specific data for applications for automatic recognition based on diplomas, automatic recognition based on acquired rights (as from 2005), and recognition based on the general system[1]. If available, please provide information on the average duration of the recognition process.

3. To what extent have the system of automatic recognition and the general system been a success? How do you see the costs and benefits? Specify in particular whether automatic recognition based on diploma, Annex V and the current notification system represent an efficient way to facilitate automatic recognition. Please submit comments for:

   - automatic recognition based on diploma
   - automatic recognition based on acquired rights
   - recognition based on the general system.

   Please specify whether there are any specific problems with Annex V.

4. Is the general system applied in your country each time the conditions for automatic recognition are not met? Are there major difficulties in the recognition procedure under the general system? Please include any comments you may have on the implementation of compensation measures. Is the migrant given the choice between an aptitude test and an adaptation period or is the choice restricted. Please explain.

5. What is your experience with the recognition procedure for EU citizens with professional qualifications obtained in a third country and already recognised in a first Member State (see Articles 2(2) and 3(3))?

6. Please describe the government structure of the competent authority or authorities in charge of the recognition.

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[1] Please provide this information unless it has already been provided to the Commission in the Database or the implementation reports.

B. TEMPORARY MOBILITY (OF A SELF-EMPLOYED OR AN EMPLOYED WORKER)

7. Are EU citizens interested in using the provisions for exercising their professional activities on a temporary and occasional basis in your Member State? How many citizens used this new system in 2008 and 2009 (per month, per year) [2]?

8. How are the provisions of Directive 2005/36/EC concerning temporary mobility applied by the competent authorities in practice taking into account the relevant provisions of the Code of Conduct? For instance:

   - How is the "legal establishment" criteria foreseen by Article 5(1) (a) interpreted in practice? What conditions does a migrant need to fulfil in his home Member State in order to be able to provide services?

   - How are the "temporary and occasional basis" criteria foreseen by Article 5.2 interpreted in practice? Do Member States assess duration, frequency, regularity and continuity of an activity and if so according to which criteria?

9. Why is a prior declaration system necessary? What do competent authorities do with the information received? Are other possibilities conceivable? Do you have any cases – and if yes how many - whereby doctors sent the declaration after the provision of services has taken place.

10. Do you charge any fee in case Article 7, § 4 applies?

C MINIMUM TRAINING REQUIREMENTS

11. To what extent are the common minimum training requirements for specialists and general practitioners set out in Title III Chapter III of Directive 2005/36/EC and as defined in Annex V in line with scientific progress and professional needs? Furthermore, are the knowledge and skills required by the directive still relevant and up to date? Please specify. What about the conditions relating to the duration of training? Do you have many specialties training, which have a common trunk. If yes, please specify which ones.

12. To what extent are the common minimum requirements for training set out in Title III Chapter III of Directive 2005/36/EC in line with scientific progress and professional needs in the last ten years? Are the knowledge and skills outlined in Article 24.3 still relevant and up to date? Please specify. What about the conditions relating to the duration of training?

13. The Directive is based on mutual trust between Member States. To what extent is such trust actually achieved? Are training programmes accredited in your country? Does accreditation of a training program in another Member State enhance trust or is it not relevant?

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[2] Please provide this information unless it has already been provided to the Commission in the Database or the implementation reports.

14. To what extent are the existing Directive provisions (see recital 39 and Article 22(b) on continuous professional development (continuous training) adequate? Is continuous training mandatory in your country and what are the exact conditions?

D. ADMINISTRATIVE COOPERATION

15. To which extent does administrative cooperation, as outlined in Articles 8, 50, and 56 of the Directive, simplify procedures for the migrant professionals?

16. Is the competent authority in your country registered with IMI? Under which circumstances does your competent authority use IMI? If not registered, why not and what would be the conditions for changing this situation?

17. Are you alerted by other Member States in case of disciplinary action or criminal sanctions taken or any other serious, specific circumstances which are likely to have consequences for the pursuit of activities under this Directive? How do you share this information? Could more be done in this respect?

E. OTHER OBSERVATIONS

18. How and when are the necessary language skills of migrants checked after recognition of the professional qualifications? Are you aware of any complaints (especially from patients/clients/employers) about insufficient language skills of migrants?

19. Does the application of Article 30 raise any specific problems?

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Ordre National des Médecins
Conseil National de l'Ordre

BUNDESÄRZTEKAMMER

General Medical Council

15 October 2010

Dear Mrs Fröhlinger

National experience reports for doctors and Berlin statement

Further to your letter sent in April 2010 and our initial response on 23 September, we are writing to inform you about the outcome of the informal network of European competent authorities responsible for the recognition of medical qualifications. We are pleased to report that to date 22 national experience reports[1] on the implementation of Directive 2005/36/EC on the mutual recognition of professional qualifications have been submitted to the European Commission by the network.

As you recall, in March 2010, the Bundesärztekammer, the Conseil National de l'Ordre des Médecins, and the General Medical Council (UK), were supported by the European Commission in coordinating an informal network of competent authorities responsible for the recognition of medical qualifications. The aim of the group was to discuss the implementation of the Directive in the EEA countries and aid the preparation of national implementation reports.

Over the past few months 28 competent authorities from 23 EEA countries held constructive plenary discussions in Paris (7 May), London (2 July) and Berlin (13 September). The meetings benefited from the European Commission's input as an observer and provided participants with an opportunity to suggest changes and clarifications to the questionnaire proposed by the Commission, share best practises, and experiences, and debate common concerns.

To facilitate discussion, the network coordinators set up a secure online platform, which served as a repository of information and helped competent authorities share their draft national reports. The platform was met with broad enthusiasm and competent authorities agreed to consider this tool in the future.

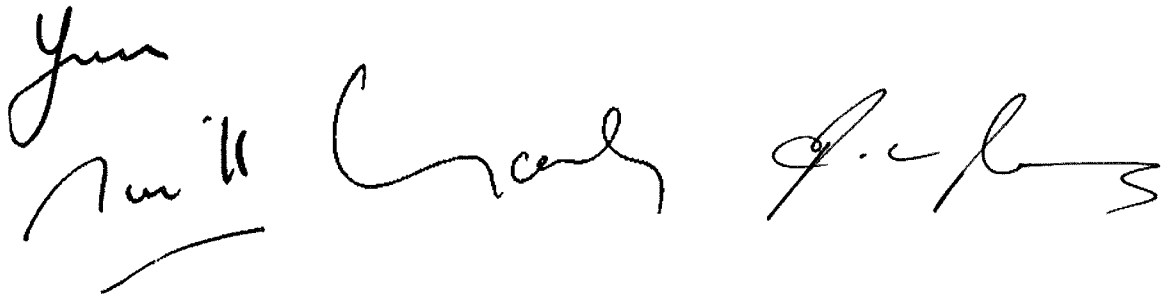
Overall the network agreed that the system of automatic recognition has facilitated the mobility of doctors and has agreed to continue to meet in the future, on an informal basis, to improve collaboration and understanding of medical education and training systems and recognition procedures across Europe.

[1] The following countries have responded to the European Commission questionnaire: Austria, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Latvia, Luxemburg, Malta, The Netherlands, Norway, Poland, Portugal, Slovenia, Spain, Sweden, and the UK.

In the course of their deliberations, competent authorities have also identified parts of the legal framework that could benefit from further examination and clarification. In this context, the network discussed and agreed a joint statement, calling on the revision of the Directive to focus on areas that will support doctor mobility and cooperation amongst competent authorities while, at the same time, ensure that patient safety in Europe is not compromised. We are very pleased to report that to date 25 competent authorities from 23 EEA countries have officially endorsed the Berlin statement and we would like to bring this to your attention. We hope that the content of the statement will be considered by the Commission in its revision of the Directive.

We would like to thank the European Commission for their positive and constructive engagement with competent authorities over the past few months and look forward to receive feedback from discussions held at the Group of Coordinators meeting held on 27 September and to contributing further to the evaluation and revision of the Directive in the coming months.

Yours sincerely



Niall Dickson	Prof Robert Nicodème	Dr Frank-Ulrich Montgomery
Chief Executive and Registar	Président de la Section Formation et Compétences Médicales	Vice-President
General Medical Council	**Conseil national de l'Ordre des médecins**	**Bundesärztekammer**

cc. Jürgen Tiedje, An Baeyens

Berlin Statement
13 September 2010

European Commission's evaluation of Directive 2005/36/EC on the mutual recognition of professional qualifications

Since May 2010 the informal network of competent authorities for the recognition of professional qualifications for doctors has held a series of meetings to discuss and share their experiences with the implementation of Directive 2005/36/EC on the mutual recognition of professional qualifications.

The network has brought together 28 competent authorities from 23 member states to stimulate discussions and support the drafting of national experience reports on the Directive.

The network agrees that the system of automatic recognition provided by Directive 2005/36/EC has proven successful in facilitating the recognition of medical qualifications within the European Economic Area.

The network has also shown that with a high level of doctor mobility around Europe, competent authorities are keen to work cooperatively and collaboratively to contribute to safe healthcare in Europe, and declare their intention to continue their collaboration within the structures of the informal network. To enhance transparency within the recognition of professional qualifications competent authorities intend to work together voluntarily to create a repository of detailed information on the content of medical training for each specialty. This may include historical information of titles and name of documents.

Competent authorities see the Commission's current evaluation of Directive 2005/36/EC as a valuable opportunity to highlight a number of areas that would benefit from further examination to ensure that professional mobility is maintained and to enhance patient safety. We would like to express our appreciation of the open and co-operative approach undertaken by the Commission in the course of the evaluation process.

Further to our meetings and the exchange of experiences in relation to the evaluation of the Directive we call on the Commission to:

- Continue to facilitate the identification of competent authorities responsible for the recognition of qualifications for doctors; require competent authorities to be listed on the Internal Market Information system (IMI); oblige competent authorities to respond to all queries in an appropriate timeframe regardless of whether they are sent through IMI or through other means; develop and improve IMI to allow competent authorities to carry out primary source verification of documents.

- Examine in cooperation with the Competent Authorities appropriate competence assurance mechanisms (e.g. CPD/CME, revalidation, etc.) for doctors. This will enhance trust in the recognition of professional qualifications and ensure patient safety by allowing competent authorities to assure themselves that the doctors they register have kept their skills and competence up to date since the award of their medical qualifications.

- Consider including the Certificate of Current Professional Status / Certificate of Good Standing to the documents listed in Annex VII.

- Explore mechanisms, such as the alert mechanism provided for by the Services Directive, that will improve the exchange of information about doctors that has a bearing on patient safety in Europe and on professional competence. Facilitate the identification of competent authorities responsible for taking regulatory action against doctors[1] to ensure that only those doctors that are fit and safe to practise avail themselves of the benefits of freedom of movement within the EEA.

- Ensure that there is legal clarity about regulatory responsibility in instances of cross-border provision of services. This should also be considered in the light of developments in the field of telemedicine and remote diagnosis, where neither the patient nor the doctor physically moves.

- Provide clarification about the term 'temporary and occasional'; support competent authorities in developing a common framework that will assist them in dealing with recognition in cases of subsequent applications for temporary and occasional provision of services (e.g. seasonal mobility).

- Examine the language provisions in the Directive to address the concerns of competent authorities in relation to language proficiency of migrant doctors in the interest of patient safety.

- Examine within the course of the revision of the Directive the increasing occurrences of false documents and fraud and find means of combating these effectively.

Further information and concrete case studies and examples in support of this statement are contained in the national experience reports submitted by competent authorities to the European Commission in September 2010.

[1] For example, the removal of a licence to practise.

Competent authorities in support of the Berlin statement

Austria	Österreichische Ärztekammer
Cyprus	ΙΑΤΡΙΚΟ ΣΥΜΒΟΥΛΙΟ ΚΥΠΡΟΥ
Czech Republic	Ministerstvo zdravotnictví
Denmark	Sundhedsstyrelsen
Estonia	Tervisemet
Finland	Sosiaali- ja terveysalan lupa- ja valvontavirasto, Valvira
France	Conseil National de l'Ordre de Médecins Ministère de la Santé
Germany	Bundesärztekammer
Hungary	Egészségügyi Engedélyezési és Közigazgatási Hivatal
Ireland	Medical Council
Italy	Ministero del lavoro, della salute e delle politiche sociali
Latvia	Latvijas Ārstu biedrība
Lithuania	Sveikatos apsaugos ministerija
Luxembourg	Ministère de la Santé
Malta	Kunsill Mediku
The Netherlands	Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst Ministerie van Volksgezondheid Welzijn en Sport - BIG register
Norway	Statens autorisasjonskontor for helsepersonell
Portugal	Ordem dos Médicos
Romania	Colegiul Medicilor din Romania
Slovenia	Ministrstvo za zdravje
Spain	Ministerio de Sanidad y Política Social
Sweden	Socialstyrelsen
UK	General Medical Council

BULGARIA

Evaluating the Professional Qualifications Directive
Experience reports from competent authorities
Doctors

POSSIBLE QUESTIONNAIRE FOR EACH SECTORAL PROFESSION

A. RECOGNITION PROCEDURE IN CASE OF MIGRATION ON A PERMANENT BASIS

1. Do you accept applications from EU citizens for the recognition of foreign diplomas sent by email or requests made on line? Under which conditions can they send documents and declarations electronically? What are your experiences in this respect?

   The Ministry of Health in Bulgaria doesn't accept applications from EU citizens for the recognition of foreign diplomas sent by email or requests made on line.

2. What is the yearly number of positive and negative decisions of recognition from 2000 to 2009? Please submit specific data for applications for automatic recognition based on diplomas, automatic recognition based on acquired rights (as from 2005), and recognition based on the general system[1]. If available, please provide information on the average duration of the recognition process.

   For 2007 – 22 of which:
   - 14 – automatic recognition (positive);
   - 7 – acquired rights (positive);
   - 1 – the general system (positive)

   For 2008 – 50 of which:
   - 26 – automatic recognition (positive);
   - 24 – suspended

   For 2009 – 12 of which:
   - 9 – automatic recognition (positive);
   - 2 – acquired rights (positive);
   - 1 – suspended

3. To what extent have the system of automatic recognition and the general system been a success? How do you see the costs and benefits? Specify in particular whether automatic recognition based on diploma, Annex V and the current notification system represent an efficient way to facilitate automatic recognition. Please submit comments for:

   - automatic recognition based on diploma
   - automatic recognition based on acquired rights
   - recognition based on the general system.

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[1] Please provide this information unless it has already been provided to the Commission in the Database or the implementation reports.

Please specify whether there are any specific problems with Annex V.
The system of automatic recognition is the fastest way for recognition of qualifications but is leading to recognition of different levels of knowledge as equal. We consider the absence of language test is a problem.
On the other hand the recognition based on the general system gives the opportunity for thorough analysis of the applicant's training and setting a compensation measure thus decreasing the differences in knowledge level and actually testing the language knowledge.

4. Is the general system applied in your country each time the conditions for automatic recognition are not met? Are there major difficulties in the recognition procedure under the general system? Please include any comments you may have on the implementation of compensation measures. Is the migrant given the choice between an aptitude test and an adaptation period or is the choice restricted. Please explain.

   The general system is applied in our country each time the conditions for automatic recognition are not met. There aren't major difficulties in the recognition procedure under the general system. The Bulgarian legislation doesn't allow the choice of compensation measure to be made by the applicant in case of doctors. The decision for the compensation measure is made by the competent authority – the Ministry of Health.

5. What is your experience with the recognition procedure for EU citizens with professional qualifications obtained in a third country and already recognised in a first Member State (see Articles 2(2) and 3(3))?

   We haven't had the case.

6. Please describe the government structure of the competent authority or authorities in charge of the recognition.

   The recognition of professional qualifications of doctors is conducted by the Ministry of Health of Bulgaria which is the competent authority for all health professions. There is an expert committee by the Minister of Health which examines the documents of the applicants and submits to the Minister of Health a motivated proposal for recognition or refusal of recognition of professional qualification.
   The procedure of recognition of a qualification is initiated by a candidate's application.
   After the receipt of the application, the competent authority informs the candidate about any missing documents and asks for additional information if necessary. After the receipt of all documents required the competent authority must take a decision within three months on the basis of the expert committee's proposals.

B. TEMPORARY MOBILITY (OF A SELF-EMPLOYED OR AN EMPLOYED WORKER)

7. Are EU citizens interested in using the provisions for exercising their professional activities on a temporary and occasional basis in your Member State? How many citizens used this new system in 2008 and 2009 (per month, per year) [2]?

   In 2009 – 3 citizens declared provision of services.

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[2] Please provide this information unless it has already been provided to the Commission in the Database or the implementation reports.

8. How are the provisions of Directive 2005/36/EC concerning temporary mobility applied by the competent authorities in practice taking into account the relevant provisions of the Code of Conduct? For instance:

   - How is the "legal establishment" criteria foreseen by Article 5(1) (a) interpreted in practice? What conditions does a migrant need to fulfil in his home Member State in order to be able to provide services?

   The applicant has to submit a certificate issued by the competent authority of the relevant member-state that he/she is legally established on its territory for the pursuing the relevant activities and is not subject of any prohibition from practising, including temporary, at the moment of delivering the certificate.

   - How are the "temporary and occasional basis" criteria foreseen by Article 5.2 interpreted in practice? Do Member States assess duration, frequency, regularity and continuity of an activity and if so according to which criteria?

   According to the national legislation (art. 11, para 2 of the Law of recognition of professional qualifications) the duration, frequency, regularity and continuity of an activity is accessed on case-by-case basis.

9. Why is a prior declaration system necessary? What do competent authorities do with the information received? Are other possibilities conceivable? Do you have any cases – and if yes how many - whereby doctors sent the declaration after the provision of services has taken place.

   The Ministry of Health collects the information for statistical and analytical purposes. On the basis of the information we supervise the professionals delivering services in our country. We don't have cases of doctors who have sent the declaration after the provision of services.

10. Do you charge any fee in case Article 7, § 4 applies?

    Article 7, § 4 of Directive 2005/36/EC is not applicable for doctors as it concerns the professions which don't enjoy automatic recognition.
    The Ministry of Health of Bulgaria doesn't charge any fee in case of Article 7, § 4, i.e. health professions which do not benefit from automatic recognition under Title III Chapter III of the Directive – physiotherapist (rehabilitator), medical laboratory technician and so on.

C MINIMUM TRAINING REQUIREMENTS

11. To what extent are the common minimum training requirements for specialists and general practitioners set out in Title III Chapter III of Directive 2005/36/EC and as defined in Annex V in line with scientific progress and professional needs? Furthermore, are the knowledge and skills required by the directive still relevant and up to date? Please specify. What about the conditions relating to the duration of training? Do you have many specialties training, which have a common trunk. If yes, please specify which ones.

    We consider the minimum training requirements for specialist training set out in Directive 2005/36/EC are not sufficient as only the duration of the specialist training is specified. There aren't any requirements about the content of the specialist training. This may lead to

recognizing as equal specialties with different content and specialist training different in range.
We consider the minimum training requirements for general practitioners are still relevant and up to date.
In our opinion the duration of training of the specialties with 3 years minimum period of training should be increased to 4 years of training – these are Anaesthetics, Ophthalmology, Otorhinolaryngology, General Haematology, Endocrinology, Physiotherapy, Dermato-venereology and Allergology.
Until 01.01.2007 the specialties in Bulgaria were divided in main specialties and profile specialties (subspecialties). After the accession of Bulgaria to the EU this division no longer exists. Most of the specialties which have been subspecialties of Internal diseases have training in Internal diseases with different duration – Gastroenterology (16 months), Rheumatology and Clinical haematology (2 years), Pneumology and phthisiatry (48 weeks), Nephrology and Endocrinology and metabolism diseases (12 months).
The specialties which have been subspecialties of Surgery have training in General surgery – 24 months for Thoracic surgery, Paediatric surgery, Plastic-reconstructive and aesthetic surgery and Vascular surgery and 12 months for Cardiosurgery.

12. To what extent are the common minimum requirements for training set out in Title III Chapter III of Directive 2005/36/EC in line with scientific progress and professional needs in the last ten years? Are the knowledge and skills outlined in Article 24.3 still relevant and up to date? Please specify. What about the conditions relating to the duration of training?

    We consider the knowledge and skills outlined in Article 24.3 still relevant and up to date as they are generally stated. We think no change in the duration of the training of 6 years is necessary.

13. The Directive is based on mutual trust between Member States. To what extent is such trust actually achieved? Are training programmes accredited in your country? Does accreditation of a training program in another Member State enhance trust or is it not relevant?

    We consider mutual trust between Member States is not fully achieved.

14. To what extent are the existing Directive provisions (see recital 39 and Article 22(b) on continuous professional development (continuous training) adequate? Is continuous training mandatory in your country and what are the exact conditions?

    According to the Bulgarian national legislation continuous medical training is organized, coordinated, carried out and registered by the professional organisation of doctors.

D. ADMINISTRATIVE COOPERATION

15. To which extent does administrative cooperation, as outlined in Articles 8, 50, and 56 of the Directive, simplify procedures for the migrant professionals?

    The administrative cooperation can reduce the duration of the procedure of recognition of professional qualification.

16. Is the competent authority in your country registered with IMI? Under which circumstances does your competent authority use IMI? If not registered, why not and what would be the conditions for changing this situation?

Yes.

17. Are you alerted by other Member States in case of disciplinary action or criminal sanctions taken or any other serious, specific circumstances which are likely to have consequences for the pursuit of activities under this Directive? How do you share this information? Could more be done in this respect?

We haven't had the case.

E. OTHER OBSERVATIONS

18. How and when are the necessary language skills of migrants checked after recognition of the professional qualifications? Are you aware of any complaints (especially from patients/clients/employers) about insufficient language skills of migrants?

According to the Bulgarian legislation all doctors who pursue their profession have to be members of the professional association of doctors. The employer decides if the language skills of the migrant are sufficient to perform the relevant activities.

19. Does the application of Article 30 raise any specific problems?

No. We haven't had problems with article 30 of Directive 2005/36/EC.

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CZECH REPUBLIC

Evaluating the Professional Qualifications Directive
Experience reports from competent authorities

POSSIBLE QUESTIONNAIRE FOR EACH SECTORAL PROFESSION

A. RECOGNITION PROCEDURE IN CASE OF MIGRATION ON A PERMANENT BASIS

1. Do you accept applications from EU citizens for the recognition of foreign diplomas sent by email or requests made on line? Under which conditions can they send documents and declarations electronically? What are your experiences in this respect? **For the time bring, the submission of applications on time is not possible. However, this issue is bring solved.**

2. What is the yearly number of positive and negative decisions of recognition from 2000 to 2009? Please submit specific data for applications for automatic recognition based on diplomas, automatic recognition based on acquired rights (as from 2005), and recognition based on the general system[1]. If available, please provide information on the average duration of the recognition process. **There is not statistic available from 2000 to 2004. The data are not archivated. The statistic from 2005 to 2009 is not structured according these criteria, so it is not possible to isolate the number of qualification recognition based on diplomas, acquired rights or the general system. Generally, in previsious years 80% qualifications were recognised on the basis of diplomas, 15 % general system, 5 % acquired rights.** The typical duration of the recognition process takes based on the automatic recognition or acquired rights takes maximaly 1 month, based on general system – 2 – 3 months. (Because Medical Profession and Qualification Recognition Department sends the whole file for an expert assessment to The Institut of Postgradual Education).

Year	2005	2006	2007	2008	2009
The number of medical workers:	**292**	**225**	**105**	**159**	**112**

3. To what extent have the system of automatic recognition and the general system been a success? How do you see the costs and benefits? Specify in particular whether automatic recognition based on diploma, Annex V and the current notification system represent an efficient way to facilitate automatic recognition. Please submit comments for:

   - automatic recognition based on diploma
   - automatic recognition based on acquired rights

[1] Please provide this information unless it has already been provided to the Commission in the Database or the implementation reports.

- recognition based on the general system.

Please specify whether there are any specific problems with Annex V. **When the diploma issued in another Member State contains all the necessary formalities (the verification, apostila, the conformity of education verified by competent authorities of the state, where the applicant received his education) then this recognition system is unambiguously the less financially demanding and time-consuming. The recognition based on required rights is as demanding and effective as the conformity. The recognition based on the general system is the most demanding and time-consuming, to however, it is very exact as the education programme is compared with the programme valid for the Czech Republic on the basis of the index and logbook (the list of practice and performances in case of specialist training) submission.**

4. Is the general system applied in your country each time the conditions for automatic recognition are not met? Are there major difficulties in the recognition procedure under the general system? Please include any comments you may have on the implementation of compensation measures. Is the migrant given the choice between an aptitude test and an adaptation period or is the choice restricted. Please explain. **Yes, the general system is applied everytime when the conditions of automatic recognition are not fulfilled. It is predominantly specialist training in a field that is not included in the Directive 2005/36/EC in appendix 5.1.3. but exist in the Czech Republic. There are difficulties only with the time-consumption genrally the assessing books 2-3 months) and financial demandingness. The migrant can choice between an aptitude test and an adaptation period. But this example has not been existing for the last years.**

5. What is your experience with the recognition procedure for EU citizens with professional qualifications obtained in a third country and already recognised in a first Member State (see Articles 2(2) and 3(3))? **This type of recognition is not common in the Czech Republic. If such a case of recognition occurs, problems are always incountered in submitting of documents issued in the first Member state of EU. The applicants often have to undergo the process of qualification as the applicants that received their education in so called Third World.**

6. Please describe the government structure of the competent authority or authorities in charge of the recognition. **Ministry of Health of the Czech Republic → Department of Education and Science → Section of medical professions and qualification recognition (and as advisory body the Institut of Postgradual education)**

B. TEMPORARY MOBILITY (OF A SELF-EMPLOYED OR AN EMPLOYED WORKER)

7. Are EU citizens interested in using the provisions for exercising their professional activities on a temporary and occasional basis in your Member State? How many citizens used this new system in 2008 **(no applicant)** and 2009 **(7 applicants)** (per

month, per year) [2]? **Yes, EU citizens areincreasingly interested in this type of the profession performance, but at this time not in the past.**

8. How are the provisions of Directive 2005/36/EC concerning temporary mobility applied by the competent authorities in practice taking into account the relevant provisions of the Code of Conduct? For instance:

   - How is the "legal establishment" criteria foreseen by Article 5(1) (a) interpreted in practice? What conditions does a migrant need to fulfil in his home Member State in order to be able to provide services?

   - How are the "temporary and occasional basis" criteria foreseen by Article 5.2 interpreted in practice? Do Member States assess duration, frequency, regularity and continuity of an activity and if so according to which criteria? **In the Czech Republic, there are two types of applications for the limited period of time. Most common is the announcement of the visiting person for the medical profession performance, that is time-limited for one year and the applicant has so submit** copy of an identification card, copy of document confirming nationality; officially verified copy of a document concerning the authorization to perform the medical profession within the EU; officially verified copy of legal performing of the medical profession in the member state of origin, (document certifying the fact that authorization was not revoked or temporarily suspended); document confirming basic qualification; officially verified copy of a document of insurance concerning the responsibility for any harm caused during the performance of the medical profession. **Another possibility is so called one-time performance announcement when it is only needed to send the Ministry of Health a letter declaring that the applicant had been invited by a health institution for one-time performances. Maximum time for the medical profession performance is two months and the medical institution advises the Ministry of Health the name, nationality, date of birth, kind of specialty training and the address of the institution where the applicant will be employed.**

9. Why is a prior declaration system necessary? What do competent authorities do with the information received? Are other possibilities conceivable? Do you have any cases – and if yes how many - whereby doctors sent the declaration after the provision of services has taken place. **The recognition unit is in charge of the archivation of all the applications submitted to the Ministry of Health. If the same applicant submits another application, only the documents whose validity is time-limited are reguired.** Yes, we have some these cases – for this year 2 cases because of a bad communication between the health institution and the physician. We sent to the employer the warning explained that is not possible to the letter declaring that the applicant had been invited by a health institution for one-time performances after this term otherwise it will be it will be considered as a brake of the law (the Act No. 95/2004 Coll. about the basic and specialist qualification recognition)

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[2] Please provide this information unless it has already been provided to the Commission in the Database or the implementation reports.

10. Do you charge any fee in case Article 7, § 4 applies? **The Ministry of Health do not charge any fee in case applying the announcement of the visiting person for the medical profession performance or one-time performance announcement.**

C MINIMUM TRAINING REQUIREMENTS

11. To what extent are the common minimum training requirements for specialists and general practitioners set out in Title III Chapter III of Directive 2005/36/EC and as defined in Annex V in line with scientific progress and professional needs? Furthermore, are the knowledge and skills required by the directive still relevant and up to date? Please specify. What about the conditions relating to the duration of training? Do you have many specialties training, which have a common trunk. (the attached document) If yes, please specify which ones. **The common minimum training requirements set out in Title III Chapter III of Directive 2005/36/EC are very general, but The Czech Republic has no problem with it. For example the minimum training programme of specialties in the Czech Republic is longer than introduced by the Directive 2005/36/EC.**

12. To what extent are the common minimum requirements for training set out in Title III Chapter III of Directive 2005/36/EC in line with scientific progress and professional needs in the last ten years? Are the knowledge and skills outlined in Article 24.3 still relevant and up to date? Please specify. What about the conditions relating to the duration of training? **The common minimum training requirements set out in Title III Chapter III of Directive 2005/36/EC are very general, but The Czech Republic has no problem with it. For example the minimum training programme of specialties is longer than introduced by the Directive 2005/36/EC.**

13. The Directive is based on mutual trust between Member States. To what extent is such trust actually achieved? **Yes, we trust every statement issued by competent authorities.** Are training programmes accredited in your country? **No, we have only accredited workplaces where physicians and dentists have to work and improve their qualification to get the certificate of specialty training.** Does accreditation of a training program in another Member State enhance trust or is it not relevant? **No, it is not relevant.**

14. To what extent are the existing Directive provisions (see recital 39 and Article 22(b) on continuous professional development (continuous training) adequate? Is continuous training mandatory in your country and what are the exact conditions? **A physician, who had finished his University studies and has started (zařadit se) his specialist training, is obliged to study to receive a Certificate of specialist training. Long life education is organized and arranged by the Institut of Postgradual Education, medical faculties and the Czech Medical Council. The Institut of Posrgradual Education gets every information about long life education . Contact person is Mrs. Řeháková; www.ipvz.cz**

D. ADMINISTRATIVE COOPERATION

15. To which extent does administrative cooperation, as outlined in Articles 8, 50, and 56 of the Directive, simplify procedures for the migrant professionals? **Administrative cooperation is very beneficial and useful, mainly email corespondence and IMI system. But sometimes not fast and sufficient enough.**

16. Is the competent authority in your country registered with IMI? Under which circumstances does your competent authority use IMI? If not registered, why not and what would be the conditions for changing this situation? **The IMI System is used by the Ministry of Health, mainly to answear the inquiries of other Member States.**

17. Are you alerted by other Member States in case of disciplinary action or criminal sanctions taken or any other serious, specific circumstances which are likely to have consequences for the pursuit of activities under this Directive? How do you share this information? Could more be done in this respect? **Yes, the Ministry of Health of Czech Republic is alerted by other Member States. We add the name of physician to the list and save it. But our department is not in charge of suspensions/restrictions. The Czech Medical Council, The Czech Dentist Council, The Czech farmacist Council are competent to this issue.**

E. OTHER OBSERVATIONS

18. How and when are the necessary language skills of migrants checked after recognition of the professional qualifications? Are you aware of any complaints (especially from patients/clients/employers) about insufficient language skills of migrants? **If an applicant does not have minimum knowledge of Czech language (secondary school or University studies in czech language, Certificate of Czech language from a language school), Ministry of Health is going to test the applicant´s language knowledge. The applicant is advised the term 1 month prior to the examination. The applicant has to understand a printed specialist text and spoken word. The applicant´s response in communication is important to find out whether he is able to understand the patient and the specialist terminology in czech language.**

19. Does the application of Article 30 raise any specific problems? **No, it does not. Because Czech physicians has received the diplomas in this branch according Annex V 5.1.4. so we has confirmed this specialty according the Article 28 if Czech general practitioners want to leave to work abroad.**

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Direfentiation of specialization according common trunks:

General (internal) trunk:

- Immunology
- Dermatovenerology
- Endocrinology
- Gastroenterology
- Geriatrics
- General Haematology
- Communicable Diseases
- Cardiology
- Biological Chemistry
- Clinical Oncology (these specialty exists only in the Czech Republic)
- Medical Genetics
- Mikrobiology-Bacteriology
- Neurology
- Renal Diseases
- Nuclear Medicine
- Pneumology and ftizeology
- Radiotherapy
- Physiotherapy
- Reumatology
- General Medicine
- General Practical Medicine

Paediatric trunk:

- Immunology
- Paediatrics
- Endocrinology
- General Haematology
- Communicable Diseases
- Biological chemistry
- Clinical Onkology
- Medical Genetics
- Child General Practical Medicine
- Physiotherapy

Surgical trunk:

- Vascular Surgery
- Dermatovenerology
- Paediatric Surgery
- Gastroenterology
- Surgery
- Thoracic Surgery
- Neurological Surgery
- Ophthalmology
- Orthopaedics
- Otorhinolaringology
- Plastic Surgery
- Physiotherapy
- Accident and Emergency Medicine

- Urology

Anaesthetics trunk:

- Only Anaesthetics

General Practical medicine´s trunk:

- Geriatrics
- General Practical Medicine

Obstetrics and Gynaecology trunk:

- Obstetrics and Gynaecology
- Medical Genetics

Hygienic trunk:

- Community Medicine

Radiology trunk:

- Nuclear Medicine
- Radiology

Patological trunk:

- Pathological Anatomy

Psychiatric trunk:

- Psychiatry

You can see many of these specialties have more than 1 trunk but not at all!
I rendered to this summary as well as the specialties which exist only in the Czech Republic.

DENMARK

Evaluating the Professional Qualifications Directive
Experience reports from competent authorities
Doctors

DENMARK

A. RECOGNITION PROCEDURE IN CASE OF MIGRATION ON A PERMANENT BASIS

1. Do you accept applications from EU citizens for the recognition of foreign diplomas sent by email or requests made on line? Under which conditions can they send documents and declarations electronically? What are your experiences in this respect?

In Denmark we prefer applicants to use our online application forms available on www.sst.dk

Documentation however must be submitted by ordinary mail as certified copies. With regard to the Certificate of Current Professional Status (CCPS) we require an original document sent directly from the competent authority.

In general we do not have any problems with applications from EU health personnel. However if in doubt we use the IMI system

2. What is the yearly number of positive and negative decisions of recognition from 2000 to 2009? Please submit specific data for applications for automatic recognition based on diplomas, automatic recognition based on acquired rights (as from 2005), and recognition based on the general system[1]. If available, please provide information on the average duration of the recognition process.

Data has already been provided to the Commission in the Database through our coordinator

3. To what extent have the system of automatic recognition and the general system been a success? How do you see the costs and benefits? Specify in particular whether automatic recognition based on diploma, Annex V and the current notification system represent an efficient way to facilitate automatic recognition. Please submit comments for:

   - automatic recognition based on diploma
   - automatic recognition based on acquired rights
   - recognition based on the general system.

Please specify whether there are any specific problems with Annex V.

Automatic recognition *based on diplomas is a success, as persons meeting minimum training*

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[1] Please provide this information unless it has already been provided to the Commission in the Database or the implementation reports.

requirements stipulated in the directive can quickly be recognised in host EU member states. The costs are low, as the work with recognition is simplified. It is optimal for the employers, who relatively quickly can recruit personnel from within the EU member states.

Automatic recognition based on ***acquired rights*** *is a success for the persons in question; if they meet the requirement of having effectively and lawfully been engaged in the relevant activities for at certain period they can also quickly get recognition.*

We however find that having effectively and lawfully been engaged in activities as a doctor not necessarily compensates for deficiencies in the medical training.

Recognition based on the ***general system*** *is good for the migrants, as they have the right to be recognised in other EU member states even though there may be substantial differences in educations. It can, however, often be difficult for the applicant to get documentation with details of the education undergone. The persons in question often have an education that goes back many years. Furthermore translation of documents will often be required, a substantial expense for the applicant.*

Compensation measures are not easily applicable. When applicants do not master the local language (Danish) they have difficulties finding positions for adaptation periods. Having to pass an aptitude test in a foreign language is equally difficult.

It is difficult to have a test system that has to take individual educational deficiencies into consideration and it is very costly.

4. Is the general system applied in your country each time the conditions for automatic recognition are not met? Are there major difficulties in the recognition procedure under the general system? Please include any comments you may have on the implementation of compensation measures. Is the migrant given the choice between an aptitude test and an adaptation period or is the choice restricted. Please explain.

Yes. The general system is applied. The migrant is given the choice between an aptitude test and an adaptation period.
See under 3.

When an applicant has chosen an adaptation period, the applicant must himself/herself find employment reflecting the deficiencies found in the education. A prerequisite for employment is often that the applicant masters the Danish language in order to find employment and successfully go through the adaptation period.

5. What is your experience with the recognition procedure for EU citizens with professional qualifications obtained in a third country and already recognised in a first Member State (see Articles 2(2) and 3(3))?

We have experienced difficulties getting documentation from competent authorities stating that the applicant has effectively and lawfully been engaged in the relevant activities for 3 years in the EU member state that recognised the third country education.

6. Please describe the government structure of the competent authority or authorities in charge of the recognition.

The National Board of Health (NBH) is a Board under the Ministry of the Interior and Health.
Registration of all health professionals (of who registration is required in Denmark) is done by the NBH in the department for education and registration (EFUA)
Supervision of health personnel is done by the NBH in the department for supervision (EfT).
Further information on the NBH is to be found on http://www.sst.dk/English.aspx

B. TEMPORARY MOBILITY (OF A SELF-EMPLOYED OR AN EMPLOYED WORKER)

7. Are EU citizens interested in using the provisions for exercising their professional activities on a temporary and occasional basis in your Member State? How many citizens used this new system in 2008 and 2009 (per month, per year) [2]?

From 2005 to 2009 13 persons have made use of the provisions for exercising their professional activities on a temporary and occasional basis. Of these 11from Sweden, 1 from Norway and 1 from Germany.
2005: 1
2006: 3
2007: 1
2008: 6
2009:2

8. How are the provisions of Directive 2005/36/EC concerning temporary mobility applied by the competent authorities in practice taking into account the relevant provisions of the Code of Conduct? For instance:

   - How is the "legal establishment" criteria foreseen by Article 5(1) (a) interpreted in practice? What conditions does a migrant need to fulfil in his home Member State in order to be able to provide services?

   - How are the "temporary and occasional basis" criteria foreseen by Article 5.2 interpreted in practice? Do Member States assess duration, frequency, regularity and continuity of an activity and if so according to which criteria?

Legal establishment is documented through administrative corporation e.g. CCPS from home member state or through IMI
Further documentation: copy of passport.
Criteria: Legally established (right to practice his/her profession)
We give the right to work temporarily within a period of 12 months. The right can be renewed. New CCPS will be required required.
If the work is of more permanent character we require that the person in question gets permanent registration.
It may be difficult to set criteria to determine what is considered temporary and what is more permanent on the basis of the article.

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[2] Please provide this information unless it has already been provided to the Commission in the Database or the implementation reports.

9. Why is a prior declaration system necessary? What do competent authorities do with the information received? Are other possibilities conceivable? Do you have any cases – and if yes how many - whereby doctors sent the declaration after the provision of services has taken place.

According to Danish legislation (Act no. 1350 of 17 December 2008 on Authorization of Health Care Professionals and on Professional Health Care Practice) the National Board of Health has to supervise medical personnel. Supervision of medical personnel is part of the system of securing patient safety. In order to be able to supervise medical personnel who on temporary or occasional basis practise in Denmark we find a prior declaration is necessary.

We have had no cases where doctors sent the declaration after the provision of services has taken place.

10. Do you charge any fee in case Article 7, § 4 applies?

No

C MINIMUM TRAINING REQUIREMENTS

11. To what extent are the common minimum training requirements for specialists and general practitioners set out in Title III Chapter III of Directive 2005/36/EC and as defined in Annex V in line with scientific progress and professional needs? Furthermore, are the knowledge and skills required by the directive still relevant and up to date? Please specify. What about the conditions relating to the duration of training? Do you have many specialties training, which have a common trunk. If yes, please specify which ones.

For the existing specialties listed in V.5.1.3, we have found no reason for proposing change in education duration based on Art 25 (3). Danish competent authority also makes approvals of the curricula. This collaboration with the scientific societies therefore contributes to ensure that duration of training and theoretical education meet the international standards and the scientific progress.

It is most relevant, that the directive stresses on the length of the specialist training as well as the theoretical education in the training program. The directive should require that member states offers more transparency about organisation, structure, length and content of their notified specialties laid down in the Annex V.

The Danish specialist reform from 2004 changed the specialist structure by cessation of subspecialties in ***surgery and internal medicine****, turning them to basic specialties. In order to ensure broad competences and skills in these areas, all trainees must accomplish 1-2 years common trunk education during the postgraduate specialist training. Therefore, these training programs have been extended to 6 years.*

12. To what extent are the common minimum requirements for training set out in Title III Chapter III of Directive 2005/36/EC in line with scientific progress and professional needs in the last ten years? Are the knowledge and skills outlined in Article 24.3 still relevant

and up to date? Please specify. What about the conditions relating to the duration of training?

The overall intentions stated in Article 24.3 a – d are still highly relevant. We find it of importance, that the hours of theory and hours of practical training in all basic and clinical subjects are well described.

Denmark could recommend, that the trans-national and/or the European dimension is more visualised in accordance with declarations from the Bologna process, i.e. the Loeven communiqué.

13. The Directive is based on mutual trust between Member States. To what extent is such trust actually achieved? Are training programmes accredited in your country? Does accreditation of a training program in another Member State enhance trust or is it not relevant?

Meetings between competent authorities where you may discuss issues/problems of mutual interest can be very fruitful. At the same time you get the opportunity to informally talk to the respective representatives of a member state/competent authority about specific problems/misunderstandings. Having access to and knowledge of the representative may enhance trust.

Trust can furthermore only be sustained when the competent authorities take on their responsibility when issuing certificates. We have unfortunately seen cases where incorrect information has been given by competent authorities about training or acquired rights. Information given did not support the evidence seen on transcripts and CVs, sent by the applicant unasked.

Accreditation is national and does therefore not necessarily enhance trust. However, EU should enforce interest among member states for international accreditation of specialist training by the European Boards of UEMS.

The basic training of medical graduates is accredited in Denmark. In addition the NBH sees and comments on the curricula, before it is approved by the Ministry of Science Technology and Innovation

14. To what extent are the existing Directive provisions (see recital 39 and Article 22(b) on continuous professional development (continuous training) adequate? Is continuous training mandatory in your country and what are the exact conditions?

The law implies that doctors must keep knowledge and skills up to date. Formal continuing education is however not mandatory in Denmark.

D. ADMINISTRATIVE COOPERATION

15. To which extent does administrative cooperation, as outlined in Articles 8, 50, and 56 of the Directive, simplify procedures for the migrant professionals?

The administrative cooperation does simplify procedures, however to a certain extent national legislation can prohibit certain information from being exchanged.

16. Is the competent authority in your country registered with IMI? Under which circumstances does your competent authority use IMI? If not registered, why not and what would be the conditions for changing this situation?

Yes. We use IMI when we find that further information is required when processing applications. IMI is a good system but time consuming. It is e.g. not always easy to find the relevant questions. Furthermore not all professions are included in the IMI system, and some competent authorities are not in the system, especially where there are many in one country.

IMI needs further development. There should e.g. be better possibilities to question the first answer received, so that you do not have to start all over with a new inquiry when you get an answer.

17. Are you alerted by other Member States in case of disciplinary action or criminal sanctions taken or any other serious, specific circumstances which are likely to have consequences for the pursuit of activities under this Directive? How do you share this information? Could more be done in this respect?

Some authorities alert the NBH.

We have a public register on our home page sst.dk. Here it is possible for anyone to see whether doctors and other registered health personnel are registered.
At the moment this information is only available in Danish, but we are working on having an English version too.

E. OTHER OBSERVATIONS

18. How and when are the necessary language skills of migrants checked after recognition of the professional qualifications? Are you aware of any complaints (especially from patients/clients/employers) about insufficient language skills of migrants?

The employer may set language requirements. Furthermore the employer must be convinced that the person they employ has sufficient language proficiencies to be able to fill in the position. We have examples of employers who contact the NBH informally because they experience language/communication problems. Some regions require that the foreign employee passes a Danish language test within the first half year of employment, if the employment should be prolonged.

Language skills are a prerequisite in order to communicate in the Danish health system. Furthermore communication is a great part of what doctors do. We find that it should be made possible to require certain language skills as part of the recognition procedure.

19. Does the application of Article 30 raise any specific problems?

Level of education can vary substantially, especially where general practice requires specialist medical training.

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GERMANY

BEWERTUNG DER RICHTLINIE 2005/36/EG

Zusammenfassung der Erfahrungsberichte der zuständigen deutschen Behörden auf Grundlage des vorgegebenen Fragebogens für den ärztlichen Beruf

A. ANERKENNUNGSVERFAHREN BEI DAUERHAFTER NIEDERLASSUNG/ WOHNSITZÄNDERUNG

1. Akzeptieren Sie Anträge von EU-Bürgern auf Anerkennung ausländischer Diplome, die per E-Mail oder online gestellt werden? Unter welchen Bedingungen können Unterlagen und Meldungen elektronisch übermittelt werden? Welche Erfahrungen haben Sie in diesem Zusammenhang gemacht?

Approbationsbehörden:
Der allgemeine Schriftverkehr, etwa zur Abklärung des Verfahrens kann per E-Mail abwickelt werden. Antragsunterlagen müssen jedoch (ggf. nachgereicht) als Originale oder beglaubigte Kopien vorgelegt werden.

Bundesärztekammer:
Voraussetzung für die Anerkennung einer fachärztlichen Weiterbildung durch die Landesärztekammern ist eine bestehende, gültige Approbation bzw. Berufserlaubnis. Die elektronische Antragstellung ist nicht einheitlich geregelt: Einige Landesärztekammern lassen keine elektronische Antragstellung zu, in anderen Kammern ist sie unter bestimmten Voraussetzungen möglich. Die Antragstellung auf Anerkennung ausländischer Diplome per E-Mail oder online begründet in der Regel jedoch lediglich eine unverbindliche Voranfrage. Um einem möglichen Missbrauch durch gefälschte Unterlagen vorzubeugen, müssen auch bei elektronischer Antragstellung zu einem späteren Zeitpunkt die Unterlagen in beglaubigter Kopie vorgelegt werden.

2. Wie viele Anerkennungsanträge wurden im Zeitraum 2000 bis 2009 jährlich genehmigt bzw. nicht genehmigt? Bitte übermitteln Sie uns spezifische Angaben zu Anträgen auf automatische Anerkennung auf der Grundlage von Diplomen, automatische Anerkennung auf der Grundlage erworbener Rechte (ab 2005) und Anerkennung nach der allgemeinen Regelung[1]. Soweit möglich, geben Sie bitte die durchschnittliche Dauer der Anerkennungsverfahren an.

Approbationsbehörden:
Daten zu der Anzahl der Anerkennungsanträge liegen der Kommission vor.
Abhängig von Qualität und Vollständigkeit der Unterlagen sowie der Mitwirkung der Antragsteller dauern die Verfahren durchschnittlich ca. 1 bis 2 Monate.

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[1] Machen Sie die Angaben bitte dann, wenn sie der Kommission nicht bereits für die Datenbank oder in den Durchführungsberichten übermittelt wurden.

Bundesärztekammer:
Die Anzahl genehmigter bzw. nicht genehmigter Anerkennungsanträge kann aufgrund der vorliegenden Datengrundlage nicht angegeben werden. Sofern Zahlen der Landesärztekammern für die Jahre 2000 bis 2005 vorliegen, ist eine signifikante Zunahme gestellter Anträge im Jahr 2004 zu beobachten. Mit Umsetzung der Richtlinie 2005/36/EG in nationales Recht, steigt die Anzahl der gestellten Anträge weiter. Die Dauer des Anerkennungsverfahrens ist in den Kammergebieten unterschiedlich. Die Mindestdauer des Verfahrens beträgt eine Woche, in manchen Landesärztekammern länger. Die zulässige Vorgabe der (Muster-)Weiterbildungsordnung 2003 in der Fassung von Juni 2010 lautet: „Das Verfahren für die Prüfung eines Antrags auf Zulassung zur fachärztlichen Tätigkeit muss innerhalb kürzester Frist abgeschlossen werden, spätestens jedoch drei Monate nach Einreichung der vollständigen Unterlagen des Arztes; die Entscheidung muss begründet werden." Die (Muster-)Weiterbildungsordnung ist nicht geltendes Recht. Rechtswirkung entfalten aber die jeweiligen Weiterbildungsordnungen, die durch die Kammerversammlungen der Ärztekammern als Satzung beschlossen und von den Aufsichtsbehörden genehmigt wurden.

3. **Inwieweit waren das System der automatischen Anerkennung und die allgemeine Regelung ein Erfolg? Wie schätzen Sie Kosten und Nutzen ein? Bitte äußern Sie sich insbesondere dazu, ob die automatische Anerkennung auf der Grundlage von Diplomen, Anhang V und das derzeitige Meldesystem die automatische Anerkennung wirksam erleichtern. Bitte machen Sie Angaben zur**

   - **automatischen Anerkennung auf der Grundlage von Diplomen,**
   - **automatischen Anerkennung auf der Grundlage erworbener Rechte,**
   - **Anerkennung nach der allgemeinen Regelung.**

   Geben Sie bitte an, ob besondere Probleme im Zusammenhang mit Anhang V bestehen.

Approbationsbehörden:

Die automatische Anerkennung auf der Grundlage von Diplomen und auf der Grundlage erworbener Rechte erleichtert und beschleunigt das Verfahren, wobei insbesondere maßgeblich ist, ob der Antragsteller eine Konformitätsbescheinigung vorlegen kann. Vereinzelt wird berichtet, dass Konformitätsbescheinigungen hinterfragt werden, wenn sich Zweifel an der Richtigkeit ergeben (Gefälligkeitsausstellungen); rumänische Bescheinigungen wurden beispielhaft erwähnt.

Die Anerkennung nach der allgemeinen Regelung spielt zwar zahlenmäßig nur eine kleine Rolle. Es ist für die Vollzugsbehörden jedoch schwierig, die Defizite der Ausbildung festzustellen (teilweise nur durch Gutachten möglich) und ob und inwieweit diese durch Berufsausübung ausgeglichen werden konnten.

Von besonderen Problemen im Zusammenhang mit Anhang V wird nur vereinzelt berichtet, da im Falle von Bulgarien, Griechenland und Zypern Dokumente in kyrillischer bzw. griechischer Schrift ausgestellt werden.

Bundesärztekammer:

Der Erfolg des Systems automatischer Anerkennung ist unstrittig, da sie eine erhebliche Erleichterung für die Landesärztekammern als zuständige Behörde für die Anerkennung der fachärztlichen Weiterbildung bedeutet (s. Ausführungen zur allgemeinen Regelung, Antwort zu Frage 4). Trotz der überwiegend positiven Erfahrung mit dem System automatischer Anerkennung ist aus Sicht der Bundesärztekammer auf systemimmanente Probleme im Zusammenhang mit Anhang V hinzuweisen:

(a) „Weiterbildungstourismus": Die Richtlinie kann zielgerichtet zur Umgehung des Weiterbildungsrechts im Herkunftsland genutzt werden. Dies ist der Fall, wenn die Abnahme der Facharztprüfung im EU-Ausland erfolgt, obwohl der Weiterzubildende über die Mitgliedschaft im Zuständigkeitsbereich einer deutschen Landesärztekammer verfügt und seine Weiterbildung in Deutschland absolviert hat.

(b) Inhaltliche Inkongruenzen: Inhalt und Titel der notifizierten Facharztbezeichnung stimmen innerhalb einer Rubrik in Anhang V nicht überein. Die fachärztliche Weiterbildung anderer Mitgliedstaaten entspricht inhaltlich nicht in allen Fällen der für Deutschland notifizierten Bezeichnung (z.B. Rubrik Gastroenterologie). Die Thoraxchirurgie und die Herzchirurgie sind in der Richtlinie nicht hinreichend präzise voneinander abgegrenzt. Durch Notifizierung von Bezeichnungen in zwei Rubriken des Anhangs V ist solchen inhaltlichen Inkongruenzen zwar entgegenzuwirken, allerdings zum Preis höherer Komplexität.

(c) Wünschenswert wäre eine Datenbank, die alte bzw. ehemalige Facharztbezeichnungen mit Enddatum auflistet, obwohl dies für Deutschland aufgrund der föderalistischen Strukturen problematisch ist.

4. Wird in Ihrem Land in allen Fällen, in denen die Bedingungen für die automatische Anerkennung nicht erfüllt sind, die allgemeine Regelung angewendet? Existieren größere Probleme mit dem Anerkennungsverfahren nach der allgemeinen Regelung? Machen Sie gegebenenfalls Angaben zur Anwendung der Ausgleichsmaßnahmen. Hat der Migrant die Wahl zwischen einer Eignungsprüfung und einem Anpassungslehrgang? Bitte machen Sie nähere Angaben.

Approbationsbehörden:
Sofern den Antragstellern die Approbation nicht im Wege der automatischen Anerkennung erteilt werden kann, kommt die allgemeine Regelung zur Anwendung. Mehrheitlich wird berichtet, dass das Verfahren ohne größere Probleme abgewickelt werden kann.
Es wird jedoch auch angemerkt, dass das Anerkennungsverfahren nach den Vorschriften der allgemeinen Regelung für Antragsteller oft nicht leicht nachzuvollziehen

ist, insbesondere was die Feststellung der Ausbildungsdefizite betrifft. Die zuständigen Behörden haben teilweise Probleme, da dort kein ausreichender medizinfachlicher Sachverstand vorhanden ist, um ausländische Ausbildungen im Hinblick auf die wesentlichen Unterschiede zur deutschen Ausbildung zu bewerten. Hierfür muss oft nach einem Sachverständigen (z. B. ein Hochschullehrer) gesucht werden, der hierzu bereit und befähigt ist.
Der Migrant hat keine Wahl zwischen Eignungsprüfung und Anpassungslehrgang. Als Ausgleichsmaßnahme wird nach der BÄO ausschließlich die sog. „Defizitprüfung" als Eignungsprüfung unter Berücksichtigung der erworbenen Berufserfahrung, nicht aber ein Anpassungslehrgang angeboten.

Bundesärztekammer:
Werden die Bedingungen für die automatische Anerkennung nicht erfüllt, wird zur Anerkennung von Facharztdiplomen durch die Landesärztekammern die allgemeine Regelung angewendet. Größere Probleme mit dem Anerkennungsverfahren bestehen zwar nicht, jedoch bedeutet die allgemeine Regelung im Vergleich zur automatischen Anerkennung einen erheblichen Verwaltungsmehraufwand.
Dieser Mehraufwand entsteht, da das Qualifikationsniveau des Antragstellers aus den vorgelegten Urkunden nicht immer zweifelsfrei ersichtlich ist. Die dann folgende Einzelfallprüfung wird notwendig, um die Übereinstimmung des durch die vorgelegte Urkunde aus dem Heimatland nachgewiesenen Qualifikationsniveaus mit dem in der Weiterbildungsordnung der jeweiligen Landesärztekammer niedergelegten Niveau zu überprüfen.
Der migrierende Arzt muss nach landesgesetzlichen Vorgaben im Fall wesentlicher Unterschiede eine **Eignungsprüfung** im Sinne einer **Defizitprüfung** ablegen. Defizitprüfung bedeutet, dass sich die Prüfung auf diejenigen Bereiche zu beschränken hat, in denen die Weiterbildung des Antragstellers hinter der in der anwendbaren Weiterbildungsordnung geregelten Weiterbildung zurückbleibt. Ohne Wissen über die Inhalte der Weiterbildung im Herkunftsland ist die Bestimmung der Defizite jedoch kaum möglich.

5. Welche Erfahrungen haben Sie mit dem Anerkennungsverfahren für EU-Bürger mit in Drittländern erworbenen Berufsqualifikationen, die bereits in einem anderen Mitgliedstaat anerkannt wurden, gemacht (s. Artikel 2 Absatz 2 und Artikel 3 Absatz 3)?

Approbationsbehörden:
Es kann nur auf wenig Erfahrung mit diesen Anerkennungsverfahren zurückgegriffen werden. Grundsätzlich bereitet es keine Probleme, die Approbation zu erteilen, sofern die zuständige Stelle seines Herkunftslandes dem Antragsteller die Anerkennung des Ausbildungsnachweises und die dreijährige rechtmäßige Ausübung des Berufes bescheinigt. In Einzelfällen ist unklar, ob die Anerkennung aufgrund der Richtlinie 2005/36/EG oder bilateraler Abkommen (z.B. Spanien, Griechenland, Österreich) erfolgte. Dies erfordert weiteren Ermittlungsaufwand. In diesem Sinne wäre es wünschenswert, wenn aus den Bescheinigungen des erstanerkennenden Staates erkennbar wäre, ob und welche Ausgleichsmaßnahmen ergriffen wurden.

Bundesärztekammer:

Die Anerkennung der wenigen Anträge von EU-Bürgern mit in Drittländern erworbenen Berufsqualifikationen, die bereits in einem anderen Mitgliedstaat anerkannt wurden, verlief bislang überwiegend problemlos.

6. Stellen Sie bitte die Organisationsstruktur der zuständigen Behörde(n) dar, die für die Anerkennungen verantwortlich ist (sind).

Approbationsbehörden:
In der föderalistischen Struktur der Bundesrepublik Deutschland führen die Länder die Bundesgesetze (hier Bundesärzteordnung - BÄO) als eigene Angelegenheit aus. In den jeweiligen Ländern sind verschiedene Behörden für die Anerkennung der ärztlichen Grundausbildung zuständig. In den meisten Ländern sind dies staatliche Mittelbehörden, bei einigen Ländern auch obere oder oberste Landesbehörden. Insgesamt sind in der Bundesrepublik Deutschland inklusive der Landesärztekammern, die auch Aufgaben im Rahmen der Berufsanerkennungsrichtlinie wahrnehmen, 40 Behörden zuständig.

Bundesärztekammer:
Zuständige Behörden für die Anerkennung der fachärztlichen Weiterbildung (Art. 25 Richtlinie 2005/36/EG) sind die Landesärztekammern, die als Körperschaften Öffentlichen Rechts der Rechtsaufsicht der Gesundheitsministerien der Länder unterstehen. Die Prüfung der eingereichten Unterlagen und die Entscheidung über die Anerkennung einer im Ausland erworbenen fachärztlichen Qualifikation erfolgt in der Regel durch die Abteilung Weiterbildung der Landesärztekammern.

B. VORÜBERGEHENDE MOBILITÄT (SELBSTÄNDIGER ODER ABHÄNGIG BESCHÄFTIGTER)

7. Zeigen die EU-Bürger Interesse an der Nutzung der Bestimmungen für die vorübergehende oder gelegentliche Ausübung ihres Berufes in Ihrem Mitgliedstaat? Wie viele Bürger haben dieses neue System 2008 und 2009 genutzt (monatlich, jährlich)[2]?

Approbationsbehörden:
Es wurde nur vereinzelt Dienstleistungserbringungen angezeigt. Es ist davon auszugehen, dass auch bei einer nur vorübergehenden Ausübung des Berufes eine Approbation beantragt wird.

Bundesärztekammer:
Der Berufszugang im Wege der Dienstleistungserbringung erfordert in Deutschland eine Vorab-Meldung bei der zuständigen Behörde. Die für den Berufszugang zuständigen Behörden sind die Approbationsbehörden. Eine Verpflichtung zu einer Mitgliedschaft bei einer Berufsorganisation wie den Landesärztekammern (LÄK) sieht die Richtlinie nicht vor und wurde daher auch nicht umgesetzt. In einigen Bundesländern ist es landesrechtlich vorgesehen, dass die LÄK von den Approbationsbehörden Kopien der Meldungen erhalten. Die LÄK berichten von einer nur sehr geringfügigen

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[2] Machen Sie die Angaben bitte dann, wenn sie der Kommission nicht bereits für die Datenbank oder in den Durchführungsberichten übermittelt wurden.

Anzahl von Kopien - gehen aber tatsächlich von einer höheren Anzahl von Dienstleistungserbringern aus, die etwa aus Unwissen eine Meldung unterlassen.

8. **Wie wenden die zuständigen Behörden – unter Berücksichtigung der relevanten Bestimmungen des Verhaltenskodex – die Bestimmungen der Richtlinie 2005/36/EG zur vorübergehenden Mobilität in der Praxis an? Geben Sie z. B. an,**

   - **wie das in Artikel 5 Absatz 1 Buchstabe a vorgesehene Kriterium der „rechtmäßigen Niederlassung" in der Praxis ausgelegt wird und welche Bedingungen ein Migrant in seinem Herkunftsmitgliedstaat erfüllen muss, um Dienstleistungen erbringen zu dürfen,**

   - **wie die in Artikel 5 Absatz 2 vorgesehenen Kriterien für den "vorübergehenden und gelegentlichen" Charakter der Berufsausübung in der Praxis ausgelegt werden, und ob die Mitgliedstaaten Dauer, Häufigkeit, regelmäßige Wiederkehr und Kontinuität der Tätigkeit prüfen (wenn ja, anhand welcher Kriterien).**

Approbationsbehörden:
Da in aller Regel die Antragsteller die mit der automatischen Anerkennung verbundene Erteilung der Approbation bevorzugen, liegen in der Praxis kaum relevante Erfahrungen zur Auslegung der o.g. Kriterien vor.

Die damit befassten Länder legen „rechtmäßige Niederlassung" dahingehend aus, dass der Dienstleistungserbringer im Herkunftsmitgliedsstaat berechtigt sein muss, den ärztlichen Beruf auszuüben. Dabei kommt es nicht auf die rechtliche Ausgestaltung (selbstständig, angestellt) an. Als Nachweise kommen Befähigungsnachweise im Sinne des Anhangs V.1.1 der Richtlinie, certificate of good standing und Strafregisterauszug in Betracht.

Unter „vorübergehender" Berufsausübung werden maximal 3 Monate verstanden, unter „gelegentlich" nicht auf Dauer angelegt, keine Kontinuität und Regelmäßigkeit.

Bundesärztekammer:
Mit Blick auf die Antwort zu Frage 7 (mangelnde Zahlen) konnte sich bislang keine belastbare Auslegungspraxis zu den Tatbestandsmerkmalen „vorübergehend" und „gelegentlich" herausbilden. Die Erläuterungen der Europäischen Kommission MARKT D/3415/2006/DE vom 10.03.2006 wiederholen lediglich den Richtlinientext des Artikel 5 Abs. 2. Es scheint sinnvoll, die in Artikel 5 Abs. 2 der Richtlinie genannten Kriterien (Dauer, Häufigkeit, regelmäßige Wiederkehr und Kontinuität der Dienstleistung) im Sinne einer in den Mitgliedstaaten einheitlich verwendeten Auslegungshilfe weiterzuentwickeln.

9. **Warum ist ein System der vorherigen Meldung notwendig? Wie verwenden die zuständigen Behörden die eingegangenen Informationen? Gäbe es andere Möglichkeiten? Gab es in Ihrem Land Fälle (wenn ja, wie viele), in denen Ärzte die Meldung nach der Erbringung von Dienstleistungen übermittelt haben?**

Approbationsbehörden:
Eine vorherige Meldung wird als notwendig erachtet, damit die zuständigen Behörden prüfen können, ob eine Berechtigung zur Erbringung der Dienstleistung besteht und die zuständigen Stellen (Approbationsbehörden, Landesärztekammern) im Hinblick auf das Patientenschutzinteresse bei denkbaren Beschwerden über die Dienstleistungserbringung reagieren können. In Einzelfällen sind Meldungen erst nach der Dienstleistungserbringung erfolgt.

Bundesärztekammer:
Da die ärztliche Tätigkeit als gefahrengeeignete Tätigkeit zu betrachten ist, ist ein System der vorherigen Meldung dringend geboten. Andere, weniger einschneidende Möglichkeiten sind nicht ersichtlich. Nur mittels eines solchen Systems ist die berufszugangs- sowie berufsausübungsrechtliche Überwachung der EU-Bürger überhaupt möglich. Ohne eine Meldung und damit Kenntnis von der Dienstleistungserbringung können die zuständigen Behörden nicht effizient handeln.

10. Werden im Fall der Anwendung des Artikels 7 Absatz 4 Gebühren erhoben?

Art. 7 Abs. 4 findet auf den Arztberuf keine Anwendung, weil sich die Regelung auf reglementierte Berufe bezieht, die nicht unter die automatische Anerkennung gemäß Titel III Kapitel III fallen.

C. MINDESTAUSBILDUNGSANFORDERUNGEN

11. Inwieweit entsprechen die in Titel III Kapitel III und in Anhang V der Richtlinie 2005/36/EG enthaltenen gemeinsamen Mindestanforderungen an die Ausbildung von Fachärzten und Allgemeinmedizinern noch dem wissenschaftlichen Fortschritt und den beruflichen Erfordernissen? Sind die in der Richtlinie geforderten Kenntnisse und Fähigkeiten noch relevant und aktuell? (Bitte machen Sie hierzu spezifische Angaben.) Was ist zu den Bestimmungen betreffend die Dauer der Ausbildung zu bemerken? Existieren in Ihrem Land unterschiedliche Facharztausbildungen mit einer gemeinsamen Basisausbildung? Falls ja, führen Sie diese bitte an.

Bundesärztekammer:
Die in Titel III Kapitel III und in Anhang V enthaltenen gemeinsamen Mindestanforderungen sehen neben einigen formalen Eckpunkten in Art. 25 Abs. 2 lediglich eine mindestens dreijährige Vollzeitausbildung für einige Fachrichtungen in Anhang V Nummer 5.1.3 vor. Die in der aktuellen (Muster-)Weiterbildungsordnung geforderten Zeiten von mindestens fünf Jahren sind aus Sicht der Bundesärztekammer aber notwendig, um die Kernkompetenzen (Kenntnisse, Fertigkeiten und Fähigkeiten), welche heute für eine adäquate Patientenversorgung erforderlich sind, sachgerecht zu vermitteln bzw. zu erwerben.
Darüber hinaus ist die Angabe von Mindestzeiten ein zwar notwendiges, nicht aber ausreichendes Kriterium. Dieses Kriterium garantiert aus unserer Sicht nicht automatisch die Gleichstellung der Ausbildungsnachweise. Die im Rahmen der Weiterbildung von Ärzten erworbenen Kernkompetenzen müssten bereits vergleichbar sein. Aus diesem Grund regt die Bundesärztekammer an, auch ein Kriterium zu berücksichtigen, das sich an inhaltlichen Aspekten orientiert.

In Deutschland existieren Facharztausbildungen mit einer gemeinsamen Basisweiterbildung, z. B. im Gebiet Innere Medizin.

12. Inwieweit entsprechen die in Titel III Kapitel III der Richtlinie 2005/36/EG enthaltenen gemeinsamen Mindestanforderungen an die Ausbildung noch dem wissenschaftlichen Fortschritt der letzten zehn Jahre und den beruflichen Erfordernissen? Sind die in Artikel 24 Absatz 3 enthaltenen Kenntnisse und Fähigkeiten noch relevant und aktuell? (Bitte machen Sie hierzu spezifische Angaben.) Was ist zu den Bestimmungen betreffend die Dauer der Ausbildung zu bemerken?

Approbationsbehörden:
Die in Artikel 24 Absatz 3 enthaltenen unbestimmten Rechtsbegriffe „angemessene Kenntnisse" bzw. „angemessene klinische Erfahrung" lassen einen erheblichen Interpretationsspielraum zu. Die Mindestanforderungen an die Ausbildung sollten deshalb konkreter formuliert werden. Zusätzlich sollte zur Qualitätssicherung eine Abschlussprüfung den Mindestanforderungen hinzugefügt werden.
In Artikel 24 Absatz 2 sollte klargestellt werden, ob die Vorgaben („mindestens sechs Jahre oder 5500 Stunden") kumulativ oder alternativ zu verstehen sind.

Bundesärztekammer:
Die in Art. 24 („Ärztliche Grundausbildung") beschriebenen Mindestanforderungen sind zu unspezifisch,. Mehrfach werden „angemessene Kenntnisse" gefordert. Ein Kriterium dafür, was angemessen ist, fehlt. Insoweit gilt das zu Frage **11.** ausgeführte. Die in Art. 24 Abs. 2 der Richtlinie festgelegte Mindestdauer der Ausbildung (mindestens sechs Jahre oder 5 500 Stunden theoretischen und praktischen Unterrichts) ist ausreichend, sollte aber keinesfalls unterschritten werden.

13. Grundlage der Richtlinie ist das Vertrauen zwischen den Mitgliedstaaten. Inwieweit existiert dieses Vertrauen wirklich? Werden in Ihrem Land Ausbildungsgänge zugelassen? Fördert es das Vertrauen, wenn ein Ausbildungsgang in einem anderen Mitgliedstaat zugelassen ist, oder ist dies ohne Bedeutung?

Approbationsbehörden:
Grundsätzlich besteht Vertrauen zwischen den Mitgliedstaaten, wobei es allerdings im Einzelfall – gehäuft bei bestimmten Ländern - vorkommen kann, dass Informationen von Behörden anderer Mitgliedstaaten hinterfragt werden müssen.
Nicht in allen Ländern findet eine so genannte Akkreditierung der Studiengänge statt. Diese formale Zulassung eines Studienganges dürfte jedoch insoweit nicht von Bedeutung sein, als davon ausgegangen werden kann, dass die Mindestvorgaben für ein Studium von den Mitgliedsstaaten richtlinienkonform umgesetzt werden.

Bundesärztekammer:
Die Anwendung der Richtlinie 2005/36/EG im Verwaltungsvollzug kann nur auf einer Vertrauensbasis erfolgen. Neben dem Vertrauen in die Echtheit der vorgelegten Urkunden geht es um das Vertrauen in die Vergleichbarkeit der in Anhang V. genannten Ausbildungsnachweise. Um dieses Vertrauen zu bewahren, bedarf es ständiger Bemühungen, die Ausbildungsgänge nicht nur zeitlich, sondern mit Hilfe eines zu bestimmenden Kriteriums auch inhaltlich aufeinander abzustimmen. Auf die Ausführungen zu Frage **11.** wird verwiesen. Insbesondere mit den neuen Mitgliedstaaten wäre eine Vertiefung des Informationsaustausches wünschenswert, um Unsicherheiten im Umgang mit Diplomen zu minimieren.

14. Inwieweit sind die derzeitigen Bestimmungen der Richtlinie zur beruflichen Weiterbildung (Erwägungsgrund 39 und Artikel 22 Buchstabe b) angemessen? Ist Weiterbildung in Ihrem Land vorgeschrieben, und wie sehen die Bestimmungen im Einzelnen aus?

Bundesärztekammer:
Die in der Richtlinie formulierten Bestimmungen zur beruflichen Weiterbildung (hier: Fortbildung) sind zwar allgemein formuliert, aber angemessen. Die ärztliche Fortbildung ist in Deutschland durch das Sozialgesetzbuch V, die Berufs- und Fortbildungsordnungen der Landesärztekammern verpflichtend vorgeschrieben.

D. VERWALTUNGSZUSAMMENARBEIT

15. Inwieweit vereinfacht die Verwaltungszusammenarbeit gemäß den Artikeln 8, 50 und 56 der Richtlinie die Verfahren für Migranten?

Approbationsbehörden:
Da der Antragsteller die jeweils erforderlichen Bescheinigungen im Original und in übersetzter bzw. beglaubigter Form vorlegen muss, kann nicht von einer Verwaltungszusammenarbeit im engeren Sinne gesprochen werden. Die Verwaltungszusammenarbeit zwischen den Mitgliedsstaaten wird durch fehlende Kenntnisse der Sprache und des Rechtssystems erschwert. Als Erleichterung werden die Konformitätsbescheinigung und die Unbedenklichkeitsbescheinigung bzw. das certificate of good standing beurteilt.

Bundesärztekammer:
Die Verwaltungszusammenarbeit vereinfacht die Verfahren für migrierende Ärzte insofern, als dass sie von den durch die gegenseitige Amtshilfe beschleunigten Verfahren profitieren. Die Regelung erleichtert die sachgerechte Beurteilung der Unterlagen des Antragstellers, vor allem in Fällen begründeter Zweifel, um ergänzende Unterlagen sowie Bestätigungen des Herkunftsstaates bei den zuständigen Behörden der Herkunftsländer anzufordern. Diese werden in der Regel unverzüglich zur Verfügung gestellt.

16. Ist die zuständige Behörde in Ihrem Land im IMI (Binnenmarktinformationssystem) registriert? Unter welchen Bedingungen nutzt Ihre zuständige Behörde das IMI? Falls sie nicht registriert ist: warum nicht, und unter welchen Bedingungen könnte sich dies ändern?

Approbationsbehörden:
Die zuständigen Behörden sind in IMI registriert. Das System wird für verschiedene Nachfragen bei Behörden der Mitgliedstaaten genutzt. Die Häufigkeit der Inanspruchnahme ist unterschiedlich, aber eher zurückhaltend. Probleme werden in der (nicht übersetzten) Freitextformulierung und in der Antwortgeschwindigkeit gesehen. Das System muss sich insgesamt noch etablieren.

Bundesärztekammern:
Die Landesärztekammern sind mehrheitlich im IMI registriert. Dennoch erfolgt keine regelmäßige Nutzung des Systems. In der Regel sind die Landesärztekammern antwortende Behörde. Die Nutzung des Systems als fragende Behörde erfolgt zumeist bei Nachfragen bezüglich eingereichter Facharzturkunden bzw. Bescheinigungen ausländischer Behörden. Als Schwächen des Systems haben sich dabei die teilweise lange Antwortdauer und das unflexible Schema für Anfragen erwiesen.

17. Werden Sie von anderen Mitgliedstaaten über disziplinarische oder strafrechtliche Sanktionen oder über sonstige schwerwiegende besondere Umstände informiert, die sich auf die Ausübung der in dieser Richtlinie erfassten Tätigkeiten auswirken könnten? Wie geben Sie solche Informationen weiter? Könnte hier mehr getan werden?

Approbationsbehörden:
Es gibt Mitgliedsstaaten, die deutsche Behörden über alle disziplinarischen Verfahren in ihrem Staatsgebiet informieren. Im übrigen fließen die o.g. Informationen nur punktuell. Einige Approbationsbehörden regen an, IMI für den Austausch dieser Informationen stärker vorzusehen. Eine Anpassung von IMI an den Vorwarnmechanismus der Dienstleistungsrichtlinie ist dringend erforderlich.

Bundesärztekammer:
Die Landesärztekammern berichten über monatliche Meldungen des GMC (UK) zu zulassungsrelevanten, disziplinarischen und strafrechtlichen Sanktionen, die sich auf die Tätigkeit der betroffenen Ärzte auswirken. Unregelmäßig wird auch aus Irland, Dänemark und Schweden informiert.
Informationen zu abgeschlossenen disziplinarischen und strafrechtlichen Sanktionen können auf Anforderung und proaktiv weitergegeben werden, sofern der neue Tätigkeitsort des Arztes bekannt ist. Die LÄK geben aber aufgrund tatsächlicher oder mutmaßlicher Datenschutzbestimmungen entsprechende Informationen nicht proaktiv an die Behörden sämtlicher Mitgliedstaaten weiter.
Der gegenseitige Informationsaustausch zwischen den Mitgliedstaaten ist sicherlich verbesserungswürdig. Anzustreben wäre unter Beachtung des Grundsatzes der Unschuldsvermutung ein einheitliches Verständnis darüber, wann, was, wie und an wen weitergeleitet werden darf.

E. Sonstige Anmerkungen

18. Wie und zu welchem Zeitpunkt werden die erforderlichen Sprachkenntnisse der Migranten geprüft, nachdem ihre Berufsqualifikation anerkannt wurde? Liegen Ihnen Informationen über Beschwerden (insbesondere von Patien-

ten/Kunden/Arbeitgebern) über ungenügende Sprachkenntnisse von Migranten vor?

Approbationsbehörden:
Die Überprüfung erfolgt im Rahmen des Approbationsverfahrens durch den Nachweis von Deutschkenntnissen mindestens auf Niveau B2 des gemeinsamen europäischen Referenzrahmens, durch eine Fachsprachenprüfung oder aufgrund der persönlichen Vorsprache des Antragstellers.

Bundesärztekammer:
Nach Artikel 53 müssen Ärzte über die für die Ausübung ihrer Berufstätigkeit erforderlichen Sprachkenntnisse verfügen. Das Sprachenerfordernis wurde für den Fall der Niederlassung eines Arztes aus einem anderen Mitgliedstaat in Deutschland in § 3 Abs. 1 Satz 1 Nr. 5 BÄO umgesetzt. Auch im Fall der Dienstleistungserbringung müssen die für die Ausübung der Dienstleistung erforderlichen Kenntnisse der deutschen Sprache vorliegen, s. § 10b Abs. 2 Satz 5 BÄO. Die Beherrschung der Sprache ist nicht Bestandteil des Anerkennungsverfahrens des Ausbildungsnachweises. In der Praxis kann diese Differenzierung dazu führen, dass dem Antragsteller zwar die Anerkennung des Ausbildungsnachweises zu bescheinigen ist, er aber mangels Sprachkenntnisse dennoch keinen Anspruch auf Erteilung der Approbation hat. Es bleibt dem Verwaltungsvollzug der Länder überlassen, in welcher Art und Weise die erforderlichen Sprachkenntnisse überprüft werden.
Generalisierte Aussagen über Beschwerden durch Patienten oder Kolleginnen und Kollegen können nicht getroffen werden.

19. Gibt es bei der Anwendung von Artikel 30 besondere Probleme?

Besondere Probleme sind nicht bekannt geworden.

GERMANY

Evaluating the Professional Qualifications Directive
Experience reports from competent authorities

QUESTIONNAIRE FOR THE MEDICAL PROFESSION

A. RECOGNITION PROCEDURE IN CASE OF MIGRATION ON A PERMANENT BASIS

1. Do you accept applications from EU citizens for the recognition of foreign diplomas sent by email or requests made on line? Under which conditions can they send documents and declarations electronically? What are your experiences in this respect?

The prerequisite for recognition of specialist medical training by the State Chambers of Physicians is an existing, valid licence. There are no consistent regulations regarding electronic application. Some State Chambers of Physicians do not permit electronic application, while it is allowed by other Chambers on certain conditions. As a general rule, however, application for the recognition of foreign diplomas by e-mail or online merely represents a non-binding, preliminary application. In the event of electronic application, certified copies of the documents also have to be submitted at a later time to prevent possible abuse by means of forged documents.

2. What is the yearly number of positive and negative decisions of recognition from 2000 to 2009? Please submit specific data for applications for automatic recognition based on diplomas, automatic recognition based on acquired rights (as from 2005), and recognition based on the general system[1]. If available, please provide information on the average duration of the recognition process.

In view of the existing data basis, it is not possible to state the number of positive and negative decisions on applications for recognition. Where figures from the State Chambers of Physicians are available for the years 2000 to 2005, a significant increase in the number of applications submitted can be seen in 2004. The number of applications submitted then continues to rise following transposition of Directive 2005/36/EC into national law. The duration of the recognition process differs in the individual Chamber areas. The minimum duration of the process is one week, and longer at some State Chambers of Physicians. The admissible specification of the (Specimen) Regulations on Specialist Training 2003, as amended in June 2010, reads: "The procedure for examining an application for admission to specialist medical activity must be completed within the shortest possible time, but no later than three months after submission of the physician's complete documents; reasons for the decision must be given." The (Specimen) Regulations on Specialist Training are not valid law. However, the individual Regulations on Specialist Training do acquire legal effect when they have been adopted as Statutes by the Assemblies of the Chambers of Physicians and approved by the supervisory authorities.

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[1] Please provide this information unless it has already been provided to the Commission in the Database or the implementation reports.

3. To what extent have the system of automatic recognition and the general system been a success? How do you see the costs and benefits? Specify in particular whether automatic recognition based on diploma, Annex V and the current notification system represent an efficient way to facilitate automatic recognition. Please submit comments for:

   - automatic recognition based on diploma
   - automatic recognition based on acquired rights
   - recognition based on the general system.

   Please specify whether there are any specific problems with Annex V.

The success of the system of automatic recognition is indisputable, since it greatly facilitates the work of the State Chambers of Physicians as the authorities responsible for the recognition of specialist medical training (see the statement on the general system, reply to Question 4). Despite the predominantly positive experience with the system of automatic recognition, the German Medical Association is of the opinion that attention needs to be drawn to system-immanent problems in connection with Annex V:

(a) "Specialist training tourism": The Directive can be specifically used to circumvent the specialist training law of the country of origin. This is the case if the specialist examination is taken in another EU country, even though the person undergoing specialist training has membership in the purview of a German State Chamber of Physicians and underwent his or her specialist training in Germany.

(b) Content-related inconsistencies: Content and title of the notified specialist title do not match under a heading in Annex V. The content of the specialist medical training of other Member States does not always correspond to the title notified for Germany (e.g. heading "Gastroenterology"). Thoracic surgery and cardiac surgery are not distinguished from each other with sufficient precision in the Directive. Although content-related inconsistencies of this kind can be counteracted by notifying titles under two headings of Annex V, this results in greater complexity.

(c) Obsolete notifications: For Germany, titles are notified in Annex V that are not (or no longer) included in the currently valid (Specimen) Regulations on Specialist Training. It would be necessary to more regularly update the Annex. It would be desirable to have a database that lists old or former specialist titles with their expiry dates, although this is a problem for Germany owing to its federal structures.

4. Is the general system applied in your country each time the conditions for automatic recognition are not met? Are there major difficulties in the recognition procedure under the general system? Please include any comments you may have on the implementation of compensation measures. Is the migrant given the choice between an aptitude test and an adaptation period or is the choice restricted. Please explain.

If the conditions for automatic recognition are not met, the general system is applied for the recognition of specialist diplomas by the State Medical Chambers. Although there are no major problems with the recognition procedure, the general system

entails a considerably greater administrative effort in comparison with automatic recognition.
This additional effort arises because the qualification level of the applicant cannot always be seen beyond doubt from the certificates submitted. The examination of the individual case that then ensues has the nature of an **examination of equivalence** and is necessary to determine whether the qualification level documented in the submitted certificate from the home country matches the level stipulated in the Regulations on Specialist Training of the respective State Chamber of Physicians.
In accordance with the specifications of State law, the migrating physician must, in the event of non-equivalence, take an **aptitude test** in the form of a **deficit test.** "Deficit test" means that the test must be limited to those areas in which the applicant's specialist training falls short of the specialist training regulated in the applicable Regulations on Specialist Training. However, without knowledge of the content of the specialist training in the country of origin, it is hardly possible to determine these deficits.

5. What is your experience with the recognition procedure for EU citizens with professional qualifications obtained in a third country and already recognised in a first Member State (see Articles 2(2) and 3(3))?

Up to now, there have mainly been no problems in connection with recognition of the few applications from EU citizens holding professional qualifications obtained in a third country that have already been recognised by another Member State.

6. Please describe the government structure of the competent authority or authorities in charge of the recognition.

The competent authorities in charge of the recognition of specialist medical training (Art. 25 Directive 2005/36/EC) are the State Chambers of Physicians, which are public-law corporations subject to the legal supervision of the Ministries of Health of the Federal States. As a rule, the Specialist Training Department of the State Chambers of Physicians is responsible for examining the documents submitted and reaching a decision on recognition of specialist medical qualifications obtained abroad.

B. TEMPORARY MOBILITY (OF A SELF-EMPLOYED OR AN EMPLOYED WORKER)

7. Are EU citizens interested in using the provisions for exercising their professional activities on a temporary and occasional basis in your Member State? How many citizens used this new system in 2008 and 2009 (per month, per year) [2]?

In Germany, access to the profession by way of providing services requires the submission of a prior declaration to the competent authority. The authorities responsible for access to the profession are the licensing authorities. The Directive does not provide for obligatory membership of a professional organisation, such as the State Chambers of Physicians, and it was consequently not implemented. The

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[2] Please provide this information unless it has already been provided to the Commission in the Database or the implementation reports.

laws of some Federal States provide for the State Chambers of Physicians to receive copies of the declarations from the licensing authorities. The State Chambers of Physicians report only a very small number of copies – but assume that there is in fact a greater number of service providers who fail to submit declarations out of ignorance, for example.

8. How are the provisions of Directive 2005/36/EC concerning temporary mobility applied by the competent authorities in practice taking into account the relevant provisions of the Code of Conduct? For instance:

   - How is the "legal establishment" criteria foreseen by Article 5(1) (a) interpreted in practice? What conditions does a migrant need to fulfil in his home Member State in order to be able to provide services?

   - How are the "temporary and occasional basis" criteria foreseen by Article 5.2 interpreted in practice? Do Member States assess duration, frequency, regularity and continuity of an activity and if so according to which criteria?

Given the reply to Question 7 (lack of figures), a standard practice regarding interpretation of the criteria "temporary" and "occasional" has not yet been able to develop. The explanations of the European Commission (MARKT D/3415/2006/DE, 10.03.2006) merely repeat the text of Article 5 Para. 2 of the Directive. It would appear sensible to further develop the criteria named in Article 5 Para. 2 of the Directive (duration, frequency, regularity and continuity of the service) in the sense of an interpretation aid applied consistently in the Member States.

9. Why is a prior declaration system necessary? What do competent authorities do with the information received? Are other possibilities conceivable? Do you have any cases – and if yes how many - whereby doctors sent the declaration after the provision of services has taken place.

Since the activity of a physician must be considered as a potentially dangerous activity, a system of prior declaration is urgently necessary. There do not appear to be any other, less drastic possibilities. A system of this kind is the only way of making it possible to monitor EU citizens under the laws on access to, and exercise of, the profession. Without a declaration, and thus awareness of the provision of services, the competent authorities cannot act effectively.

10. Do you charge any fee in case Article 7, § 4 applies?

No reply possible, since Art. 7 Para. 4 is not applied to physicians.

C MINIMUM TRAINING REQUIREMENTS

11. To what extent are the common minimum training requirements for specialists and general practitioners set out in Title III Chapter III of Directive 2005/36/EC and as defined in Annex V in line with scientific progress and professional needs? Furthermore, are the knowledge and skills required by the directive still relevant and up to date? Please specify. What about the conditions relating to the duration of training? Do you have many specialties training, which have a common trunk. If yes, please specify which ones.

Apart from a few basic formal points in Art. 25 Para. 2, the common minimum requirements contained in Title III Chapter III and Annex V merely provide for a minimum of three years of full-time training for a number of disciplines in Annex V No. 5.1.3. From the point of view of the German Medical Association, however, the periods of at least five years required in the current (Specimen) Regulations on Specialist Training are necessary in order to correctly communicate or acquire the core competencies (knowledge, skills and abilities) needed for providing appropriate patient care today.
Moreover, the stipulation of minimum periods is a necessary, but inadequate criterion. From our point of view, this criterion does not guarantee automatic equivalence of the evidence of formal qualifications. The core competencies acquired in the framework of the specialist training of physicians should already be comparable in themselves. For this reason, the German Medical Association suggests that consideration should also be given to a criterion geared to content-related aspects.
In Germany, there are specialist training courses that include common basic specialist training, e.g. in the field of internal medicine.

12. To what extent are the common minimum requirements for training set out in Title III Chapter III of Directive 2005/36/EC in line with scientific progress and professional needs in the last ten years? Are the knowledge and skills outlined in Article 24.3 still relevant and up to date? Please specify. What about the conditions relating to the duration of training?

The minimum requirements described in Art. 24 ("Basic medical training") are too unspecific. "Adequate knowledge" is repeatedly called for. There is no criterion regarding what is adequate. The statement under Question **11** thus applies in this respect. The minimum duration of the training, stipulated in Art. 24 Para. 2 of the Directive (at least six years of study or 5,500 hours of theoretical and practical training) is sufficient, but should on no account be shorter.

13. The Directive is based on mutual trust between Member States. To what extent is such trust actually achieved? Are training programmes accredited in your country? Does accreditation of a training program in another Member State enhance trust or is it not relevant?

In the execution of administrative tasks, Directive 2005/36/EC can only be applied on a basis of trust. In addition to trust in the authenticity of the certificates submitted, it is a question of trust in the equivalence of the evidence of formal qualifications named in Annex V. In order to preserve this trust, there is a need for constant endeavours to harmonise the training courses, not only in terms of time, but also, with the help of a criterion to be determined, in terms of content. Reference is made to the statement on Question **11**. Expansion of the exchange of information would be desirable, especially with the new Member States, in order to minimise uncertainties in dealing with diplomas.

14. To what extent are the existing Directive provisions (see recital 39 and Article 22(b) on continuous professional development (continuous training) adequate? Is continuous training mandatory in your country and what are the exact conditions?

Although the provisions on continuous professional development (here: continuous training) formulated in the Directive are worded in a general manner, they are appropriate. Continuing medical training in Germany is prescribed as obligatory by Book V of the Social Security Code and the Professional Regulations and Regulations on Continuing Training of the State Chambers of Physicians.

D. ADMINISTRATIVE COOPERATION

15. To which extent does administrative cooperation, as outlined in Articles 8, 50, and 56 of the Directive, simplify procedures for the migrant professionals?

Administrative cooperation simplifies the procedures for migrant physicians in that they benefit from the procedures accelerated by mutual administrative aid. The regulation facilitates correct assessment of the applicant's documents, especially in cases of justified doubt, when additional documents and confirmations from the country of origin need to be requested from the competent authorities. These are usually made available without delay.

16. Is the competent authority in your country registered with IMI? Under which circumstances does your competent authority use IMI? If not registered, why not and what would be the conditions for changing this situation?

The majority of the State Chambers of Physicians are registered with IMI. Nonetheless, no regular use is made of the system. As a rule, the State Chambers of Physicians are the responding authority. Use of the system as an enquiring authority usually occurs in connection with enquiries regarding submitted specialist certificates or certificates from foreign authorities. In this context, the occasionally long response times and the inflexible procedure for enquiries have proven to be weaknesses of the system.

17. How could a professional card (see Recital 32 of the Directive) facilitate recognition of professional qualifications and provision of temporary services? Under which conditions could it be issued by professional associations?

18. Are you alerted by other Member States in case of disciplinary action or criminal sanctions taken or any other serious, specific circumstances which are likely to have consequences for the pursuit of activities under this Directive? How do you share this information? Could more be done in this respect?

The State Chambers of Physicians report, via monthly reports of the GMC (UK), on licensing-related, disciplinary and criminal sanctions impacting the activity of the affected physicians. Information is also received from Ireland, Denmark and Sweden at irregular intervals.
Information on completed disciplinary and criminal sanctions can be shared on request and proactively, insofar as the physician's new place of activity is known. However, based on actual or presumed data protection regulations, the State Chambers of Physicians do not proactively forward corresponding information to the authorities of all Member States.

The mutual exchange of information between the Member States is certainly in need of improvement. Observing the principle of presumption of innocence, the aim should be to arrive at a common understanding of when what may be forwarded to whom, and how.

E. OTHER OBSERVATIONS

19. How and when are the necessary language skills of migrants checked after recognition of the professional qualifications? Are you aware of any complaints (especially from patients/clients/employers) about insufficient language skills of migrants?

According to Article 53, physicians must have the language skills necessary for exercising their professional activity. The language requirement was implemented in Art. 3 Para. 1, first sentence, No. 5 Federal Medical Code for cases of establishment of a physician from another Member State in Germany. In the case of providing services, too, the knowledge of the German language necessary for providing the services must be present, see Art. 10b Para. 2, fifth sentence, Federal Medical Code. Mastery of the language is not part of the recognition procedure for evidence of formal qualifications. In practice, this distinction can lead to a situation where the applicant receives certification of recognition of the evidence of formal qualifications, but nevertheless has no entitlement to granting of a licence for lack of language skills. It is at the discretion of the administrative authorities of the Federal States to decide how the necessary language skills are checked.
No generalised statement can be made regarding complaints by patients or colleagues.

20. Does the application of Article 30 raise any specific problems?

No final assessment can be given, since the State Chambers of Physicians are not always the competent authorities, or sometimes have only few or no procedures on their records.

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ESTONIA

Evaluating the Professional Qualifications Directive
Experience reports from competent authorities

QUESTIONNAIRE FOR DOCTORS (Estonia)

A. RECOGNITION PROCEDURE IN CASE OF MIGRATION ON A PERMANENT BASIS

1. Do you accept applications from EU citizens for the recognition of foreign diplomas sent by email or requests made on line? Under which conditions can they send documents and declarations electronically? What are your experiences in this respect?

   At present we do not accept documents which have been sent by e-mail. Emails, however, can be used to give a provisional assessment. We do accept documents that have sent and signed electronically (digital signature). However, we have had no cases where an EU citizen has submitted an application electronically.

2. What is the yearly number of positive and negative decisions of recognition from 2000 to 2009? Please submit specific data for applications for automatic recognition based on diplomas, automatic recognition based on acquired rights (as from 2005), and recognition based on the general system[1]. If available, please provide information on the average duration of the recognition process.

   See database for statistics. Average duration of process: one month.

3. To what extent have the system of automatic recognition and the general system been a success? How do you see the costs and benefits? Specify in particular whether automatic recognition based on diploma, Annex V and the current notification system represent an efficient way to facilitate automatic recognition. Please submit comments for:

   - automatic recognition based on diploma

     This has worked well.

   - automatic recognition based on acquired rights

     This has worked well.

   - recognition based on the general system.

     No experience.

   Please specify whether there are any specific problems with Annex V.

   No.

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[1] Please provide this information unless it has already been provided to the Commission in the Database or the implementation reports.

4. Is the general system applied in your country each time the conditions for automatic recognition are not met? Are there major difficulties in the recognition procedure under the general system? Please include any comments you may have on the implementation of compensation measures. Is the migrant given the choice between an aptitude test and an adaptation period or is the choice restricted. Please explain.

   No experience.
   According to the law, there is no choice in compensation measures: an aptitude test is compulsory.

5. What is your experience with the recognition procedure for EU citizens with professional qualifications obtained in a third country and already recognised in a first Member State (see Articles 2(2) and 3(3))?

   We have had only a little experience with this. Being registered in another member state before applying for registration in Estonia is a positive sign.

6. Please describe the government structure of the competent authority or authorities in charge of the recognition.

   The Health Board is a governmental authority of the Estonian Ministry of Social Affairs, which is empowered by a legal order of the Government of the Republic. Estonia is a small country with a small population. There are no local authorities. The Health Board is the leading, coordinating and consulting agency in the field of public health, also dealing with the recognition of health care professionals' qualifications.
   The Health Board holds the national registers of health care professionals (doctors, dentists, midwives, nurses, pharmacists and assistant pharmacists), issues and revokes registration certificates, appropriate certificates to Estonian health care professionals who wish to work in EU/EEA member states or in Switzerland, issues and revokes activity licenses to health care providers. • Compares, in line with legislation, foreign professional qualifications of applicants applying for regulated healthcare posts in Estonia, and makes recognition decisions;
   • Cooperates and exchanges information with competent authorities on disciplinary decisions that may affect the recognition of an applicant's professional qualification;
   • Monitors the number of recognition applications and submits relevant reports to the Ministry of Education and Research;
   • Issues certificates and documents that are necessary for the recognition of the professional qualifications in Estonia or in another country.
   The responsible unit for dealing with healthcare qualifications is
   the Unit of Registers and Licences. Head: Ms Evi Lindmäe (evi.lindmae@terviseamet.ee)
   The Health Board, Gonsiori 29,15157 Tallinn, Estonia
   http://www.terviseamet.ee

B. TEMPORARY MOBILITY (OF A SELF-EMPLOYED OR AN EMPLOYED WORKER)

7. Are EU citizens interested in using the provisions for exercising their professional activities on a temporary and occasional basis in your Member State? How many citizens used this new system in 2008 and 2009 (per month, per year) [2]?

   There has been only one case (in 2010).

8. How are the provisions of Directive 2005/36/EC concerning temporary mobility applied by the competent authorities in practice taking into account the relevant provisions of the Code of Conduct? For instance:

   - How is the "legal establishment" criteria foreseen by Article 5(1) (a) interpreted in practice? What conditions does a migrant need to fulfil in his home Member State in order to be able to provide services?

     He/she must be registered in the home country and have a legal right to practice in the home country.

   - How are the "temporary and occasional basis" criteria foreseen by Article 5.2 interpreted in practice? Do Member States assess duration, frequency, regularity and continuity of an activity and if so according to which criteria?

     According to the law, the frequency and duration of temporary provision of services is assessed case by case.

9. Why is a prior declaration system necessary? What do competent authorities do with the information received? Are other possibilities conceivable? Do you have any cases – and if yes how many - whereby doctors sent the declaration after the provision of services has taken place.

   Prior declaration is necessary to make sure that the person is indeed qualified to provide the planned service. There have been no cases of declaration after the provision of services.

10. Do you charge any fee in case Article 7, § 4 applies?

    No.

C MINIMUM TRAINING REQUIREMENTS

11. To what extent are the common minimum training requirements for specialists and general practitioners set out in Title III Chapter III of Directive 2005/36/EC and the compulsory training subjects as defined in Annex V in line with scientific progress and professional needs? Furthermore, are the knowledge and skills required by the directive still relevant and up to date? Please specify. What about the conditions relating to the duration of training? Do you have many specialties training, which have a common trunk. If yes, please specify which ones.

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[2] Please provide this information unless it has already been provided to the Commission in the Database or the implementation reports.

The minimum training requirements are at present sufficient to ensure that there is at least a satisfactory level of competence.
No, our specialties' training is separate for each specialty.

12. To what extent are the common minimum requirements for training set out in Title III Chapter III of Directive 2005/36/EC in line with scientific progress and professional needs in the last ten years? Are the knowledge and skills outlined in Article 24.3 still relevant and up to date? Please specify. What about the conditions relating to the duration of training?

    With each passing year, the basic training for doctors involves new aspects – aspects that were previously part of specialization. This means that the basics must be covered in an even shorter period. This issue will become increasingly important in the future.

13. The Directive is based on mutual trust between Member States. To what extent is such trust actually achieved? Are training programmes accredited in your country? Does accreditation of a training program in another Member State enhance trust or is it not relevant?

    Yes, training programmes in Estonia undergo international accreditation. Yes, such accreditations do enhance trust.

14. To what extent are the existing Directive provisions (see recital 39 and Article 22(b) on continuous professional development (continuous training) adequate? Is continuous training mandatory in your country and what are the exact conditions?

    The continuous training of health care professionals is mandatory in Estonia and there are clear requirements in law (mandatory 60 academic hours per year). It is the duty of the employer to finance the continuous training of employees (same conditions for self-employed persons).
    The professional associations for specialist doctors organize a voluntary assessment of competence every 5 years. This process provides information to the employer, and the result of the assessment is recorded in the registry of health care professionals.

D. ADMINISTRATIVE COOPERATION

15. To which extent does administrative cooperation, as outlined in Articles 8, 50, and 56 of the Directive, simplify procedures for the migrant professionals?

    Administrative cooperation between competent authorities is essential. However, cooperation is much easier with a single institution per country as compared to federal states where every state / region has their own competent authority or branch.

16. Is the competent authority in your country registered with IMI? Under which circumstances does your competent authority use IMI? If not registered, why not and what would be the conditions for changing this situation?

    Yes. We have used IMI both ways – for making enquiries and replying to questions.

17. Are you alerted by other Member States in case of disciplinary action or criminal sanctions taken or any other serious, specific circumstances which are likely to have consequences for the pursuit of activities under this Directive? How do you share information about suspensions/restrictions with competent authorities in other Member States? Could more be done in this respect?

The sharing of information about suspensions and restrictions depends on the basic principles of the legal system – it sets limits as to whether proactive or reactive information exchange is possible, and determines how the disciplinary measures are regulated. Since it is the employer who sets disciplinary penalties, the Health Board may not be aware of minor breaches. The Health Board does share information about suspensions and restrictions if needed. We are aware of the GMC alert system.

E. OTHER OBSERVATIONS

18. How and when are the necessary language skills of migrants checked after recognition of the professional qualifications? Are you aware of any complaints (especially from patients/clients/employers) about insufficient language skills of migrants?

According to Estonian law, it is the duty of the employer to ensure sufficient language skills when dealing with the public. The Estonian Language Board carries out inspections and responds to complaints from the public.

19. Does the application of Article 30 raise any specific problems?

No experience.

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IRELAND

Evaluating the Professional Qualifications Directive
Experience reports from competent authorities

QUESTIONNAIRE FOR THE MEDICAL PROFESSION

(the Medical Council of Ireland)

A. RECOGNITION PROCEDURE IN CASE OF MIGRATION ON A PERMANENT BASIS

1. Do you accept applications from EU citizens for the recognition of foreign diplomas sent by email or requests made on line? Under which conditions can they send documents and declarations electronically? What are your experiences in this respect?

   The Medical Council presently only accepts paper applications. An online application process for all medical practitioners will be introduced in the near future. It will be possible to submit the application form online. While it may also be possible for applicants to submit supporting documentation electronically, for security reasons paper copies of supporting documentation will also be required.

2. What is the yearly number of positive and negative decisions of recognition from 2000 to 2009? Please submit specific data for applications for automatic recognition based on diplomas, automatic recognition based on acquired rights (as from 2005), and recognition based on the general system[1]. If available, please provide information on the average duration of the recognition process.

   Please see the tables below for data on applications granted and refused.

Registration Granted

Year	00	01	02	03	04	05	06	07	08	09
General Registration	117	105	130	107	170	239	299	407	328	98
Specialist Registration[+]	9	43	65	83	55	59	71	87	212	95
General Registration (Acq Rights)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Specialist Registration (Acq Rights)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

[+]As it was not possible to apply directly for specialist registration until commencement of Part 6 of the Medical Practitioners Act 2007 on 16th March 2009, all specialist applicants were already on the General Register of Medical Practitioners by virtue of EU/EEA qualifications. Hence the figures for specialists are a subset of the first row of figures, for general registration, with the partial exception of 2009 when the commencement of Part 6 of the MPA 2007 on 16th March 2009 provided for direct applications for specialist registration.

Registration Refused[+]

Year	00	01	02	03	04	05	06	07	08	09
General Registration	X	X	X	X	X	X	X	X	X	X
Specialist Registration	X	X	X	X	X	X	X	X	X	X

[1] Please provide this information unless it has already been provided to the Commission in the Database or the implementation reports.

General Registration (Acq Rights)	X	X	X	X	X	X	X	X	X	X
Specialist Registration (Acq Rights)	X	X	X	X	X	X	X	X	X	X

+This information is to follow

To date, only two applications have been considered under the specific provisions of the General System. One applicant was refused in the first instance and the applicant has requested an appeal of the refusal. One applicant is currently undergoing assessment.

3. To what extent have the system of automatic recognition and the general system been a success? How do you see the costs and benefits? Specify in particular whether automatic recognition based on diploma, Annex V and the current notification system represent an efficient way to facilitate automatic recognition. Please submit comments for:

   - automatic recognition based on diploma

   Administratively, the benefits are that a medical practitioner can be registered efficiently, based on certification by the competent authorities of the home member states. For the most part, the use of Annex V means that once the diplomas listed in Annex V 5.1.1 and 5.1.2 are received (and for specialist qualifications confirmation that the documentation at Annex V 5.1.3. or V 5.1.4. meets the minimum training requirements), the applicant will be considered eligible for registration on either the General Division or Specialist Division of the Register of Medical Practitioners.

   The costs mainly centre on possible issues concerning patient safety. Several concerns have been raised by Postgraduate Training Bodies in Ireland that the minimum duration of training required for many specialties is now shorter than that required of trainees in Ireland. For example:

   - *The Royal College of Physicians of Ireland offers training programmes in 25 medical specialties. All but 5 specialties require basic specialist training of 2 years plus higher specialist training of 5 years. This means that for the specialty of Obstetrics & Gynaecology for instance, the required length of training in Ireland is of 1 year's duration greater than the minimum requirement of 4 years set down in the Directive.*

   - *The Royal College of Surgeons in Ireland offers training programmes in 11 surgical specialties. All but four of the specialties require basic specialist training of 2 years plus higher specialist training of 6 years. This means that in the specialty of Plastic, Reconstructive and Aesthetic Surgery for instance, the required length of training in Ireland is of one year's greater duration than the minimum requirements of 5 years set down in the Directive.*

   Concerns have been expressed in relation to there being no effective method of comparing the contents of training programmes leading to the award of qualifications under the Directive. Concerns have also been expressed in relation to the absence of systematic language testing. To date, in Ireland, applicants from EU/EEA member states are exempt from any form of language test by the Medical Council. Instead language proficiency testing is left to the discretion of the employer. There are also serious concerns that medical practitioners who do not undertake internship training are entitled to registration to practise unsupervised.

   - automatic recognition based on acquired rights

Most of the applications received under acquired rights provisions have come from medical practitioners who trained in member states that joined the European Union after 1990. Administratively, acquired rights are now easier to understand and process than the acquired rights provisions under EU Directive 93/16/EEC. Problems with assessing acquired rights rarely occur and when they do they generally concern how the acquired right was obtained. The Medical Council comes across the occasional type of scenario, below:

- *The attestations are not always clear - the home member state appears to grant an acquired right in the attestation submitted, but on close examination or when further queries are made, the home member state is unable to certify that the applicant's training is compliant with Articles 23, 27 or 30.*

- *Justified doubts arise concerning the granting of the acquired right – for example the applicant has trained in a 3rd country, or a country that was a 3rd country before acceding to the European Union, and has been granted an acquired right by the member state in which they are currently established. For example, they trained in Romania but are granted an acquired right by Hungary.*

- recognition based on the general system.

The General System for recognition has proved very confusing. Presently, the Medical Council only treats applications under the General System if the host Competent Authority recommends that this is how the application should be processed. Applications for which there is no specific instruction undergo the same assessment of training and experience as applicants from 3rd Countries or applicants who have applied 'self structured training and experience' attained in Ireland.

Please specify whether there are any specific problems with Annex V.

There are two main problems with Annex V:

- *The situation where the specialty is recognised in the host member state but not in the home member state and vice versa. When this happens the applicant's training and experience is assessed under the Medical Council's own rules, in accordance with Section 47(1)(a)&(f) of the Medical Practitioners Act, 2007, i.e. their application will be sent to an approved Postgraduate Training Body for assessment.*

- *The situation where the specialty is listed under Annex V 5.1.3 but it is not clear the content of training is the same as the content of training in Ireland. Two examples here are 'thoracic surgery' (cardiothoracic in Ireland) and 'Ophthamology' (which exists as two specialties in Ireland, medical Ophthalmology and Ophthalmic Surgery, which have significant differences in duration and content of training). There is a risk that medical practitioners will be deemed specialists in specialties which have a very different training content than that of a graduate of the training programme in Ireland.*

- *The situation where medical practitioners who do not undertake internship training are entitled to registration to practise unsupervised.*

4. Is the general system applied in your country each time the conditions for automatic recognition are not met? Are there major difficulties in the recognition procedure under the general system? Please include any comments you may have on the implementation of compensation measures. Is the migrant given the choice between an aptitude test and an adaptation period or is the choice restricted. Please explain.

The General System is presently only applied when the home member state recommends that the application be treated under the General System. However, the Hocsman principle of taking all training, experience and qualifications into account, is applied in all cases where the applicant does not qualify for automatic recognition.

The Medical Council's current policy, based on the only case to date, is that an aptitude test or adaptation period will be offered. In the case of the aptitude test, this will constitute the same exam applied to a graduate of the training programme in Ireland. For example, if a graduate of a training programme in Ireland must sit and pass a membership or exit exam at specialist level, this is the exam that will be offered. There have been as yet no applications for General Registration (Basic Medical Training) treated under the General System. The Council is in the process of changing its rules and may decide to apply the general system across the board were automatic recognition is not possible.

- *Aptitude Tests*
  Where the Medical Council anticipates problems occurring, particularly at specialist level, is that not all 52 specialties recognised in Ireland have an aptitude test set at a level that determines the applicant is a trained specialist. For example in Anaesthesia, the exam is used as a specialist training 'gateway' and is set at a level that determines whether the applicant can progress to the latter two years of specialist training.

- *Adaptation Periods*
  In relation to offering an adaptation period, the Medical Council anticipates issues around securing funded posts and also in unfairly disadvantaging applicants under other routes who are also required to undergo adaptation periods, but who may be 'first in the queue' to be offered such a period of training / supervised practice.

The offering of a choice means that the bar is potentially set lower than that for an applicant who completed 'self structured' training in Ireland or a 3rd country applicant. Furthermore, it is not always possible to offer an exam. There should be more discretion available. An applicant being assessed under the provisions for 3rd Country or 'self-structured' assessment may find that they are obliged to sit an exam and undertake a period of supervised practice or further training (adaptation period). This structural difference in approach means that the Medical Council cannot fully quantify the applicant's training and experience, because applicants under the General System are offered a choice, where an applicant who completed self-structured training in Ireland or completed training in a 3rd country would not be offered a choice.

Finally, the Postgraduate Training Bodies in Ireland delegated with the responsibility of assessing specialist applications that do not qualify for automatic recognition find that it is very challenging assessing applications from member states where the training

structure is different; where log-books and records may not have been kept in a manner easily understood by the assessors etc, or where the medical practitioner is unwilling / unable to translate all relevant documentation into English. This also makes it difficult to equate the duration and quality of training.

5. What is your experience with the recognition procedure for EU citizens with professional qualifications obtained in a third country and already recognised in a first Member State (see Articles 2(2) and 3(3))?

   If a medical practitioner provides evidence of 'first time' establishment in a member state and recognition as a specialist there, the Medical Council will request the medical practitioner to provide an attestation from the member state of establishment, certifying that the medical practitioner's recognition is compliant with Article 3(3). If the medical practitioner cannot provide such an attestation, the medical practitioner will be treated under Section 47(1)(a)&(f) of the Medical Practitioners Act 2007, i.e. their application will be sent to an approved Postgraduate Training Body for assessment.

6. Please describe the government structure of the competent authority or authorities in charge of the recognition.

   The Competent Authority in Ireland is a 25 member Council, comprised of 12 medical members and 13 non-medical members. The Council sets the direction of the organisation and its policies, which are then implemented by the Executive. It is an independent statutory authority, establishment under the Medical Practitioners Acts 1978 and 2007. It is a centralised authority with one office, in Dublin. The Medical Council reports to the Government Department of Health and Children.

B. TEMPORARY MOBILITY (OF A SELF-EMPLOYED OR AN EMPLOYED WORKER)

7. Are EU citizens interested in using the provisions for exercising their professional activities on a temporary and occasional basis in your Member State? How many citizens used this new system in 2008 and 2009 (per month, per year) [2]?

   Since the introduction of provisions of services on a temporary or occasional basis, 5 medical practitioners have applied in 2008 and 74 have applied in 2009. This type of registration is currently under review.

8. How are the provisions of Directive 2005/36/EC concerning temporary mobility applied by the competent authorities in practice taking into account the relevant provisions of the Code of Conduct? For instance:

   - How is the "legal establishment" criteria foreseen by Article 5(1) (a) interpreted in practice? What conditions does a migrant need to fulfil in his home Member State in order to be able to provide services?

     In order to make an application for 'Visiting EEA Registration' applicants must provide:

[2] Please provide this information unless it has already been provided to the Commission in the Database or the implementation reports.

a. *a written declaration to be made in advance (and renewed each year of registration) which outlines the service to be provided (including location and regularity) and includes the details of any insurance cover or other means of professional indemnity;*
b. *proof of EU/EFTA citizenship (notarised/attested copy EU/EFTA passport);*
c. *an attestation certifying that the holder is legally established in a Member State for the purpose of pursuing the activities concerned and that he is not prohibited from practising, even temporarily, at the moment of delivering the attestation (Certificate of Current Professional Status / Good Standing from the EU/EFTA authority with whom they are currently fully registered and any other authority with whom they hold/held any type of registration in the past five years); and*
d. *evidence of professional qualifications (notarised/attested copy primary medical degree, if not clearly indicated on their CCPS/COGS).*

Applicants will be regarded as eligible if they meet the following requirements:

In order to be eligible for this type of registration, the applicant must provide proof that they are:

a. an EU/EFTA citizen;

b. fully registered with a recognised authority in another EU/EFTA member state; and

c. intending to practise medicine within the Republic of Ireland only on a temporary or occasional basis.

- How are the "temporary and occasional basis" criteria foreseen by Article 5.2 interpreted in practice? Do Member States assess duration, frequency, regularity and continuity of an activity and if so according to which criteria?

  The Medical Council assesses each application on its own merits. This criterion is currently under review by the Council as it is undefined in the MPA 2007 and the Directive.

9. Why is a prior declaration system necessary? What do competent authorities do with the information received? Are other possibilities conceivable? Do you have any cases – and if yes how many - whereby doctors sent the declaration after the provision of services has taken place.

   The prior declaration system is necessary to ensure that the public are adequately protected from the risk that the medical practitioner is not properly qualified, certified or in good standing with the home member state.

10. Do you charge any fee in case Article 7, § 4 applies?

    No fee is charged for the temporary and occasional provision of services as per the provisions of the MPA 2007.

C MINIMUM TRAINING REQUIREMENTS

11. To what extent are the common minimum training requirements for specialists and general practitioners set out in Title III Chapter III of Directive 2005/36/EC and as defined in Annex V in line with scientific progress and professional needs? Furthermore, are the knowledge and skills required by the directive still relevant and up to date? Please specify. What about the conditions relating to the duration of training? Do you have many specialties training, which have a common trunk. If yes, please specify which ones.

    The minimum duration of training for most specialties in Ireland now exceeds the minimum training requirements in the Directive. As the Medical Council would not be familiar with the content of the training programmes listed for member states, it is not possible to comment on whether programmes in general are in line with scientific progress and professional needs. Training programmes in Ireland are revised by the undergraduate Medical Schools and postgraduate training bodies on an ongoing basis.

12. To what extent are the common minimum requirements for training set out in Title III Chapter III of Directive 2005/36/EC in line with scientific progress and professional needs in the last ten years? Are the knowledge and skills outlined in Article 24.3 still relevant and up to date? Please specify. What about the conditions relating to the duration of training?

    The Medical Council accredits undergraduate medical programmes using the World Federation for Medical Education Global Standards for Quality Improvement in Medical Education: European Specifications. This framework assesses the medical programme under the domains of Mission and Objectives, Educational Programme, Assessment of Students, Students, Academic Staff/Faculty, Educational Resources, Programme Evaluation, Governance and Administration, and Continuous Renewal. The Medical Council ensures that for many of the domains, the quality standard set by the WFME is regarded as the basic standard. Ensuring that undergraduate medical programmes satisfy the requirements of Article 24 of Directive 2005/36/EC is actually legislated for in the Medical Practitioners Act 2007 under Section 87 (2). Therefore, in its accreditation of undergraduate medical programmes, the Medical Council also ensures that under Article 24(2) of the EU Directive, that basic medical training comprises a total of at least six years of study or 5,500 hours of theoretical and practical training provided by, or under the supervision of, a university. The Medical Council also ensures that all basic medical programmes fulfil the EU Directive criteria outlined under Article 24(3).

13. The Directive is based on mutual trust between Member States. To what extent is such trust actually achieved? Are training programmes accredited in your country? Does accreditation of a training program in another Member State enhance trust or is it not relevant?

    See above for information on accreditation of undergraduate training programmes.

    With regard to Postgraduate Medical Education and Training, the Medical Council has recently defined its accreditation standards for postgraduate medical education and training. These standards are based the Australian Medical Council's "Accreditation Standards for Specialist Medical Education and Training". The accreditation of postgraduate training bodies is commencing shortly and these standards will form the

framework of criteria by which the Medical Council will be assessing Postgraduate Training Bodies. The criteria are as follows:

Context of Education and Training
Outcomes of the Training Programme
The Education and Training Programme – Curriculum Content
The Training Programme – Teaching and Learning
The Curriculum – Assessment of Learning
The Curriculum – Monitoring and Evaluation
Implementing the Curriculum - Trainees
Implementing the Training Programme – Delivery of Educational Resources
Continuing Professional Development

14. To what extent are the existing Directive provisions (see recital 39 and Article 22(b) on continuous professional development (continuous training) adequate? Is continuous training mandatory in your country and what are the exact conditions?

There is increasing recognition of the importance of medical practitioners' maintaining their professional competence with many medical regulators moving towards mandatory learning-based systems for the maintenance of professional competence, with or without mandatory periodic assessment and renewal of professionals. Article 22(b) encourages local arrangements in each member state in this regard; however, this means that a variety of approaches are currently being taken. The question of common standards, reciprocity, ease of workforce movement and public protection all arise as a result. We would welcome dialogue at a European level on harmonisation of member state approaches to Article 22(b) – this would better facilitate movement of the health workforce and better ensure public safety.
Within the Irish context, since 2002, there has been a concerted drive by the Medical Council to encompass maintenance of professional competence within the scope of its regulation to maintain public trust in registered medical professionals and promote patient safety and quality of care. We have worked closely with the Department of Health and Children to introduce the statutory provisions for professional competence (which includes continuing professional development) within Part 11 of the Medical Practitioners Act, 2007, which commenced on 1 May 2010.
The 2007 Medical Practitioners Act provides a new legal framework under which the Medical Council must ensure that all registered medical practitioners in Ireland maintain their professional competence under Part 11 of the Act. The Act places a duty on all registered medical practitioners to participate in the Council's Professional Competence Schemes. Every registered medical practitioner will be required to register with a professional competence scheme by 1st May 2011 and engage in activities to maintain professional competence.
With the maintenance of professional competence being a mandatory requirement it will help to ensure that the registered medical practitioners skills and practice are up to date and that they will benefit from the knowledge and expertise of others working in the profession, it will also provide for a quality improvement process.
The Council will recognise postgraduate training bodies which will have responsibility for the day-to-day administration of schemes on behalf of the Council. The Council recognises that most registered medical practitioners maintain their professional competence as a matter of course. Therefore, as a first step, schemes for the maintenance of professional competence will place a regulatory framework around what already exists and works. In developing and

introducing its Professional Competence Schemes, the Council has made every effort to ensure that the new duties being placed on registered medical practitioners, on employers, on the postgraduate training bodies and on the Irish health care system are practical, sustainable and can enhance the safety and quality of care. The schemes will be closely monitored in accordance with the legislative obligations and, as necessary, will be modified in light of the experience.

There will be two elements to the schemes as outlined below.

1. Continuing Professional Development (CPD)

Registered medical practitioners will be expected to accumulate a minimum of 50 CPD credits over a 12-month period. Credits will be gained from a range of different activities, for example to educational activities that happen in the normal work-place as well as those that involve attendance at regional, national or international meetings.

2. Clinical Audit

As part of the Council's Professional Competence Schemes, all registered medical practitioners will have a duty to participate in clinical audits. The Council is working with postgraduate training bodies to ensure that this element of the scheme supports reflective practice and that it is a structured process with identifiable steps.

D. ADMINISTRATIVE COOPERATION

15. To which extent does administrative cooperation, as outlined in Articles 8, 50, and 56 of the Directive, simplify procedures for the migrant professionals?

For Article 8 the Medical Council asks the competent authorities of other member states for Certificates of Current Professional Status as part of the application process.

For Article 50 and the documentation referenced in Annex VII the Medical Council requires that the applicant provides:

- *A Certificate of Current Professional Status*
- *An attestation to accompany the Specialist Medical Qualification issued under Article 25 and Annex V 5.1.2 and V 5.1.3. (or Article 28 and Annex V 5.1.4), or issued under Article 23, or Article 3(3) as appropriate.*
- *Other than a 'tick-box' disclosure concerning bankruptcy and / or registered court judgements, in the general declaration medical practitioners complete as part of their applications, proof of financial standing or insurance is generally not sought by the Medical Council*

The Medical Council uses IMI to verify that a Specialist Medical Qualification meets the appropriate requirements under circumstances where the applicant does not provide an attestation.

If the applicant does not provide an attestation with the qualification, the Medical Council uses IMI to obtain this information. The Medical Council also finds IMI and SOLVIT of great assistance in resolving justified doubts.

For Article 56 the Medical Council regularly liaises with the competent authorities of other EU Member States in relation to individual applications for registration. Liaison most frequently occurs via IMI. The Medical Council finds home competent authorities very prompt and co-operative. The Medical Council also finds the national co-ordinator very useful when seeking the correct authority to talk to. This is particularly the case in countries which operate a federal system such as Germany and Poland.

The Medical Council finds that IMI in particular makes administrative co-operation as outlined in the above Articles very efficient and effective.

16. Is the competent authority in your country registered with IMI? Under which circumstances does your competent authority use IMI? If not registered, why not and what would be the conditions for changing this situation?

The Medical Council is registered with IMI. (See 15 above).

17. How could a professional card (see Recital 32 of the Directive) facilitate recognition of professional qualifications and provision of temporary services? Under which conditions could it be issued by professional associations?

The Medical Council would not rely solely on a professional card for the purpose of registration and would continue to apply its current verification processes.

18. Are you alerted by other Member States in case of disciplinary action or criminal sanctions taken or any other serious, specific circumstances which are likely to have consequences for the pursuit of activities under this Directive? How do you share this information? Could more be done in this respect?

The Medical Council currently receives regular circulars from the United Kingdom listing fitness to practice proceedings and outcomes in that jurisdiction. The circulars are sent via e-mail. The United Kingdom is the only EU / EEA member state currently sending such information to the Medical Council in Ireland. It would help if it were obligatory to do so.

E. OTHER OBSERVATIONS

19. How and when are the necessary language skills of migrants checked after recognition of the professional qualifications? Are you aware of any complaints (especially from patients/clients/employers) about insufficient language skills of migrants?

On legal advice, language testing of EU/EEA citizens is left to the employer. The Medical Council does not have any formal statistics on complaints originating due to insufficient language skills. However, insufficient language skills are a matter of great concern to the Council and at the time of writing the Council is presently re-visiting language requirements as part of its public consultation on revised registration rules, open for submissions until 14th September 2010 and viewable at www.medicalcouncil.ie .

20. Does the application of Article 30 raise any specific problems?

The application of acquired rights for General Medical Practitioners is treated in the same manner as acquired rights for other medical specialties for applicants from EU/EEA member states. Medical practitioners from EU/EEA member states who hold acquired rights are, upon application, granted specialist registration and also entry into the national social security scheme in Ireland, known as the General Medical Services (GMS scheme). For applicants who completed 'self-structured' training, or who otherwise are not certified as automatically having acquired rights, they are assessed under the guidelines set down in the Department of Health and Children's GMS Circular 3/96 which incorporates the acquired rights provisions originally set down under EU Directive 93/16/EEC.

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GREECE

ΕΛΛΗΝΙΚΗ ΔΗΜΟΚΡΑΤΙΑ
ΥΠΟΥΡΓΕΙΟ ΥΓΕΙΑΣ &
ΚΟΙΝΩΝΙΚΗΣ ΑΛΛΗΛΕΓΓΥΗΣ
ΓΕΝΙΚΗ Δ/ΝΣΗ ΥΠΗΡΕΣΙΩΝ ΥΓΕΙΑΣ
ΔΙΕΥΘΥΝΣΗ ΕΠΑΓΓΕΛΜΑΤΩΝ
ΥΓΕΙΑΣ & ΠΡΟΝΟΙΑΣ
ΤΜΗΜΑ Α

Ταχ Δ/νση : Αριστοτέλους
Ταχ. Κώδικας : 101 87 Αθήνα
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Τηλέφωνο : 210-52.30.406
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Αθήνα, 27 - 8- 2010
Αριθμ. Πρωτ. Υ7α/Γ.Π 81298

ΠΡΟΣ: Το Υπουργείο Παιδείας
Διά Βίου Μάθησης και Θρησκευμάτων
Δ/νση Ευρωπαϊκής Ενωσης
Τμήμα Δ
Αναγνώριση Επαγγελματικών Προσόντων
Α. Παπανδρέου 37
151 80 Μαρούσι

ΘΕΜΑ: Παρέχονται πληροφορίες
ΣΧΕΤ. Το αρ. πρωτ. 75346/ΙΑ/28-6-2010 έγγραφό σας
Σε απάντηση του παραπάνω σχετικού σας γνωρίζουμε τα εξής:

POSSIBLE QUESTIONNAIRE FOR EACH SECTORAL PROFESSION

1. ***ΣΥΣΤΗΜΑ ΑΥΤΟΜΑΤΗΣ ΑΝΑΓΝΩΡΙΣΗΣ ΕΠΑΓΓΕΛΜΑΤΙΚΩΝ ΠΡΟΣΟΝΤΩΝ***

A. RECOGNITION PROCEDURE IN CASE OF MIGRATION ON A PERMANENT BASIS

1. Μέχρι σήμερα οι ενδιαφερόμενοι καταθέτουν τα δικαιολογητικά τους απευθείας στις αρμόδιες υπηρεσίας της Νομαρχιακής Αυτοδιοίκησης.

2. Σχετικά με τα στατιστικά στοιχεία, που αφορούν τις αναγνωρίσεις επαγγελματικών τίτλων με το σύστημα της αυτόματης αναγνώρισης από το 2005 έως το 2008 σας αναφέρουμε τα εξής:
Κατά το έτος 2008 συνολικά οι αναγνωρίσεις επαγγελματικών τίτλων ιατρών, οδοντιάτρων , φαρμακοποιών , νοσηλευτών/τριών, είναι:

ΜΕ ΤΟ ΣΥΣΤΗΜΑ ΤΗΣ ΑΥΤΟΜΑΤΗΣ ΑΝΑΓΝΩΡΙΣΗΣ
ΙΑΤΡΟΙ ΒΑΣΙΚΗΣ ΕΚΠΑΙΔΕΥΣΗΣ: 441
ΙΑΤΡΟΙ ΕΙΔΙΚΕΥΜΕΝΟΙ : 85
ΙΑΤΡΟΙ ΓΕΝΙΚΗΣ ΙΑΤΡΙΚΗΣ: 13
ΟΔΟΝΤΙΑΤΡΟΙ ΒΑΣΙΚΗΣ ΕΚΠΑΙΔΕΥΣΗΣ: 38
ΟΡΘΟΔΟΝΤΙΚΟΙ: 16

ΦΑΡΜΑΚΟΠΟΙΟΙ: 90

ΝΟΣΗΛΕΥΤΕΣ/ΤΡΙΕΣ: 6

Η εμπειρία μας από το σύστημα αυτόματης αναγνώρισης επαγγελματικών τίτλων είναι θετική. Δεν παρουσιάσθηκαν ιδιαίτερα προβλήματα..

3. Στις παραπάνω αναγνωρίσεις δεν υπήρξαν προβλήματα. Ολες οι παραπάνω αναγνωρίσεις έγιναν με βάση τον επαγγελματικό τίτλο.

4. Μέχρι σήμερα, δεν έχουμε επαρκή εμπειρία από την εφαρμογή του Γενικού συστήματος αναγνώρισης επαγγελματικών τίτλων.

5. Έχουμε λίγες περιπτώσεις αναγνώρισης τίτλων, που αποκτήθηκαν σε τρίτες χώρες, από κοινοτικούς υπηκόους , που έχουν εργασθεί τρία χρόνια στο κράτος μέλος της α αναγνώρισης. Δεν έχουν παρατηρηθεί προβλήματα κατά τη διαδικασία της β αναγνώρισης.

6. Η Δ/νση Υγιεινής της Νομαρχιακής Αυτοδιοίκησης είναι επιφορτισμένη με τη χορήγηση άδειας άσκησης επαγγέλματος στους ενδιαφερόμενους, που έχουν αποκτήσει τίτλο σπουδών, ή τίτλο ειδικότητας, σ ένα από τα τομεακά επαγγέλματα. Μέχρι τις 31-12-2010 η Νομαρχιακή Αυτοδιοίκηση θα έχει την παραπάνω αρμοδιότητα, ενώ από την 1-1-2011 η αρμοδιότητα θα μεταβιβασθεί στις αρμόδιες υπηρεσίες της Περιφέρειας.

B. TEMPORARY MOBILITY (OF A SELF-EMLOYED OR AN EMPLOYED WORKER)

7.8.9 Αναφορικά με την προσωρινή παροχή υπηρεσιών από κοινοτικό υπήκοο, η εμπειρία μας είναι περιορισμένη λόγω της πρόσφατης ενσωμάτωσης της Οδηγίας 2005/36/ΕΚ στο εσωτερικό μας δίκαιο με το Π.Δ 38/2010 (ΦΕΚ 78/τ.Α/2010).

C. MINIMUM TRAINING REQUIREMENTS

10. 11. Δεν υπάρχει μέχρι σήμερα εκτεταμένη εμπειρία.

12. Η συνεχιζόμενη εκπαίδευση των επιστημόνων υγείας δεν είναι υποχρεωτική βάσει νομοθεσίας. Λόγω όμως της αναγκαιότητας παρακολούθησης σεμιναρίων , συνεδρίων και μετεκπαιδεύσεων στα πλαίσια της επιστημονικής προόδου σχεδόν όλοι οι επιστήμονες επιλέγουν τη συνεχιζόμενη εκπαίδευση, για την καλύτερη παροχή υπηρεσιών προς τους πολίτες.

D. ADMINISTRATIVE COOPERATION

13.14.15. Οι αρμόδιες υπηρεσίες της Νομαρχιακής Αυτοδιοίκησης μέσω του I.M.I ανταλλάσσουν πληροφορίες, χωρίς ιδιαίτερα προβλήματα, με τους αρμόδιους φορείς των κρατών-μελών. Το σύστημα αυτό είναι πολύ βοηθητικό και εξυπηρετικό, για την επίλυση οποιασδήποτε απορίας σχετικά με την αναγνώριση τίτλων σπουδών κοινοτικών υπηκόων.

16. Η ανταλλαγή των σχετικών πληροφοριών γίνεται μέσω του συστήματος I.M. I. Μέχρι σήμερα δεν έχουμε αντιμετωπίσει ιδιαίτερα προβλήματα στην επικοινωνία και στην ανταλλαγή απόψεων. Πιστεύουμε, ότι το κλίμα ανάμεσα στη χώρα μας και στα άλλα κράτη μέλη είναι αρκετά καλό.

E. OTHER OBSERVATIONS

Σχετικά με το θέμα της γλωσσομάθειας δεν έχουν καταγραφεί παράπονα, ίσως επειδή μέχρι σήμερα δεν έχουμε εφαρμόσει το θεσμό της προσωρινής παροχής υπηρεσιών. Σχετικά με τους μόνιμα εγκατεστημένους επαγγελματίες δεν έχουν καταγγελθεί παράπονα περί μη γνώσης επαρκώς της ελληνικής γλώσσας.
Μετά την αναγνώριση των επαγγελματικών τίτλων και με την ισχύουσα νομοθεσία Ιατροί , που ενδιαφέρονται να εργασθούν σε Νοσοκομεία του Ε.Σ.Υ δίνουν εξετάσεις στο ΚΕ.Σ.Υ στην ελληνική γλώσσα.

2. *ΓΕΝΙΚΟ ΣΥΣΤΗΜΑ ΑΝΑΓΝΩΡΙΣΗΣ ΕΠΑΓΓΕΛΜΑΤΙΚΩΝ ΠΡΟΣΟΝΤΩΝ (ΜΕΤΑΔΕΥΤΕΡΟΒΑΘΜΙΑΣ ΕΚΠΑΙΔΕΥΣΗΣ)*

Από την μέχρι σήμερα εφαρμογή Κοινοτικών Οδηγιών έχουν παρατηρηθεί, στο πλαίσιο του Γενικού Συστήματος αναγνώρισης επαγγελματικών προσόντων μεταδευτεροβάθμιας εκπαίδευσης, τα ακόλουθα προβλήματα :

Α) θέματα που αφορούν την πληρότητα των υποβαλλόμενων δικαιολογητικών του προς κρίση φακέλου :

-υποβολή οδηγού σπουδών αντί προγράμματος σπουδών

-υποβολή πιστοποιητικού αποφοίτησης χωρίς αναφορά στο χρόνο φοίτησης(έτη σπουδών)

-υποβολή πιστοποιητικού ασφάλισης, ιδίως από Γερμανία, με αναφορά σε συνολικό χρόνο ασφάλισης χωρίς διακριτή αναφορά στο χρόνο ασφάλισης, ο οποίος αφορά το προς αναγνώριση επάγγελμα και κατά κανόνα ασφράγιστου και ανυπόγραφου από την εκδούσα αρχή

Β) θέματα που αφορούν επικύρωση τίτλων σπουδών :

-υποβολή τίτλου σπουδών χωρίς θεώρηση της Χάγης ή με απλή φωτοτυπία αυτής

Γ) Θέματα που αφορούν τον προσδιορισμό της αρμόδιας αρχής σχετικά με θεωρήσεις τίτλων, πιστοποιήσεις επαγγελματικών προσόντων :

-σύγχιση ως προς την αρμόδια αρχή για την θεώρηση της Χάγης (π.χ. στην Ιταλία η σχετική αρμοδιότητα ανήκει στις Νομαρχιακές Αυτοδιοικήσεις, στην Γερμανία σε αρμόδια Εισαγγελική αρχή κτλ)
-σύγχιση ως προς την αρμόδια αρχή πιστοποίησης επαγγελματικών προσόντων (τίτλων σπουδών, αδειών)
Π.χ. έκδοση αδειών από επαγγελματικούς φορείς στην Μ. Βρετανία, ή από Δήμους στην Γερμανία

Δ) Θέματα που αφορούν ένταξη επαγγελματικών τίτλων σε συναφή επαγγέλματα :
πχ. Παιδαγωγός που αναγωρίζεται ως Βρεφονηπιοκόμος

Ε) θέματα που αφορούν αναγνώριση περιορισμένης εκπαίδευσης ή επαγγελματικής εμπειρίας :
-αξιολόγηση περιπτώσεων με αμελητέα εκπαίδευση (π.χ Αισθητικοί με ένα ή τρεις μήνες εκπαίδευση) και έλλειψη προϋπηρεσίας ή πολύ μικρή εμπειρία (προϋπηρεσία)

Στ) Στατιστικά δεδομένα :
Αναφορικά με το Γενικό Σύστημα αναγνώρισης επαγγελματικών προσόντων, σημειώνουμε ότι υποβάλλονται ετησίως, περίπου 100 φάκελοι, στα αρμόδιο Συμβούλιο αναγνώρισης

επαγγελματικών προσόντων μεταδευτεροβάθμιας εκπαίδευσης. Στην πλειοψηφία των περιπτώσεων αυτών επιβάλλεται μέτρο αναπλήρωσης που σχετίζεται με διενέργεια πρακτικής άσκησης.

Εσωτερική Διανομή
Γρ. Προϊστ. Γεν. Δ/νσης
Υπηρεσιών Υγείας
ΔΥ7α

Ο ΠΡΟΪΣΤΑΜΕΝΟΣ ΤΗΣ Δ/ΝΣΗΣ
α/α

Α. Κοφινάς

SPAIN

Evaluating the Professional Qualifications Directive
Experience reports from competent authorities

POSSIBLE QUESTIONNAIRE FOR EACH SECTORAL PROFESSION

A. RECOGNITION PROCEDURE IN CASE OF MIGRATION ON A PERMANENT BASIS

1. Do you accept applications from EU citizens for the recognition of foreign diplomas sent by email or requests made on line? Under which conditions can they send documents and declarations electronically? What are your experiences in this respect?

Yes, we accept e-mailed or online applications. The required documents accompanying the application for recognition shall be original documents or certified copies. We must verify the authenticity of the documents accompanying the application, therefore applicants shall submit them in paper format; we do not admit electronic submission unless they are submitted with a digital signature certificate. In order to ensure the authenticity of the documents, we, the relevant authorities for recognition, should have a record of digital signature certificates to issue the required documents (diplomas, certificate in accordance with Directive 2005/36, etc.).

2. What is the yearly number of positive and negative decisions of recognition from 2000 to 2009? Please submit specific data for applications for automatic recognition based on diplomas, automatic recognition based on acquired rights (as from 2005), and recognition based on the general system[1]. If available, please provide information on the average duration of the recognition process.

Until September 2009 the relevant Authority for professional recognition was the Ministry of Education of Spain, attachment sent in the required data☒

3. To what extent have the system of automatic recognition and the general system been a success? How do you see the costs and benefits? Specify in particular whether automatic recognition based on diploma, Annex V and the current notification system represent an efficient way to facilitate automatic recognition. Please submit comments for:

   - automatic recognition based on diploma
   - automatic recognition based on acquired rights
   - recognition based on the general system.

   Please specify whether there are any specific problems with Annex V.

   As regards the harmonisation of training to obtain a degree, diploma or qualification, the automatic system based on diplomas has the advantage of

[1] Please provide this information unless it has already been provided to the Commission in the Database or the implementation reports.

reducing the required documentation to be provided by the applicant, as well as the procedures and verifications to be carried out by the relevant authority for the recognition. This simplification makes this system faster than the general system.

The automatic system based on acquired rights has also the advantage of being faster than the general system; however, it has been observed that applicants are often unaware of the Directive 2005/36, and when their recognition is based on acquired rights, they do not provide the certificates issued by the relevant authorities to prove compliance with the requirements of the Directive. In such cases, they should be required to provide these certificates and the period for the resolution of recognition is longer.

In principle, the automatic system involving full confidence in the certificates issued by the relevant Authorities of the EU is considered advantageous since training is harmonised. This same advantage may become a disadvantage if the certificates issued do not ensure compliance with the requirements established for recognition in the Directive.

Recognition based on the general system involves a more complex procedure and further documentation required from the applicant than in the automatic system. For instance, it requires comparing the training programmes and establishing Expert committees for their verification and the adoption, where appropriate, of compensatory measures; this means that the resolution will take longer. Therefore, it would be advisable to extend the automatic system to those occupations that currently do not have it implemented.

Finally, in relation with Annex V, we have noticed that in certain cases, the title of the diplomas listed therein do not match with the diplomas presented by applicants, these being subsequent to the reference dates indicated in the Annex and meeting the training requirements of the Directive. A certificate of compliance with the Directive has to be requested and, therefore, the procedure is delayed.

4. Is the general system applied in your country each time the conditions for automatic recognition are not met? Are there major difficulties in the recognition procedure under the general system? Please include any comments you may have on the implementation of compensation measures. Is the migrant given the choice between an aptitude test and an adaptation period or is the choice restricted. Please explain.

As a matter of fact, when the conditions for automatic recognition are not met, the general system is applied, which, as we have already indicated, requires a more complex procedure thus it is delayed in time.

In those cases where degrees are not specialist degrees, compensatory measures are complicated, either because other government agencies not belonging to this Ministry have to be involved or because the cooperation of Professional Associations has to be requested. Moreover, if volume becomes important, it may be costly for our System.

5. What is your experience with the recognition procedure for EU citizens with professional qualifications obtained in a third country and already recognised in a first Member State (see Articles 2(2) and 3(3))?

So far, we have not had problems with professional qualifications obtained in a third country and already recognised in a State Member. Those who have applied for recognition in this way and have presented a certificate (of the EU Member State that made the recognition) stating that this first recognition has been made according to the requirements set out in Title III, Chapter III of the Directive, but in most cases they did not have the certificate of three years' experience in the said country, thus we could not apply the procedure of the Directive.

6. Please describe the government structure of the competent authority or authorities in charge of the recognition.

Ministry of Health and Social Policy of Spain

- Director-General for Professional Organisation, National Health System Cohesion and Senior Inspectorate, who is the head of the relevant Body for the resolution of procedures, by delegation of the Minister.
- Deputy-Director for Professional Organisation, who runs, supervises and makes proposals for resolution to the Director-General.
- Head of Area, who advises and makes proposals for resolution.
- Head of Service, who coordinates the administrative support staff, supervises their work and makes proposals for resolution.
- Administrative support assistants.

Sometimes requires collaboration of the Professional Association of Physicians.

B. TEMPORARY MOBILITY (OF A SELF-EMPLOYED OR AN EMPLOYED WORKER)

7. Are EU citizens interested in using the provisions for exercising their professional activities on a temporary and occasional basis in your Member State? How many citizens used this new system in 2008 and 2009 (per month, per year) [2]?

Since September 2009, the date on which the Ministry took over the responsibility for professional recognition, only one recognition has been made for the temporary or occasional practice of the profession (not being a physician). We believe this is because applicants prefer to apply for permanent recognition, which means that they do not need to renew their application and which does not require prior declaration of the provision of services they intend to carry out.

8. How are the provisions of Directive 2005/36/EC concerning temporary mobility applied by the competent authorities in practice taking into account the relevant provisions of the Code of Conduct? For instance:

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[2] Please provide this information unless it has already been provided to the Commission in the Database or the implementation reports.

- How is the "legal establishment" criteria foreseen by Article 5(1) (a) interpreted in practice? What conditions does a migrant need to fulfil in his home Member State in order to be able to provide services?

The requirement for legal establishment in the State of origin to practice the profession in question shall be demonstrated by the applicant by submitting a supporting certificate issued by the relevant authority of the said State.

- How are the "temporary and occasional basis" criteria foreseen by Article 5.2 interpreted in practice? Do Member States assess duration, frequency, regularity and continuity of an activity and if so according to which criteria?

Applicants shall describe the services to be provided in their prior declaration, with particular reference to their continuity or temporality, as well as to their periodicity.

9. Why is a prior declaration system necessary? What do competent authorities do with the information received? Are other possibilities conceivable? Do you have any cases – and if yes how many - whereby doctors sent the declaration after the provision of services has taken place.

As we have already stated in answer number 7, since September 2009, the date when this Ministry of Health and Social Policy of Spain took over such responsibility, there has only been an application for temporary establishment in our country. Applicants choose to request for permanent recognition; we believe it is because the procedure is virtually the same and to avoid future renewals. Not requiring fees for temporary establishment is not an advantage, since no fees are currently being charged either for permanent professional recognition in Spain.

The non-requirement to join a professional association for temporary establishment shall not be regarded as a significant advantage for applicants.

Prior declaration is necessary since it replaces the application for recognition and specifies the temporality of services.

We have not these cases.

10. Do you charge any fee in case Article 7, § 4 applies?

No, we do not charge any fee.

C MINIMUM TRAINING REQUIREMENTS

11. To what extent are the common minimum training requirements for specialists and general practitioners set out in Title III Chapter III of Directive 2005/36/EC and as defined in Annex V in line with scientific progress and professional needs? Furthermore, are the knowledge and skills required by the directive still relevant and up to date? Please specify. What about the conditions relating to the duration of training? Do you have many specialties training, which have a common trunk. If yes, please specify which ones.

We believe that the common minimum conditions of training set forth in Title III, Chapter III of the Directive 2005/36/CE are appropriate and valid at present.
As for the conditions relating to the duration of training, we believe that the establishment of minimum training periods is adequate.
At present we are studying the specialized medical training in various specialties common trunks.

12. To what extent are the common minimum requirements for training set out in Title III Chapter III of Directive 2005/36/EC in line with scientific progress and professional needs in the last ten years? Are the knowledge and skills outlined in Article 24.3 still relevant and up to date? Please specify. What about the conditions relating to the duration of training?

Reproduce the answer in question 11.

13. The Directive is based on mutual trust between Member States. To what extent is such trust actually achieved? Are training programmes accredited in your country? Does accreditation of a training program in another Member State enhance trust or is it not relevant?

In principle, we trust the veracity of the certificates issued by the relevant authorities for the EU recognition, and we suppose that the requirements as regards training have undergone prior harmonisation for automatic recognition.

We recognise diplomas (based on certain programmes that we do not require) in the automatic system. Recognition requires prior verification of the training programme in the general system. There are no accredited foreign training programmes, we have only accredited ours. Recognition of a training programme by another State improves confidence, but is not significant.

14. To what extent are the existing Directive provisions (see recital 39 and Article 22(b) on continuous professional development (continuous training) adequate? Is continuous training mandatory in your country and what are the exact conditions?

We believe that the provisions of the Directive in this point referred to continuous training are adequate.

In Spain, pursuant to the Spanish Act on the Organisation of Healthcare Professions (LOPS), continuous training is a right and obligation of workers; and it is taken into account both in terms of selective tests and for professional development and career.

D. ADMINISTRATIVE COOPERATION

15. To which extent does administrative cooperation, as outlined in Articles 8, 50, and 56 of the Directive, simplify procedures for the migrant professionals?

It is an effective instrument to simplify the procedure.

16. Is the competent authority in your country registered with IMI? Under which circumstances does your competent authority use IMI? If not registered, why not and what would be the conditions for changing this situation?

Yes, Spain is registered with the Internal Market Information System (IMI). We use it when in doubt or when we need information, as well as to answer questions from other relevant authorities.

However, while we consider it a great step forward, it should be further improved since it is very slow and the closed question system not always responds to the need. We have sometimes observed that e-mail communication is faster and more effective.

17. Are you alerted by other Member States in case of disciplinary action or criminal sanctions taken or any other serious, specific circumstances which are likely to have consequences for the pursuit of activities under this Directive? How do you share this information? Could more be done in this respect?

No, we have never received an alert from the competent authority of another Member State. Among the documents that we require is the certificate of good standing issued by the competent Authorities of the State of origin, provided by the competent Authorities concerned or directly .

E. OTHER OBSERVATIONS

18. How and when are the necessary language skills of migrants checked after recognition of the professional qualifications? Are you aware of any complaints (especially from patients/clients/employers) about insufficient language skills of migrants?

Language skills are tested after recognition. Currently in the resolutions for recognition it is established that the beneficiary shall have the necessary language skills for the practice of the profession.

We are concerned about this issue because there have already been complaints from both patients and employers and we believe they should be required in advance.

19. Does the application of Article 30 raise any specific problems?

No, we had no problems in the implementation of article 30 of Directive.

Spain

RESOLUCIONES FAVORABLES A LA TITULACIÓN 331 LICENCIADO EN MEDICINA

	2003	2004	2005	2006	2007	2008
Homologaciones concedidas de forma directa	3309	2517	2442	3205	4722	7649
Homologaciones concedidas tras la superación de una prueba	49	113	179	182	95	55
Homologaciones concedidas por Ejecuciones de sentencia	2	1		2		1
Homologaciones condicionadas a previa superación de prueba	156	434	244	103	7	65
TOTAL	**3516**	**3065**	**2865**	**3492**	**4824**	**7770**

Spain

RECONOCIMIENTOS CONCEDIDOS POR TITULACIONES							
TIT_SOL	NOM_TIT	2003	2004	2005	2006	2007	2008
214	Médico Especialista en Anatomía Patológica		2	4	5	5	7
216	Médico Especialista en Anestesiología y Reanimación	32	30	45	82	93	75
217	Médico Especialista en Angiología y Cirugía Vascular	2		1	0	1	5
219	Médico Especialista en Aparato Digestivo	1	1	1	4	4	3
222	Médico Especialista en Cardiología	2	3		6	10	12
224	Médico Especialista en Cirugía General y del Aparato Digestivo	24	23	19	32	52	63
228	Médico Especialista en Cirugía Pediátrica	2	2		3	3	5
229	Médico Especialista en Cirugía Plástica, Estética y Reparadora	8	3	8	6	11	15
233	Médico Especialista en Cirugía Torácica		1	3	4	7	6
234	Médico Especialista en Dermatología Médico-Quirúrgica y Venereología	9	6	6	7	4	11
237	Médico Especialista en Endocrinología y Nutrición	1		2	2	3	2
242	Médico Especialista en Hematología y Hemoterapia	3	5	4	2	6	2
249	Médico Especialista en Medicina Familiar y Comunitaria	62	62	67	81	92	85
251	Médico Especialista en Medicina Interna	23	12	19	28	55	43
253	Médico Especialista en Medicina Nuclear	3	1	2	1	0	2
254	Médico Especialista en Medicina Preventiva y Salud Pública	2		1	2	2	0
256	Médico Especialista en Microbiología y Parasitología			1			0
257	Médico Especialista en Nefrología	2			1	0	4
258	Médico Especialista en Neumología	3	1	4	1	7	4
259	Médico Especialista en Neurocirugía	3	4	4	8	7	8
261	Médico Especialista en Neurología	3		7	3	5	7
262	Médico Especialista en Obstetricia y Ginecología	16	14	22	36	49	34
263	Médico Especialista en Oftalmología	16	19	13	7	13	15
266	Médico Especialista en Oncología Radioterápica	3	3	2	2	1	3
267	Médico Especialista en Otorrinolaringología	8	9	11	18	5	7
269	Médico Especialista en Psiquiatría	12	8	11	15	14	17
271	Médico Especialista en Radiodiagnóstico	3	6	7	9	16	19
273	Médico Especialista en Medicina Física y Rehabilitación	1	1	1	3	3	3
274	Médico Especialista en Reumatología	2		4	1	3	3
276	Médico Especialista en Cirugía Ortopédica y Traumatalogía	22	12	17	39	36	27
278	Médico Especialista en Urología	6	5	8	10	16	13
279	Médico Especialista en Pediatría y sus Áreas Específicas	1	7	13	22	24	36
331	Licenciado en Medicina	229	221	303	378	533	524
	TOTAL	**504**	**461**	**610**	**818**	**1080**	**1060**

Spain

MEDICOS BASICO 2009

DCPAIS	Educación	Sanidad	TOTAL REC. LIC. MEDICINA 2009
Alemania	66	1	67
Austria	2	1	3
Bélgica	6		6
Bulgaria	14		14
Dinamarca	4		4
Eslovaquia	2		2
Eslovenia	2		2
Estonia	1		1
Finlandia	1		1
Francia	15	2	17
Grecia	7		7
Hungría	6		6
Italia	123	4	127
Letonia	2		2
Lituania	1		1
Países Bajos	7		7
Polonia	41		41
Portugal	10		10
Reino Unido	11	1	12
República Checa	6	3	9
Rumanía	65	2	67
Suecia	4		4
Suiza	1		1
TOTAL	397	14	411

Autoridad competente desde 01/01/2009 a 31/08/2009: Ministerio de Educación
Autoridad competente desde 01/09/2009 a 31/12/2009: Ministerio de Sanidad y Política Social

Spain

MEDICOS ESPECIALISTAS 2009

DCPAIS	NOM_TIT	EDUCACIÓN	SANIDAD
Italia	Médico Especialista en Anatomía Patológica	1	
Portugal	Médico Especialista en Anatomía Patológica	2	
Alemania	Médico Especialista en Anestesiología y Reanimación	3	
Bulgaria	Médico Especialista en Anestesiología y Reanimación	4	
Eslovaquia	Médico Especialista en Anestesiología y Reanimación	1	
Francia	Médico Especialista en Anestesiología y Reanimación	1	
Hungría	Médico Especialista en Anestesiología y Reanimación	3	
Italia	Médico Especialista en Anestesiología y Reanimación	9	1
Polonia	Médico Especialista en Anestesiología y Reanimación	3	
Portugal	Médico Especialista en Anestesiología y Reanimación	7	
Suecia	Médico Especialista en Anestesiología y Reanimación	1	
Italia	Médico Especialista en Angiología y Cirugía Vascular	2	
Polonia	Médico Especialista en Angiología y Cirugía Vascular	1	
Rumanía	Médico Especialista en Angiología y Cirugía Vascular	2	
Francia	Médico Especialista en Aparato Digestivo	1	
Suecia	Médico Especialista en Aparato Digestivo	1	
Alemania	Médico Especialista en Cardiología	1	
Hungría	Médico Especialista en Cardiología	1	
Italia	Médico Especialista en Cardiología	1	
Países Bajos	Médico Especialista en Cardiología	1	
Polonia	Médico Especialista en Cardiología	1	
Portugal	Médico Especialista en Cardiología	3	1
Suecia	Médico Especialista en Cardiología	1	
Alemania	Médico Especialista en Cirugía General y del Aparato Digestivo	2	1
Bulgaria	Médico Especialista en Cirugía General y del Aparato Digestivo	1	
Dinamarca	Médico Especialista en Cirugía General y del Aparato Digestivo	1	
Francia	Médico Especialista en Cirugía General y del Aparato Digestivo	1	
Hungría	Médico Especialista en Cirugía General y del Aparato Digestivo	2	
Italia	Médico Especialista en Cirugía General y del Aparato Digestivo	9	
Polonia	Médico Especialista en Cirugía General y del Aparato Digestivo	7	
Portugal	Médico Especialista en Cirugía General y del Aparato Digestivo	8	1
Rumanía	Médico Especialista en Cirugía General y del Aparato Digestivo	7	
Italia	Médico Especialista en Cirugía Maxilofacial	1	
Portugal	Médico Especialista en Cirugía Oral y Maxilofacial	1	

Alemania	Médico Especialista en Cirugía Ortopédica y Traumatología	5	
Bulgaria	Médico Especialista en Cirugía Ortopédica y Traumatología	1	
Dinamarca	Médico Especialista en Cirugía Ortopédica y Traumatología	1	
Italia	Médico Especialista en Cirugía Ortopédica y Traumatología	3	
Polonia	Médico Especialista en Cirugía Ortopédica y Traumatología	2	
Portugal	Médico Especialista en Cirugía Ortopédica y Traumatología	1	
Italia	Médico Especialista en Cirugía Pediátrica	1	
Portugal	Médico Especialista en Cirugía Pediátrica	1	
Rumanía	Médico Especialista en Cirugía Pediátrica	1	
Alemania	Médico Especialista en Cirugía Plástica, Estética y Reparadora	1	
Bélgica	Médico Especialista en Cirugía Plástica, Estética y Reparadora	1	
Dinamarca	Médico Especialista en Cirugía Plástica, Estética y Reparadora	1	
Francia	Médico Especialista en Cirugía Plástica, Estética y Reparadora	1	
Italia	Médico Especialista en Cirugía Plástica, Estética y Reparadora	9	1
Países Bajos	Médico Especialista en Cirugía Plástica, Estética y Reparadora	1	
Polonia	Médico Especialista en Cirugía Plástica, Estética y Reparadora	1	
Portugal	Médico Especialista en Cirugía Plástica, Estética y Reparadora	1	
Rumanía	Médico Especialista en Cirugía Plástica, Estética y Reparadora	2	
Grecia	Médico Especialista en Cirugía Torácica	1	
Italia	Médico Especialista en Cirugía Torácica	4	
Alemania	Médico Especialista en Dermatología Médico-Quirúrgica y Vener	4	
Bulgaria	Médico Especialista en Dermatología Médico-Quirúrgica y Vener	2	
Noruega	Médico Especialista en Dermatología Médico-Quirúrgica y Vener	1	
Suecia	Médico Especialista en Dermatología Médico-Quirúrgica y Vener	1	
Suiza	Médico Especialista en Dermatología Médico-Quirúrgica y Vener	1	
Francia	Médico Especialista en Endocrinología y Nutrición	1	
Italia	Médico Especialista en Endocrinología y Nutrición	1	
Italia	Médico Especialista en Estomatología	1	
Alemania	Médico Especialista en Hematología y Hemoterapia	1	
Italia	Médico Especialista en Hematología y Hemoterapia	1	
Polonia	Médico Especialista en Hematología y Hemoterapia	1	
Portugal	Médico Especialista en Hematología y Hemoterapia	2	
Alemania	Médico Especialista en Medicina Familiar y Comunitaria	6	
Austria	Médico Especialista en Medicina Familiar y Comunitaria	2	
Bulgaria	Médico Especialista en Medicina Familiar y Comunitaria	2	
Francia	Médico Especialista en Medicina Familiar y Comunitaria	5	
Grecia	Médico Especialista en Medicina Familiar y Comunitaria	1	

Países Bajos	Médico Especialista en Medicina Familiar y Comunitaria	1
Polonia	Médico Especialista en Medicina Familiar y Comunitaria	2
Portugal	Médico Especialista en Medicina Familiar y Comunitaria	14
Reino Unido	Médico Especialista en Medicina Familiar y Comunitaria	6
República Checa	Médico Especialista en Medicina Familiar y Comunitaria	2
Rumanía	Médico Especialista en Medicina Familiar y Comunitaria	13
Suecia	Médico Especialista en Medicina Familiar y Comunitaria	1
Italia	Médico Especialista en Medicina Física y Rehabilitación	1
Países Bajos	Médico Especialista en Medicina Física y Rehabilitación	1
Alemania	Médico Especialista en Medicina Interna	2
Bulgaria	Médico Especialista en Medicina Interna	1
Estonia	Médico Especialista en Medicina Interna	1
Hungría	Médico Especialista en Medicina Interna	2
Italia	Médico Especialista en Medicina Interna	2
Polonia	Médico Especialista en Medicina Interna	6
Portugal	Médico Especialista en Medicina Interna	11
Rumanía	Médico Especialista en Medicina Interna	1
Suecia	Médico Especialista en Medicina Interna	3
Portugal	Médico Especialista en Medicina Preventiva y Salud Pública	1
Reino Unido	Médico Especialista en Medicina Preventiva y Salud Pública	1
Alemania	Médico Especialista en Medicina del Trabajo	2
Polonia	Médico Especialista en Medicina del Trabajo	1
Rumania	Médico Especialista en Medicina del Trabajo	2
Suecia	Médico Especialista en Nefrología	2
Bulgaria	Médico Especialista en Neumología	1
Eslovenia	Médico Especialista en Neumología	1
Rumanía	Médico Especialista en Neumología	1
Alemania	Médico Especialista en Neurocirugía	1
Polonia	Médico Especialista en Neurocirugía	1
Rumania	Médico Especialista en Neurocirugía	1
Alemania	Médico Especialista en Neurología	2
Hungría	Médico Especialista en Neurología	1
Italia	Médico Especialista en Neurología	1
Polonia	Médico Especialista en Neurología	2
Alemania	Médico Especialista en Obstetricia y Ginecología	4
Bulgaria	Médico Especialista en Obstetricia y Ginecología	1
Hungría	Médico Especialista en Obstetricia y Ginecología	1

Italia	Médico Especialista en Obstetricia y Ginecología	5	
Polonia	Médico Especialista en Obstetricia y Ginecología	4	
Portugal	Médico Especialista en Obstetricia y Ginecología	1	
Reino Unido	Médico Especialista en Obstetricia y Ginecología	1	
Rumanía	Médico Especialista en Obstetricia y Ginecología	1	
Bélgica	Médico Especialista en Oftalmología	1	
Dinamarca	Médico Especialista en Oftalmología	1	
Portugal	Médico Especialista en Oftalmología	2	
Rumania	Médico Especialista en Oftalmología	1	
Italia	Médico Especialista en Oncología Radioterápica	1	
Bulgaria	Médico Especialista en Otorrinolaringología	1	
Italia	Médico Especialista en Otorrinolaringología	1	
Países Bajos	Médico Especialista en Otorrinolaringología	1	
Reino Unido	Médico Especialista en Otorrinolaringología	1	
Rumanía	Médico Especialista en Otorrinolaringología	2	
Alemania	Médico Especialista en Pediatría y sus Áreas Específicas	3	
Bélgica	Médico Especialista en Pediatría y sus Áreas Específicas	1	
Bulgaria	Médico Especialista en Pediatría y sus Áreas Específicas	2	
Francia	Médico Especialista en Pediatría y sus Áreas Específicas		1
Italia	Médico Especialista en Pediatría y sus Áreas Específicas	1	
Polonia	Médico Especialista en Pediatría y sus Áreas Específicas	2	
Portugal	Médico Especialista en Pediatría y sus Áreas Específicas	1	
Rumanía	Médico Especialista en Pediatría y sus Áreas Específicas	6	
Bélgica	Médico Especialista en Psiquiatría	1	
Bulgaria	Médico Especialista en Psiquiatría	1	
Francia	Médico Especialista en Psiquiatría	1	
Hungría	Médico Especialista en Psiquiatría	1	
Italia	Médico Especialista en Psiquiatría	3	
Países Bajos	Médico Especialista en Psiquiatría	2	
Portugal	Médico Especialista en Psiquiatría	4	
Reino Unido	Médico Especialista en Psiquiatría	2	
Suecia	Médico Especialista en Psiquiatría	1	
Alemania	Médico Especialista en Radiodiagnóstico	3	
Francia	Médico Especialista en Radiodiagnóstico	2	
Italia	Médico Especialista en Radiodiagnóstico	1	
Polonia	Médico Especialista en Radiodiagnóstico	1	
Portugal	Médico Especialista en Radiodiagnóstico	1	

Hungría	Médico Especialista en Reumatología	1	
Alemania	Médico Especialista en Urología	1	
Dinamarca	Médico Especialista en Urología	1	
Italia	Médico Especialista en Urología	3	
Polonia	Médico Especialista en Urología	1	
TOTAL por Ministerio		**331**	**6**
TOTAL		**337**	

Autoridad competente desde 01/01/2009 a 31/08/2009: Ministerio de Educación
Autoridad competente desde 01/09/2009 a 31/12/2009: Ministerio de Sanidad y Política Social

FRANCE

RAPPORT D'EXPERIENCE

CONSEIL NATIONAL DE L'ORDRE DES MEDECINS

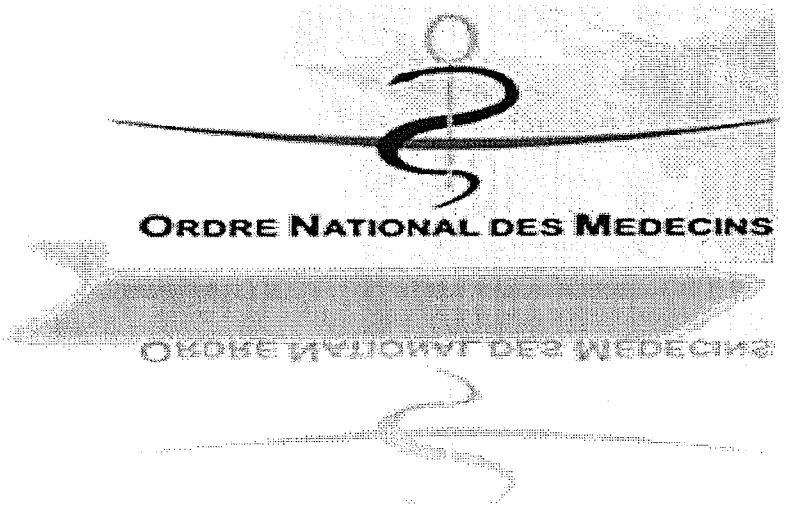
FRANCE

Evaluating the Professional Qualifications Directive
Experience reports from competent authorities

17 Septembre 2010

QUESTIONNAIRE FOR

THE MEDICAL PROFESSION



Avant Propos

Le rapport d'expérience de référence est celui rédigé en langue Française, la version anglaise est également disponible pour information.

Les informations contenues dans le rapport d'expérience ont un caractère général uniquement, qui ne visent pas à aborder les circonstances spécifiques propres à un individu ou à une entité en particulier. La publication du rapport d'expérience vise à promouvoir l'accès du public aux informations relatives aux objectifs, activités et réalisations du Conseil National de l'Ordre des Médecins. Les informations qu'il comporte ne constituent pas un avis professionnel ou juridique.

Ces informations ont un objectif informatif, en qualité d'autorité compétente pour la reconnaissance des qualifications des médecins.

Seuls les textes de la législation française publiés dans les éditions papier du Journal officiel de la république française font foi, ou dans les bulletins officiels.

A. RECOGNITION PROCEDURE IN CASE OF MIGRATION ON A PERMANENT BASIS

1. Do you accept applications from EU citizens for the recognition of foreign diplomas sent by email or requests made on line? Under which conditions can they send documents and declarations electronically? What are your experiences in this respect?

En France, il n'y a pas de procédure en ligne ou par l'intermédiaire d'un site internet pour la reconnaissance des qualifications, que ce soit pour les demandes relevant de la reconnaissance automatique (Ordre des Médecins) ou pour celles relevant du régime général (Ministère chargé de la Santé).
Les dossiers concernant la reconnaissance doivent être individuels et personnels, réalisés sur dossiers papiers.

Figurent notamment dans le dossier, la copie des diplômes et titres, des attestations, accompagnées le cas échéant d'une traduction, faite par un traducteur agréé auprès des tribunaux français ou habilité à intervenir auprès des autorités judiciaires ou administratives d'un Etat membre de l'Union européenne.

Le médecin qui demande son inscription au tableau de l'ordre dont il relève remet sa demande ou l'adresse par lettre recommandée avec demande d'avis de réception au président du conseil de l'ordre du département dans lequel il veut établir sa résidence professionnelle.
Par commodité, l'Ordre des médecins tolère les copies des titres, certificat et attestations envoyés par mail ou fax avant la transmission des documents papiers obligatoires.

Cependant, le Conseil National de l'Ordre des Médecins constate de plus en plus de faux : des titres, diplômes et attestations de conformité.
Le Conseil National de l'Ordre des Médecins est très vigilant sur l'authenticité des titres, d'autant plus que la réglementation française impose à l'Ordre de vérifier l'exactitude des titres et diplômes qui permettent l'exercice de la médecine en France (cf. Système I.M.I).

2. What is the yearly number of positive and negative decisions of recognition from 2000 to 2009? Please submit specific data for applications for automatic recognition based on diplomas, automatic recognition based on acquired rights (as from 2005), and recognition based on the general system[1]. If available, please provide information on the average duration of the recognition process.

Voir annexe III pour les données statistiques.

Le Conseil National de l'Ordre des Médecins n'a pas de données précises quant aux décisions négatives : demande sans suite, pièces manquantes ou refus.

Le Conseil National de l'Ordre des Médecins n'a pas non plus de données précises quant aux décisions positives qui distinguent la reconnaissance automatique : droits acquis, conformité.

Une procédure est en cours de développement.

Les commissions « régime général » se réunissent très régulièrement par spécialités et l'ensemble de la procédure instituée respecte les délais.

[1] Please provide this information unless it has already been provided to the Commission in the Database or the implementation reports.

3. To what extent have the system of automatic recognition and the general system been a success? How do you see the costs and benefits? Specify in particular whether automatic recognition based on diploma, Annex V and the current notification system represent an efficient way to facilitate automatic recognition. Please submit comments for:

- **automatic recognition based on diploma automatic**
- **recognition based on acquired rights**
- **recognition based on the general system.**
- **Please specify whether there are any specific problems with Annex V.**

La Directive 2005/36/CE vise la reconnaissance des qualifications et prévoit une certaine harmonisation des conditions relatives à la formation et à l'accès aux différentes spécialités médicales. Parmi les normes minimales relatives à la formation des médecins spécialistes figurent notamment celles concernant la durée minimale de la formation spécialisée, son mode d'enseignement et le lieu où elle doit s'effectuer (Article 25 de la directive 2005/36/CE).
De la même manière la Directive 2005/36/CE précise les conditions minimales de la formation de base.

La reconnaissance automatique est un succès en matière de mobilité des médecins.

Cependant, le système actuel n'offre pas de garantie que le médecin ait, en l'état actuel, les connaissances, les compétences et l'expérience requises afin d'exercer. En effet, un médecin ayant les diplômes et titres nécessaires à une inscription peut n'avoir jamais exercé sa discipline ou avoir été autorisé à exercer.

C'est pourquoi une condition supplémentaire d'autorisation d'exercice ou d'inscription serait un gage de confiance mutuelle pour la reconnaissance des qualifications.

Le processus de reconnaissance automatique dépend essentiellement des autorités compétentes qui délivrent les certificats conformément aux dispositions de la directive 2005/36/CE.

Par exemple, certains dossiers mentionnent des certificats délivrés en vertu de l'article 23.1 alors que le médecin a exercé hors de l'Espace Economique Européen (EEE). Nous avons également reçu des certificats de conformité sur des titres de spécialités ne figurant pas à la Directive (exemple : la génétique médicale).
Dans certaines situations, l'autorité compétente ne peut confirmer que le médecin a effectivement et licitement exercé sur leur territoire pendant au moins trois années consécutives au cours des cinq années précédant la date de délivrance du certificat (par exemple l'autorité compétente ne dispose pas d'informations sur le médecin).

De la même manière, alors que la directive spécifie la durée de l'expérience professionnelle, nous nous interrogeons sur l'interprétation de cette disposition. Doit-on comprendre 3 ans d'expérience professionnelle avec un exercice plein et entier et une plénitude d'exercice ?
En effet, certains dossiers laissent apparaitre que les médecins avaient un exercice restreint ou limité. Cependant, aucune disposition n'existe pour nous assurer que le médecin a une expérience effective certifiée par l'Etat membre d'origine.

Il serait nécessaire d'inclure une disposition permettant aux autorités compétentes de s'assurer que l'expérience professionnelle est certifiée par l'Etat membre d'origine.

Enfin, certaines expériences ont démontré que les médecins ayant bénéficié de la reconnaissance automatique n'avaient pas les connaissances et les compétences nécessaires pour pouvoir exercer, notamment dans des spécialités très techniques et à risques (exemple : anesthésie-réanimation). Notre analyse nous amène à penser que ces difficultés proviennent des conditions matérielles d'exercice et de l'organisation des soins dans les différents Etats membres.

Dans une certaine mesure, un minimum d'harmonisation des maquettes de formation spécialisée permettrait, à terme, une reconnaissance fondée non seulement sur la durée mais aussi sur le contenu, puisque les champs d'activités et les intitulés peuvent être très différents sur l'espace de l'Union européenne en fonction de l'organisation sanitaire de chaque pays.
D'ailleurs, il ressort de nombreux dossiers que même si la spécialité n'existe pas dans un pays, l'activité en tant que telle existe bien (exemple cardiologie en Autriche ou en Slovénie, la chirurgie pédiatrique en Belgique ou au Pays Bas).

L'intérêt d'harmoniser les qualifications c'est donc, sans prétention exhaustive :

- **Mieux comprendre les différences des qualifications (17 de communes en France sur l'ensemble de l'annexe V qui en compte 52), pour la reconnaissance automatique et le régime général ;**
- **Mieux comprendre l'adéquation entre spécialité et exercice et notamment les champs d'activités de chaque spécialité ;**
- **Permettre l'introduction des spécialités médicales comme la réanimation médicale, la génétique médicale, l'oncologie médicale qui sont présentes dans plusieurs pays européens ;**
- **Assurer une meilleure confiance mutuelle des Etats membres sur l'attestation de conformité délivrée par les Etats Membres ;**
- **S'assurer du champ d'activité de la médecine générale, un exercice plein et entier, reconnu en France et dans plusieurs pays Européens comme une spécialité.**

Mais surtout, l'intérêt est de permettre plus d'automatisme dans la reconnaissance des qualifications telle que prévue dans la Directive 2005/36/CE et assurer une interprétation harmonisée de la situation des médecins notamment sur la production des attestations de conformité délivrée par les Etats Membres.

Concernant les spécialités non présentes à l'annexe V de la directive 2005/36/CE : la génétique médicale, l'oncologie médicale, la réanimation médicale. Elles peuvent exister dans certains Etats membres. Elles existent en France, mais elles n'ouvrent pas droit à la reconnaissance automatique en France. De la même manière, certaines spécialités sont listées à l'annexe V de la directive 2005/36/CE, mais ne sont pas présentes pour la France dans l'Annexe : la gériatrie, la médecine d'urgence, l'allergologie.

Nous sommes conscients que les annexes de la directive 2005/36/CE doivent être modifiées. Il serait bénéfique pour tous, qu'une mise à jour plus fréquente soit instituée, avec l'ensemble des autorités compétentes, l'Université et les Institutions intéressées.

Pour ce qui a trait au régime général, son application est satisfaisante dans l'ensemble.

Des difficultés demeurent néanmoins lorsqu'il s'agit d'analyser et de comparer les formations et l'expérience professionnelle des demandeurs aux conditions requises en France. Nous ne comprenons pas toujours quel est le champ de compétence et les actes réalisés dans l'Etat membre d'accueil par le demandeur, puisque les appellations et l'organisation des spécialités diffèrent dans chaque Etat membre.

De même, l'expérience professionnelle est souvent décrite en terme de périodes de temps (nombre de mois, d'années...), sans toujours préciser le

volume horaire de l'exercice et sans que l'on sache précisément les actes qui ont été réalisés ou s'ils ont été réalisés sous la supervision d'un autre professionnel.

4. Is the general system applied in your country each time the conditions for automatic recognition are not met? Are there major difficulties in the recognition procedure under the general system? Please include any comments you may have on the implementation of compensation measures. Is the migrant given the choice between an aptitude test and an adaptation period or is the choice restricted. Please explain.

En France, le régime général est appliqué quand les conditions permettant de bénéficier de la reconnaissance automatique ne sont pas remplies.

Des mesures de compensation peuvent être prévues afin de reconnaitre la spécialité, notamment dans le cas de non-conformité, de spécialités non existantes dans le pays ou non prévues par l'annexe V point 5.1.3 de la Directive 2005/36/CE.

Ainsi, dans le cas où l'examen des qualifications professionnelles attestées par l'ensemble des titres de formation et de l'expérience professionnelle pertinente fait apparaître des différences substantielles au regard des qualifications requises pour l'accès à la profession dans la spécialité concernée et son exercice en France, le ministre de la Santé exige que l'intéressé se soumette à une mesure de compensation qui consiste, au choix du demandeur, en une épreuve d'aptitude ou en un stage d'adaptation dans la spécialité concernée.

La France a choisi de ne pas faire jouer la dérogation prévue par la directive pour imposer un certain type de mesure de compensation.

En effet pour :

- Les titulaires de titres de formation délivrés par un Etat tiers (Hors Union européenne), et reconnus dans un Etat de l'Union européenne permettant d'y exercer légalement la profession ;
- Les titulaires de titres de formation délivrés par l'un des Etats de l'Union européenne, ne répondant pas aux conditions de

reconnaissance automatique mais permettant d'exercer légalement la profession de médecin dans cet Etat ;

Une Commission « régime général » présidée par le Ministère de la santé en France, comprenant les Commissions de qualification placées auprès du Conseil National de l'Ordre des Médecins, un représentant du Ministère de l'enseignement supérieur et deux représentants du Conseil National de l'Ordre des Médecins, peut demander des mesures compensatoires au ressortissant se traduisant, au choix du migrant, par une épreuve d'aptitude ou un stage d'adaptation (3 ans maximum) complété éventuellement par une formation complémentaire.

- L'épreuve d'aptitude peut prendre la forme d'interrogations écrites ou orales ou les deux, notées sur 20, portant sur chacune des matières qui n'ont pas été enseignées initialement ou non acquises au cours de l'expérience professionnelle.
  En cas de réussite à l'épreuve d'aptitude, le ministre chargé de la santé autorise l'intéressé à exercer la profession.
  En cas d'échec, il refuse l'autorisation d'exercice.

- Le stage d'adaptation s'effectue dans un établissement de santé public ou privé agréé par les services régionaux de l'Etat.
  Le stagiaire est placé sous la responsabilité pédagogique d'un professionnel qualifié exerçant depuis au moins trois ans. Ce dernier établit un rapport d'évaluation.
  Le stage, qui comprend éventuellement une formation théorique complémentaire, est validé par le responsable de la structure d'accueil, sur proposition du médecin enseignant qui évalue le stagiaire.
  La décision sur la demande d'autorisation d'exercice est prise après un nouvel avis de la commission « régime général ».

La Commission « régime général » rencontre deux principales difficultés :

- L'une concerne la production et l'interprétation d'informations quant à la formation et l'expérience du médecin.
- L'autre concerne l'interprétation des conditions d'exercice et le champ d'activité dans le pays d'origine par rapport à une spécialité donnée.

5. What is your experience with the recognition procedure for EU citizens with professional qualifications obtained in a third country and already recognised in a first Member State (see Articles 2(2) and 3(3))?

L'Ordonnance n° 2009-1585 du 17 décembre 2009 a complété la transposition des mesures de la directive 2005/36 relatives au Régime Général pour les titulaires de titres de formation délivrés par un Etat tiers, et reconnus dans un Etat de l'Union européenne permettant d'y exercer légalement la profession (Article L4111-2 II du Code de la santé publique).

Article L4111-2 II du Code de la santé publique : « L'autorité compétente peut également, après avis d'une commission composée notamment de professionnels, autoriser individuellement à exercer la profession de médecin dans la spécialité concernée, les ressortissants d'un Etat membre de l'Union européenne ou d'un autre Etat partie à l'accord sur l'Espace économique européen, titulaires de titres de formation délivrés par un Etat tiers, et reconnus dans un Etat, membre ou partie, autre que la France, permettant d'y exercer légalement la profession. »

Dans le cas où l'examen des qualifications professionnelles attestées par l'ensemble des titres de formation et de l'expérience professionnelle pertinente fait apparaître des différences substantielles au regard des qualifications requises pour l'accès à la profession et son exercice en France, l'autorité compétente exige que l'intéressé se soumette à une mesure de compensation qui consiste, au choix du demandeur, en une épreuve d'aptitude ou en un stage d'adaptation dans la spécialité ou le domaine concerné ».

La Commission dite « régime général » prévue par le Décret n° 2009-958 du 29 juillet 2009 propose un avis au Ministère chargé de la santé pour l'obtention d'une autorisation ministérielle d'exercice dont les modalités ont été précisées par l'arrêté du 27 avril 2010.

Le fondement juridique de la Directive 2005/36/CE sur la reconnaissance des titres délivrés par les pays tiers à l'Union européenne correspond à l'article 3 (3) où il précise qu' « e*st assimilé à un titre de formation tout titre de formation délivré dans un pays tiers dès lors que son titulaire a, dans la profession concernée, une expérience professionnelle de trois ans sur le territoire de l'État membre qui a reconnu ledit titre conformément à l'article 2, paragraphe 2, et certifiée par celui-ci.* »

Par conséquent, la République Française a préféré être plus généreuse en ne requérant pas nécessairement les trois années d'expérience professionnelle, mais une simple prérogative d'exercice qui au demeurant, nécessite uniquement que le candidat ait la possibilité ou la faculté d'exercer sur le territoire qui a procédé à la reconnaissance du titre obtenu dans un pays hors de l'Union européenne.

Outre la difficulté d'obtenir la certitude et la confirmation que les candidats à cette procédure ont bien une prérogative d'exercice, le Conseil National de l'Ordre des Médecins a constaté que de nombreux candidats à une procédure nationale de première reconnaissance d'autorisation d'exercice s'orientent vers la procédure du régime général après un échec ou un avis défavorable.

En effet, après un détour rapide dans un pays européen, les candidats obtiennent une « reconnaissance » ou une « homologation » de leur titre académique.

Cette démarche constitue un détournement de l'esprit de la Directive 2005/36/CE auquel il faudrait remédier.

6. Please describe the government structure of the competent authority or authorities in charge of the recognition.

En France, la compétence pour la reconnaissance des qualifications professionnelles est répartie entre le Conseil National[2] de l'Ordre des Médecins et le Ministre chargé de la Santé[3].

Il n'existe aucun rapport de hiérarchie entre ces deux autorités compétentes.

La reconnaissance automatique des qualifications, qu'elle soit fondée sur le titre de formation ou qu'elle découle des droits acquis, relève de la compétence du Conseil National de l'Ordre des Médecins.

Le Ministre chargé de la Santé est compétent pour l'application du régime général.

Le Conseil National de l'Ordre des Médecins (CNOM) regroupe obligatoirement tous les médecins[4] habilités à exercer.

Le Conseil National de l'Ordre des Médecins veille au maintien des principes de moralité, de probité, de compétence et de dévouement indispensables à l'exercice de la médecine et à l'observation, par tous leurs membres, des devoirs professionnels, ainsi que des règles édictées par le code de déontologie.

Il assure la défense de l'honneur et de l'indépendance de la profession médicale.

Il peut organiser toutes œuvres d'entraide et de retraite au bénéfice de leurs membres et de leurs ayants droit.

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[2] http://www.conseil-national.medecin.fr/

[3] http://www.sante-sports.gouv.fr/

[4] Sauf cas particuliers

Il accomplit sa mission par l'intermédiaire des Conseils départementaux, des Conseils régionaux ou interrégionaux et du Conseil national de l'ordre.

L'activité du Conseil National de l'Ordre des Médecins est organisée autour de 4 chapitres (« Section ») :

- Ethique et déontologie et inscription des médecins
- Formation, qualifications et compétences des médecins
- Exercice professionnel et organisation des soins
- Santé publique et démographie

Le disciplinaire est également assuré par l'Ordre.

B. TEMPORARY MOBILITY (OF A SELF-EMPLOYED OR AN EMPLOYED WORKER)

7. Are EU citizens interested in using the provisions for exercising their professional activities on a temporary and occasional basis in your Member State? How many citizens used this new system in 2008 and 2009 (per month, per year) [5]?

En France, l'autorité compétente pour la procédure de libre prestation de services est le Conseil National de l'Ordre des Médecins.

En 2008, 31 prestataires ont été déclarés et 30 n'ont pas donné suite.

En 2009, 39 prestataires ont été déclarés et 33 n'ont pas donné suite.

8. How are the provisions of Directive 2005/36/EC concerning temporary mobility applied by the competent authorities in practice taking into account the relevant provisions of the Code of Conduct? For instance:

- **How is the "legal establishment" criteria foreseen by Article 5(1) (a) interpreted in practice? What conditions does a migrant need to fulfil in his home Member State in order to be able to provide services ?**

Selon la réglementation française un médecin de l'Union européenne peut exercer temporairement et occasionnellement la médecine sur le territoire français sans être inscrit au tableau d'un Conseil départemental de l'Ordre des Médecins.

Cet exercice temporaire et occasionnel est subordonné à une déclaration préalable dont les modalités sont fixées par décret.

Le caractère temporaire et occasionnel de la prestation est apprécié, par le Conseil National de l'Ordre des Médecins, au cas par cas, notamment en

[5] Please provide this information unless it has already been provided to the Commission in the Database or the implementation reports.

fonction de la durée, de la fréquence, de la périodicité et de la continuité de l'activité du médecin.

Conditions requises pour bénéficier du régime de la libre prestation de services.
Le médecin doit :

1. être ressortissant d'un Etat membre de l'Union européenne ou partie à l'Accord sur l'Espace économique européen et titulaire de diplômes, certificats ou autres titres obtenus dans l'un de ces Etats ;
2. être légalement établi c'est-à-dire être en situation régulière d'exercice dans un État membre autre que la France (le médecin ne doit pas être privé, même temporairement, du droit d'exercer dans son pays) ;
3. avant la première prestation de services, il doit adresser au Conseil National de l'Ordre des Médecins une déclaration, accompagnée de pièces justificatives ;

En outre, le médecin prestataire doit apporter la preuve, par tout moyen, qu'il possède :

1. une connaissance suffisante de la langue française ;
2. les qualifications professionnelles requises pour la pratique de l'activité concernée. En cas de doute, le Conseil National de l'Ordre des Médecins peut procéder à une vérification des connaissances linguistiques ou des qualifications professionnelles du médecin, au besoin par l'intermédiaire du Conseil départemental.

Lorsque la déclaration et les pièces justificatives sont complètes, le médecin est enregistré sur une liste spécifique tenue par le Conseil national.

Il est dispensé du versement d'une cotisation.

Le Conseil National de l'Ordre des Médecins adresse au médecin un récépissé précisant son numéro d'enregistrement, les qualifications

professionnelles déclarées et le cas échéant, la caisse primaire d'assurance maladie compétente.

La déclaration de prestation de services est annuelle. Toutefois, le médecin doit informer le Conseil National de l'Ordre des Médecins de toute modification de la situation établie par sa déclaration et fournir les pièces justificatives s'y rapportant.

Le médecin doit renouveler sa déclaration chaque année s'il compte exercer de manière temporaire et occasionnelle sur le territoire français.

La difficulté d'apprécier le critère d'établissement dans le pays d'origine survient fréquemment, notamment lorsque nous n'avons pas d'informations précises sur l'activité du médecin. En effet, les dispositions relatives à la prestation de services limitent le champ d'appréciation de l'activité du médecin dans le pays d'origine.

- **How are the "temporary and occasional basis" criteria foreseen by Article 5.2 interpreted in practice? Do Member States assess duration, frequency, regularity and continuity of an activity and if so according to which criteria?**

D'une manière générale les termes 'temporaire et occasionnel' sont ambigus et nous souhaiterions des éclaircissements sur la durée envisagée par un médecin souhaitant faire une libre prestation de services.

Dans la plupart des situations les médecins souhaitent effectuer des remplacements de médecins en France ou avoir une opinion quant à une future installation en France.

Cependant, les règles très souples de la libre prestation de services ne permettent pas d'effectuer un examen approfondi des dossiers de demande de prestation de services. Le mécanisme actuel ne permet pas non plus de s'assurer que les règles de la libre prestation de services ne sont pas utilisées afin de contourner les règles sur l'établissement.

Ainsi la requalification d'une situation temporaire en situation d'établissement stable par les autorités compétentes, semble délicate au vu des dispositions actuelles.

Les dispositions de la Directive 2005/36/CE devraient être modifiées afin de laisser plus d'amplitude aux autorités compétentes pour demander éventuellement des précisions ou données complémentaires eu égard aux risques pour la santé publique. Par exemple, l'information quant à la couverture assurantielle devrait être primordiale. Comment vérifier que le médecin ait bien une assurance couvrant les actes qu'il est susceptible d'effectuer en France ou dans un pays européen ?

Chaque autorité compétente doit s'assurer que les médecins qui exercent sur le territoire national répondent à des règles professionnelles et de compétences, ce que ne permettent pas les dispositions européennes actuelles.

9. Why is a prior declaration system necessary? What do competent authorities do with the information received? Are other possibilities conceivable? Do you have any cases – and if yes how many - whereby doctors sent the declaration after the provision of services has taken place.

Lorsque les titres de formation ne bénéficient pas de la reconnaissance automatique, les qualifications professionnelles du prestataire peuvent être vérifiées avant la première prestation de services. En cas de différence substantielle entre les qualifications du prestataire et la formation exigée en France pour l'exercice de la profession de médecin dans la spécialité concernée, de nature à nuire à la santé publique, les autorités compétentes demandent au prestataire d'apporter la preuve qu'il a acquis les connaissances et compétences manquantes, notamment au moyen de mesures de compensation.

La France a choisi de ne pas transposer la déclaration a posteriori.

10. Do you charge any fee in case Article 7, § 4 applies?

A l'heure actuelle, la procédure de demande d'une prestation de services n'est soumise à aucun frais.

C MINIMUM TRAINING REQUIREMENTS

11. To what extent are the common minimum training requirements for specialists and general practitioners set out in Title III Chapter III of Directive 2005/36/EC and as defined in Annex V in line with scientific progress and professional needs? Furthermore, are the knowledge and skills required by the directive still relevant and up to date? Please specify. What about the conditions relating to the duration of training? Do you have many specialties training, which have a common trunk. If yes, please specify which ones.

En France, les internes[6] reçoivent à temps plein une formation théorique et pratique de trois à cinq ans selon le diplôme d'études spécialisées envisagé.

Pour chaque diplôme d'études spécialisées (« DES »), le temps de préparation, le programme des enseignements, la durée et la nature des fonctions pratiques qui doivent être exercées dans les stages hospitaliers ou extrahospitaliers, notamment le nombre de semestres à valider par spécialité, ainsi que les règles de validation applicables constituent la maquette de formation. Ces maquettes sont fixées par arrêté des ministres chargés de l'enseignement supérieur et de la santé (cf. Annexe II).

Il est institué, dans certaines disciplines ou spécialités, des diplômes d'études spécialisées complémentaires dont la liste est fixée par arrêté des ministres chargés de l'enseignement supérieur et de la santé (cf. Annexe I).

Ces diplômes sont de deux types :

- les diplômes du groupe I, d'une durée de deux ans, qui n'ouvrent pas à la qualification de spécialiste ;

- les diplômes du groupe II, d'une durée de trois ans, qui ouvrent droit à la qualification de spécialiste correspondant à l'intitulé du diplôme.

La formation en vue des diplômes d'études spécialisées complémentaires est dispensée à temps plein. Elle comporte un enseignement théorique et une formation pratique accomplie dans des lieux de stage agréés ou auprès de

[6] Etudiant en médecine de 3ème cycle avec une fonction de soignant en autonomie supervisée.

praticiens agréés-maîtres de stage dans les mêmes conditions que celles qui s'appliquent à la formation en vue des diplômes d'études spécialisées.

Pour chaque diplôme d'études spécialisées complémentaires, le temps de préparation, le programme des enseignements, la durée et la nature des fonctions pratiques qui doivent être exercées dans les stages hospitaliers ou extrahospitaliers, notamment le nombre de semestres à valider par spécialité, constituent la maquette de formation

Le contenu de chaque diplôme d'études spécialisées et de chaque diplôme d'études spécialisées complémentaires est précisé dans une maquette dont la validation est obligatoire.

Certains DESC se font après l'internat (post internat) comme les spécialités chirurgicales.

Voir annexes I et II pour les maquettes des « DES » et « DESC » du groupe II.

Le Conseil National de l'Ordre des Médecins remarque que de nombreux médecins européens ont obtenu un titre de spécialiste sans avoir effectué une formation de spécialité dans le pays d'obtention du titre ou certificat de spécialiste. En effet, il semble que des médecins ont obtenu le titre de formation sur la base d'une formation non qualifiante en France ou dans un autre pays européen.

Il apparait que la situation de ces médecins relève du régime général de la Directive 2005/36/CE relative à la reconnaissance des qualifications.

Enfin, même si les diplômes acquis en France ou dans un pays de l'Union européenne n'ouvrant pas à la spécialité sont d'une grande qualité, ils ne peuvent permettre à un autre pays de l'Union européenne de considérer que le médecin ait suivi une formation de spécialiste conforme à l'article 25 de la Directive 2005/36/CE sans un examen approfondi.

12. To what extent are the common minimum requirements for training set out in Title III Chapter III of Directive 2005/36/EC in line with scientific progress and professional needs in the last ten years? Are the knowledge and skills outlined in Article 24.3 still relevant and up to date? Please specify. What about the conditions relating to the duration of training?

Il existe un manque d'information sur la nature et le contenu des formations, connaissances et compétences requises pour la formation des médecins dans les États membres. Sans cette information essentielle, l'autorité compétente peut avoir la légitime interrogation quant à la qualité de la formation médicale étant donnée le caractère très général des dispositions prévues dans la directive 2005/36/CE.

Il est essentiel de définir des normes sur la formation ainsi que sur le contenu de la formation médicale.

En effet, à ce jour, l'adéquation des formations repose largement sur la durée de la formation au détriment du contenu et du champ de compétences que développe la formation médicale.
Une harmonisation de la durée et du contenu engendrerait une plus grande confiance des autorités compétentes et un meilleur examen des dossiers.

L'expérience actuelle montre un manque de confiance des autorités compétentes sur la formation médicale de base ou de spécialité.
Il nous apparait urgent d'identifier et comparer la formation et l'apprentissage en Europe non seulement pour une meilleure reconnaissance mais aussi et surtout pour une qualité des soins et un impératif de santé publique.

C'est seulement une fois cette démarche mise en place et la connaissance des systèmes de formation et d'assurance qualité que la reconnaissance automatique pourrait s'effectuer pleinement.

D'avantage de coopération, de concertation avec les autorités compétentes permettraient de partager au mieux l'expertise et la connaissance de la réglementation. Le groupe de coordonnateurs et les comités relatifs à la reconnaissance des qualifications professionnelles pourraient bénéficier de ce fait, d'une part des expériences et des difficultés rencontrées et d'autre part de l'expertise reconnue des autorités compétentes en matière de formation et de la réglementation.

13. The Directive is based on mutual trust between Member States. To what extent is such trust actually achieved? Are training programmes accredited in your country? Does accreditation of a training program in another Member State enhance trust or is it not relevant?

Le considérant (19) de la directive précise que « *la libre circulation et la reconnaissance mutuelle des titres de formation de médecin, [...] devraient se fonder sur le principe fondamental de la reconnaissance automatique des titres de formation sur la base d'une coordination des conditions minimales de formation. En outre, l'accès dans les États membres aux professions de médecin [...] devrait être subordonné à la possession d'un titre de formation déterminé, ce qui donne la garantie que l'intéressé a suivi une formation qui remplit les conditions minimales établies. Ce système devrait être complété par une série de droits acquis dont bénéficient les professionnels qualifiés sous certaines conditions* ».

A cet égard, il est constant que la directive vise notamment la reconnaissance mutuelle des diplômes, certificats et autres titres de médecin spécialiste et ceci afin de permettre aux États membres de procéder à ladite reconnaissance mutuelle dans le but de placer l'ensemble des professionnels ressortissants des États membres sur un relatif pied d'égalité à l'intérieur de l'Union européenne. Par ailleurs, la directive 2005/36/CE prévoit une certaine harmonisation des conditions relatives à la formation et à l'accès aux différentes spécialités médicales.

Parmi les normes minimales relatives à la formation des médecins spécialistes figurent notamment celles concernant la durée minimale de la formation spécialisée, son mode d'enseignement et le lieu où elle doit s'effectuer (Article 25 de la directive).

C'est à ce titre que le Conseil National de l'Ordre des Médecins conçoit la reconnaissance des qualifications.
S'agissant du respect des normes minimales de formation, il y a lieu de constater que le législateur communautaire, en insistant sur la durée minimale de la formation spécialisée a voulu s'assurer de conditions minimales relatives à la formation ouvrant droit aux titres de spécialistes.

Cependant, plus que pour d'autres activités ou professions, la formation des médecins ne peut être réalisée sans précaution garantissant que la formation et l'expérience atteignent un niveau suffisant au regard des exigences nationales de santé publique. Le Conseil National de l'Ordre des Médecins comprend aussi la raison pour laquelle une reconnaissance automatique des titres est un gage d'efficacité dans le processus qu'à la condition que l'État membre d'origine fournisse des assurances quant à la qualification de spécialistes des ressortissants communautaires formés sur son territoire.

En effet, des distorsions nuiraient outre à la lisibilité de la réglementation applicable mais porteraient aussi atteinte à l'intérêt des ressortissants communautaires, dans la mesure où ceux-ci seraient exposés aux risques objectivement plus nombreux de violation du principe d'égalité inhérents à la multiplicité des critères d'appréciation nationaux ou communautaires.

Ce droit à la reconnaissance des qualifications fait partie intégrante des effets de la directive puisque, s'il en était privé, le médecin ne disposerait pas de toutes les qualités qui permettent d'obtenir le titre de médecin et ferait peser un doute sur la réalité de son droit à exercer la profession de médecin, ce qui constituerait un obstacle sérieux tant à l'accès de la profession qu'à la liberté d'établissement.

Ainsi, la possession d'un titre de formation délivré par un organisme accrédité par une institution témoigne du suivi d'un cursus particulier

d'acquisition de connaissances et de qualifications. Dans ces conditions, ces formations ne peuvent être désignées que par leur appellation prévue dans la Directive et notamment dans l'annexe V de la Directive, faute de quoi des réalités différentes se cacheraient derrière une appellation unique, sans justification particulière.

Or, l'expérience montre que des titres de formation délivrés par des autorités compétentes reprennent les intitulés et les dénominations des titres sans pour autant conférer un titre de spécialiste.

Dès lors, seul le certificat de conformité peut permettre de s'assurer d'une part que la formation est conforme et d'autre part que le titre est bien celui présent à l'annexe V. 5.1.3 de la Directive 2005/36/CE.

Il importe donc que les formations soient distinguées et appréciées pour ce qu'elles sont. Cette exigence implique qu'un État membre soit en droit de prescrire que le bénéficiaire a acquis un titre de formation de médecins spécialiste conformément à l'article 25 de la directive et que les durées minimales des formations médicales spécialisées ne sont pas inférieures à celles visées à l'annexe V, point 5.1.3.

Il serait nécessaire de s'assurer que la formation s'effectue bien sous le contrôle des autorités ou des organismes compétents.

14. To what extent are the existing Directive provisions (see recital 39 and Article 22(b) on continuous professional development (continuous training) adequate? Is continuous training mandatory in your country and what are the exact conditions?

En France actuellement, le développement professionnel continu a pour objectifs l'évaluation des pratiques professionnelles, le perfectionnement des connaissances, l'amélioration de la qualité et de la sécurité des soins ainsi que la prise en compte des priorités de santé publique et de la maîtrise médicalisée des dépenses de santé.
Une nouvelle procédure va être instituée.

En France, il constitue une obligation déontologique et légale pour tous médecins.
L'Ordre des Médecins s'assure du respect par les médecins inscrits au tableau de l'ordre de leur obligation de développement professionnel continu.

Par contre, la directive 2005/36/CE n'autorise actuellement pas le contrôle par les autorités compétentes, lors de la demande de reconnaissance, de l'obligation d'avoir suivi une formation médicale continue.

Ce vide juridique constitue inévitablement une légitime interrogation quant à la mise à jour des connaissances et compétences du médecin souhaitant bénéficier d'une demande de reconnaissance de qualification.

D. ADMINISTRATIVE COOPERATION

15. To which extent does administrative cooperation, as outlined in Articles 8, 50, and 56 of the Directive, simplify procedures for the migrant professionals?

La coopération administrative entre les différentes autorités compétentes est essentielle et indispensable dans la mesure où il est nécessaire d'avoir des informations complémentaires sur la formation ou la situation d'un médecin.

Dans de nombreuses situations, la coopération administrative a permis de régulariser la situation du médecin, de s'assurer de l'interprétation des attestations délivrées ou de permettre de procéder à des corrections.

Nous avons remarqué que des médecins ont obtenu des attestations délivrées par erreur.

Il serait utile de mettre en place un mécanisme d'alerte, notamment par l'intermédiaire d'IMI[7], signifiant à l'ensemble des autorités la délivrance de documents soit frauduleux soit erronés.

16. Is the competent authority in your country registered with IMI? Under which circumstances does your competent authority use IMI? If not registered, why not and what would be the conditions for changing this situation?

Le Conseil National de l'Ordre des Médecins et le Ministère chargé de la Santé sont enregistrés dans le système IMI en qualité d'autorités compétentes. Le système IMI est utilisé afin de compléter le dossier du migrant ou avoir confirmation sur la situation du médecin.

Il serait utile que l'enregistrement des autorités compétentes soit obligatoire afin que l'ensemble des autorités concernées puisse apporter des informations fiables et certifiées.

[7] IMI= Système d'information du marché intérieur. Est une application en ligne sécurisée qui permet aux autorités nationales, régionales et locales de communiquer facilement et rapidement avec les autorités d'autres pays. Le système est accessible par internet et ne nécessite l'installation d'aucun logiciel. Pour plus d'informations : http://ec.europa.eu/internal_market/imi-net/index_fr.html

Un approfondissement des fonctions et des questions serait également très prometteur sur cet outil indispensable. Par exemple la confirmation de l'autorisation d'exercice, le niveau de l'autorisation d'exercice (plénitude d'exercice ou non), les droits acquis en médecine générale,...

17. How could a professional card (see Recital 32 of the Directive) facilitate recognition of professional qualifications and provision of temporary services? Under which conditions could it be issued by professional associations?

Le Conseil National de l'Ordre des Médecins s'engage actuellement avec les autorités ministérielles françaises à la diffusion d'une carte électronique à l'ensemble des médecins inscrits au Tableau de l'Ordre des médecins.
Le Conseil National de l'Ordre des Médecins, en qualité d'autorité compétente et d'autorité d'enregistrement, autorisera l'émission et la distribution d'une carte électronique d'identité professionnelle aux médecins inscrits au Tableau de l'Ordre. Les certificats électroniques pour la carte seront délivrés par l'Agence[8] des Systèmes d'Information Partagés de Santé.
Le Conseil National de l'Ordre des Médecins considère que l'idée de la carte européenne est séduisante. Cependant, actuellement, la dimension européenne du projet de carte électronique d'identité professionnelle nationale n'est pas prévue.

Le Ministère chargé de la Santé considère qu'une carte professionnelle serait utile, notamment dans les cas de libre prestation de services. Les procédures administratives seraient limitées pour les migrants à partir du moment où les informations essentielles figureraient dans une base de données et où les autorités compétentes pourraient échanger entre elles des informations directement.

[8] http://esante.gouv.fr/

Un tel projet nécessite néanmoins un examen approfondi, notamment pour ce qui est des questions de sécurité, d'interopérabilité et de traduction des informations dans les 23 langues officielles de l'Union européenne.
En tout état de cause, les autorités compétentes devront garder la main sur un tel projet et ne pas laisser les organismes professionnels seuls gérer ce type de données personnelles.

18. Are you alerted by other Member States in case of disciplinary action or criminal sanctions taken or any other serious, specific circumstances which are likely to have consequences for the pursuit of activities under this Directive? How do you share this information? Could more be done in this respect?

L'amélioration des échanges d'informations quant aux décisions touchant l'exercice du médecin ou sa capacité à exercer demeure un défi que seule la législation européenne peut harmoniser.
En effet, les différentes législations nationales sur la protection des données, la confidentialité et la publicité des décisions ou des procédures en cours s'opposent parfois à la communication de ces informations.
Cependant, cet échange est aussi un gage pour la sécurité des patients afin de s'assurer de la compétence du médecin, de son éthique et de sa capacité à exercer dans le pays d'origine.

Ainsi, des décisions définitives, accompagnées de la description des faits en cause et les procédures en cours pourraient faire l'objet d'un signalement auprès des autorités compétentes d'une manière sécurisée et permettant ainsi d'assurer le respect des dispositions nationales.

E. OTHER OBSERVATIONS

19. How and when are the necessary language skills of migrants checked after recognition of the professional qualifications? Are you aware of any complaints (especially from patients/clients/employers) about insufficient language skills of migrants?

La maitrise de la langue fait partie intégrante de la compétence médicale. De notre point de vue la capacité du médecin à communiquer efficacement et intelligiblement dans la langue de l'État membre hôte devrait être une condition préalable à la reconnaissance. Chaque autorité compétente devrait être capable d'évaluer la maitrise de la langue.

En France, lors de la demande de reconnaissance, le médecin doit fournir tous les éléments de nature à établir qu'il possède les connaissances linguistiques nécessaires à l'exercice de la profession de médecin.

Le médecin qui demande son inscription au tableau du lieu d'exercice de son choix doit apporter la preuve d'une connaissance suffisante de la langue française. En cas de doute, le président du Conseil départemental de l'Ordre des Médecins ou son représentant peut entendre l'intéressé. Une vérification peut être faite à la demande du Conseil de l'Ordre ou de l'intéressé par le médecin inspecteur départemental de santé publique.

Dans certaines situations le médecin effectue un stage linguistique en milieu médical afin de se familiariser avec l'organisation sanitaire, le langage utilisé et les différentes dénominations médicales.

20. Does the application of Article 30 raise any specific problems?

Considérant que les autorités compétentes de chaque État membre délivrent, sur demande, un certificat attestant le droit d'exercer les activités de médecin généraliste dans le cadre de leur régime national de sécurité sociale, sans un titre de formation visé à l'annexe V, point 5.1.4, aux médecins qui sont titulaires de droits acquis, le Conseil National de l'Ordre des Médecins a beaucoup de difficultés à déterminer quelles prorogatives ont les médecins

qui ont le droit d'exercer dans le cadre de leur régime national de sécurité sociale. En effet, le régime national de sécurité sociale est, par définition, très différent pour chaque pays de l'Union européenne.

Comment apprécier les prérogatives d'exercices sur la base d'un régime national de sécurité sociale ? Pour ne prendre que l'exemple de la France et de manière schématique, la relation entre un médecin et le régime national de sécurité sociale est purement conventionnelle. La relation entre un médecin et le régime national de sécurité sociale ne détermine donc pas la compétence du médecin. Ainsi en France, un médecin non conventionné, inscrit au Tableau, peut exercer tout aussi bien qu'un médecin conventionné.

Par ailleurs, dans certains pays nous constatons que des médecins ont des relations avec le régime national de sécurité sociale sans pour autant avoir la plénitude d'exercice. L'exercice peut prendre la forme d'un exercice limité à la prévention uniquement, de dépistage, de protection,...ou dans une structure sous la responsabilité et la supervision d'un médecin habilité.

Etant donné que chaque État membre reconnaît les certificats délivrés aux ressortissants des États membres par les autres États membres en leur donnant le même effet sur son territoire qu'aux titres de formation qu'il délivre et qui permettent l'exercice des activités de médecin généraliste dans le cadre de son régime national de sécurité sociale, il en demeure que certains médecins peuvent obtenir plus de droit que dans leur pays de provenance.

Par conséquent, il nous apparaît nécessaire de clarifier les droits attachés aux médecins relevant d'un régime national de sécurité sociale ou de modifier l'exigence de cette mesure en spécifiant les modalités et les conditions attachées à cet exercice.

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Version anglaise pour information

A. RECOGNITION PROCEDURE IN CASE OF MIGRATION ON A PERMANENT BASIS

1. Do you accept applications from EU citizens for the recognition of foreign diplomas sent by email or requests made on line? Under which conditions can they send documents and declarations electronically? What are your experiences in this respect?

In France, there is no online procedure or Internet site for the recognition of qualifications (French Medical Council - Order of Doctors – "Ordre des Médecins") or for the general system (Ministry of Health).

Applications concerning recognition must be individual and personal.

In particular, the application includes copies of diplomas, qualifications and certificates accompanied where necessary by a translation carried out by a translator authorized by French courts or certified to work with a European Union Member State's judicial or administrative authorities.

The doctor requesting registration with the relevant French Medical Council gives his request or sends it by registered post with acknowledgement of receipt to the President of the Council of the Order in the department in which he wishes to establish his professional residence.

For convenience's sake, the French National Medical Council accepts copies of qualifications, certificates and attestations sent by email or fax before the reception of the mandatory original documents.

However, the French National Medical Council has noted that there are more and more forgeries: qualifications, diplomas and certificates of conformity.

The National Council of the Order of Doctors is highly vigilant regarding the authenticity of qualifications, all the more because French regulations require the Order to verify the qualifications and diplomas allowing the practice of medicine in France. (c.f. I.M.I System)

2. What is the yearly number of positive and negative decisions of recognition from 2000 to 2009? Please submit specific data for applications for automatic recognition based on diplomas, automatic recognition based on acquired rights (as from 2005), and recognition based on the general system[9]. If available, please provide information on the average duration of the recognition process.

See annex III for the statistical data.

The French National Medical Council does not have precise data regarding the following negative decisions: requests for registration that are not followed up, incomplete applications or refusal.
The French National Medical Council does not have precise data regarding the positive decisions that distinguish automatic recognition: acquired rights, conformity.
This procedure is under development.

The commissions for each speciality have been meeting regularly and the implemented procedure is respecting the deadlines.

[9] Please provide this information unless it has already been provided to the Commission in the Database or the implementation reports.

3. To what extent have the system of automatic recognition and the general system been a success? How do you see the costs and benefits? Specify in particular whether automatic recognition based on diploma, Annex V and the current notification system represent an efficient way to facilitate automatic recognition. Please submit comments for:

- **automatic recognition based on diploma automatic**
- **recognition based on acquired rights**
- **recognition based on the general system.**
- **Please specify whether there are any specific problems with Annex V.**

The Directive 2005/36/CE deals with the recognition of qualifications and makes provisions for a certain harmonization of the conditions concerning training and access to different medical specialities. Among the minimum norms regarding the training of specialists are those concerning the minimum length of the specialized training, the method of instruction and the place where it is to be carried out (Article 25 of the Directive 2005/36/CE).

In like manner, the Directive 2005/36/CE specifies the minimum conditions of basic training.

The system of automatic recognition provided by Directive 2005/36/EC has proven successful in facilitating the recognition of medical qualifications within the European Economic Area.

However, the current system does not offer a guarantee that the doctor actually has the skills and experience necessary to practice. In fact, a doctor fulfilling the criteria of diplomas and qualifications necessary for registration may never have practiced his discipline, nor have been declared fit to practice.

This is why an additional condition of fitness to practice or registration in the country of origin would be a guarantee of mutual confidence for the recognition of qualifications.

The process of automatic recognition depends essentially on the competent authorities that deliver certificates conforming to the measures of the Directive 2005/36/CE.
For example, some applications mention certificates delivered on the strength of Article 23.1 even when the doctor has practiced outside the European Economic Area (EEA). We have also received conformity certificates regarding qualifications not listed in the Annex of the Directive 2005/36/CE (example: medical genetics).
In certain situations, the competent authority can confirm only that the doctor has effectively and lawfully practiced in their territory for at least three consecutive years out of the five years preceding the certificate's date of issue (for example, the competent authority does not have any information about the doctor).

In the same manner, while the Directive 2005/36/CE specifies the length of professional experience, we wonder about the interpretation of this provision. Is this intended to mean 3 years of professional experience with full and complete practice and fully practicing?
Indeed, it is apparent in some applications that the doctors had a restricted or limited practice. However, no provisions exist to assure us that the doctor has real experience certified by the Member State of origin.
It would be necessary to include a provision enabling competent authorities to satisfy themselves that the professional experience has been certified by the Member State of origin.

Finally, certain experiences have demonstrated that doctors benefiting from automatic recognition did not have necessary knowledge or experience to practice, notably in highly technical and specialised techniques (for example: anaesthesiology and intensive care). Our analysis leads us to believe that

these difficulties stem from the material conditions of practice and healthcare organization in different Member States.

To a certain extent, a minimum level of harmonisation of specialist training would eventually lead to the benefit of recognition that was based not only on the duration but also on the content of the training, since fields of activity and their names can be very different throughout the European Union depending on the healthcare body of each country.

Moreover, many applications show that even if the speciality does not exist in one country, the activity itself may well do (for example, the field of cardiology exists in Austria or in Slovenia but does not lead to a speciality as a cardiologist, or the field of paediatric surgery in Belgium or in Netherlands which does not necessarily lead to a speciality).

Therefore, the advantages of harmonising qualifications are as follows (without claiming to be exhaustive):

- Better understand the differences between qualifications (17 communes in France out of the 52 of Annex V of the Directive), for automatic recognition and the general system;
- Better understand the correspondence between professional qualification and real professional activity and in particular the fields of activity for each specialisation;
- Allow the introduction of medical specialities such as intensive care, medical genetics, medical oncology, which are present in several European countries;
- Ensure greater mutual confidence between Member States about the certificate of conformity issued by Member States;
- Secure the field of activity of general medicine, a full and complete practice, recognised as a speciality in France and several other European countries.

Above all, however, the advantage is to allow a greater level of automatic functioning in the recognition of qualifications as set out in the Directive 2005/36/CE and to ensure a harmonised interpretation of the situation of doctors, in particular regarding the production of conformity certificates issued by Member States.
Concerning the specialities not presented in Annex V of the Directive 2005/36/CE: medical genetics, medical oncology and intensive care. These specialities exist in certain Member States. They exist in France, although they do not lead to automatic recognition in France. Equally, certain specialities are listed in Annex V of the Directive 2005/36/CE, but are not present for France in the Annex: geriatrics, emergency medicine, allergology.
We are aware that the annexes of the Directive 2005/26/CE are to be modified. It would be beneficial for all to institute a more frequent updating, with all competent authorities, the University and the Institutions concerned.

The general system is satisfactory.

There are still some difficulties about the appreciation, the analysis of the training, when it comes to compare with the national requirements.
The scope of the practise and the medical acts they perform *in concreto* are hard to understand, as the names and the organisation of the specialities can be different in each member state.

Also, the duration of the professional experience often comes in length of time (months, years...), without any specification about the amount of hours and without specifying the medical acts performed and if those acts have been done under supervision or not.

4. Is the general system applied in your country each time the conditions for automatic recognition are not met? Are there major difficulties in the recognition procedure under the general system? Please include any comments you may have on the implementation of compensation measures. Is the migrant given the choice between an aptitude test and an adaptation period or is the choice restricted. Please explain.

In France, the general system is applied when the conditions for the automatic recognition are not met.

Compensation measures can be provided for in order to recognise the speciality, in particular in the case of non-conformity of specialities that do not exist in the country or are not accounted for in Annex V point 5.1.3 of the Directive 2005/36/CE.

Thus, where the examination of professional qualifications attested by formal qualifications and pertinent professional experience shows substantial differences in terms of the qualifications required for access to the profession in the relevant speciality and its practice in France, the Ministry of Health requires the applicant to accept a compensation measure and the applicant has a choice between an aptitude test or an adaptation period in the speciality concerned.

France has decided not to use the exception allowed by the directive to impose a specific kind of compensation measure.

The compensation measures are for:

- Holders of formal qualifications issued by a third State (outside the European Union), and recognised in a State of the European Union permitting the legal practice of the profession there;
- Holders of formal qualifications issued by one of the European Union States, not satisfying conditions of automatic recognition but permitting the legal practice of medicine in that State;

A "general system" Commission chaired by the Ministry of Health in France, including the qualification Commissions under the auspices of the French National Medical Council, a Ministry of higher education representative and two representatives of the French National Medical Council, could request

compensatory measures of the national, chosen by the candidate, resulting in an aptitude test or an adaptation period (maximum 3 years) and possibly completed by supplementary training.

- The aptitude test can take the form of written and/or oral exams, marked out of 20, on subjects not taught during initial training or acquired during professional experience.

  Upon success on the aptitude test, the Ministry of Health authorises the applicant to practice.

  In case of failure, it refuses authorisation to practice.

- The adaptation period takes place in a public or private healthcare establishment, accredited by the regional healthcare agency.

  The trainee is placed under the pedagogical responsibility of a qualified professional who has practiced for at least three years. This professional writes an evaluation report.

  The period, which can include extra theoretical training, is validated by the head of the host structure, upon recommendation by the clinical tutor who evaluates the participant.

  The decision regarding the request for authorisation to practice is taken after a new recommendation from the "general system" commission.

The "general system" Commission encounters two main difficulties.
One concerns the production and the interpretation of information regarding the doctor's training and experience.
The other concerns the interpretation of the conditions of practice and the field of activity in the country of origin for a given speciality.

5. What is your experience with the recognition procedure for EU citizens with professional qualifications obtained in a third country and already recognised in a first Member State (see Articles 2(2) and 3(3))?

The Ordinance n° 2009-1585 of 17th December 2009 implemented the measures of Directive 2005/36 relative to the General System for holders of formal qualifications issued by a third State, and recognised in a European Union State allowing the legal practice of the profession there (Article L4111-2 of the Public Health Code).

Article L4111-2 of the Public Health Code: "The competent authority can also, on the recommendation of a commission composed notably of professionals, grant authorisation to practice the profession of doctor in the relevant speciality to a national of a European Union Member State or contracting Party to the European Economic Area Agreement, holders of formal qualifications issued by a third State, and recognised in a State, member or contracting party, other than France, allowing them to lawfully practice the profession there."

Where the examination of professional qualifications attested by training certificates and pertinent professional experience shows substantial differences in terms of the qualifications required for access to the profession in the speciality concerned and its practice in France, the competent authority requires the applicant to accept a compensation measure which consists, at the applicant's choice, of an aptitude test or an adaptation period in the specialisation concerned.

The Commission known as the "general system Commission", provided for by the Decree n° 2009-958 of 29th July 2009, proposes a recommendation to the Ministry of Health to obtain ministerial authorisation to practice, the terms of which were specified in the ruling of 27th April 2010.

The legal foundation of the Directive 2005/36/CE on the recognition of certificates issued by third countries outside the European Union corresponds to Article 3(3) where it is specified that *" formal qualifications issued by a third country shall be regarded as evidence of formal qualifications if the holder has three years' professional experience in the profession concerned on the territory of the Member State which recognised the said qualifications in accordance with Article 2 paragraph 2, certified by that Member State."*

As a result, the French Republic preferred to be more generous by not requiring necessary the three years of professional experience, but rather a simple right to practice, which for the resident requires only that the candidate have the possibility or the ability to practice in the country which carried out the recognition of the certificate obtained in a country outside the European Union.

Besides the difficulty of obtaining certitude and confirmation that the candidates of this procedure do indeed have a right to practice, the National Council of the Order of Doctors has noted that numerous candidates using a national procedure of primary recognition of fitness to practice turn to the general system procedure after failure or rejection. Indeed, after a brief detour in a European country, candidates obtain "recognition" or "approval" of their academic certificate.

This procedure constitutes a misappropriation of the spirit of Directive 2005/36/CE, which must be remedied.

6. Please describe the government structure of the competent authority or authorities in charge of the recognition.

In France, we have two competent authorities that recognise the professional qualifications: The Conseil[10] National de l'Ordre des Médecins - French National Medical Council and the Ministry of Health[11].
Those two entities are independent and do not report to one another.

The automatic recognition of qualifications, whether it is based on diplomas or on acquired rights, falls under the responsibility of the French Medical Council - Conseil National de l'Ordre des Médecins.

The Ministry of health is in charge of the general system.

The French Medical Council – Ordre des Médecins[12]- necessarily includes all doctors[13] licensed to practice.

The French National Medical Council ensures the maintenance of the principles of morality, integrity, competence and dedication that are indispensable to the practice of medicine and the observation, by all its members, of professional duties, as well as regulations prescribed by the deontological code.

It is responsible for defending the honour of the medical profession.

It can organise all activities of mutual aid and retirement benefiting its members and their beneficiaries.

[10] http://www.conseil-national.medecin.fr/

[11] http://www.sante-sports.gouv.fr/

[12] http://www.conseil-national.medecin.fr/

[13] Except special cases

It carries out its mission through departmental councils, regional or interregional councils and the national council of the Order.

The French National Medical Council activities is organised around four chapters ("Sections"):

- Ethical and deontological registration of doctors
- Training, qualifications and skills of doctors
- Professional practice and healthcare organisation
- Public healthcare and demography

Disciplinary procedures are also carried out by the Order.

B. TEMPORARY MOBILITY (OF A SELF-EMPLOYED OR AN EMPLOYED WORKER)

7. Are EU citizens interested in using the provisions for exercising their professional activities on a temporary and occasional basis in your Member State? How many citizens used this new system in 2008 and 2009 (per month, per year) [14]?

In France, the competent authority for the free provision of service procedure is the French National Medical Council - Conseil National de l'Ordre des Médecins.

In 2008, 31 service providers were declared and 30 did not follow up.
In 2009, 39 service providers were declared and 33 did not follow up.

8. How are the provisions of Directive 2005/36/EC concerning temporary mobility applied by the competent authorities in practice taking into account the relevant provisions of the Code of Conduct? For instance:

- **How is the "legal establishment" criteria foreseen by Article 5(1) (a) interpreted in practice? What conditions does a migrant need to fulfil in his home Member State in order to be able to provide services ?**

According to French regulations, a European doctor can practice medicine in France on a temporary and occasional basis without being registered with a departmental council of the Order.
This temporary and occasional practice is subject to a prior declaration the terms of which are fixed by decree.
The temporary and occasional character of the provision of service is assessed by the French National Medical Council, case by case, notably depending on the duration, the frequency, the periodicity and the continuity of the doctor's activity.
Conditions required in order to benefit from the system of free provision of services.

[14] Please provide this information unless it has already been provided to the Commission in the Database or the implementation reports.

The doctor must:

1. be a national of a Member State of the European Union or a consenting Party to the European Economic Area Agreement and a holder of diplomas, certificates or other qualifications obtained in one of these States;
2. be legally established, i.e. in a legal situation of practice in a Member State other than France (the doctor must not lose, even temporarily, his right to practice in his country);
3. before the first provision of services, he must send a declaration to the French National Medical Council, accompanied by documentary evidence;

In addition, the doctor providing the service must furnish the proof, by any means, that he possesses:

1. sufficient knowledge of the French language;
2. the professional qualifications required for the practice of the relevant activity. In case of doubt, the National Council of the Order of Doctors may carry out a verification of the doctor's language skills or professional qualifications, if necessary through the departmental Council.

When the declaration and the documentary evidence are complete, the doctor is registered on a specific list held by the French National Medical Council.

He is exempt from the payment of a subscription fee.

The French National Medical Council sends the doctor a receipt specifying his registration number, the professional qualifications declared and, where necessary, the competent primary health insurance fund.
The declaration of service provision is annual. However, the doctor must inform the French National Medical Council of any change in the situation set out in the declaration and furnish the relevant documentary evidence.

The doctor must renew his declaration every year if he wishes to practice in France on a temporary and occasional basis.
The difficulty of assessing the criterion of establishment in the country of origin arises frequently, in particular when we do not have precise information about the activity of the doctor. Indeed, the provisions concerning the provision of services limit the field of assessment of the doctor's activity in his country of origin.

- **How are the "temporary and occasional basis" criteria foreseen by Article 5.2 interpreted in practice? Do Member States assess duration, frequency, regularity and continuity of an activity and if so according to which criteria?**

Generally speaking the terms "temporary and occasional" are ambiguous and we would like clarifications regarding the duration envisaged by a doctor wishing to provide services freely. In most situations, doctors wish to carry out replacements for doctors in France or wish to form an opinion about a future move to France.
However, the highly flexible rules for the free provision of service do not allow for an in-depth examination of applications for provision of services.
The provisions do not give any guarantee that the mechanism of free provisions of services cannot be used to bypass the conditions required for the establishment.

The qualification of an abusive situation of temporary exercise into the procedure of establishment is difficult with the actual provisions.

The provisions of the Directive 2005/36/CE should be modified in order to grant more leeway to competent authorities to ask for possible precisions or additional data to guarantee patient safety. For example, information regarding insurance cover should be essential. How can one verify that a doctor is indeed insured for actions he is susceptible of performing in France or in another European country?

Each competent authority must ensure that doctors practising in the national territory meet professional regulations and competences, this is not permitted by the current European provisions.

9. Why is a prior declaration system necessary? What do competent authorities do with the information received? Are other possibilities conceivable? Do you have any cases – and if yes how many - whereby doctors sent the declaration after the provision of services has taken place.

When the formal proof of qualification does not confer automatic recognition, the service provider's professional qualifications could be checked before the first provision of services. In case of substantial difference between the service provider's qualifications and the training required in France for the practice of the medical profession in the relevant specialisation, so as to endanger public health, competent authorities ask the service provider to furnish proof that he has acquired the missing knowledge and skills, notably using compensation measures.
France chose not to transpose a posteriori declaration

10. Do you charge any fee in case Article 7, § 4 applies?

At the present time, the procedure of requesting provision of service is not subject to any fee.

C MINIMUM TRAINING REQUIREMENTS

11. To what extent are the common minimum training requirements for specialists and general practitioners set out in Title III Chapter III of Directive 2005/36/EC and as defined in Annex V in line with scientific progress and professional needs? Furthermore, are the knowledge and skills required by the directive still relevant and up to date? Please specify. What about the conditions relating to the duration of training? Do you have many specialties training, which have a common trunk. If yes, please specify which ones.

In France, interns[15] receive full time theoretical and practical training lasting between three and five years according to the specialised studies diploma envisaged.

For each specialist studies diploma ("Diplôme d'études specialises, DES"), the preparation time, the programme of instruction, the duration and the nature of the practical duties that must be carried out in hospital placements and in extra-hospital placements, in particular the number of semesters to be validated per speciality, as well as the applicable validation rules constitute the training model. These models are defined by ruling of the Ministries of Health and Higher Education (cf. Annex I).

In certain disciplines or specialities, supplementary specialist studies diplomas are instituted, the list of which is fixed by ruling of the Ministries of Health and Higher Education (cf. Annex I and II).

These diplomas are of two types:

- Group I diplomas, with a duration of two years, which not entitle the holder to a specialist qualification;
- Group II diplomas, with a duration of three years, which entitle the holder to a specialist qualification corresponding to the title of the diploma.

[15] Student in specialized training with a function of caregiver in a supervised autonomy.

Training in preparation for supplementary studies diplomas is full time. It includes theoretical instruction and practical training carried out in the certified premises of the placement or with an accredited placement supervisor under the same conditions as those applying to training with a view to specialist studies diplomas.
For each supplementary specialist studies diploma, the preparation time, the programme of instruction, the duration and the nature of the practical duties that must be carried out in hospital placements and in extra-hospital placements, in particular the number of semesters to be validated per speciality, as well as the applicable validation rules constitute the training model.

The content of each specialist studies diploma and of each additional specialist studies diploma is specified in a model whose validation is mandatory.

See the annex I and II for the "DES" and "DESC" schemas from Group II.

The French National Medical Council has noted that numerous European doctors have obtained the status of specialist without having carried out speciality training in the country where the certificate of specialist is obtained. Indeed, it seems that doctors have obtained the formal proof of qualification on the basis of non-qualifying training in France or in another European country.
It appears that the situation of these doctors comes under the scope of the general system of the Directive 2005/36/CE relative to the recognition of qualifications.
Finally, even if the diplomas acquired in France or in a country of the European Union not leading to a speciality are of high quality, they cannot enable another country of the European Union to consider that the doctor has followed specialist training in accordance with Article 25 of the Directive 2005/36/CE without an in-depth examination.

12. To what extent are the common minimum requirements for training set out in Title III Chapter III of Directive 2005/36/EC in line with scientific progress and professional needs in the last ten years? Are the knowledge and skills outlined in Article 24.3 still relevant and up to date? Please specify. What about the conditions relating to the duration of training?

There is a lack of information concerning the nature and the content of the qualifications, knowledge and skills required for the training of doctors in Member States. Without this essential information, the competent authority may have legitimate doubts regarding the quality of the medical training, given the highly general nature of the provisions set out in Directive 2005/36/CE.

It is essential to define norms for the training as well as for the content of the medical training.

In fact, at the present time, the adequacy of training is based largely on the duration of the training to the detriment of the content and the field of knowledge developed by the medical training.

Harmonisation of the duration and the content would inspire greater confidence in the competent authorities and ensure a better examination of applications.

Present experience shows a lack of confidence by the competent authorities concerning basic or specialist medical training.

We feel urgent identification and comparison of training and learning in Europe is needed, not only for improved recognition, but above all for better quality healthcare and as a duty to public health.

Only once this is put into action, and training and quality assurance systems are known can automatic recognition operate with full efficacy.

Greater co-operation and consultation with competent authorities would enable expertise and knowledge of the regulations to be shared in the best way. The group of co-ordinators and the committees working with the recognition of professional qualifications could benefit both from the experience and the difficulties already encountered and also from the

recognised expertise of competent authorities regarding training and regulation.

13. The Directive is based on mutual trust between Member States. To what extent is such trust actually achieved? Are training programmes accredited in your country? Does accreditation of a training program in another Member State enhance trust or is it not relevant?

Recital (19) of the directive specifies that *"freedom of movement and the mutual recognition of the evidence of formal qualifications of doctors, [...] should be based on the fundamental principle of automatic recognition of the evidence of formal qualifications on the basis of coordinated minimum conditions for training. In addition, access in the Member States to the professions of doctor [...] should be made conditional upon the possession of a given qualification ensuring that the person concerned has undergone training which meets the minimum conditions laid down. This system should be supplemented by a number of acquired rights from which qualified professionals benefit under certain conditions."*

In this regard, it is clear that the directive is directed in particular at the mutual recognition of specialist doctors' diplomas, certificates and other formal qualifications, in order to allow Member States to carry out the said mutual recognition with the aim of placing all professionals from Member States on an equal footing within the European Union.

In addition, the Directive 2005/36/CE provides for a certain harmonisation of the conditions concerning training and the access to different medical specialities.

Among the minimum norms relative to the training of specialist doctors are notably those concerning the minimum duration of the specialist training course, its method of instruction and the establishment where it is carried out (Article 25 of the Directive).

This is how the French National Medical Council sees the recognition of qualifications.

Concerning respect for minimum training norms, it should be noted that the EC legislator, by emphasising the minimum duration of specialist training, attempted to ensure minimum conditions concerning the training that conferred the status of specialist.

However, more than for other activities or professions, the training of doctors cannot be achieved without a precaution that guarantees that the training and the experience reach a sufficient level from the point of view of national public health requirements. The French National Medical Council understands the reason why automatic recognition of qualifications is a guarantee of efficacy in the process only on the condition that the Member State of origin provides assurance regarding the qualification of specialists of European nationals trained on its territory.

In fact, distortions would harm not only the transparency of the applicable legislation, but would also undermine the interest of European nationals, insofar as they would be exposed to objectively more numerous risks of violation of the principle of equality inherent to the multiplicity of national or European assessment criteria.

This right to the recognition of qualifications is an integral part of the directive's effects since, if a doctor were deprived of it, he would not have all the qualities that would enable him to obtain the title of doctor and would lead to doubt about the legitimacy of his right to practice the profession of doctor, which would constitute a serious obstacle just as much to access to the profession as to the freedom of establishment.

Thus, possession of a training certificate issued by a body accredited by an institution proves that a particular curriculum of knowledge and skills acquisition has been followed.

In these conditions, these training courses can only be designated by the name set out in the Directive and in particular in the Annex, failing which different realities would hide behind a single designation, with no particular justification.

However, experience shows that training certificates issued by the bodies use the titles and the designation of statuses without necessarily conferring the status of specialist. Experience also reveals that competent authorities issue

qualifications to doctors who have obtained recognition of a qualification issued in a third country.

Consequently, only the conformity certificate can ascertain that both the training complies with Annex V. 5.1.3. of the Directive 2005/36/CE and that the certificate is indeed present in this Annex.

It is therefore important for training courses to be distinguished and assessed for what they are. This requirement implies that a Member State is entitled to stipulate that the beneficiary has acquired a specialist doctor training certificate in accordance with Article 25 of the Directive and that the minimum durations of specialised medical training are not less than those specified in Annex V, point 5.1.3.

It should be necessary to ensure that the training does indeed take place under the control of competent authorities or bodies.

14. To what extent are the existing Directive provisions (see recital 39 and Article 22(b) on continuous professional development (continuous training) adequate? Is continuous training mandatory in your country and what are the exact conditions?

In France actually, continuous professional development has as its objectives the evaluation of professional practices, perfecting knowledge, improvement of healthcare quality and safety as well as the recognition of public healthcare priorities and the medical control of healthcare spending.

It constitutes a deontological and legal obligation for all doctors.

A new law is actually in force.

The Order of Doctors makes sure that the doctors registered with the Order respect their obligation of continuous professional training. On the other hand, the directive 2005/36/CE does not at present authorise the competent authorities to verify, upon request for recognition, the obligation of having followed a continuous professional training course.

This incapacity inevitably leads to legitimate doubt regarding the updating of knowledge and skills of a doctor wishing to benefit from a qualification recognition request.

D. ADMINISTRATIVE COOPERATION

15. To which extent does administrative cooperation, as outlined in Articles 8, 50, and 56 of the Directive, simplify procedures for the migrant professionals?

Administrative cooperation between the different competent authorities is essential and vital insofar as it is necessary to have supplementary information about a doctor's situation.

In numerous situations, administrative cooperation has enabled a doctor's situation to be regularised, as well as ascertaining the interpretation of issued attestations or allowing corrections to be carried out.

We have noted that some doctors have obtained attestations issued in error. It would be useful to instigate an alert mechanism, in particular through IMI, informing all authorities of fraudulent or erroneous documents.

16. Is the competent authority in your country registered with IMI? Under which circumstances does your competent authority use IMI? If not registered, why not and what would be the conditions for changing this situation?

The French National Medical Council and the Ministry of Health are registered in the IMI[16] system as a competent authority. The IMI system is used in order to complete the migrant's file or to obtain confirmation regarding the situation of a doctor.

It would be useful for the registration of competent authorities to be mandatory, enabling all the concerned authorities to bring reliable and certified information.

A more thorough investigation of these functions and questions would also be useful regarding this vital tool. For example: confirmation of fitness to practice, the level of fitness to practice (fully practicing or not), acquired rights in general medicine...

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[16] IMI= Internal Market Information System, is a secure online application that allows national, regional and local authorities to communicate quickly and easily with their counterparts abroad. IMI is accessible via the internet without the need to install any additional software. For more information: http://ec.europa.eu/internal_market/imi-net/index_en.html

17. How could a professional card (see Recital 32 of the Directive) facilitate recognition of professional qualifications and provision of temporary services? Under which conditions could it be issued by professional associations?

The French National Medical Council is currently committed together with the French authorities to distribute an electronic card to all physicians registered in France.

The French National Medical Council, as competent authority and record authority, will authorize the electronic professional identity card issue and distribution. Electronic certificates for the card will be given by l'Agence[17] des Systèmes d'Information Partagés de Santé ("Agency of the health information system").

The French National Medical Council considers the idea of the European card is interesting. However, now, the European level of the national project of electronic professional identity card is not planned.

The Ministry of Health agrees that a professional card could be helpful, especially in cases of temporary provision of services. The administrative procedures would be limited for the migrant. If the necessary information could be stored in a database, the competent authorities would exchange information directly.

Some items need to be clarified, however, such as the scope of the card, the guarantee of the update and the upload of the information on the card, the translation on the 23 european languages, the interoperability and the security.

The question of the cost and of the authority in charge needs to be determined as well.

[17] www.sante-sports.gouv.fr

In any case, the competent authorities must monitor the process and not let the professional bodies alone deal with such sensitive personal information.

18. Are you alerted by other Member States in case of disciplinary action or criminal sanctions taken or any other serious, specific circumstances which are likely to have consequences for the pursuit of activities under this Directive? How do you share this information? Could more be done in this respect?

The improvement of information exchange regarding decisions about a doctor's practice or his capacity to practice remains a challenge that only European legislation can harmonise.

Indeed, different national legislation on data protection, confidentiality and the publicity of decisions or procedures underway are sometimes a barrier to the communication of this information.

However, this exchange is also a guarantee of patient safety in order to ascertain the skills of the doctor, his ethics and his capacity to practice in the country of origin.

Thus, definitive decisions with the description of the incriminated facts and procedures underway could be dealt with by securely informing competent authorities and thus ensuring that national provisions can be respected.

E. OTHER OBSERVATIONS

19. How and when are the necessary language skills of migrants checked after recognition of the professional qualifications? Are you aware of any complaints (especially from patients/clients/employers) about insufficient language skills of migrants?

Mastery of the language is an integral part of medical competence. From our point of view, the capacity of a doctor to communicate effectively and intelligibly in the language of the host Member State would be a prior

condition for recognition. Each competent authority should be capable of assessing the mastery of the language.

In France, when a recognition request is made, the doctor must provide all the documents required to establish that he has the language skills necessary to practice the medical profession.

The doctor requesting registration with the list of his chosen area of practice must demonstrate sufficient knowledge of the French language. In case of doubt, the president of the departmental council of the order or his representative may call the applicant to audition. Verification by the medical inspector of the department of public health may be carried out upon the request of the Council of the Order or the applicant.

In certain situations the doctor may take part in a language course in a medical environment in order to familiarise himself with the healthcare organisation, the language used and the different medical terms.

20. Does the application of Article 30 raise any specific problems?

Considering that the competent authorities of each Member State issue, upon request, a certificate attesting the right to practice the activities of general practitioner within the framework of their national social security system, without formal proof of qualification figuring in Annex V, point 5.1.4, to doctors who hold acquired rights, the National Council of the Order of Doctors has a lot of difficulty determining the prerogatives of the doctors with the right to practice within the framework of their national social security system. Indeed, the national social security system is, by definition, very different for each country in the European Union.
How does one assess the prerogatives of practice on the basis of a national health service? Taking only the example of France, and in simple terms, the relationship between a doctor and the National Health Service is purely contractual. Therefore, the relationship between a doctor and the National

Health Service does not determine the competence of the doctor. Thus, in France, a private doctor, registered with the Roll, may practice just as well as a doctor in the National Health Service.

In addition, in certain countries we note that doctors have relationships with the National Health Service without nevertheless being able to fully practice. Practice can take the form of practice limited to prevention, screening, protection... or in a structure under the responsibility and the supervision of an accredited doctor.

Given that each Member State recognises the certificates issued to nationals of Member States by other Member States, giving them the same value in its territory as is given to the qualifications that it issues and which permit practice of the activities of general practitioner within the framework of its National Health Service, it is clear that certain doctors can obtain more rights than in their country of origin.

Consequently, we feel it is necessary to clarify the rights attached to doctors belonging to a National Health Service or to modify the requirement of this provision by specifying the terms and conditions attached to this practice.

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ANNEXE I

Liste des Diplômes d'Etudes Spécialisées

→ Anatomie et Cytologie Pathologiques

→ Anesthésie réanimation

→ Biologie Médicale

→ Cardiologie et maladies vasculaires

→ Chirurgie générale

→ Dermatologie et vénéréologie

→ Endocrinologie, diabète, maladies métaboliques

→ Gastro-entérologie et Hépatologie

→ Génétique médicale

→ Gynécologie médicale

→ Gynécologie obstétrique

→ Hématologie (avec les 2 options : Maladies du sang, Onco-hématologie)

→ Médecine générale

→ Médecine interne

→ Médecine nucléaire

→ Médecine physique et de réadaptation

→ Médecine du travail

→ Néphrologie

→ Neurochirurgie

→ Neurologie

→ Oncologie (avec les 3 options : médicale, radiothérapique, Onco-hématologie)

→ Ophtalmologie

→ Oto-rhino-laryngologie et chirurgie cervico-faciale

→ Pédiatrie

→ Pneumologie

→ Psychiatrie

→ Radiodiagnostic et imagerie médicale

→ Rhumatologie

→ Santé publique et médecine sociale

→ Stomatologie

➢ DIPLÔME D'ÉTUDES SPÉCIALISÉES D'ANATOMIE ET CYTOLOGIE PATHOLOGIQUES - DURÉE : CINQ ANS

I - Enseignements (trois cents heures environ)

A) Enseignements généraux

- Méthodologie de l'évaluation des pratiques de soins et de la recherche clinique et épidémiologique en anatomie et cytologie pathologiques ;
- Organisation, gestion, éthique, droit et responsabilité médicale en anatomie et cytologie pathologiques.

B) Enseignements spécifiques

- Principes des techniques histochimiques, immunohistochimiques et de biologie cellulaire et moléculaire utilisées en anatomie et cytologie pathologiques ; recueil et transfert des données ;
- Autopsies médico-scientifiques de l'adulte, de l'enfant et du fœtus ;
- Organisation et prise en charge des prélèvements autopsiques, extemporanés et des urgences en anatomie et cytologie pathologiques ;
- Épidémiologie et physiopathologie des maladies inflammatoires et dysimmunitaires, des pathologies de surcharge et troubles du métabolisme, des maladies cardiovasculaires, de l'athérome et des troubles circulatoires, des pathologies environnementales et iatrogènes, du vieillissement, des syndromes malformatifs et des maladies génétiques ;
- Principes de cancérogenèse ; classification et dépistage des tumeurs et des états pré-cancéreux ; histo- et cytodiagnostic ; histopronostic et suivi thérapeutique ;
- Principes généraux et suivi anatomo-cytopathologique des transplantations d'organes ;
- Applications de l'anatomo-cytopathologie aux appareils et systèmes suivants : cardiovasculaire, respiratoire, digestif et foie, génital féminin et sein, grossesse, embryon, fœtus et enfant, urinaire et génital masculin, glandes endocrines, système nerveux, tissus hémo- lymphopoïétiques, peau, appareil locomoteur, ORL, œil, cavité buccale.

II - Formation pratique

A) Sept semestres dans des services agréés pour le diplôme d'études spécialisées d'anatomie et cytologie pathologiques, dont au moins cinq doivent être accomplis dans des services hospitalo-universitaires ou conventionnés. Ces semestres doivent être effectués dans au moins deux services ou départements différents ;

B) Trois semestres dans des services agréés pour d'autres diplômes d'études spécialisées que le diplôme d'anatomie et cytologie pathologiques, ou pour des diplômes d'études spécialisées complémentaires.

➢ **DIPLÔME D'ÉTUDES SPECIALISÉES D'ANESTHÉSIE-RÉANIMATION - DURÉE : CINQ ANS**

I - Enseignements (trois cents heures environ)

A) Enseignements généraux
- Méthodologie de l'évaluation des pratiques de soins et de recherche clinique et épidémiologique en anesthésie-réanimation.
- Organisation, gestion, éthique, droit et responsabilité médicale en anesthésie- réanimation.

B) Enseignements spécifiques
- Anatomie fonctionnelle appliquée à l'anesthésie ; physiologie, pharmacologie et physique appliquées à l'anesthésie-réanimation ;
- Douleur, analgésie-anesthésie loco-régionale ;
- Fonction respiratoire et anesthésie ;
- Fonction cardio-vasculaire et anesthésie ;
- Système nerveux et anesthésie ;
- Troubles du métabolisme et anesthésie ;
- Hémostase et transfusion ;
- Anesthésie en obstétrique ;.
- Anesthésie pédiatrique ;
- Anesthésie en ORL, ophtalmologie et stomatologie ;
- Anesthésie en chirurgie générale ;
- Réanimation respiratoire ;
- Réanimation cardio-vasculaire ;
- Réanimation neurologique ;
- Réanimation et milieu intérieur-nutrition ;
- Réanimation pédiatrique et en obstétrique ;
- Réanimation et pathologie infectieuse ;
- Réanimation digestive ;
- Réanimation en traumatologie ;
- Médecine d'urgence ;
- Évaluation et éthique en réanimation.

II - Formation pratique

A) Sept semestres dans des services agréés pour le diplôme d'études spécialisées d'anesthésie-réanimation, dont quatre semestres dans des services d'anesthésie comprenant la pratique de l'anesthésie et des soins périopératoires dans les spécialités suivantes :
- chirurgie générale ;
- chirurgie pédiatrique ;
- chirurgie du segment céphalique (oto-rhino-laryngologie, ophtalmologie, stomatologie) ;
- chirurgie orthopédique ;
- chirurgie urologique ;
- chirurgie thoracique et cardiovasculaire,

et trois semestres de formation en réanimation dont au moins deux doivent être accomplis dans des services hospitalo-universitaires ou conventionnés. Au moins un semestre doit être effectué dans un service de réanimation adulte ou pédiatrique.
Les autres semestres peuvent être effectués : soit dans un service d'aide médicale urgente, soit dans une structure d'anesthésie en chirurgie cardiothoracique ou en neurochirurgie, ou bien dans un service d'urgence comportant une activité de déchocage.
B) Un semestre dans un service de réanimation hospitalo-universitaire ou conventionné agréé pour le DESC de réanimation médicale.
C) Deux semestres dans des services agréés pour la spécialité.
La formation pratique hospitalière comprend la participation à des gardes formatrices dans la spécialité.

➢ DIPLÔME D'ÉTUDES SPECIALISÉES DE BIOLOGIE MEDICALE

1 - Option biologie polyvalente

I - Objectifs

1) Compléter et approfondir les connaissances du niveau 1, notamment dans la spécialité non validée au cours des quatre premiers semestres (immunologie ou parasitologie-mycologie - niveau 1).

2) Acquérir de nouveaux objectifs spécifiques au "niveau 2 polyvalent"

a) Dossier biologique multidisciplinaire :

- validation du dossier biologique multidisciplinaire ;
- conduite du dialogue clinico-biologique, fondé sur des connaissances théoriques et pratiques permettant notamment d'évaluer la pertinence de la prescription d'examens biologiques dans le cadre d'une prise en charge globale du patient.

b) Participation du biologiste dans les missions transversales des établissements publics et privés :

- hygiène et prévention des infections nosocomiales ;
- sécurité transfusionnelle-hémovigilance ;
- réactovigilance-biologie délocalisée.

c) Connaissance du management :

- organisation du laboratoire ;
- gestion administrative ;
- sécurité au laboratoire.

d) Assurance qualité :

- management de la qualité ;
- gestion des risques.

II - Cursus

Le cursus est constitué de **quatre semestres libres.**

Toutefois, une formation en biologie polyvalente ne peut être satisfaisante sans l'acquisition des connaissances fondamentales dans les disciplines majeures de la biologie, ni sans une expérience dans un laboratoire polyvalent. Il est donc fortement conseillé d'effectuer :

- 1 semestre en parasitologie-mycologie ou immunologie (en fonction du semestre effectué au cours du niveau 1) ;
- 1 semestre en biologie polyvalente.

➢ DIPLOME D'ETUDES SPECIALISEES DE CARDIOLOGIE ET MALADIES VASCULAIRES

Durée : quatre ans
Internes nommés à compter du 1er novembre 2009

I - Enseignements

(Deux cent cinquante heures environ)

A - Enseignements généraux

- méthodologie de l'évaluation des pratiques de soins et de la recherche clinique et épidémiologique en cardiologie et maladies vasculaires ;
- organisation, gestion, éthique, droit et responsabilité médicale en cardiologie et maladies vasculaires.

B - Enseignements spécifiques

- anatomie, embryologie et physiologie du système cardiovasculaire ;
- principes de biologie cellulaire et moléculaire appliqués au système cardiovasculaire ;
- pharmacologie (métabolisme, posologie, action et toxicité) des médicaments usuels en cardiologie et maladies vasculaires ;
- épidémiologie et génétique des affections cardiovasculaires ;
- facteurs de risque cardiovasculaires et prévention des affections cardiovasculaires ;
- explorations invasives et non-invasives en cardiologie et maladies vasculaires ;
- physiopathologie, anatomopathologie, diagnostic, pronostic et traitement des maladies du système cardiovasculaire : maladie coronaire, hypertension artérielle systémique et pulmonaire, hypotension orthostatique, valvulopathies et endocardites infectieuses, myocardites et myocardiopathies, péricardites, troubles du rythme et de la conduction, cardiopathies congénitales, tumeurs du cour, pathologie aortique, artériopathies des membres, maladie thrombo-embolique, malformations vasculaires, insuffisance cardiaque ;
- organisation et prise en charge des urgences cardiovasculaires ;
- principes généraux, indications et suivi de la chirurgie cardiaque et vasculaire et des transplantations.

II - Formation pratique

A - Cinq semestres dans des services agréés pour le diplôme d'études spécialisées de cardiologie et maladies vasculaires, dont trois au moins doivent être accomplis dans des services hospitalo-universitaires ou conventionnés. Un semestre sera consacré à l'apprentissage des techniques d'explorations cardiaques dans le cadre d'une unité fonctionnelle d'explorations et/ou d'imagerie cardiaque, dans un service ou dans un laboratoire d'explorations fonctionnelles agréés pour le diplôme d'études spécialisées de cardiologie et maladies vasculaires. Ces semestres doivent être effectués dans deux services ou départements différents.
B - Un semestre d'initiation à la prise en charge des pathologies vasculaires réalisé dans un service agréé pour le diplôme d'études spécialisées de cardiologie et maladies vasculaires ou pour le diplôme d'études spécialisées complémentaires de médecine vasculaire ou pour le diplôme d'études spécialisées complémentaires de chirurgie vasculaire.
C - Deux semestres dans des services agréés pour d'autres diplômes d'études spécialisées que le diplôme d'études spécialisées de cardiologie et maladies vasculaires, de préférence dans des services agréés pour les diplôme d'études spécialisées d'endocrinologie et métabolismes, de médecine interne, de néphrologie, de neurologie, de pédiatrie (à orientation cardiologique), de pneumologie ou de radiodiagnostic et imagerie médicale, ou pour le diplôme d'études spécialisées complémentaires de réanimation médicale.

➢ **DIPLÔME D'ÉTUDES SPÉCIALISÉES DE CHIRURGIE GENERALE**
- DURÉE : CINQ ANS

I - Enseignements (deux cent cinquante heures environ)

A) Enseignements de base
- Anatomie chirurgicale ;
- Acte opératoire, méthodologie chirurgicale ;
- Pathologie générale ;
- Traumatologie ;
- Urgences chirurgicales non traumatiques.

B) Enseignements spécifiques

Enseignements dispensés dans le cadre de la formation théorique du diplôme d'études spécialisées ou du diplôme d'études spécialisées complémentaires pour lequel est agréé le service dans lequel l'interne est affecté.

II - Formation pratique

A) Huit semestres dans des services agréés pour l'un des diplôme d'études spécialisées ou des diplômes d'études spécialisées complémentaires de la discipline des spécialités chirurgicales, dont :
- un semestre au moins dans les services agréés pour le diplôme d'études spécialisées de chirurgie générale, mention chirurgie osseuse ;
- un semestre au moins dans des services agréés pour le diplôme d'études spécialisées de chirurgie générale, mention chirurgie viscérale.

B) Deux semestres dans des services agréés pour la spécialité ou pour une autre spécialité.

- **DIPLÔME D'ÉTUDES SPÉCIALISÉES DE DERMATOLOGIE ET VÉNÉRÉOLOGIE - DURÉE : QUATRE ANS**

I - Enseignements (deux cent cinquante heures environ)

A) Enseignements généraux
- Méthodologie de l'évaluation des pratiques de soins et de la recherche clinique et épidémiologique en dermatologie et vénéréologie ;
- Organisation, gestion, éthique, droit et responsabilité médicale en dermatologie et vénéréologie.

B) Enseignements spécifiques
- Anatomie, embryologie, développement, biologie et physiologie de la peau, des muqueuses et des phanères ;
- Principes de génétique, d'immunologie, d'infectiologie et d'oncologie appliqués à la peau, aux muqueuses et aux phanères ;
- Pharmacologie (métabolisme, posologie, action et toxicité) des médicaments usuels en dermatologie et vénéréologie ;
- Explorations endoscopiques, histologiques et fonctionnelles de la peau, des muqueuses et des phanères ;
- Epidémiologie, physiopathologie, anatomopathologie, diagnostic, pronostic et traitement des maladies de la peau, des muqueuses et des phanères : dermatoses infectieuses, parasitaires et mycosiques, dermatoses inflammatoires, allergiques et dys-immunitaires, dermatoses tropicales, tumeurs cutanées et lymphomes, manifestations dermatologiques des maladies systémiques, pathologie des glandes sébacées, sudorales et des annexes, pathologie des muqueuses, pathologie vasculaire et phlébologie, pathologie de la lumière et de la pigmentation
- Épidémiologie, prise en charge et prévention des maladies sexuellement transmissibles ;
- Dermatologie pédiatrique et génodermatoses ;
- Thérapeutiques et petite chirurgie dermatologiques, photothérapie, dermatologie esthétique et cosmétologique.

II - Formation pratique

A) Quatre semestres dans des services agréés pour le diplôme d'études spécialisées de dermatologie et vénéréologie, dont trois au moins doivent être accomplis dans des services hospitalo-universitaires ou conventionnés. Ces semestres doivent être effectués dans au moins deux services ou départements différents.
B) Quatre semestres libres, dont trois au moins doivent être accomplis dans des services agréés pour d'autres diplômes d'études spécialisées que le diplôme d'études spécialisées de dermatologie et vénéréologie ou pour des diplômes d'études spécialisées complémentaires.

➢ DIPLÔME D'ÉTUDES SPÉCIALISÉES D'ENDOCRINOLOGIE-DIABÈTE-MALADIES MÉTABOLIQUES (Durée : quatre ans)

I - Enseignements

(Deux cent cinquante heures environ)

A) Enseignements généraux :

- Méthodologie de l'évaluation des pratiques de soins et de la recherche clinique et épidémiologique en endocrinologie ;
- Organisation, gestion, éthique, droit et responsabilité médicale en endocrinologie.

B) Enseignements spécifiques :

- Anatomie, embryologie, développement et physiologie des glandes endocrines ;
- Principes de génétique, d'immunologie et d'oncologie appliqués à l'endocrinologie ;
- Pharmacologie (métabolisme, posologie, action et toxicité) des médicaments usuels en endocrinologie ;
- Explorations morphologiques, histologiques et fonctionnelles en endocrinologie ;
- Bases physiologiques de la nutrition et de l'alimentation ;
- Épidémiologie, physiopathologie, anatomopathologie, diagnostic, pronostic et traitement des maladies des glandes endocrines : insuffisances antéhypophysaires et syndromes d'hypersécrétion hypophysaire, insuffisances thyroïdienne et hyperthyroïdies, hypo-, pseudo-hypo- et hyperparathyroïdies, insuffisances surrénaliennes et hypercorticismes, hypogonadismes, hyperandrogénie, dysgénésies gonadiques, troubles héréditaires de l'hormonosynthèse, tumeurs sécrétantes et non-secrétantes ;
- Épidémiologie, physiopathologie, anatomopathologie, diagnostic, pronostic et traitement des troubles du métabolisme et des pathologies de la nutrition : diabète, hypoglycémies, obésité et troubles du comportement alimentaire, dyslipoprotéinémies ;
- Épidémiologie, physiopathologie, anatomopathologie, diagnostic, pronostic et traitement des états intersexués, des troubles pubertaires et de la reproduction ;
- Organisation et prise en charge des urgences en endocrinologie ;
- Principes généraux, indications et suivi de la chirurgie et des transplantations en endocrinologie.

II - Formation pratique

A) Quatre semestres dans des services agréés pour le diplôme d'études spécialisées d'endocrinologie, diabète, maladies métaboliques, dont trois au moins doivent être accomplis dans des services hospitalo-universitaires ou conventionnés. Ces semestres doivent être effectués dans au moins deux services ou départements différents.

B) Un semestre dans un service agréé pour le diplôme d'études spécialisées de cardiologie et maladies vasculaires, de gynécologie-obstétrique et gynécologie médicale, de médecine nucléaire, de neurologie, de néphrologie ou de pédiatrie (à orientation endocrinologique), ou dans un laboratoire d'explorations fonctionnelles agréé pour le diplôme d'études spécialisées d'endocrinologie, diabète, maladies métaboliques

C) Trois semestres dans des services agréés pour d'autres diplômes d'études spécialisées que le diplôme d'études spécialisées d'endocrinologie, diabète, maladies métaboliques ou pour des diplômes d'études spécialisées complémentaires.

➢ DIPLÔME D'ÉTUDES SPÉCIALISÉES DE GASTROENTÉROLOGIE ET HÉPATOLOGIE - DURÉE : QUATRE ANS

I - Enseignements (deux cent cinquante heures environ)

A) Enseignements généraux
- Méthodologie de l'évaluation des pratiques de soins et de la recherche clinique et épidémiologique en hépato-gastroentérologie ;
- Organisation, gestion, éthique, droit et responsabilité médicale en hépato-gastroentérologie.

B) Enseignements spécifiques
- Anatomie, embryologie, développement et physiologie du foie et de l'appareil digestif ;
- Principes de génétique, d'immunologie et d'oncologie appliqués au foie et à l'appareil digestif ;
- Pharmacologie (métabolisme, posologie, action et toxicité) des médicaments usuels en hépato-gastroentérologie ;
- Explorations endoscopiques, histologiques et fonctionnelles du foie et de l'appareil digestif ;
- Épidémiologie, physiopathologie, anatomopathologie, diagnostic, pronostic et traitement des maladies du foie et de l'appareil digestif : diarrhées infectieuses, parasitoses, infection à Helicobacter pylori, pathologie motrice et sensitive du tube digestif, maladies inflammatoires, maladie coeliaque, déficits immunitaires, hépatites virales, hépatopathies auto-immunes, pathologies des voies biliaires, pancréatites aiguës et chroniques, cancers digestifs, pathologie iatrogène et dépendances en particulier liées à l'alcool ;
- Bases physiologiques de la nutrition et de l'alimentation ; nutrition artificielle ;
- Endoscopie et proctologie pratique ; utilisation diagnostique et thérapeutique ;
- Organisation et prise en charge des urgences en hépato-gastroentérologie ;
- Principes généraux, indications et suivi de la chirurgie et des transplantations en hépato-gastroentérologie.

II - Formation pratique

A) Quatre semestres dans des services agréés pour le diplôme d'études spécialisées de gastroentérologie et hépatologie, dont trois au moins doivent être accomplis dans des services hospitalo-universitaires ou conventionnés. Ces semestres doivent être effectués dans au moins deux services ou départements différents.
B) Un semestre dans un service agréé pour le diplôme d'études spécialisées de gastroentérologie et hépatologie, ou dans un laboratoire d'explorations fonctionnelles agréé pour le diplôme d'études spécialisées de gastroentérologie et hépatologie.
C) Trois semestres dans des services agréés pour d'autres diplômes d'études spécialisées que le diplôme d'études spécialisées de gastroentérologie et hépatologie ou pour des diplômes d'études spécialisées complémentaires.

➢ DIPLÔME D'ÉTUDES SPÉCIALISÉES DE GÉNÉTIQUE MÉDICALE (CLINIQUE, CHROMOSOMIQUE ET MOLÉCULAIRE) - DURÉE : QUATRE ANS

I - Enseignements (deux cent cinquante heures environ)

A) Enseignements généraux

- Méthodologie de l'évaluation des pratiques de soins et de la recherche clinique et épidémiologique en génétique ;
- Organisation, gestion, éthique, droit et responsabilité médicale appliqués à l'exercice de la génétique.

B) Enseignements spécifiques

- Structure des chromosomes et organisation du matériel nucléaire ;
- Mécanismes cytogénétiques et moléculaires des remaniements chromosomiques constitutionnels et acquis ;
- Structure et organisation moléculaire et dynamique des génomes nucléaires et mitochondrial ;
- Gènes du développement : compréhension des mécanismes de l'embryogenèse normale et pathologique ;
- égulation normale et pathologique de l'expression des gènes ;
- Cartographie physique et génétique ; clonage positionnel ; notions de bio-informatique ;
- Analyses de liaison et de ségrégation ;
- Transgenèse et modèles animaux ;
- Hérédité mendélienne ; hérédité non traditionnelle ; hérédité mitochondriale ;
- Génétique moléculaire des maladies humaines constitutionnelles et acquises ;
- Caryotype normal et pathologique ; expression clinique des anomalies chromosomiques constitutionnelles ;
- Syndromologie et étiologie des syndromes malformatifs ;
- Génétique des maladies multifactorielles ;
- Génétique des populations : loi de Hardy-Weinberg, sélection, dérive génétique, déséquilibre de liaison ;
- Génétique épidémiologique ; génétique des caractères quantitatifs ;
- Conseil génétique ; calcul de risque ;
- Indication et organisation des tests génétiques, du diagnostic prénatal et du diagnostic préimplantatoire ;
- Dépistage néonatal et médecine prédictive ;
- ıérapeutique et prévention des maladies génétiques.

II - Formation pratique

A) Quatre semestres dans des services agréés pour le diplôme d'études spécialisées de génétique médicale (clinique, chromosomique et moléculaire) dont un semestre dans un service à orientation "génétique moléculaire", un semestre dans un service à orientation "génétique chromosomique" et un semestre dans un service à orientation "génétique clinique".
Trois au moins de ces semestres doivent être accomplis dans des services hospitalo-universitaires ou conventionnés. Ces semestres doivent être effectués dans au moins deux services ou départements différents ;
B) Un semestre dans un service agréé pour les diplômes d'études spécialisées de pédiatrie ;
C) Trois semestres libres, comportant au plus un semestre dans un service agréé pour les diplômes d'études spécialisées de génétique médicale (clinique, chromosomique et moléculaire) ou de pédiatrie.

➢ **DIPLÔME D'ÉTUDES SPÉCIALISÉES DE GYNÉCOLOGIE MÉDICALE**
- DURÉE : QUATRE ANS

I - Enseignements (deux cent cinquante heures environ)

A) Enseignements généraux
- Méthodologie de l'évaluation des pratiques de soins et de la recherche clinique en gynécologie
- Épidémiologie et santé publique ;
- Organisation, gestion, éthique, droit et responsabilité médicale en gynécologie, économie de la santé.

B) Enseignements spécifiques
1) Gynécologie
- Gynécologie organique, bénigne et maligne y compris pathologies infectieuses et sénologie ;
- Urgences gynécologiques ;
- Explorations organiques et fonctionnelles (colposcopie, hystéroscopie, échographie, imagerie, cytologie et anatomo-pathologie, hormonologie) ;
- Génétique et cytogénétique.

2) Obstétrique
- Grossesse normale, génétique et diagnostic prénatal ;
- Grossesse pathologique, urgences obstétricales ;
- Accouchement normal et pathologique.

3) Hormonologie

- Biochimie hormonale, biologie cellulaire et moléculaire ;
- Physiologie hormonale (puberté, cycle menstruel, ménopause) ;
- Pathologies hormonales et maladies métaboliques ;
- Pharmacologie (hormonothérapies substitutives et autres) ;
- Contraception, orthogénie ;
- Stérilité dont assistance médicale à la procréation ;
- Sexologie et médecine psychosomatique ;
- Andrologie.

II - Formation pratique

a) trois semestres dans des services de gynécologie-obstétrique agréés pour le diplôme d'études spécialisées de gynécologie-obstétrique.
b) Trois semestres dans des services agréés pour les diplômes d'études spécialisées de gynécologie médicale, d'endocrinologie et métabolismes, d'oncologie ou pour le diplôme d'études spécialisées complémentaires de médecine de la reproduction ; un de ces semestres peut également être effectué dans un service où sont réalisées des explorations fonctionnelles et agréé pour les diplômes d'études spécialisées de radiodiagnostic et imagerie médicale, ou d'anatomie et cytologie pathologiques ou pour les diplômes d'études spécialisées complémentaires de biologie de la reproduction, de biologie hormonale et métabolique, de biologie moléculaire ou de cytogénétique humaine.
c) Deux semestres libres.

➢ **DIPLÔME D'ÉTUDES SPÉCIALISÉES DE GYNÉCOLOGIE-OBSTÉTRIQUE - DURÉE : CINQ ANS**

I - Enseignements (trois cents heures environ)

A) Enseignements généraux
- Méthodologie de l'évaluation des pratiques de soins et de la recherche clinique en gynécologie obstétrique ;
- Épidémiologie et santé publique ;
- Organisation, gestion, éthique, droit et responsabilité médicale en gynécologie obstétrique, économie de la santé.

B) Enseignements spécifiques

1) Formation de base
- Grossesse normale ;
- Grossesse pathologique ;
- Accouchement normal. Suites de couches normales et pathologiques ;
- Accouchements pathologiques. Interventions obstétricales ;
- Gynécologie générale ;
- Le sein et sa pathologie.

2) Formation thématique
- Gynécologie médicale ;
- Oncologie gynécologique et mammaire ;
- Chirurgie gynécologique et mammaire ;
- Reproduction, sexualité, fertilité ;
- Diagnostic prénatal, médecine foetale.

II - Formation pratique

A) Cinq semestres dans des services agréés pour le diplôme d'études spécialisées de gynécologie obstétrique.
B) Deux semestres dans des services agréés notamment, pour le diplôme d'études spécialisées de chirurgie générale et les diplômes d'études spécialisées complémentaires de chirurgie viscérale et digestive, de chirurgie urologique et de chirurgie vasculaire.
C) Trois semestres libres.

➢ DIPLÔME D'ÉTUDES SPÉCIALISÉES D'HÉMATOLOGIE - DURÉE : CINQ ANS

Le diplôme d'études spécialisées d'hématologie comporte deux options :
- Maladies du sang ;
- Onco-hématologie.

I - Enseignements (trois cents heures environ)

A) Enseignements généraux

- Méthodologie de l'évaluation des pratiques de soins et de la recherche clinique et épidémiologique en hématologie ;
- Organisation, gestion, éthique, droit et responsabilité médicale en hématologie.

B) Enseignements de base communs aux deux options

- Principes de biologie cellulaire et moléculaire, de cytogénétique, de génomique, d'histopathologie, d'immunologie et d'oncologie appliqués à l'hématologie et à la cancérologie ;
- Pharmacologie (métabolismes, posologie, action et toxicité) des médicaments usuels en hématologie et cancérologie ;
- Explorations par les techniques d'imagerie en hématologie et cancérologie ;
- Cellules souches et différenciation des lignées ; mort cellulaire et oncogénèse ;
- Cancérogenèse physique, chimique et virale ; croissance et progression tumorale ; métastases ;
- Auto-immunité, immunologie et généralités sur l'histopathologie des tumeurs ;
- Hémostase et angiogénèse ;
- Épidémiologie, physiopathologie, cyto- et histopathologie, diagnostic, pronostic et traitement des maladies du sang : maladie de Hodgkin, lymphomes non-hodgkiniens, myélomes, syndromes myélo- et lymphoprolifératifs, myélodysplasies, leucémies aigües, syndromes paranéoplasiques ;
- Principes généraux des thérapeutiques en onco-hématologie : chimiothérapie, hormonothérapies, biothérapies (transfusions, thérapie cellulaire, immunothérapie) et de la chirurgie oncologique ; introduction à la radiobiologie et à la radiothérapie ;
- Prise en charge de la douleur ; accompagnement et soins palliatifs ;
- Aspects psychologiques et sociaux.

C) Enseignements spécifiques

a) de l'option maladies du sang

- Facteurs de croissance, cytokines et anticorps monoclonaux, immunophénotypage ;
- Exploration, diagnostic, prévention et traitement des anémies, des cytopénies auto-immunes, de l'aplasie médulaire, des syndromes hémorragiques et des thromboses ; complications infectieuses ;
- Généralités sur les tumeurs solides ;
- Autogreffes et allogreffes ;
- Transfusions et thérapies cellulaires.

b) de l'option onco-hématologie

- Facteurs de croissance, cytokines et anticorps monoclonaux, immunophénotypage ;
- Exploration, diagnostic, prévention et traitement des tumeurs du sein, des tumeurs des voies aérodigestives supérieures, des tumeurs digestives, des tumeurs bronchopulmonaires et mésothéliomes, des tumeurs du rein et de la prostate, de l'utérus et des ovaires ;
- Innovation et pharmacologie des chimiothérapies ;
- Autogreffes et allogreffes ;
- Transfusions et thérapies cellulaires ;
- Innovations thérapeutiques.

II - Formation pratique

A) Formation commune de base

- Deux semestres dans des services cliniques agréés pour le diplôme d'études spécialisées d'hématologie (option maladies du sang).
- Un semestre dans un centre de transfusion- thérapie cellulaire agréé pour le diplôme d'études spécialisées complémentaires d'hémobiologie-transfusion.
- Un semestre dans un laboratoire d'hématologie agréé pour le diplôme d'études spécialisées de biologie médicale. Trois au moins de ces semestres doivent être effectués dans des services hospitalo-universitaires ou conventionnés. Ces semestres doivent être effectués dans deux services ou départements différents.

B) Option maladies du sang

a) un ou deux semestres dans des services agréés pour les diplômes d'études spécialisées d'hématologie (option maladies du sang) ou d'oncologie (option oncologie médicale) ou dans un service agréé pour le diplôme d'études spécialisées complémentaires de réanimation médicale ;
b) un ou deux semestres dans des laboratoires d'anatomie pathologique, d'hématologie, d'immunologie ou de virologie agréés pour les diplômes d'études spécialisées d'anatomie et cytologie pathologiques ou d'hématologie, ou dans un centre de transfusion-thérapie cellulaire agréé pour le diplôme d'études spécialisées complémentaires d'hémobiologie-transfusion ;
c) deux semestres au moins dans des services agréés pour d'autres diplômes d'études spécialisées ou diplômes d'études spécialisées complémentaires que ceux d'anatomie et cytologie pathologiques, d'hématologie, d'oncologie et d'hémobiologie-transfusion.

C) Option onco-hématologie

a) deux semestres dans des services agréés pour le diplôme d'études spécialisées d'oncologie (option oncologie médicale), et un semestre dans un service de radiothérapie agréé pour le diplôme d'études spécialisées d'oncologie (option oncologie radiothérapique) ;
b) un semestre dans un laboratoire d'anatomie pathologique ou biologie des tumeurs agréé pour le diplôme d'études spécialisées d'anatomie et cytologie pathologiques ;

c) deux semestres dans des services agréés pour d'autres diplômes d'études spécialisées ou diplômes d'études spécialisées complémentaires que ceux d'anatomie et cytologie pathologiques, d'hématologie, d'oncologie, d'hémobiologie-transfusion.

➢ **DIPLÔME D'ÉTUDES SPÉCIALISÉES DE MÉDECINE GÉNÉRALE**
- DURÉE : TROIS ANS

I - Enseignements (deux cents heures environ)

A) Enseignements généraux
- Méthodologie de l'évaluation des pratiques de soins et de la recherche clinique en médecine générale ;
- Épidémiologie et santé publique ;
- Organisation, gestion, éthique, droit et responsabilité médicale en médecine générale, économie de la santé.

B) Enseignements spécifiques
- La médecine générale et son champ d'application ;
- Gestes et techniques en médecine générale ;
- Situations courantes en médecine générale : stratégies diagnostiques et thérapeutiques, leur évaluation ;
- Conditions de l'exercice professionnel en médecine générale et place des médecins généralistes dans le système de santé ;
- Formation à la prévention, l'éducation à la santé et l'éducation thérapeutique ;
- Préparation du médecin généraliste au recueil des données en épidémiologie, à la documentation, à la gestion du cabinet, à la formation médicale continue, à l'évaluation des pratiques professionnelles et à la recherche en médecine générale.

II - Formation pratique

A) Deux semestres obligatoires dans des lieux de stage hospitaliers agréés au titre de la discipline de la médecine générale :
- un au titre de la médecine d'adultes : médecine générale, médecine interne, médecine polyvalente, gériatrie ;
- un au titre de la médecine d'urgence.

B) Deux semestres dans un lieu de stage agréé au titre de la discipline médecine générale :
- un semestre au titre de la pédiatrie et/ou de la gynécologie ;
- un semestre libre ;

C) Un semestre auprès d'un médecin généraliste, praticien agréé - maître de stage.

D) Un semestre, selon le projet professionnel de l'interne de médecine générale, effectué en dernière année d'internat, soit en médecine générale ambulatoire (sous la forme d'un stage autonome en soins primaires ambulatoires supervisé), soit dans une structure médicale agréée dans le cadre d'un projet personnel validé par le coordonnateur de médecine générale.
Dans l'ensemble du cursus, des temps de formation à la prise en charge psychologique et psychiatrique des patients sont obligatoires. Ils sont réalisés à l'occasion de stages effectués dans les services et structures, y compris ambulatoires, agréés pour la formation des internes et habilités pour cette formation.

➢ **DIPLÔME D'ÉTUDES SPÉCIALISÉES DE MÉDECINE INTERNE**
- DURÉE : 10 SEMESTRES

I - Enseignements (trois cents heures environ)

Pour les internes nommés à compter du 1er novembre 2003.

A) Enseignements généraux

- Méthodologie de l'évaluation des pratiques de soins et de la recherche clinique en médecine interne ;
- Épidémiologie et santé publique ;
- Organisation, gestion, éthique, droit et responsabilité médicale en médecine interne, économie de la santé.

B) Enseignements spécifiques

- Maladies inflammatoires et/ou systémiques, notamment connectivites et autres pathologies auto-immunes, sarcöidose et granulomatoses systémiques, vascularites, amyloses, fibroses idiopathiques, polyartrite, mastocytose, histiocytoses ;
- Pathologie artérielle dégénérative et inflammatoire, maladie veineuse thrombo-embolique ;
- Maladies infectieuses et tropicales ;
- Lymphomes, cancers métastasés, syndromes paranéoplastiques ;
- Particularités de la pathologie et de la prise en charge du patient âgé ;
- Pathologie liée à l'environnement ;
- Allergie ;
- Immunodépression ;
- Troubles endocriniens et métaboliques ;
- Imbrication somatopsychique ;
- Principales maladies orphelines et maladies génétiques à révélation tardive ;
- Principales familles médicamenteuses et éléments de pharmacologie clinique ;
- Épidémiologie et problèmes de santé publique.

II - Formation pratique

A) Trois semestres au moins dans des services agréés pour le diplôme d'études spécialisées de médecine interne dont deux au moins doivent être effectués dans des services hospitalo-universitaires.
B) Un semestre dans un service de gériatrie.
C) Un semestre dans un service d'accueil et des urgences ou dans un service de réanimation ou dans un service de soins intensifs.
D) Cinq semestres dans des services hospitaliers agréés pour un autre diplôme d'études spécialisées ou pour un diplôme d'études spécialisées complémentaires, notamment de cancérologie, d'allergologie et immunologie clinique, de médecine vasculaire, de nutrition, de pathologie infectieuse et tropicale.
Les internes préparant le diplôme d'études spécialisées de médecine interne doivent effectuer deux semestres sur les dix semestres de la formation pratique dans des services d'un centre hospitalier non universitaire agréé pour le diplôme d'études spécialisées de médecine interne ou pour un autre diplôme d'études spécialisées.

➢ **DIPLÔME D'ÉTUDES SPÉCIALISÉES DE MÉDECINE NUCLÉAIRE**
- DURÉE : QUATRE ANS

I - Enseignements (deux cent cinquante heures environ)

A) Enseignements généraux
- Méthodologie de l'évaluation des pratiques de soins et de la recherche clinique et épidémiologique en médecine nucléaire ;
- Organisation, gestion, éthique, droit et responsabilité médicale en médecine nucléaire.

B) Enseignements spécifiques
1. Notions fondamentales sur la radioactivité et les rayonnements ;
2. Dosimètrie, radiobiologie, radiothérapie, radioprotection ;
3. Agents, instrumentation et méthodologie ;
4. Logistique des explorations et stratégie diagnostique ;
5. Modélisation des études cinétiques à l'aide de molécules marquées ;
6. Radio-analyse, radiopharmacie et radiopharmacologie ;
7. Radiothérapie métabolique ;
8. Imagerie fonctionnelle et métabolique par RMN, multimodalité, recalage, fusion d'images ;
9. Apport et méthodologie de l'utilisation des positons en recherche ;
10. Médecine nucléaire appliquée à l'exploration cardiovasculaire et pulmonaire, à l'endocrinologie, l'hématologie, l'oncologie, la rhumatologie, la néphro-urologie, la pédiatrie, la neurologie, etc. ;
11. Aspects administratifs et réglementaires en médecine nucléaire.

Les enseignements sont réalisés à l'Institut national des sciences et techniques nucléaires à Saclay, à l'exception des items 4 à 9.

II - Formation pratique

A) Quatre semestres dans des services agréés pour le diplôme d'études spécialisées de médecine nucléaire, dont trois au moins doivent être accomplis dans des services hospitalo-universitaires ou conventionnés. Ces semestres doivent être effectués dans au moins deux services ou départements différents.

B) Quatre semestres dans des services agréés pour d'autres diplômes d'études spécialisées que le diplôme d'études spécialisées de médecine nucléaire ou pour des diplômes d'études spécialisées complémentaires.

➢ DIPLÔME D'ÉTUDES SPÉCIALISÉES DE MÉDECINE PHYSIQUE ET DE RÉADAPTATION - DURÉE : QUATRE ANS

I - Enseignements (deux cent cinquante heures environ)

A) Enseignements généraux

- Méthodologie de l'évaluation des pratiques de soins et de recherche clinique et épidémiologique en médecine physique et de réadaptation ;
- Organisation, gestion éthique, droit et responsabilité médicale en médecine physique et de réadaptation.

B) Enseignements spécifiques

- Bases anatomiques de la médecine physique et de réadaptation ;
- Physiologie de la posture et du mouvement, de la cognition et du comportement, du fonctionnement sphinctérien et de l'adaptation à l'effort ;
- Bilan clinique et paraclinique ;
- Épidemiologie, physiopathologie, diagnostic, pronostic et traitement des incapacités et handicaps : troubles des gestes et de préhension, troubles de l'équilibre, de la marche, de la locomotion et des déplacements, troubles des gestes et de préhension, troubles de l'adaptation à l'effort, troubles des fonctions cognitives et de la communication, troubles de la maîtrise sphinctérienne ;
- Médecine physique et de réadaptation et activités physiques et sportives ;
- Médecine physique et de réadaptation de l'enfant et de la personne âgée ;
- Prise en charge de la douleur par les méthodes médicamenteuses, physiques et de médecine manuelle ;
- Prise en charge des altérations de la qualité de vie ;
- Psychologie et réadaptation sociale des personnes handicapées.

II - Formation pratique

A) Quatre semestres dans des services agréés pour le diplôme d'études spécialisées de médecine physique et de réadaptation, dont trois au moins doivent être accomplis dans des services hospitalo-universitaires ou conventionnés. Ces semestres doivent être effectués dans au moins deux services ou départements différents.

B) Deux semestres dans un service agréé pour des diplômes d'études spécialisées de neurologie, de pédiatrie ou de rhumatologie.

C) Deux semestres libres, comportant au plus un semestre dans un service agréé pour le diplôme d'études spécialisées de médecine physique et de réadaptation.

➢ **DIPLÔME D'ÉTUDES SPÉCIALISÉES DE MÉDECINE DU TRAVAIL**
- DURÉE : QUATRE ANS

I - Enseignements (deux cent cinquante heures environ)

- Aspects généraux du monde du travail ;
- Différentes catégories de main d'œuvre, exercices professionnels particuliers ;
- Exercice de la médecine du travail et son cadre réglementaire ;
- Méthodologie : métrologie, épidémiologie, statistiques, informatique.
- Physiologie, ergonomie ;
- Toxicologie ;
- Pathologies professionnelles ;
- Prévention des risques professionnels.

II - Formation pratique

Quatre semestres dans des services agréés pour le diplôme d'études spécialisées de médecine du travail, dont au moins un semestre doit être accompli dans un service extra-hospitalier.
Quatre semestres dans des services agréés pour d'autres spécialités médicales.

➢ DIPLÔME D'ÉTUDES SPÉCIALISÉES DE NÉPHROLOGIE - DURÉE : QUATRE ANS

I - Enseignements (deux cent cinquante heures environ)

A) Enseignements généraux

- Méthodologie de l'évaluation des pratiques de soins et de la recherche clinique et épidémiologique en néphrologie ;
- Organisation, gestion, éthique, droit et responsabilité médicale en néphrologie.

B) Enseignements spécifiques

- Anatomie, embryologie, développement et physiologie du rein et de l'appareil urinaire ;
- Principes de génétique, d'immunologie et d'oncologie appliqués à la néphrologie ;
- Pharmacologie (métabolisme, posologie, action et toxicité) des médicaments usuels en néphrologie ;
- Explorations endoscopiques, histologiques et fonctionnelles du rein et de l'appareil urinaire ;
- Régulation de la composition du milieu intérieur ; troubles hydro-électrolytiques et de l'équilibre acido-basique ;
- Classification des néphropathies ;
- Épidémiologie, physiopathologie, anatomopathologie, diagnostic, pronostic et traitement des maladies du rein et de l'appareil urinaire : insuffisance rénale aiguë et fonctionnelle, hypertension artérielle, glomérulonéphrites primitives et secondaires, infections urinaires, néphropathies interstitielles acquises, uropathies malformatives, lithiases, cancer du rein, néphropathies congénitales et héréditaires, néphropathies toxiques et médicamenteuses, atteintes rénales au cours des maladies systémiques, néphropathies vasculaires, insuffisance rénale chronique ;
- Organisation et prise en charge des urgences en néphrologie ;
- Dialyse, transplantations et organisation de la prise en charge de l'insuffisance rénale terminale.

II - Formation pratique

A) Trois semestres dans des services agréés pour le diplôme d'études spécialisées de néphrologie, dont deux au moins doivent être accomplis dans des services hospitalo-universitaires ou conventionnés. Ces semestres doivent être effectués dans au moins deux services ou départements différents.

B) Un semestre dans un service agréé pour le diplôme d'études spécialisées complémentaires de réanimation médicale.

C) Quatre semestres libres, comportant au plus un semestre dans un service ou dans un laboratoire d'explorations fonctionnelles agréé pour le diplôme d'études spécialisées de néphrologie, de préférence dans des services agréés pour les diplômes d'études spécialisées de cardiologie et maladies vasculaires, d'endocrinologie et métabolismes, de médecine interne ou de pédiatrie (à orientation néphrologique).

➢ **DIPLÔME D'ÉTUDES SPÉCIALISÉES DE NEUROCHIRURGIE**
- DURÉE : CINQ ANS

I - Enseignements (trois cents heures environ)

- Sciences fondamentales du système nerveux ;
- Examen complémentaires du système nerveux ;
- Pression hydrodynamique et hémodynamique intracrâniennes : régulation et pathologie ;
- Traumatismes cranio-cérébraux ;
- Urgences vasculaires cérébrales et traitement chirurgical de l'ischémie cérébrale ;
- Traumatismes rachidiens, médullo-radiculaires ; plaies des nerfs ;
- Tumeurs cérébrales ; lésions expansives non tumorales ;
- Tumeurs cranio-cérébrales extra-parenchymateuses ;
- Malformations vasculaires cérébrales ;
- Pathologie radiculo-médullaire non traumatique ; pathologie chirurgicale des nerfs périphériques ;
- Neurochirurgie fonctionnelle ;
- Neurochirurgie pédiatrique.

II - Formation pratique

A) Cinq semestres dans des services agréés pour le diplôme d'études spécialisées de neurochirurgie.
B) Deux semestres dans des services agréés pour d'autres diplômes d'études spécialisées ou diplômes d'études spécialisées complémentaires de chirurgie.
C) Trois semestres dans des services agréés pour la spécialité ou pour une autre spécialité, dont un de préférence dans un service agréé pour le diplôme d'études spécialisées de neurologie.
En vue de leur inscription définitive au diplôme d'études spécialisées de neurochirurgie, les internes devront avoir acquis une formation théorique portant notamment sur :
- la traumatologie ;
- les urgences chirurgicales non traumatiques ;
- l'anatomie chirurgicale ;
- la pathologie générale, l'acte opératoire, la méthodologie chirurgicale.

➢ **DIPLÔME D'ÉTUDES SPÉCIALISÉES DE NEUROLOGIE**
- DURÉE : QUATRE ANS

I - Enseignements (deux cent cinquante heures environ)

A) Enseignements généraux
- Méthodologie de l'évaluation des pratiques de soins et de la recherche clinique et épidémiologique en neurologie ;
- Organisation, gestion, éthique, droit et responsabilité médicale en neurologie.

B) Enseignements spécifiques
- Anatomie, embryologie, développement et physiologie du système nerveux ;
- Principes de génétique, d'immunologie et d'oncologie appliqués au système nerveux ;
- Pharmacologie (métabolisme, posologie, action et toxicité) des médicaments usuels en neurologie ;
- Neuropsychologie et psychobiologie des comportements ;
- Explorations fonctionnelles en neurologie ;
- Épidémiologie, physiopathologie, anatomopathologie, diagnostic, pronostic et traitement des maladies du système nerveux : épilepsie, céphalées, maladies du système extrapyramidal, maladies neurodégénératives acquises et génétiques, tumeurs, maladies vasculaires, maladies infectieuses, maladies inflammatoires, maladies des nerfs périphériques et des muscles ;
- Grands cadres sémiologiques et nosologiques en psychiatrie ;
- Toxicomanies et dépendances ;
- Organisation et prise en charge des urgences en neurologie ;
- Principes généraux de neurochirurgie et de neurotraumatologie.

II - Formation pratique

A) Quatre semestres dans des services agréés pour le diplôme d'études spécialisées de neurologie, dont trois au moins doivent être accomplis dans des services hospitalo-universitaires ou conventionnés. Ces semestres doivent être effectués dans au moins deux services ou départements différents.
B) Un semestre dans un service agréé pour le diplôme d'études spécialisées de neurologie, ou dans un laboratoire d'explorations fonctionnelles agréé pour le diplôme d'études spécialisées de neurologie.
C) Trois semestres dans des services agréés pour d'autres diplômes d'études spécialisées que le diplôme d'études spécialisées de neurologie ou pour des diplômes d'études spécialisées complémentaires.

➢ DIPLÔME D'ÉTUDES SPÉCIALISÉES D'ONCOLOGIE

Durée : cinq ans

Pour les internes nommés après le 1er novembre 2007

Le diplôme d'études spécialisées d'oncologie comporte trois options :
a) Oncologie médicale ;
b) Oncologie radiothérapique ;
c) Onco-hématologie.

I - Enseignements
(trois cents heures environ)

A) Enseignements généraux
- Méthodologie de l'évaluation des pratiques de soins et de la recherche clinique et épidémiologique en oncologie ;
- Organisation, gestion, éthique, droit et responsabilité médicale en oncologie.

B) Enseignements de base communs aux trois options
- Principes de biologie cellulaire et moléculaire, de cytogénétique, de génomique, d'histopathologie, d'immunologie et d'oncologie appliqués à l'hématologie et à la cancérologie ;
- Pharmacologie (métabolisme, posologie, action et toxicité) des médicaments usuels en hématologie et cancérologie ;
- Explorations par les techniques d'imagerie en hématologie et cancérologie ;
- Cellules souches et différenciation des lignées ; mort cellulaire et oncogénèse ;
- Cancérogenèse physique, chimique et virale ; croissance et progression tumorale ; métastases ;
- Auto-immunité, immunologie et généralités sur l'histopathologie des tumeurs ;
- Hémostase et angiogénèse ;
- Épidémiologie, physiopathologie, cyto- et histopathologie, diagnostic, pronostic et traitement des tumeurs du sein, des tumeurs bronchopulmonaires et mésothéliomes, des tumeurs digestives, des tumeurs du rein et de la prostate, de l'utérus et des ovaires, de la maladie de Hodgkin et des lymphomes non-hodgkiniens ;
- Principes généraux des thérapeutiques en onco-hématologie : chimiothérapie, hormonothérapies, biothérapies (transfusions, thérapie cellulaire, immunothérapie) et de la chirurgie oncologique ; introduction à la radiobiologie et à la radiothérapie ;
- Prise en charge de la douleur ; accompagnement et soins palliatifs ;
- Aspects psychologiques et sociaux.

C) Enseignements spécifiques :
a) de l'option oncologie médicale
Facteurs de croissance, cytokines et anticorps monoclonaux, immunophénotypage ;
- Approfondissement de l'étude des tumeurs solides mentionnées au paragraphe précédent (enseignements de base communs aux trois options) ;
- Exploration, diagnostic, prévention et traitement des sarcomes des os et tissus mous, des tumeurs cutanées, des tumeurs des voies aéro-digestives supérieures, des tumeurs du système nerveux central ;
- Syndromes paranéoplasiques ;
- Tumeurs de l'enfant ;
- Autogreffes ;
- Innovations thérapeutiques.

b) de l'option oncologie radiothérapique

- Notions physiques de base ;
- Approfondissement de l'enseignement de la radiobiologie, de la radiophysique, des techniques d'irradiation par organe, de la dosimétrie et de la radioprotection ;
- Exploration, diagnostic, prévention et traitement des tumeurs énumérées au paragraphe précédent (enseignements spécifiques de l'option oncologie médicale) ;
- Tumeurs de l'enfant ;
- Innovations en radiothérapie.

c) de l'option onco-hématologie

- Facteurs de croissance, cytokines et anticorps monoclonaux, immunophénotypage ;
- Exploration, diagnostic, prévention et traitement des maladies du sang : maladie de Hodgkin, lymphomes non-hodgkiniens, myélomes, syndromes myélo- et lymphoprolifératifs ; myélodysplasies, leucémies aiguës, syndromes paranéoplasiques ;
- Innovation et pharmacologie des chimio thérapies
- Autogreffes et allogreffes ;
- Transfusions et thérapies cellulaires ;
- Innovations thérapeutiques.

1 Formation pratique

A) Option oncologie médicale

a) Quatre semestres dans des services agréés pour le diplôme d'études spécialisées d'oncologie. Deux au moins de ces semestres doivent être effectués dans des services hospitalo- universitaires ou conventionnés. Ces semestres doivent être effectués dans deux services ou départements différents ;
b) Un semestre dans des services agréés pour le diplôme d'études spécialisées d'oncologie (option oncologie radiothérapique).
c) Un semestre dans des services agréés pour le diplôme d'études spécialisées d'hématologie
d) Quatre semestres libres dans au moins deux disciplines dans des services agréés pour d'autres diplômes d'études spécialisées ou diplômes d'études spécialisées complémentaires autres que ceux de l'option oncologie médicale.

B) Option oncologie radiothérapique

a) Quatre semestres dans des services agréés pour le diplôme d'études spécialisées d'oncologie pour l'option oncologie radiothérapique,
b) Deux semestres dans des services agréés pour le diplôme d'études spécialisées d'oncologie (option oncologie médicale).
c) Quatre semestres libres dans au moins deux disciplines dans des services agréés pour d'autres diplômes d'études spécialisées ou diplômes d'études spécialisées complémentaires que ceux de l'option oncologie radiothérapique.

C) Option onco-hématologie

a) Trois semestres dans des services agréés pour le diplôme d'études spécialisées d'oncologie (option oncologie médicale).
b) Un semestre dans un des services agréés pour le diplôme d'études spécialisées d'oncologie (option oncologie radiothérapique).
c) Trois semestres dans des services agréés pour le diplôme d'études spécialisées d'hématologie.
d) Un semestre dans un des services agréés pour le diplôme d'études spécialisées de biologie médicale.
e) Deux semestres dans des services agréés pour d'autres diplômes d'études spécialisées.

➢ **DIPLÔME D'ÉTUDES SPÉCIALISÉES D'OPHTALMOLOGIE**
- DURÉE : CINQ ANS

I - Enseignements (trois cents heures environ)

A) Enseignements généraux
- Méthodologie de l'évaluation des pratiques de soins et de la recherche clinique et épidémiologique en ophtalmologie ;
- Organisation, gestion, éthique, droit et responsabilité médicale en ophtalmologie.

B) Enseignements spécifiques

- Principes généraux de chirurgie ;
- Anatomie, embryologie, développement et physiologie du globe oculaire et de ses annexes ;
- Principes de génétique, d'immunologie et d'oncologie appliqués à l'ophtalmologie ;
- Pharmacologie (métabolisme, posologie, action et toxicité) des médicaments usuels en ophtalmologie ;
- Explorations fonctionnelles en ophtalmologie ;
- Épidémiologie, physiopathologie, anatomopathologie, diagnostic, pronostic et traitement des maladies du globe oculaire et de ses annexes : affections orbitaires, pathologies palpébrales et de l'appareil lacrymal, anomalies de la réfraction, maladies de la conjonctive et de la cornée, pathologies du cristallin et chirurgie de la cataracte, maladies inflammatoires, maladies de la choroïde et de ses vaisseaux, maladies de la rétine et de ses vaisseaux, dystrophies choriorétiniennes héréditaires, pathologie vitréorétinienne chirurgicale, tumeurs de l'œil et de ses annexes, glaucomes et hypotonies oculaires, pathologies oculo-motrices et pathologie iatrogène ;
- Expression oculaire des maladies systémiques et manifestations oculaires d'affections neurologiques, infectieuses, endocrinologiques et chirurgicales à point de départ extra-oculaire ;
- Dépistage, prise en charge et prévention des maladies cécitantes et liées au vieillissement ;
- Organisation et prise en charge des urgences en ophtalmologie.

II - Formation pratique

A) Six semestres dans des services agréés pour le diplôme d'études spécialisées d'ophtalmologie, dont quatre au moins doivent être accomplis dans des services hospitalo-universitaires ou conventionnés. Ces semestres doivent être effectués dans au moins deux services ou départements différents.
B) Quatre semestres dans des services agréés pour des diplômes d'études spécialisées qui peuvent être acquis dans le cadre du troisième cycle de médecine spécialisée, dont au moins un semestre dans un service agréé pour un diplôme d'études spécialisées de la discipline des spécialités médicales (de préférence endocrinologie et métabolismes, médecine interne ou neurologie) et au moins un semestre dans un service agréé pour le diplôme d'études spécialisées complémentaires de chirurgie maxillo-faciale et stomatologie, de neurochirurgie ou d'oto-rhino-laryngologie et chirurgie cervico-faciale ; au cours de ces quatre semestres, un septième semestre peut éventuellement être effectué dans un service agréé pour le diplôme d'études spécialisées d'ophtalmologie.

➢ DIPLOME D'ETUDES SPECIALISEES D'OTO-RHINO-LARYNGOLOGIE ET CHIRURGIE CERVICO-FACIALE

(Durée : cinq ans)

Internes nommés à compter du 1er novembre 2009

I - Enseignements (Trois cents heures environ)

A) Enseignements généraux :

- Méthodologie de l'évaluation des pratiques de soins et de la recherche clinique et épidémiologique en oto-rhino-laryngologie et chirurgie cervico-faciale ;
- Organisation, gestion, éthique, droit et responsabilité médicale appliqués à l'exercice de l'oto-rhino-laryngologie et de la chirurgie cervico-faciale.

B) Enseignements spécifiques :

- Principes généraux de chirurgie ;
- Anatomie, embryologie, développement et physiologie de l'oreille, des cavités rhino-sinusiennes et des voies aéro-digestives ;
- Principes de génétique, d'immunologie et d'oncologie appliqués à l'oto-rhino-laryngologie ;
- Pharmacologie (métabolisme, posologie, action et toxicité) des médicaments usuels en oto-rhino-laryngologie ;
- Explorations fonctionnelles en oto-rhino-laryngologie ;
- Pathologie de l'oreille ;
- Pathologie rhino-sinusienne ;
- Pathologie du larynx et des voies aéro-digestives ;
- Audio-phonologie ; Phoniatrie
- Cancers des voies aéro-digestives ;
- Pathologie O.R.L. du nourrisson et de l'enfant, y compris les malformations cervico-faciales ;
- Traumatologie cervico-faciale ;
- Pathologie des aires ganglionnaires cervicales ;
- Pathologie des loges salivaires et thyroïdiennes ;
- Chirurgie plastique, esthétique et réparatrice cervico-faciale ;
- Chirurgie des tumeurs cutanées cervico-faciales ;
- Pathologie du rocher et de la base du crâne ;
- Organisation et prise en charge des urgences en oto-rhino-laryngologie et chirurgie cervico-faciale.

II - Formation pratique

A) Sept semestres dans des services agréés pour le diplôme d'études spécialisées d'oto-rhino-laryngologie et chirurgie cervico-faciale, dont 5 au moins doivent être accomplis dans des services hospitalo-universitaires ou conventionnés. Ces semestres doivent être effectués dans au moins deux services ou départements différents ; un semestre doit être accompli dans une unité d'explorations fonctionnelles d'O.R.L. agréée (audio-phonologie et phoniatrie, exploration fonctionnelle otoneurologique.).

B) Trois semestres dans des services agréés pour une autre spécialité, dont deux au moins dans des services de la discipline « spécialités chirurgicales ». L'un de ces deux stages doit être effectué dans un service de chirurgie générale, viscérale, vasculaire, thoracique et cardiovasculaire ou orthopédique et traumatologie ; l'autre doit être effectué, soit dans le même type de service, soit dans un service de neurochirurgie, de chirurgie plastique reconstructrice et esthétique, ou de chirurgie maxillo-faciale et de stomatologie. Un semestre peut être accompli dans un service agréé pour un autre diplôme d'études spécialisées : cancérologie, pédiatrie, neurologie ou pneumologie.

➢ **DIPLÔME D'ÉTUDES SPÉCIALISÉES DE PÉDIATRIE**
- DURÉE : QUATRE ANS

I - Enseignements (deux cent cinquante heures environ)

A) Enseignements généraux
- Méthodologie de l'évaluation des pratiques de soins et de la recherche clinique et épidémiologique en pédiatrie ;
- Organisation, gestion, éthique, droit et responsabilité médicale en pédiatrie.

B) Enseignements spécifiques
- Développement de l'embryon et du fœtus ; prévalence de la prématurité et de l'hypotrophie à la naissance ;
- Croissance et développement somatique, sensoriel et psychologique normal et pathologique du nourrisson et de l'enfant ;
- Puberté et sexualité de l'enfant et de l'adolescent ;
- Alimentation et nutrition du nourrisson et de l'enfant ;
- Pharmacologie (métabolisme, posologie, action et toxicité) des médicaments usuels en pédiatrie ;
- Explorations fonctionnelles en pédiatrie ;
- Morbidité et mortalité périnatale et infantile dans le monde ;
- Épidémiologie, physiopathologie, anatomopathologie, diagnostic, pronostic et traitement des maladies du fœtus et du nouveau-né, du nourrisson, de l'enfant et de l'adolescent ;
- Protection maternelle et infantile, organisation des naissances et prévention de la prématurité et de l'hypotrophie ;
- Prévention et prise en charge des malformations, des maladies génétiques, des handicaps et de la maltraitance chez l'enfant ; diagnostic anténatal et dépistage néonatal ;
- Programmes de vaccination ;
- Organisation et prise en charge de la douleur chez l'enfant et des urgences médico-chirurgicales pédiatriques.

II - Formation pratique

A) Cinq semestres dans des services agréés pour le diplôme d'études spécialisées de pédiatrie, dont quatre au moins doivent être accomplis dans des services hospitalo-universitaires ou conventionnés. Ces semestres doivent être effectués dans au moins deux services ou départements différents.
Durant ces cinq semestres, le candidat doit avoir validé au moins un stage semestriel dans une unité de pédiatrie générale, dans une unité de néonatologie et dans une unité spécialisée dans les urgences (service de réanimation pédiatrique ou service de pédiatrie d'urgence ou prise de vingt-six gardes formatrices dans des unités de réanimation pédiatrique).
B) Un semestre dans un service agréé pour les diplômes d'études spécialisées de pédiatrie, de génétique, de gynécologie-obstétrique et gynécologie médicale ou de santé publique et médecine sociale ;
C) Deux semestres dans des services agréés pour d'autres diplômes d'études spécialisées que le diplôme d'études spécialisées de pédiatrie ou pour des diplômes d'études spécialisées complémentaires.

➢ DIPLÔME D'ÉTUDES SPÉCIALISÉES DE PNEUMOLOGIE - DURÉE : QUATRE ANS

I - Enseignements (deux cent cinquante heures environ)

A) Enseignements généraux
- Méthodologie de l'évaluation des pratiques de soins et de la recherche clinique et épidémiologique en pneumologie ;
- Organisation, gestion, éthique, droit et responsabilité médicale en pneumologie.

B) Enseignements spécifiques
- Anatomie, embryologie, développement et physiologie de l'appareil respiratoire ;
- Principes de génétique, d'immunologie et d'oncologie appliqués à la pneumologie ;
- Pharmacologie (métabolisme, posologie, action et toxicité) des médicaments usuels en pneumologie ;
- Explorations endoscopiques, histologiques et fonctionnelles de l'appareil respiratoire ; tests cutanés allergologiques ;
- Épidémiologie, physiopathologie, anatomopathologie, diagnostic, pronostic et traitement des maladies de l'appareil respiratoire : infections respiratoires, insuffisances respiratoires aiguës, bronchopneumopathies obstructives, dilatation des bronches, mucoviscidose, tuberculose, pneumopathies interstitielles, asthme et pneumopathies d'hypersensibilité, cancer du poumon, maladies de la plèvre et du médiastin, maladies vasculaires, maladie thrombo-embolique, syndrome d'apnée du sommeil, pneumopathies congénitales et héréditaires, pathologie respiratoire de l'immunodéprimé, insuffisance respiratoire chronique ;
- Pathologie respiratoire iatrogène, professionnelle et environnementale ;
- Organisation et prise en charge des urgences en pneumologie ;
- Principes généraux, indications et suivi de la chirurgie et des transplantations en pneumologie.

II - Formation pratique

A) Quatre semestres dans des services agréés pour le diplôme d'études spécialisées de pneumologie dont trois au moins doivent être accomplis dans des services hospitalo-universitaires ou conventionnés. Ces semestres doivent être effectués dans au moins deux services ou départements différents.

B) Un semestre dans un service agréé pour le diplôme d'études spécialisées de pneumologie ou dans un laboratoire d'explorations fonctionnelles agréé pour le diplôme d'études spécialisées de pneumologie.

C) Trois semestres dans des services agréés pour d'autres diplômes d'études spécialisées que le diplôme d'études spécialisées de pneumologie, de préférence dans des services agréés pour le diplôme d'études spécialisées de cardiologie et maladies vasculaires, de médecine interne, d'oncologie, de pédiatrie (à orientation pneumologique), de radiodiagnostic et imagerie médicale, ou dans des services agréés pour des diplômes d'études spécialisées complémentaires, de préférence d'allergologie et immunologie clinique ou de réanimation médicale.

➢ DIPLÔME D'ÉTUDES SPÉCIALISÉES DE PSYCHIATRIE - DURÉE : QUATRE ANS

I - Enseignements (deux cent cinquante heures environ)

A) Enseignements généraux
- Méthodologie de l'évaluation des pratiques de soins et de la recherche clinique et épidémiologique en psychiatrie ;
- Organisation, gestion, éthique, droit et responsabilité médicale en psychiatrie.

B) Enseignements spécifiques
- Développement et physiologie du système nerveux ;
- Principes de génétique appliqués à la psychiatrie ;
- Pharmacologie (métabolisme, posologie, action et toxicité) des médicaments usuels en psychiatrie ;
- Neurobiologie des comportements ;
- Histoire de la psychiatrie et évolution des concepts ;
- Modèles théoriques de référence : biologique et neuroanatomique, comportemental et cognitif, psychanalytique, systémique, ... ;
- Critères de diagnostic et classification des maladies mentales ;
- Épidémiologie, sémiologie descriptive et psychopathologie des grands syndromes psychiatriques de l'enfant, de l'adolescent, de l'adulte et de la personne âgée ;
- Grands cadres sémiologiques et nosologiques en neurologie ;
- Toxicomanies et dépendances ;
- Thérapeutiques biologiques, socio-éducatives, institutionnelles ; psychothérapie et thérapies familiales ;
- Organisation et prise en charge des urgences psychiatriques ;
- Psychiatrie légale.

II - Formation pratique

A) Quatre semestres dans des services agréés pour le diplôme d'études spécialisées de psychiatrie, dont un au moins doit être accompli dans un service hospitalo-universitaire ou conventionné. Ces semestres doivent être effectués dans au moins deux services ou départements différents.
B) Deux semestres dans un service agréé pour le diplôme d'études spécialisées complémentaires de psychiatrie de l'enfant et de l'adolescent.
C) Deux semestres dans des services agréés pour d'autres diplômes d'études spécialisées ou diplômes d'études spécialisées complémentaires que le diplôme d'études spécialisées de psychiatrie ou le diplôme d'études spécialisées complémentaires de psychiatrie de l'enfant et de l'adolescent.

➢ DIPLÔME D'ÉTUDES SPÉCIALISÉES DE RADIODIAGNOSTIC ET IMAGERIE MÉDICALE - DURÉE : CINQ ANS

I - Enseignements (trois cents heures environ)

A) Enseignements généraux

- Méthodologie de l'évaluation des pratiques de soins et de recherche clinique et épidémiologique en radiodiagnostic et imagerie médicale ;
- Organisation, gestion, éthique, droit et responsabilité médicale en radiodiagnostic et imagerie médicale.

B) Enseignements spécifiques

- Notions fondamentales sur la radioactivité et les rayonnements ;
- Effets des radiations ionisantes, dosimétrie, radiobiologie, radioprotection ;
- Bases physiques et technologiques de l'imagerie par les rayons X, les ultrasons, la résonance magnétique nucléaire et les autres techniques d'imagerie non invasives ;
- Produits de contraste ;
- Bases physiques et technologiques en médecine nucléaire, applications ;
- Imagerie anatomique et fonctionnelle normale, variantes, évolution climatérique par les différentes techniques d'imagerie ;
- Imagerie diagnostique et interventionnelle : femme, sein, fœtus, enfant, tête-cou, système nerveux, locomoteur, cardiovasculaire, imagerie urologique, thorax, digestif ;
- Organisation et prise en charge des urgences en imagerie médicale.

II - Formation pratique

A) Huit semestres dans des services agréés pour le diplôme d'études spécialisées de radiodiagnostic et imagerie médicale, dont cinq au moins doivent être accomplis dans des services hospitalo-universitaires ou conventionnés. Ces semestres doivent être effectués dans au moins deux services ou départements différents.

B) Deux semestres dans des services agréés pour des diplômes d'études spécialisées ou diplômes d'études spécialisées complémentaires autres que le diplôme d'études spécialisées de radiodiagnostic et imagerie médicale.

➢ DIPLÔME D'ÉTUDES SPÉCIALISÉES DE RHUMATOLOGIE - DURÉE : QUATRE ANS

I - Enseignements (deux cent cinquante heures environ)

A) Enseignements généraux

- Méthodologie de l'évaluation des pratiques de soins et de la recherche clinique et épidémiologique en rhumatologie ;
- Organisation, gestion, éthique, droit et responsabilité médicale en rhumatologie.

B) Enseignements spécifiques

- Anatomie, embryologie, développement et physiologie de l'appareil locomoteur ;
- Principes de génétique, d'immunologie et d'oncologie appliqués à la rhumatologie ;
- Pharmacologie (métabolisme, posologie, action et toxicité) des médicaments usuels en rhumatologie ;
- Régulation du métabolisme phosphocalcique ;
- Imagerie et explorations de l'appareil locomoteur ;
- Classification des affections ostéo-articulaires ;
- Épidémiologie, physiopathologie, anatomopathologie, diagnostic, pronostic et traitement des maladies ostéo-articulaires : arthrites infectieuses, rhumatismes inflammatoires et connectivites, arthropathies métaboliques, arthrose rachidienne et des membres, pathologie péri-articulaire et disco-vertébrale, algies radiculaires et vertébrales, ostéopathies métaboliques et endocriniennes, dystrophies osseuses, tumeurs des os, pathologie ostéo-articulaire d'origine professionnelle ou sportive, pathologie ostéo-articulaire du sujet âgé et de l'enfant ;
- Podologie ;
- Organisation et prise en charge de la douleur et des urgences en rhumatologie ;
- Rhumatologie interventionnelle ;
- Thérapeutiques, médecine physique, rééducation, crénothérapie, médecines manuelles et alternatives en rhumatologie.

II - Formation pratique

A) Quatre semestres dans des services agréés pour le diplôme d'études spécialisées de rhumatologie, dont trois au moins doivent être accomplis dans des services hospitalo-universitaires ou conventionnés. Ces semestres doivent être effectués dans au moins deux services ou départements différents.

B) Deux semestres dans un service agréé pour les diplômes d'études spécialisées de dermatologie et vénéréologie, de médecine interne, de médecine physique et de réadaptation, de neurologie, d'oncologie ou de radiodiagnostic et imagerie médicale, ou pour les diplômes d'études spécialisées complémentaires d'allergologie et immunologie clinique ou de chirurgie orthopédique et traumatologie.

C) Deux semestres dans des services agréés pour d'autres diplômes d'études spécialisées que le diplôme d'études spécialisées de rhumatologie ou dans des services agréés pour des diplômes d'études spécialisées complémentaires.

➢ DIPLÔME D'ÉTUDES SPÉCIALISÉES DE SANTÉ PUBLIQUE ET MÉDECINE SOCIALE - DURÉE : QUATRE ANS

I - Enseignements (deux cent cinquante heures environ)

A) Enseignements de base

- Communication : techniques de communication et d'éducation pour la santé, documentation, informatique ;
- Épidémiologie : épidémiologie descriptive et analytique, statistique, démographie ;
- Planification ; évaluation des institutions sanitaires ; programmation des actions de santé et prévention ;
- Économie : organisation et gestion du système de santé, économie de la santé ;
- Droit : bases du droit administratif, constitutionnel et civil ; protection sociale, droit sanitaire et social ;
- Environnement : méthodes d'études de l'environnement physique et hygiène du milieu ; méthodes des sciences sociales appliquées à l'analyse du fonctionnement des institutions et des politiques sanitaires et sociales.

B) Enseignements optionnels

Deux enseignements à choisir parmi les suivants :

- Environnement et hygiène du milieu ;
- Épidémiologie ;
- Organisation et gestion des services de santé ;
- Santé communautaire.

II - Formation pratique

A) Quatre semestres dans des services agréés pour le diplôme d'études spécialisées de santé publique et médecine sociale, dont au moins un semestre doit être accompli dans un service extra-hospitalier.

B) Quatre semestres dans des services agréés pour la spécialité ou pour une autre spécialité.

➢ **DIPLÔME D'ÉTUDES SPÉCIALISÉES DE STOMATOLOGIE**
- DURÉE : QUATRE ANS

I - Enseignements (deux cent cinquante heures environ)

- Embryologie, anatomie, physiologie, anatomopathologie dento-maxilo-faciale ;
- Affection des dents, du paradonte et de l'appareil manducateur ;
- Orthopédie dento-maxillo-faciale ;
- Stomatologie médicale ;
- Tumeurs bénignes et malignes de la muqueuse buccale et des maxillaires ;
- Affections des glandes salivaires ;
- Traumatologie dento-maxillaire ;
- Réhabilitation orale, prothèse maxilo-faciale.

II - Formation pratique

A) Quatre semestres dans des services agréés pour le diplôme d'études spécialisées de stomatologie.
B) Quatre semestres dans des services agréés pour la spécialité ou pour une autre spécialité.

ANNEXE II

Liste
des Diplômes d'Etudes Spécialisées Complémentaires qualifiants (DESC II)

(3 ans d'études)

- CHIRURGIE DE LA FACE ET DU COU
- CHIRURGIE INFANTILE
- CHIRURGIE MAXILLO-FACIALE et STOMATOLOGIE
- CHIRURGIE ORTHOPEDIQUE et TRAUMATOLOGIE
- CHIRURGIE PLASTIQUE, RECONSTRUCTRICE et ESTHETIQUE
- CHIRURGIE THORACIQUE et CARDIOVASCULAIRE
- CHIRURGIE UROLOGIQUE
- CHIRURGIE VASCULAIRE
- CHIRURGIE VISCERALE et DIGESTIVE
- GERIATRIE
- REANIMATION MEDICALE

- **DIPLÔME D'ÉTUDES SPÉCIALISÉES COMPLÉMENTAIRES DE CHIRURGIE DE LA FACE ET DU COU**
  - DURÉE : SIX SEMESTRES

I - Enseignements (cent cinquante heures environ)

Trois enseignements à choisir parmi les suivants :
- Chirurgie cervicale ;
- Chirurgie faciale ;
- Chirurgie des cancers des voies aérodigestives supérieures ;
- Chirurgie de la base du crâne, du rocher et du massif facial ;
- Chirurgie esthétique et réparatrice cervico- faciale et chirurgie des tumeurs cutanées ;
- Chirurgie des malformations congénitales cervico-faciales ;
- Chirurgie du corps thyroïde.

II - Formation pratique

Six semestres dans des services agréés pour le diplôme d'études spécialisées complémentaires de chirurgie de la face et du cou.

III - Diplômes d'études spécialisées permettant de postuler le diplôme d'études spécialisées complémentaires de chirurgie de la face et du cou

Diplôme d'études spécialisées d'oto-rhino- laryngologie et diplôme d'études spécialisées de chirurgie générale, avec l'accord de l'enseignant coordonnateur du diplôme d'études spécialisées complémentaires.

➢ DIPLÔME D'ÉTUDES SPÉCIALISÉES COMPLÉMENTAIRES DE CHIRURGIE INFANTILE - DURÉE : SIX SEMESTRES

I - Enseignements (deux cent heures environ)

- Embryologie, organogenèse et tératogenèse ;
- Diagnostic anténatal ;
- Physiologie du nouveau-né, du prématuré et du dysmature ;
- Croissance et puberté ;
- Lésions traumatiques des membres, du crâne, du rachis et des ceintures ;
- Pathologie acquise non traumatique des membres, du cou, du rachis, du squelette et de la face
- Pathologies neuro-musculaires congénitales et acquises ;
- Pathologie acquise, congénitale et tumorale de la peau, des parois, du tube digestif et de ses annexes, des voies respiratoires et des poumons, du diaphragme, de l'appareil cardiovasculaire, de l'appareil uro-génital, du système nerveux, de la rate et des arcs branchiaux ;
- Réanimation chirurgicale pédiatrique.

II - Formation pratique

Six semestres dans des services agréés pour le diplôme d'études spécialisées complémentaires de chirurgie infantile, répartis si possible dans des services de chirurgie viscérale, de chirurgie infantile orthopédique, de chirurgie infantile urologique et/ou de chirurgie infantile générale. Ces semestres doivent être effectués dans au moins deux services différents.

III - Diplôme d'études spécialisées permettant de postuler le diplôme d'études spécialisées complémentaires de chirurgie infantile

Diplôme d'études spécialisées de chirurgie générale, avec l'accord de l'enseignant coordonnateur du diplôme d'études spécialisées complémentaires.

➢ DIPLÔME D'ÉTUDES SPÉCIALISÉES COMPLÉMENTAIRES DE CHIRURGIE MAXILLO-FACIALE ET STOMATOLOGIE - DURÉE : SIX SEMESTRES

I - Enseignements (deux cent heures environ)

A) Enseignements généraux

- Méthodologie de l'évaluation des pratiques de soins et de la recherche clinique et épidémiologie en chirurgie maxillo-faciale et stomatologie ;
- Organisation, gestion, droit et responsabilité médicale en chirurgie maxillo-faciale et stomatologie.

B) Enseignements spécifiques

- Pathologies médicales stomatologiques et maxillo-faciales ;
- Stomatologie chirurgicale ;
- Chirurgie pré-prothétique et implantologie ;
- Pathologie de l'articulation temporo-mandibulaire ;
- Traumatologie cranio-maxillo-faciale (parties molles et osseuses) ;
- Pathologie tumorale bénigne et maligne, y compris les tumeurs cutanées ;
- Pathologie médicale et chirurgicale des glandes salivaires ;
- Chirurgie reconstructrice cranio-maxillo- faciale ;
- Chirurgie orthognathique et orthopédie dento-maxillo-faciale ;
- Chirurgie plastique, esthétique et réparatrice maxillo-faciale ;
- Chirurgie des malformations cranio-faciales, y compris des fentes labio-maxillo-palatines.

II - Formation pratique

Six semestres dans des services agréés pour le diplôme d'études spécialisées complémentaires de chirurgie maxillo-faciale et stomatologie. Ces semestres doivent être effectués dans au moins deux services ou départements différents.

III - Diplôme d'études spécialisées permettant de postuler le diplôme d'études spécialisées complémentaires de chirurgie maxillo-faciale et stomatologie

Diplôme d'études spécialisées de chirurgie générale, avec l'accord de l'enseignant coordonnateur du diplôme d'études spécialisées complémentaires.

➢ DIPLÔME D'ÉTUDES SPÉCIALISÉES COMPLÉMENTAIRES DE CHIRURGIE ORTHOPÉDIQUE ET TRAUMATOLOGIE - DURÉE : SIX SEMESTRES

I - Enseignements (deux cent heures environ)

- Biomécanique ;
- Infections des os et articulations ;
- Tumeurs et dystrophies ;
- Pathologie traumatique et non traumatique des membres, du crâne, du cou, du rachis et des ceintures ;
- Traumatismes des vaisseaux, des nerfs et des muscles ;
- Polytraumatismes ;
- Orthopédie pédiatrique.

II - Formation pratique

Six semestres dans des services agréés pour le diplôme d'études spécialisées complémentaires de chirurgie orthopédique et traumatologie dont au moins un semestre dans un service d'orthopédie pédiatrique. Les semestres de chirurgie orthopédique doivent être effectués dans au moins deux services différents.

III - Diplôme d'études spécialisées permettant de postuler le diplôme d'études spécialisées complémentaires de chirurgie orthopédique et traumatologie

Diplôme d'études spécialisées de chirurgie générale, avec l'accord de l'enseignant coordonnateur du diplôme d'études spécialisées complémentaires.

➢ DIPLÔME D'ÉTUDES SPÉCIALISÉES COMPLÉMENTAIRES DE CHIRURGIE PLASTIQUE RECONSTRUCTRICE ET ESTHÉTIQUE - DURÉE : SIX SEMESTRES

I - Enseignements (deux cent heures environ)

- Cicatrisation normale et pathologique ;
- Greffes ;
- Lambeaux : locaux, à distance, libres ;
- Transferts composites libres microchirurgicaux ;
- Brûlures ;
- Radiolésions ;
- Tumeurs malignes cutanées ;
- Angiomes et lymphangiomes ;
- Chirurgie plastique et esthétique cervico- faciale, thoraco-abdominale, de la main et des membres.

II - Formation pratique

Six semestres dans des services agréés pour le diplôme d'études spécialisées complémentaires de chirurgie plastique, reconstructrice et esthétique. Ces semestres doivent être effectués dans au moins deux services différents.

III - Diplôme d'études spécialisées permettant de postuler le diplôme d'études spécialisées complémentaires de chirurgie plastique reconstructrice et esthétique

Diplôme d'études spécialisées de chirurgie générale, avec l'accord de l'enseignant coordonnateur du diplôme d'études spécialisées complémentaires.

➢ DIPLÔME D'ÉTUDES SPÉCIALISÉES COMPLÉMENTAIRES DE CHIRURGIE THORACIQUE ET CARDIO-VASCULAIRE - DURÉE : SIX SEMESTRES

I - Enseignements (deux cent heures environ)

- Cardiopathies vasculaires acquises ;
- Cardiopathies ischémiques et chirurgie coronarienne ;
- Malformations congénitales cardio-vasculaires ;
- Pathologie acquise de l'aorte, des gros vaisseaux et de leurs branches ;
- Pathologie pleurale et broncho-pulmonaire : tumeurs bénignes et malignes ;
- Maladies de systèmes ;
- Infections ;
- Parasitologie ;
- Malformations ;
- Affections dégénératives ;
- Traumatismes thoraciques ;
- Pathologie des parois du thorax ;
- Pathologie des régions voisines : cou, creux sus-claviculaires, creux axillaires, étages sus-mésocoliques ;
- Affections du médiastin ; affections de la trachée et de l'œsophage ;
- Physiologie cardio-vasculaire et respiratoire ;
- Réanimation respiratoire et cardio-circulatoire.

II - Formation pratique

Six semestres dans des services agréés pour le diplôme d'études spécialisées complémentaires de chirurgie thoracique et cardio-vasculaire. Ces semestres doivent être effectués dans au moins deux services différents.

III - Diplôme d'études spécialisées permettant de postuler le diplôme d'études spécialisées complémentaires de chirurgie thoracique et cardio- vasculaire

Diplôme d'études spécialisées de chirurgie générale, avec l'accord de l'enseignant coordonnateur du diplôme d'études spécialisées complémentaires.

➢ DIPLÔME D'ÉTUDES SPÉCIALISÉES COMPLÉMENTAIRES DE CHIRURGIE UROLOGIQUE - DURÉE : SIX SEMESTRES

I - Enseignements (deux cent heures environ)

- Sciences fondamentales en urologie ;
- Pathologie tumorale ;
- Lésions infectieuses et parasitaires du tractus urinaire ;
- Lithiase urinaire ;
- Lésions traumatiques ;
- Pathologie fonctionnelle de la vessie ;
- Anomalie congénitale ;
- Andrologie ;
- Insuffisance rénale ;
- Techniques chirurgicales ;
- Urgences en urologie.

II - Formation pratique

Six semestres dans des services agréés pour le diplôme d'études spécialisées complémentaires de chirurgie urologique. Ces semestres doivent être effectués dans au moins deux services différents.

III - Diplôme d'études spécialisées permettant de postuler le diplôme d'études spécialisées complémentaires de chirurgie urologique

Diplôme d'études spécialisées de chirurgie générale, avec l'accord de l'enseignant coordonnateur du diplôme d'études spécialisées complémentaires.

➢ DIPLÔME D'ÉTUDES SPÉCIALISÉES COMPLÉMENTAIRES DE CHIRURGIE VASCULAIRE - DURÉE : SIX SEMESTRES

I - Enseignements (deux cent heures environ)

- Histologie, physiologie et anatomo-pathologie circulatoire (artères, veines, lymphatiques) ;
- Explorations morphologiques et hémodynamiques en pathologie vasculaire ;
- Pathologie et thérapeutique chirurgicale des affections de l'aorte, des artères des membres inférieurs et des artères à destinée génitale, des troncs supra-aortiques, des artères à destinée cérébrale et des artères des membres supérieurs, des artères viscérales, du système veineux et du système lymphatique ;
- Explorations et thérapeutiques endo-luminales des affections artérielles et veineuses ;
- Microchirurgie vasculaire ;
- Anesthésie et réanimation de l'opéré vasculaire ;
- Thérapeutiques médicales des affections vasculaires.

II - Formation pratique

Six semestres dans des services agréés pour le diplôme d'études spécialisées complémentaires de chirurgie vasculaire. Ces semestres doivent être effectués dans au moins deux services différents.

III - Diplôme d'études spécialisées permettant de postuler le diplôme d'études spécialisées complémentaires de chirurgie vasculaire

Diplôme d'études spécialisées de chirurgie générale, avec l'accord de l'enseignant coordonnateur du diplôme d'études spécialisées complémentaires.

➢ DIPLÔME D'ÉTUDES SPÉCIALISÉES COMPLÉMENTAIRES DE CHIRURGIE VISCÉRALE ET DIGESTIVE - DURÉE : SIX SEMESTRES

I - Enseignements (deux cent heures environ)

- Chirurgie de l'œsophage et du diaphragme ;
- Chirurgie de l'estomac, du duodénum et du jéjuno-iléon ;
- Chirurgie colorectale et proctologique ;
- Chirurgie du foie, de la rate et du système porte ;
- Chirurgie des voies biliaires et du pancréas ;
- Chirurgie pariétale ;
- Chirurgie des cavités péritonéale et pelvienne ;
- Chirurgie du sein et des glandes endocrines.

II - Formation pratique

Six semestres dans des services agréés pour le diplôme d'études spécialisées complémentaires de chirurgie viscérale. Ces semestres doivent être effectués dans au moins deux services différents.

III - Diplôme d'études spécialisées permettant de postuler le diplôme d'études spécialisées complémentaires de chirurgie viscérale et digestive

Diplôme d'études spécialisées de chirurgie générale, avec l'accord de l'enseignant coordonnateur du diplôme d'études spécialisées complémentaires.

➢ DIPLÔME D'ÉTUDES SPÉCIALISÉES COMPLÉMENTAIRES DE GÉRIATRIE - DURÉE : SIX SEMESTRES

I - Enseignements (deux cents heures environ)

A) Enseignements généraux

- Méthodologie : évaluation des pratiques de soins - Recherche clinique et épidémiologique en gériatrie ;
- Éthique du soin et de la recherche clinique en gériatrie - Droit et responsabilité médicale en gériatrie.

B) Enseignements spécifiques

- Aspects épidémiologiques et démographiques du vieillissement.

Biologie du vieillissement

- Génétique moléculaire et mécanismes moléculaires fondamentaux du vieillissement ;
- Vieillissement cellulaire et matriciel ;
- Modèles d'études du vieillissement et leurs limites (exemples de modèles expérimentaux, in vivo et in vitro) ;
- Vieillissement des tissus et organes.

Les grands processus pathologiques survenant chez les personnes âgées et leurs traitements

- Pathologies neurodégénératives (notamment Alzheimer et maladie apparentées) ;
- Pathologies cardio-vasculaires ;
- Pathologies osthéoarticulaires ;
- Troubles métaboliques spécifiques ;
- Dénutrition ;
- Atteintes sensorielles et locomotrices.

Spécificités liées au grand âge

- Les pathologies chroniques et la polypathologie ;
- La pathologie en cascade ;
- Le concept de fragilité ;
- Perte d'autonomie : du concept à l'évaluation et à la prise en charge ;
- Psychologie du vieillissement - états de régression - désafférentation sensorielle ;
- La fin de vie - Soins palliatifs.

Spécificités des prises en charge en gériatrie

- Maniement des médicaments - Particularités des effets iatrogènes ;
- Rééducation - réadaptation ;
- Prise en charge psychogériatrique ;
- Évaluations gérontologiques.

Santé publique et vieillissement

- Le patient âgé et son environnement ;
- Organisations des structures gérontologiques ;
- Filières et réseaux ;
- Organisation des soins gériatriques à domicile, à l'hôpital ;
- Protection juridique des personnes âgées.

Prévoyance et prévention en gérontologie

- Longévité, vieillissement réussi (prévoyance et prévention primaires) ;
- Préventions secondaires et tertiaires des handicaps liés au vieillissement.

II - Formation pratique

La durée de la formation pratique est de 6 semestres :
A) Trois semestres - dont deux en post-internat -dans des services de gériatrie ;
B) Trois semestres dans des services validant pour le DESC de gériatrie dont si possible un de médecine interne.
Au cas où un candidat n'aurait pas accompli le semestre de gériatrie pendant son internat, le coordonnateur du DESC peut accepter qu'il valide la totalité de ses stages pratiques en cours de post-internat.

III - Diplôme d'études spécialisées permettant de postuler le diplôme d'études spécialisées complémentaires de gériatrie

- Cardiologie et maladies vasculaires ;
- Endocrinologie et métabolisme ;
- Gastro-entérologie et hépatologie ;
- Dermatologie et vénéréologie ;
- Hématologie ;
- Médecine générale ;
- Médecine interne ;
- Médecine physique et de réadaptation ;
- Néphrologie ;
- Neurologie ;
- Oncologie.
- Pneumologie ;
- Psychiatrie ;
- Rhumatologie ;
- Santé publique et médecine sociale,

avec l'accord de l'enseignant coordonnateur du diplôme d'études spécialisées complémentaires.

Le coordonnateur du DESC peut accepter un candidat titulaire d'un DES autre que ceux mentionnés ci-dessus.

➢ DIPLÔME D'ÉTUDES SPÉCIALISÉES COMPLÉMENTAIRES DE RÉANIMATION MÉDICALE - DURÉE : SIX SEMESTRES

I - Enseignements (deux cents heures environ)

A) Enseignements généraux
- Méthodologie de l'évaluation des pratiques de soins et de recherche clinique et épidémiologique en réanimation médicale ;
- Organisation, gestion, éthique, droit et responsabilité médicale en réanimation.

B) Enseignements spécifiques
- Bases physiologiques et physiopathologiques de la réanimation ;
- Techniques de réanimation ;
- Réanimation respiratoire ;
- Réanimation cardio-vasculaire ;
- Réanimation métabolique et nutrition ;
- Réanimation et pathologie infectieuse ;
- Réanimation et neurologie ;
- Réanimation et pathologie digestive ;
- Réanimation et hémato-cancérologie ;
- Réanimation et toxicologie ;
- Syndrome de défaillances poly-viscérales ;
- Urgences et réanimation ;
- Méthodologie des essais cliniques en réanimation ;
- Réanimation pédiatrique et en obstétrique ;
- Éléments de traumatologie et de réanimation péri-opératoire ;
- Évaluation et qualité en réanimation.

II - Formation pratique

La durée de la formation pratique est de six semestres.
A) Trois semestres dans des services agréés pour le diplôme d'études spécialisées complémentaires de réanimation médicale, dont deux au moins doivent être accomplis dans des services hospitalo-universitaires ou conventionnés. Deux de ces semestres doivent être accomplis après l'internat et comporter des fonctions hospitalo-universitaires ou hospitalières.
B) Un semestre dans un service agréé pour le diplôme d'études spécialisées complémentaires de réanimation médicale ou dans un service de réanimation chirurgicale agréé pour le diplôme d'études spécialisées d'anesthésie-réanimation ou dans une unité de soins intensifs d'un service agréé pour les diplômes d'études spécialisées permettant de postuler de diplôme d'études spécialisées complémentaires de réanimation médicale.
C) Deux semestres libres dans des services agréés pour les diplômes d'études spécialisées permettant de postuler le diplôme d'études spécialisées complémentaires de réanimation médicale et comportant de préférence une unité de soins intensifs.
La formation pratique hospitalière comprend la participation à des gardes formatrices dans la spécialité.

III - Diplôme d'études spécialisées permettant de postuler le diplôme d'études spécialisées complémentaires de réanimation médicale

Diplômes d'études spécialisées de :
- Anesthésie-réanimation ;
- Cardiologie et maladies vasculaires ;
- Endocrinologie et métabolismes ;
- Gastroentérologie et hépatologie ;
- Dermatologie et vénéréologie ;
- Hématologie ;
- Médecine interne ;
- Médecine physique et de réadaptation ;
- Néphrologie ;
- Neurologie ;
- Oncologie (option médicale et option onco-hématologique) ;
- Pédiatrie ;
- Pneumologie ;
- Rhumatologie ;
- Chirurgie générale,

avec l'accord de l'enseignant coordonnateur du diplôme d'études spécialisées

Effectifs par origine du diplôme et par spécialité
Au 1er janvier 2010

1 – Anatomie et cytologie-pathologiques

Anatomie et cytologie-pathologiques (en activité régulière)	Diplôme	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Autorisé plein exercice	ROUMANIE					2						2
	sous-total					**2**						**2**
Diplôme d'un pays de la CEE	AUTRICHE	1	1		0	0	0	0	0	0	0	**2**
	BELGIQUE	0	0		0	0	0	1	0	1	1	**3**
	BULGARIE	0	0		0	0	0	0	2	0	0	**2**
	ITALIE	0	0		1	1	0	0	2	1	1	**6**
	PAYS-BAS	0	0		1	0	0	0	0	0	0	**1**
	POLOGNE	0	0		0	0	0	1	0	0	0	**1**
	ROUMANIE	0	0		0	0	1	1	9	1	3	**15**
	SLOVAQUIE	0	0		0	0	1	0	0	0	0	**1**
	sous-total	**1**	**1**		**2**	**1**	**2**	**3**	**13**	**3**	**5**	**31**
NPA (art L 4111-2 1 et 1bis du CSP)	ROUMANIE								2			**2**
	sous-total								**2**			**2**
TOTAL		**1**	**1**		**2**	**3**	**2**	**3**	**15**	**3**	**5**	**35**

2 – Anesthésie-Réanimation

Anesthésie-Réanimation (en activité régulière)	Diplôme	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Autorisé Hocsman	BULGARIE			1		0	0		0	0		**1**
	POLOGNE			1		0	0		0	0		**1**
	REPUBLIQUE TCHEQUE			0		0	0		1	0		**1**
	ROUMANIE			0		0	2		1	1		**4**
	SUEDE			0		1	0		0	0		**1**
	sous-total			**2**		**1**	**2**		**2**	**1**		**8**
Autorisé P.A.C.	HONGRIE	1										**1**
	sous-total	**1**										**1**
Autorisé plein exercice	BULGARIE	2	0	1	1	2	0					**6**
	ITALIE	0	1	0	0	0	0					**1**
	LITUANIE	0	0	0	0	0	1					**1**
	POLOGNE	1	0	0	1	1	0					**3**
	REPUBLIQUE TCHEQUE	1	0	0	0	0	0					**1**
	ROUMANIE	6	1	4	1	3	0					**15**
	sous-total	**10**	**2**	**5**	**3**	**6**	**1**					**27**
Diplôme d'un pays de la CEE	ALLEMAGNE	15	14	7	10	8	8	21	9	10	6	**108**
	BELGIQUE	11	9	11	10	15	13	10	7	9	6	**101**
	BULGARIE	0	0	0	0	0	0	0	16	15	6	**37**
	ESPAGNE	0	0	2	0	0	1	1	1	0	1	**6**
	GRANDE-BRETAGNE	0	0	0	0	0	1	0	0	1	1	**3**
	GRECE	0	0	0	0	0	0	0	0	0	1	**1**
	HONGRIE	0	0	0	0	2	0	0	0	1	2	**5**
	ITALIE	2	0	3	2	1	2	1	7	7	4	**29**
	LETTONIE	0	0	0	0	3	0	2	0	0	0	**5**
	LITUANIE	0	0	0	0	1	2	1	2	1	3	**10**
	POLOGNE	0	0	0	1	7	6	1	2	1	0	**18**
	PORTUGAL	0	1	0	0	0	0	0	0	1	1	**3**
	REPUBLIQUE TCHEQUE	0	0	0	0	0	0	1	3	1	3	**8**
	ROUMANIE	0	0	0	0	0	0	0	66	35	25	**126**
	SLOVAQUIE	0	0	0	0	1	3	4	0	1	0	**9**
	SUEDE	0	0	0	0	0	0	1	0	0	0	**1**
	sous-total	**28**	**24**	**23**	**23**	**38**	**36**	**43**	**113**	**83**	**59**	**470**
NPA (art L 4111-2 1 et 1bis du CSP)	BELGIQUE	0						1		0		**1**
	ITALIE	0						1		0		**1**
	LITUANIE	0						0		1		**1**
	ROUMANIE	1						1		0		**2**
	sous-total	**1**						**3**		**1**		**5**
TOTAL		**40**	**26**	**30**	**26**	**45**	**39**	**46**	**115**	**85**	**59**	**511**

3 – Réanimation médicale

Réanimation médicale (en activité régulière)	Diplôme	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Autorisé P.A.C.	ROUMANIE		1									1
	sous-total		**1**									**1**
Diplôme d'un pays de la CEE	ESPAGNE									1		1
	sous-total									**1**		**1**
TOTAL			**1**							**1**		**2**

4 – Biologie médicale

Biologie médicale (en activité régulière)	Diplôme	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Autorisé plein exercice	BULGARIE		1									1
	sous-total		**1**									**1**
Diplôme d'un pays de la CEE	BELGIQUE		2	1	1	1	1	1	0	1	0	**8**
	BULGARIE		0	0	0	0	0	0	0	1	0	**1**
	ITALIE		0	0	1	0	0	0	0	0	1	**2**
	ROUMANIE		0	0	0	0	0	0	9	7	5	**21**
	sous-total		**2**	**1**	**2**	**1**	**1**	**1**	**9**	**9**	**6**	**32**
NPA (art L 4111-2 1 et 1bis du CSP)	ROUMANIE								1		1	**2**
	sous-total								**1**		**1**	**2**
TOTAL			**3**	**1**	**2**	**1**	**1**	**1**	**10**	**9**	**7**	**35**

5 – Cardiologie et maladies vasculaires

Cardiologie et maladies vasculaires (en activité régulière)	Diplôme	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Inconnu	POLOGNE	1		0		0			0			1
	ROUMANIE	0		1		1			1			3
	sous-total	**1**		**1**		**1**			**1**			**4**
Autorisé Hocsman	REPUBLIQUE TCHEQUE			0					1			1
	ROUMANIE			1					0			1
	sous-total			**1**					**1**			**2**
Autorisé plein exercice	BULGARIE	1	1	1	0	1						4
	POLOGNE	1	1	0	0	0						2
	ROUMANIE	9	0	3	4	1						17
	sous-total	**11**	**2**	**4**	**4**	**2**						**23**
Diplôme d'un pays de la CEE	ALLEMAGNE	1	0	0	0	0	0	2	1	0	0	4
	AUTRICHE	0	1	0	0	0	0	0	0	0	0	1
	BELGIQUE	0	1	0	2	2	1	3	6	6	3	24
	BULGARIE	0	0	0	0	0	0	0	2	0	1	3
	ESPAGNE	0	0	0	1	0	0	1	0	0	0	2
	GRECE	0	0	0	0	0	0	1	0	0	0	1
	HONGRIE	0	0	0	0	0	0	0	0	0	2	2
	ITALIE	2	1	1	0	1	2	2	0	0	0	9
	LETTONIE	0	0	0	0	0	0	0	1	0	0	1
	LITUANIE	0	0	0	0	0	0	0	0	1	0	1
	POLOGNE	0	0	0	0	0	0	0	3	2	1	6
	PORTUGAL	0	0	0	0	0	0	0	0	0	1	1
	REPUBLIQUE TCHEQUE	0	0	0	0	0	0	0	1	0	0	1
	ROUMANIE	0	0	0	0	0	0	2	23	6	13	44
	sous-total	**3**	**3**	**1**	**3**	**3**	**3**	**11**	**37**	**15**	**21**	**100**
NPA (art L 4111-2 1 et 1bis du CSP)	BULGARIE					0			0		1	1
	ROUMANIE					1			1		0	2
	sous-total					**1**			**1**		**1**	**3**
TOTAL		**15**	**5**	**7**	**7**	**7**	**3**	**11**	**40**	**15**	**22**	**132**

6 – Chirurgie de la face et du cou

- Aucune inscription

7 – Chirurgie générale

Chirurgie générale (en activité régulière)	Diplôme	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Inconnu	ITALIE										1	1
	sous-total										1	1
Autorisé Hocsman	ROUMANIE									1		1
	SLOVAQUIE									1		1
	sous-total									2		2
Autorisé plein exercice	BELGIQUE	0		0	0	0		1				1
	BULGARIE	1		0	0	0		0				1
	POLOGNE	0		0	1	0		0				1
	ROUMANIE	2		1	2	2		0				7
	sous-total	3		1	3	2		1				10
Diplôme d'un pays de la CEE	ALLEMAGNE	3	0	0	1	1	0	2	2	1	1	11
	BELGIQUE	5	1	3	3	2	7	7	8	5	6	47
	BULGARIE	0	0	0	0	0	0	0	1	0	1	2
	ESPAGNE	0	0	0	0	0	1	0	0	0	0	1
	GRECE	0	0	0	0	0	1	0	0	0	1	2
	HONGRIE	0	0	0	0	0	0	1	1	0	0	2
	ITALIE	4	1	4	8	0	5	8	8	9	6	53
	LITUANIE	0	0	0	0	1	0	0	0	0	0	1
	POLOGNE	0	0	0	0	0	1	1	0	1	0	3
	PORTUGAL	1	0	0	0	0	0	0	0	0	0	1
	ROUMANIE	1	0	0	0	0	0	1	17	9	5	33
	sous-total	14	2	7	12	4	15	20	37	25	20	156
TOTAL		17	2	8	15	6	15	21	37	27	21	169

8 – Chirurgie infantile

Chirurgie infantile (en activité régulière)	Diplôme	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Autorisé Hocsman	ROUMANIE										1	1
	sous-total										1	1
Diplôme d'un pays de la CEE	ALLEMAGNE	0		0	0	0		0	0	0	1	1
	BELGIQUE	1		0	1	1		0	0	0	0	3
	ESPAGNE	0		0	0	1		0	0	0	0	1
	ITALIE	0		2	1	1		2	0	0	1	7
	ROUMANIE	0		0	0	0		0	4	1	3	8
	sous-total	**1**		**2**	**2**	**3**		**2**	**4**	**1**	**5**	**20**
TOTAL		**1**		**2**	**2**	**3**		**2**	**4**	**1**	**6**	**21**

9 – Chirurgie maxillo-faciale

Chirurgie maxillo-faciale (en activité régulière)	Diplôme	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Diplôme d'un pays de la CEE	BELGIQUE			1					0		0	1
	ITALIE			1					0		2	3
	ROUMANIE			0					1		0	1
TOTAL				**2**					**1**		**2**	**5**

10 – Chirurgie orthopédique et traumatologie

Chirurgie orthopédique et traumatologie (en activité régulière)	Diplôme	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Autorisé Hocsman	ROUMANIE				1							1
	sous-total				**1**							**1**
Autorisé plein exercice	REPUBLIQUE TCHEQUE	1	0	0	0	0						1
	ROUMANIE	2	1	1	1	2						7
	sous-total	**3**	**1**	**1**	**1**	**2**						**8**
Diplôme d'un pays de la CEE	ALLEMAGNE	0	0	1	0	3	1	2	2	0	1	**10**
	AUTRICHE	0	0	0	1	0	0	0	0	0	0	**1**
	BELGIQUE	3	1	4	4	1	2	3	2	1	3	**24**
	BULGARIE	0	0	0	0	0	0	0	2	0	0	**2**
	GRANDE-BRETAGNE	0	0	0	0	0	0	1	0	0	0	**1**
	GRECE	0	0	0	0	0	0	1	0	0	0	**1**
	ITALIE	3	2	0	0	0	0	1	0	3	1	**10**
	POLOGNE	0	0	0	0	0	0	0	1	0	0	**1**
	ROUMANIE	0	0	0	0	0	0	0	19	5	2	**26**
	SUEDE	0	0	0	1	0	0	0	0	0	0	**1**
	sous-total	**6**	**3**	**5**	**6**	**4**	**3**	**8**	**26**	**9**	**7**	**77**
NPA (art L 4111-2 1 et 1bis du CSP)	POLOGNE			0				0		1		**1**
	ROUMANIE			1				1		0		**2**
	sous-total			**1**				**1**		**1**		**3**
TOTAL		**9**	**4**	**7**	**8**	**6**	**3**	**9**	**26**	**10**	**7**	**89**

11 - CPRE

CPRE (en activité régulière)	Diplôme	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Autorisé plein exercice	ROUMANIE	1										1
	sous-total	**1**										**1**
Diplôme d'un pays de la CEE	ALLEMAGNE	1	0	0	1		0	0	0	0	0	**2**
	BELGIQUE	0	1	0	0		2	0	0	1	0	**4**
	ITALIE	1	0	1	1		0	0	1	0	1	**5**
	LITUANIE	0	0	0	0		0	1	0	0	0	**1**
	ROUMANIE	0	0	0	0		0	0	2	3	0	**5**
	sous-total	**2**	**1**	**1**	**2**		**2**	**1**	**3**	**4**	**1**	**17**
TOTAL		**3**	**1**	**1**	**2**		**2**	**1**	**3**	**4**	**1**	**18**

12 – Chirurgie thoracique et cardio-vasculaire

Chirurgie thoracique et cardio-vasculaire (en activité régulière)	Diplôme	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Autorisé plein exercice	ROUMANIE			1								1
	sous-total			**1**								**1**
Diplôme d'un pays de la CEE	ALLEMAGNE	0	0	0	0	0	0	1	0	0	0	**1**
	ITALIE	2	2	3	2	1	3	2	3	2	5	**25**
	ROUMANIE	0	0	0	0	0	0	0	7	4	1	**12**
	sous-total	**2**	**2**	**3**	**2**	**1**	**3**	**3**	**10**	**6**	**6**	**38**
NPA (art L 4111-2 1 et 1bis du CSP)	ROUMANIE										1	1
	sous-total										**1**	**1**
TOTAL		**2**	**2**	**4**	**2**	**1**	**3**	**3**	**10**	**6**	**7**	**40**

13 – Chirurgie urologique

Chirurgie urologique (en activité régulière)	Diplôme	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Autorisé plein exercice	ROUMANIE			1								**1**
	sous-total			**1**								**1**
Diplôme d'un pays de la CEE	ALLEMAGNE		0	0	0	0	1	0	2	2	1	**6**
	AUTRICHE		1	0	0	0	0	0	0	1	0	**2**
	BELGIQUE		2	4	1	2	1	1	1	2	5	**19**
	BULGARIE		0	0	0	0	0	0	0	0	2	**2**
	HONGRIE		0	0	0	0	0	0	1	0	0	**1**
	ITALIE		1	0	1	0	0	0	0	1	0	**3**
	ROUMANIE		0	0	0	0	0	0	4	2	2	**8**
	SLOVAQUIE		0	0	0	0	1	0	0	0	0	**1**
	sous-total		**4**	**4**	**2**	**2**	**3**	**1**	**8**	**8**	**10**	**42**
TOTAL			**4**	**5**	**2**	**2**	**3**	**1**	**8**	**8**	**10**	**43**

14 – Chirurgie vasculaire

Chirurgie vasculaire (en activité régulière)	Diplôme	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Autorisé plein exercice	POLOGNE		1									**1**
	sous-total		**1**									**1**
Diplôme d'un pays de la CEE	BELGIQUE	0	1		1	2	1	0	0	0	0	**5**
	HONGRIE	0	0		0	0	0	0	0	0	1	**1**
	ITALIE	1	0		0	0	2	3	1	2	0	**9**
	ROUMANIE	0	0		0	0	0	0	1	3	0	**4**
	sous-total	**1**	**1**		**1**	**2**	**3**	**3**	**2**	**5**	**1**	**19**
TOTAL		**1**	**2**		**1**	**2**	**3**	**3**	**2**	**5**	**1**	**20**

15 – Chirurgie viscérale et digestive

Chirurgie viscérale et digestive (en activité régulière)	Diplôme	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Inconnu	ROUMANIE								1			**1**
	sous-total								**1**			**1**
Autorisé plein exercice	ROUMANIE					1	1					**2**
	sous-total					**1**	**1**					**2**
Diplôme d'un pays de la CEE	ALLEMAGNE	1	0	0	0	1	0	1				**3**
	BELGIQUE	1	0	1	0	0	0	0				**2**
	ESPAGNE	0	0	0	0	1	0	0				**1**
	ITALIE	2	1	1	0	0	1	0				**5**
	ROUMANIE	0	0	0	1	0	0	0				**1**
	sous-total	**4**	**1**	**2**	**1**	**2**	**1**	**1**				**12**
TOTAL		**4**	**1**	**2**	**1**	**3**	**2**	**1**	**1**			**15**

16 – Dermatologie et vénéréologie

Dermatologie et vénéréologie (en activité régulière)	Diplôme	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Autorisé plein exercice	BULGARIE	1	0	0		0						**1**
	ITALIE	0	0	1		0						**1**
	ROUMANIE	1	1	0		1						**3**
	sous-total	**2**	**1**	**1**		**1**						**5**
Diplôme d'un pays de la CEE	ALLEMAGNE	2	4	1	1	1	1		1	0	0	**11**
	BELGIQUE	0	1	0	0	2	0		0	0	0	**3**
	BULGARIE	0	0	0	0	0	0		2	1	1	**4**
	ESTONIE	0	0	0	0	1	0		0	0	0	**1**
	GRECE	0	0	0	0	0	1		0	0	0	**1**
	ITALIE	0	0	0	1	0	0		0	0	0	**1**
	POLOGNE	0	0	0	0	0	1		0	0	0	**1**
	ROUMANIE	0	0	0	0	0	0		8	3	3	**14**
	sous-total	**2**	**5**	**1**	**2**	**4**	**3**		**11**	**4**	**4**	**36**
TOTAL		**4**	**6**	**2**	**2**	**5**	**3**		**11**	**4**	**4**	**41**

17 – Endocrinologie et métabolisme

Endocrinologie et métabolisme (en activité régulière)	Diplôme	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Inconnu	ROUMANIE	1										**1**
	sous-total	**1**										**1**
Autorisé plein exercice	BULGARIE	1			0							**1**
	REPUBLIQUE TCHEQUE	1			0							**1**
	ROUMANIE	1			2							**3**
	sous-total	**3**			**2**							**5**
Diplôme d'un pays de la CEE	BELGIQUE	1	1			0	0	0	0	0	0	**2**
	GRECE	0	0			0	1	0	0	0	0	**1**
	ITALIE	0	0			1	1	0	0	0	0	**2**
	LETTONIE	0	0			0	1	0	0	0	0	**1**
	POLOGNE	0	0			0	1	0	0	0	0	**1**
	ROUMANIE	0	0			0	0	1	11	4	2	**18**
	sous-total	**1**	**1**			**1**	**4**	**1**	**11**	**4**	**2**	**25**
TOTAL		**5**	**1**		**2**	**1**	**4**	**1**	**11**	**4**	**2**	**31**

18 – Gastro-entérologie et hépatologie

Gastro-entérologie et hépatologie (en activité régulière)	Diplôme	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Inconnu	ROUMANIE	1										**1**
	sous-total	**1**										**1**
Autorisé plein exercice	POLOGNE	0		0	1	0						**1**
	ROUMANIE	2		1	2	1						**6**
	sous-total	**2**		**1**	**3**	**1**						**7**
Diplôme d'un pays de la CEE	ALLEMAGNE	0		0	0	0	0	1	0	0	0	**1**
	BELGIQUE	0		3	0	3	3	1	0	0	0	**10**
	BULGARIE	0		0	0	0	0	0	0	0	1	**1**
	ESPAGNE	0		0	1	0	0	0	0	0	0	**1**
	ITALIE	0		0	1	1	1	1	0	0	0	**4**
	PAYS-BAS	1		0	0	0	0	0	0	0	0	**1**
	POLOGNE	0		0	0	0	0	1	0	0	0	**1**
	ROUMANIE	0		0	0	0	0	0	15	2	6	**23**
	sous-total	**1**		**3**	**2**	**4**	**4**	**4**	**15**	**2**	**7**	**42**
NPA (art L 4111-2 1 et 1bis du CSP)	ITALIE									1		**1**
	sous-total									**1**		**1**
TOTAL		**4**		**4**	**5**	**5**	**4**	**4**	**15**	**3**	**7**	**51**

19 – Génétique médicale

Génétique médicale (en activité régulière)	Diplôme	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Diplôme d'un pays de la CEE	BELGIQUE		1			0	1					**2**
	ITALIE		0			2	0					**2**
TOTAL			**1**			**2**	**1**					**4**

20 – Gériatrie

Gériatrie (en activité régulière)	Diplôme	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Autorisé plein exercice	BULGARIE	1							0			**1**
	POLOGNE	2							0			**2**
	ROUMANIE	1							1			**2**
	sous-total	**4**							**1**			**5**
Diplôme d'un pays de la CEE	ESPAGNE				0		2	0	0	0	0	**2**
	HONGRIE				0		0	0	1	0	0	**1**
	ITALIE				0		0	1	1	0	0	**2**
	PAYS-BAS				1		0	0	0	0	0	**1**
	ROUMANIE				0		0	0	3	2	1	**6**
	sous-total				**1**		**2**	**1**	**5**	**2**	**1**	**12**
NPA (art L 4111-2 1 et 1bis du CSP)	ROUMANIE		1									**1**
	sous-total		**1**									**1**
TOTAL		**4**	**1**		**1**		**2**	**1**	**6**	**2**	**1**	**18**

21 – Gynécologie médicale

Gynécologie médicale (en activité régulière)	Diplôme	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Diplôme d'un pays de la CEE	BELGIQUE	1						1				**2**
TOTAL		**1**						**1**				**2**

22 – Gynécologie médicale et obstétrique

Gynécologie médicale et obstétrique (en activité régulière)	Diplôme	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Autorisé plein exercice	BULGARIE			0	1							**1**
	ROUMANIE			1	1							**2**
TOTAL				**1**	**2**							**3**

23 – Gynécologie-Obstétrique

Gynécologie-Obstétrique (en activité régulière)	Diplôme	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Autorisé Hocsman	BULGARIE								1	1		**2**
	sous-total								**1**	**1**		**2**
Autorisé P.A.C.	ROUMANIE		1									**1**
	sous-total		**1**									**1**
Autorisé plein exercice	ITALIE	0		0	0	1	0					**1**
	LITUANIE	0		0	0	0	1					**1**
	POLOGNE	0		2	0	0	0					**2**
	ROUMANIE	4		2	2	4	0					**12**
	sous-total	**4**		**4**	**2**	**5**	**1**					**16**
Diplôme d'un pays de la CEE	ALLEMAGNE	1	2	2	2	1	4	2	0	2	1	**17**
	BELGIQUE	3	1	2	6	1	1	6	3	0	4	**27**
	BULGARIE	0	0	0	0	0	0	0	2	4	0	**6**
	ESPAGNE	0	0	0	1	0	0	0	0	0	0	**1**
	GRANDE-BRETAGNE	0	0	0	0	0	0	0	1	0	0	**1**
	GRECE	0	0	0	0	2	0	0	0	0	0	**2**
	HONGRIE	0	0	0	0	0	1	0	0	0	1	**2**
	ITALIE	1	1	0	2	2	0	2	2	1	2	**13**
	PAYS-BAS	0	0	0	0	0	0	0	0	1	0	**1**
	POLOGNE	0	0	0	0	0	1	1	1	1	0	**4**
	REPUBLIQUE TCHEQUE	0	0	0	0	1	0	0	1	0	1	**3**
	ROUMANIE	0	0	1	0	0	0	0	21	8	9	**39**
	SUEDE	0	0	0	1	0	0	0	0	0	0	**1**
	sous-total	**5**	**4**	**5**	**12**	**7**	**7**	**11**	**31**	**17**	**18**	**117**
NPA (art L 4111-2 1 et 1bis du CSP)	LITUANIE										1	**1**
	sous-total										**1**	**1**
TOTAL		**9**	**5**	**9**	**14**	**12**	**8**	**11**	**32**	**18**	**19**	**137**

24 – Hématologie

Hématologie (en activité régulière)	Diplôme	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Autorisé Hocsman	ALLEMAGNE										1	1
	sous-total										1	1
Autorisé plein exercice	ITALIE			1								1
	sous-total			1								1
Diplôme d'un pays de la CEE	ALLEMAGNE			0				0	1	0	0	1
	GRECE			1				0	0	0	0	1
	ITALIE			0				1	2	0	1	4
	REPUBLIQUE TCHEQUE			0				1	0	0	0	1
	ROUMANIE			0				0	9	4	0	13
	sous-total			1				2	12	4	1	20
NPA (art L 4111-2 1 et 1bis du CSP)	ITALIE							1				1
	sous-total							1				1
TOTAL				2				3	12	4	2	23

25 – Médecine du travail

Médecine du travail (en activité régulière)	Diplôme	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Autorisé plein exercice	ESPAGNE	1			0							1
	ROUMANIE	0			1							1
	sous-total	1			1							2
Diplôme d'un pays de la CEE	ALLEMAGNE	0	1	1	0	0	0	0	0	0	0	2
	BELGIQUE	4	2	2	5	2	3	4	2	1	0	25
	ESPAGNE	0	0	0	1	0	0	0	0	0	0	1
	HONGRIE	0	0	0	0	0	0	0	0	1	1	2
	ITALIE	0	0	0	0	0	1	0	1	1	2	5
	PAYS-BAS	0	0	0	0	0	0	0	0	1	0	1
	ROUMANIE	0	0	0	0	0	0	0	6	8	7	21
	sous-total	4	3	3	6	2	4	4	9	12	10	57
TOTAL		5	3	3	7	2	4	4	9	12	10	59

26 – Médecine générale

Médecine générale (en activité régulière)	Diplôme	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Autorisé plein exercice	ROUMANIE				1							1
					1							1
Diplôme d'un pays de la CEE	ALLEMAGNE	0	0		1	1	0	0	1	0	1	4
	BELGIQUE	0	1		6	4	4	4	3	3	3	28
	BULGARIE	0	0		0	0	0	0	0	1	3	4
	ESPAGNE	0	0		1	0	2	1	0	0	0	4
	GRANDE-BRETAGNE	1	0		0	0	0	0	1	0	0	2
	HONGRIE	0	0		0	0	0	0	0	1	0	1
	ITALIE	0	0		0	1	0	0	0	0	2	3
	PAYS-BAS	0	0		0	1	1	0	0	0	1	3
	POLOGNE	0	0		0	0	0	1	1	0	1	3
	ROUMANIE	0	0		0	0	0	0	2	7	23	32
		1	1		8	7	7	6	8	12	34	84
TOTAL		1	1		9	7	7	6	8	12	34	85

27 – Médecine générale non qualifiée

Médecine générale non qualifiée (en activité régulière)	Diplôme	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Inconnu	POLOGNE	1	1			0						2
	ROUMANIE	0	1			2						3
	sous-total	**1**	**2**			**2**						**5**
Autorisé en formation	BULGARIE							0	1			1
	ROUMANIE							1	0			1
	sous-total							**1**	**1**			**2**
Autorisé Hocsman	BULGARIE			0			0		0	1	1	2
	ESPAGNE			0			1		1	0	0	2
	PARAGUAY			0			0		0	1	0	1
	REPUBLIQUE TCHEQUE			0			0		0	1	0	1
	ROUMANIE			1			0		1	0	1	3
	SLOVAQUIE			0			0		1	0	0	1
	sous-total			**1**			**1**		**3**	**3**	**2**	**10**
Autorisé P.A.C.	BULGARIE	0	0	1		0	0					1
	HONGRIE	0	0	0		1	0					1
	POLOGNE	0	0	0		0	1					1
	ROUMANIE	2	1	2		0	1					6
	sous-total	**2**	**1**	**3**		**1**	**2**					**9**
Autorisé plein exercice	ALLEMAGNE	0	1	0	1	1	0		0			3
	BELGIQUE	0	1	1	0	0	0		0			2
	BULGARIE	2	1	1	0	1	0		3			8
	ESPAGNE	0	1	0	0	1	0		0			2
	HONGRIE	1	0	0	0	0	0		0			1
	ITALIE	0	0	1	0	1	0		0			2
	POLOGNE	9	1	0	0	0	0		0			10
	REPUBLIQUE TCHEQUE	1	0	0	0	2	0		1			4
	ROUMANIE	20	10	11	6	9	1		1			58
	sous-total	**33**	**15**	**14**	**7**	**15**	**1**		**5**			**90**
Diplôme d'un pays de la CEE	ALLEMAGNE	10	10	9	6	12	17	13	21	15	0	113
	AUTRICHE	0	0	2	0	0	1	2	0	0	0	5
	BELGIQUE	12	23	23	30	26	14	18	18	18	0	182
	BULGARIE	0	0	0	0	0	0	0	5	19	0	24
	ESPAGNE	2	4	4	7	6	3	4	4	4	0	38
	GRANDE-BRETAGNE	3	4	2	1	0	2	2	5	4	1	24
	GRECE	0	1	0	0	4	3	2	2	3	0	15

	HONGRIE	0	0	0	0	2	1	2	3	1	0	**9**
	IRLANDE	0	0	0	0	1	0	0	2	0	0	**3**
	ITALIE	3	2	1	8	12	12	8	16	11	0	**73**
	LETTONIE	0	0	0	0	0	1	0	1	0	0	**2**
	MALTE	0	0	0	0	0	0	0	0	1	0	**1**
	PAYS-BAS	1	0	1	0	0	0	0	1	0	1	**4**
	POLOGNE	0	0	0	1	9	20	8	4	3	0	**45**
	PORTUGAL	0	1	0	0	0	2	0	0	1	0	**4**
	REPUBLIQUE TCHEQUE	0	0	0	0	2	1	1	0	2	0	**6**
	ROUMANIE	0	0	0	0	0	0	1	163	122	3	**289**
	SLOVAQUIE	0	0	0	0	2	3	2	1	1	0	**9**
	SUEDE	0	0	1	0	0	0	1	1	0	0	**3**
	sous-total	**31**	**45**	**43**	**53**	**76**	**80**	**64**	**247**	**205**	**5**	**849**
NPA (art L 4111-2 1 et 1bis du CSP)	BULGARIE									1		**1**
	sous-total									**1**		**1**
TOTAL		**67**	**63**	**61**	**60**	**94**	**84**	**65**	**256**	**209**	**7**	**966**

28 – Médecine interne

Médecine interne (en activité régulière)	Diplôme	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Inconnu	ROUMANIE					1						1
						1						**1**
Autorisé plein exercice	LETTONIE	0		0	0	0			1			1
	ROUMANIE	6		3	6	3			0			18
		6		**3**	**6**	**3**			**1**			**19**
Diplôme d'un pays de la CEE	ALLEMAGNE	2	0	0	1	2	1	1	1	2	1	**11**
	AUTRICHE	0	0	0	0	0	0	0	0	0	1	**1**
	BELGIQUE	0	3	0	0	0	0	1	1	2	3	**10**
	BULGARIE	0	0	0	0	0	0	0	2	2	2	**6**
	DANEMARK	0	0	1	0	0	0	0	0	0	0	**1**
	HONGRIE	0	0	0	0	0	0	0	0	0	1	**1**
	ITALIE	0	0	0	1	1	1	1	1	3	1	**9**
	PAYS-BAS	1	0	0	0	0	0	0	0	0	0	**1**
	POLOGNE	0	0	0	0	4	1	1	0	2	2	**10**
	PORTUGAL	0	1	0	0	0	0	0	1	0	0	**2**
	ROUMANIE	0	0	0	0	0	0	0	31	8	13	**52**
	SUEDE	0	0	0	0	1	0	0	0	0	1	**2**
		3	**4**	**1**	**2**	**8**	**3**	**4**	**37**	**19**	**25**	**106**
TOTAL		**9**	**4**	**4**	**8**	**12**	**3**	**4**	**38**	**19**	**25**	**126**

29 – Médecine nucléaire

Médecine nucléaire (en activité régulière)	Diplôme	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Autorisé plein exercice	ROUMANIE				2							2
	sous-total				**2**							**2**
Diplôme d'un pays de la CEE	BELGIQUE	1	1	0		2	2	1	1	1	0	9
	GRECE	0	0	0		0	1	0	0	0	0	1
	ITALIE	1	1	1		0	2	1	0	1	0	7
	ROUMANIE	0	0	0		0	0	0	5	1	1	7
	SLOVAQUIE	0	0	0		0	1	1	0	0	0	2
	sous-total	**2**	**2**	**1**		**2**	**6**	**3**	**6**	**3**	**1**	**26**
TOTAL		**2**	**2**	**1**	**2**	**2**	**6**	**3**	**6**	**3**	**1**	**28**

30 – Médecine physique et de réadaptation

Médecine physique et de réadaptation (en activité régulière)	Diplôme	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Autorisé plein exercice	POLOGNE	1										1
		1										**1**
Diplôme d'un pays de la CEE	BELGIQUE	2		1		2	2	1	2	0	1	**11**
	BULGARIE	0		0		0	0	0	2	0	2	**4**
	ESPAGNE	0		0		0	0	0	0	0	1	**1**
	ITALIE	0		0		1	0	0	0	2	0	**3**
	PORTUGAL	0		0		0	0	0	0	1	0	**1**
	ROUMANIE	0		0		0	0	0	6	3	5	**14**
		2		**1**		**3**	**2**	**1**	**10**	**6**	**9**	**34**
TOTAL		**3**		**1**		**3**	**2**	**1**	**10**	**6**	**9**	**35**

31 – Néphrologie

Néphrologie (en activité régulière)	Diplôme	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Autorisé plein exercice	BULGARIE	0	0	1	0	0						**1**
	PARAGUAY	0	0	0	1	0						**1**
	ROUMANIE	2	3	6	3	5						**19**
		2	**3**	**7**	**4**	**5**						**21**
Diplôme d'un pays de la CEE	ALLEMAGNE	1	0		1	0	0	0	0	0	0	**2**
	BELGIQUE	0	2		1	0	0	1	0	0	0	**4**
	BULGARIE	0	0		0	0	0	0	1	0	2	**3**
	HONGRIE	0	0		0	0	0	0	0	2	0	**2**
	ITALIE	0	0		0	0	1	1	0	0	0	**2**
	POLOGNE	0	0		0	2	0	1	0	0	0	**3**
	ROUMANIE	0	0		0	0	0	0	14	4	5	**23**
	SLOVAQUIE	0	0		0	0	0	0	1	0	0	**1**
		1	**2**		**2**	**2**	**1**	**3**	**16**	**6**	**7**	**40**
NPA (art L 4111-2 1 et 1bis du CSP)	ROUMANIE								1			**1**
									1			**1**
TOTAL		**3**	**5**	**7**	**6**	**7**	**1**	**3**	**17**	**6**	**7**	**62**

32 – Neuro-psychiatrie

Neuro-psychiatrie (en activité régulière)	Diplôme	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Diplôme d'un pays de la CEE	BELGIQUE		1	1		1	1	1	2			7
TOTAL			**1**	**1**		**1**	**1**	**1**	**2**			**7**

33 – Neurochirurgie

Neurochirurgie (en activité régulière)	Diplôme	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Inconnu	ROUMANIE								1			1
	sous-total								**1**			**1**
Autorisé plein exercice	ROUMANIE	1										1
	sous-total	**1**										**1**
Diplôme d'un pays de la CEE	ALLEMAGNE	2	1	0	0	1	0	0	0	0	1	**5**
	AUTRICHE	0	0	0	0	0	0	0	0	0	1	**1**
	BELGIQUE	0	0	1	0	0	0	0	0	0	2	**3**
	ESPAGNE	0	1	0	0	0	0	0	0	0	0	**1**
	GRECE	0	0	0	0	0	0	0	0	1	1	**2**
	ITALIE	0	0	0	1	0	1	1	3	0	0	**6**
	LITUANIE	0	0	0	0	0	0	0	0	0	1	**1**
	POLOGNE	0	0	0	0	0	0	1	0	1	0	**2**
	ROUMANIE	0	0	0	0	0	1	0	4	4	2	**11**
	sous-total	**2**	**2**	**1**	**1**	**1**	**2**	**2**	**7**	**6**	**8**	**32**
TOTAL		**3**	**2**	**1**	**1**	**1**	**2**	**2**	**8**	**6**	**8**	**34**

34 – Neurologie

Neurologie (en activité régulière)	Diplôme	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Autorisé en formation	ROUMANIE							1				1
								1				1
Autorisé Hocsman	REPUBLIQUE TCHEQUE								1			1
									1			1
Autorisé plein exercice	BULGARIE	1		0		1						2
	PARAGUAY	0		1		0						1
	ROUMANIE	1		1		6						8
		2		2		7						11
Diplôme d'un pays de la CEE	ALLEMAGNE	0	1		3	1	3	2	1	1	0	12
	BELGIQUE	0	1		1	2	2	2	0	2	2	12
	BULGARIE	0	0		0	0	0	0	2	1	0	3
	ESPAGNE	1	3		2	0	1	0	0	1	0	8
	GRANDE-BRETAGNE	0	0		0	0	0	1	0	0	0	1
	ITALIE	3	0		1	0	1	0	1	2	7	15
	POLOGNE	0	0		0	1	0	0	2	0	0	3
	REPUBLIQUE TCHEQUE	0	0		0	1	0	0	0	0	0	1
	ROUMANIE	0	0		0	0	0	0	18	7	5	30
		4	5		7	5	7	5	24	14	14	85
NPA (art L 4111-2 1 et 1bis du CSP)	ROUMANIE									1		1
										1		1
TOTAL		6	5	2	7	12	7	6	25	15	14	99

35 – Onco-hématologie

Onco-hématologie (en activité régulière)	Diplôme	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Autorisé plein exercice	ROUMANIE					1						1
						1						1
Diplôme d'un pays de la CEE	ROUMANIE								1			1
									1			1
TOTAL						1			1			2

36 – Oncologie médicale

Oncologie médicale (en activité régulière)	Diplôme	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Autorisé plein exercice	ROUMANIE			1	1	1						**3**
	SLOVAQUIE			1	0	0						**1**
				2	**1**	**1**						**4**
Diplôme d'un pays de la CEE	BELGIQUE	1		0	0	1	0		0		0	**2**
	ITALIE	0		1	1	1	2		3		0	**8**
	ROUMANIE	0		0	0	0	0		10		1	**11**
	SLOVAQUIE	0		0	0	0	1		0		0	**1**
		1		**1**	**1**	**2**	**3**		**13**		**1**	**22**
TOTAL		**1**		**3**	**2**	**3**	**3**		**13**		**1**	**26**

37 – Ophtalmologie

Ophtalmologie (en activité régulière)	Diplôme	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Autorisé plein exercice	GRECE	1	0		0							**1**
	POLOGNE	0	1		0							**1**
	ROUMANIE	3	0		1							**4**
	sous-total	**4**	**1**		**1**							**6**
Diplôme d'un pays de la CEE	ALLEMAGNE	0	1	1	2	0	5	5	1	2	1	**18**
	BELGIQUE	1	2	3	2	4	1	2	3	0	2	**20**
	BULGARIE	0	0	0	0	0	0	0	0	4	2	**6**
	DANEMARK	0	0	0	0	0	0	0	0	1	0	**1**
	ESPAGNE	0	0	0	1	1	0	0	1	1	1	**5**
	ESTONIE	0	0	0	0	0	0	0	0	1	0	**1**
	GRANDE-BRETAGNE	0	0	0	0	0	0	0	0	0	1	**1**
	GRECE	0	0	0	1	1	0	2	0	0	1	**5**
	HONGRIE	0	0	0	0	2	1	1	0	1	0	**5**
	ITALIE	0	0	0	1	3	1	1	1	0	3	**10**
	LETTONIE	0	0	0	0	0	1	0	0	0	0	**1**
	LITUANIE	0	0	0	0	0	1	0	0	0	0	**1**
	POLOGNE	0	0	0	0	1	4	1	5	3	1	**15**
	REPUBLIQUE TCHEQUE	0	0	0	0	0	0	0	1	0	0	**1**
	ROUMANIE	0	0	0	0	0	0	0	20	8	10	**38**
	SLOVAQUIE	0	0	0	0	0	1	0	0	0	0	**1**
	sous-total	**1**	**3**	**4**	**7**	**12**	**15**	**12**	**32**	**21**	**22**	**129**
NPA (art L 4111-2 1 et 1bis du CSP)	ROUMANIE								1		1	**2**
	sous-total								**1**		**1**	**2**
TOTAL		**5**	**4**	**4**	**8**	**12**	**15**	**12**	**33**	**21**	**23**	**137**

38 – ORL

ORL (en activité régulière)	Diplôme	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Autorisé Hocsman	ROUMANIE					1						1
						1						1
Autorisé P.A.C.	ROUMANIE		1									1
			1									1
Autorisé plein exercice	POLOGNE	1										1
	ROUMANIE	1										1
		2										2
Diplôme d'un pays de la CEE	ALLEMAGNE	0	1	1	1	0	1	1	2	0	0	7
	AUTRICHE	1	0	0	0	0	0	0	0	1	0	2
	BELGIQUE	1	1	1	1	1	2	0	1	2	3	13
	BULGARIE	0	0	0	0	0	0	0	0	0	1	1
	ESPAGNE	0	1	0	0	0	0	0	0	0	0	1
	HONGRIE	0	0	0	0	0	0	0	0	1	2	3
	ITALIE	1	0	0	0	0	2	0	1	5	2	11
	LETTONIE	0	0	0	0	0	0	0	0	0	1	1
	LITUANIE	0	0	0	0	0	0	0	0	1	0	1
	POLOGNE	0	0	0	0	0	2	1	1	0	0	4
	ROUMANIE	0	0	0	0	0	0	1	9	3	4	17
		3	3	2	2	1	7	3	14	13	13	61
NPA (art L 4111-2 1 et 1bis du CSP)	BULGARIE								0	1		1
	ROUMANIE								1	0		1
									1	1		2
TOTAL		5	4	2	2	2	7	3	15	14	13	67

39 – Pédiatrie

Pédiatrie (en activité régulière)	Diplôme	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Autorisé P.A.C.	ROUMANIE	1										1
		1										1
Autorisé plein exercice	BULGARIE	1	0	0	0	0			1		0	2
	HONGRIE	0	0	1	0	0			1		0	2
	POLOGNE	1	1	1	1	0			0		0	4
	ROUMANIE	5	1	3	6	4			0		1	20
		7	2	5	7	4			2		1	28
Diplôme d'un pays de la CEE	ALLEMAGNE	2	2	4	5	5	1	7	2	2	5	35
	BELGIQUE	1	5	3	9	3	3	3	4	7	4	42
	BULGARIE	0	0	0	0	0	0	0	1	8	5	14
	ESPAGNE	3	0	0	2	2	1	2	1	0	0	11
	ESTONIE	0	0	0	0	1	0	0	0	0	0	1
	GRANDE-BRETAGNE	0	1	0	0	0	0	0	0	0	1	2
	GRECE	0	1	0	0	2	0	0	0	0	1	4
	HONGRIE	0	0	0	0	0	1	0	1	1	0	3
	IRLANDE	0	0	0	1	0	0	0	0	0	0	1
	ITALIE	1	0	1	0	0	6	2	0	3	2	15
	LETTONIE	0	0	0	0	0	1	0	0	0	0	1
	LITUANIE	0	0	0	0	1	0	0	0	0	0	1
	PAYS-BAS	0	1	0	0	0	1	2	0	0	0	4
	POLOGNE	0	0	0	0	2	2	1	3	0	0	8
	REPUBLIQUE TCHEQUE	0	0	0	0	0	0	3	3	0	0	6
	ROUMANIE	0	0	0	0	1	0	0	28	7	11	47
	SLOVAQUIE	0	0	0	0	0	0	2	0	0	0	2
		7	10	8	17	17	16	22	43	28	29	197
NPA (art L 4111-2 1 et 1bis du CSP)	BELGIQUE					1		0	0		0	1
	BULGARIE					0		0	0		1	1
	GRECE					0		2	0		0	2
	PARAGUAY					0		0	0		1	1
	ROUMANIE					0		0	1		1	2
						1		2	1		3	7
TOTAL		15	12	13	24	22	16	24	46	28	33	233

40 - Pneumologie

Pneumologie (en activité régulière)	Diplôme	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Autorisé P.A.C.	ROUMANIE	1										1
	sous-total	**1**										**1**
Autorisé plein exercice	ROUMANIE	1	2		1	2						6
	sous-total	**1**	**2**		**1**	**2**						**6**
Diplôme d'un pays de la CEE	BELGIQUE	0	0	1	0		1	3	1	0	1	7
	BULGARIE	0	0	0	0		0	0	0	0	1	1
	ESPAGNE	0	0	1	1		0	0	0	0	0	2
	GRANDE-BRETAGNE	0	0	0	0		1	0	0	0	0	1
	GRECE	1	0	0	0		2	0	0	0	0	3
	IRLANDE	0	0	0	0		0	0	0	0	1	1
	ITALIE	0	1	0	1		1	0	0	1	0	4
	ROUMANIE	0	0	0	0		0	0	19	6	11	36
	sous-total	**1**	**1**	**2**	**2**		**5**	**3**	**20**	**7**	**14**	**55**
NPA (art L 4111-2 1 et 1bis du CSP)	LETTONIE								1			1
	sous-total								**1**			**1**
TOTAL		**3**	**3**	**2**	**3**	**2**	**5**	**3**	**21**	**7**	**14**	**63**

41 – Psychiatrie

Psychiatrie (en activité régulière)	Diplôme	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Inconnu	ROUMANIE		1									1
	sous-total		**1**									**1**
Autorisé Hocsman	POLOGNE					1	0					1
	ROUMANIE					0	1					1
	sous-total					**1**	**1**					**2**
Autorisé P.A.C.	ROUMANIE	1	1	1								3
	sous-total	**1**	**1**	**1**								**3**
Autorisé plein exercice	BULGARIE	1	1	0	1	0						3
	HONGRIE	0	0	1	0	0						1
	LETTONIE	0	0	1	0	0						1
	LITUANIE	0	0	1	0	0						1
	POLOGNE	5	2	0	0	0						7
	ROUMANIE	6	6	14	19	15						60
	sous-total	**12**	**9**	**17**	**20**	**15**						**73**
Diplôme d'un pays de la CEE	ALLEMAGNE	2	2	1	1	0	0	0	0	1	0	7
	AUTRICHE	1	0	0	0	0	0	0	0	0	0	1
	BELGIQUE	4	1	2	4	3	3	3	2	0	4	26
	BULGARIE	0	0	0	0	0	0	0	0	5	0	5
	ESPAGNE	1	1	0	1	1	0	0	1	1	2	8
	GRANDE-BRETAGNE	0	1	1	0	0	0	0	0	0	0	2
	GRECE	0	0	0	0	1	0	0	0	0	1	2
	HONGRIE	0	0	0	0	0	0	0	1	0	2	3
	ITALIE	2	1	0	0	1	0	3	1	1	3	12
	LETTONIE	0	0	0	0	1	0	0	0	0	0	1
	LITUANIE	0	0	0	0	0	0	0	0	2	0	2
	PAYS-BAS	0	0	1	0	0	0	0	0	1	1	3
	POLOGNE	0	0	0	0	2	1	2	0	0	0	5
	REPUBLIQUE TCHEQUE	0	0	0	0	0	2	0	0	0	0	2
	ROUMANIE	1	0	1	0	0	2	0	74	11	15	104
	SLOVAQUIE	0	0	0	0	0	0	0	0	0	1	1
	sous-total	**11**	**6**	**6**	**6**	**9**	**8**	**8**	**79**	**22**	**29**	**184**
NPA (art L 4111-2 1 et 1bis du CSP)	LITUANIE			0				0	0	0	1	1
	ROUMANIE			1				2	7	1	2	13
	sous-total			**1**				**2**	**7**	**1**	**3**	**14**
TOTAL		**24**	**17**	**25**	**26**	**25**	**9**	**10**	**86**	**23**	**32**	**277**

42 – Psychiatrie de l'enfant et de l'adolescent

Psychiatrie de l'enfant et de l'adolescent (en activité régulière)	Diplôme	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Autorisé P.A.C.	ROUMANIE	1										1
	sous-total	**1**										**1**
Autorisé plein exercice	ROUMANIE			1		1						2
	sous-total			**1**		**1**						**2**
Diplôme d'un pays de la CEE	ALLEMAGNE	0			0	0	1	1	1	0	0	3
	BELGIQUE	0			0	1	0	1	0	0	0	2
	ITALIE	2			1	0	1	1	0	1	1	7
	LITUANIE	0			0	0	1	0	0	1	0	2
	ROUMANIE	0			0	0	0	0	9	2	2	13
	sous-total	**2**			**1**	**1**	**3**	**3**	**10**	**4**	**3**	**27**
TOTAL		**3**		**1**	**1**	**2**	**3**	**3**	**10**	**4**	**3**	**30**

43 – Radiodiagnostic et imagerie médicale

Radiodiagnostic et imagerie médicale (en activité régulière)	Diplôme	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Autorisé plein exercice	POLOGNE	2	0		0	0						**2**
	REPUBLIQUE TCHEQUE	0	0		1	0						**1**
	ROUMANIE	5	1		1	2						**9**
	sous-total	**7**	**1**		**2**	**2**						**12**
Diplôme d'un pays de la CEE	ALLEMAGNE	0	1	1	1	3	5	2	2	1	1	**17**
	BELGIQUE	5	4	8	11	7	6	7	3	5	7	**63**
	BULGARIE	0	0	0	0	0	0	0	0	2	4	**6**
	ESPAGNE	1	0	1	1	2	0	0	0	1	0	**6**
	GRECE	0	0	1	2	0	0	1	0	0	0	**4**
	HONGRIE	0	0	0	0	2	0	2	0	0	1	**5**
	ITALIE	0	0	0	0	1	1	7	6	8	3	**26**
	LITUANIE	0	0	0	0	0	1	0	0	3	1	**5**
	POLOGNE	0	0	0	0	2	2	1	0	1	1	**7**
	REPUBLIQUE TCHEQUE	0	0	0	0	0	0	0	1	1	0	**2**
	ROUMANIE	0	0	0	0	0	0	0	50	26	21	**97**
	sous-total	**6**	**5**	**11**	**15**	**17**	**15**	**20**	**62**	**48**	**39**	**238**
NPA (art L 4111-2 1 et 1bis du CSP)	POLOGNE								0	1		**1**
	ROUMANIE								1	0		**1**
	sous-total								**1**	**1**		**2**
TOTAL		**13**	**6**	**11**	**17**	**19**	**15**	**20**	**63**	**49**	**39**	**252**

44 – Radiothérapie et onco-radiothérapie

Radiothérapie et onco-radiothérapie (en activité régulière)	Diplôme	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Autorisé plein exercice	BULGARIE	0	1		0	0						1
	POLOGNE	1	0		0	0						1
	ROUMANIE	0	0		1	1						2
		1	1		1	1						4
Diplôme d'un pays de la CEE	ALLEMAGNE	1	0		0	0	0	0	0	0	1	2
	BELGIQUE	1	1		1	2	1	2	1	1	1	11
	ESPAGNE	0	0		1	0	0	0	0	0	0	1
	ITALIE	1	0		0	1	0	0	3	1	2	8
	PAYS-BAS	0	0		0	0	0	1	0	0	0	1
	ROUMANIE	0	0		0	0	0	0	8	5	4	17
	SLOVAQUIE	0	0		0	0	1	0	0	0	0	1
		3	1		2	3	2	3	12	7	8	41
NPA (art L 4111-2 1 et 1bis du CSP)	ESPAGNE										1	1
											1	1
TOTAL		4	2		3	4	2	3	12	7	9	46

45 – Rhumatologie

Rhumatologie (en activité régulière)	Diplôme	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Autorisé plein exercice	POLOGNE	1			0	0						1
	ROUMANIE	0			1	1						2
	sous-total	1			1	1						3
Diplôme d'un pays de la CEE	ALLEMAGNE		0			1		0	0	0		1
	BELGIQUE		0			1		1	0	1		3
	BULGARIE		0			0		0	0	2		2
	ESPAGNE		0			0		0	1	0		1
	ITALIE		1			1		0	0	2		4
	ROUMANIE		0			1		0	6	3		10
	sous-total		1			4		1	7	8		21
TOTAL		1	1		1	5		1	7	8		24

46 – Santé publique et médecine sociale

Santé publique et médecine sociale (en activité régulière)	Diplôme	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Autorisé plein exercice	ROUMANIE				1							**1**
	sous-total				**1**							**1**
Diplôme d'un pays de la CEE	BELGIQUE	1						0	0		0	**1**
	BULGARIE	0						0	0		1	**1**
	ESPAGNE	0						1	0		0	**1**
	GRANDE-BRETAGNE	0						1	0		0	**1**
	ROUMANIE	0						0	2		0	**2**
	sous-total	**1**						**2**	**2**		**1**	**6**
TOTAL		**1**			**1**			**2**	**2**		**1**	**7**

47 – Spécialité médecine générale

Spécialité médecine générale (en activité régulière)	Diplôme	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Autorisé plein exercice	POLOGNE	3	0	0		0						3
	REPUBLIQUE TCHEQUE	1	0	1		1						3
	ROUMANIE	4	1	2		0						7
	sous-total	**8**	**1**	**3**		**1**						**13**
Diplôme d'un pays de la CEE	ALLEMAGNE	4	1	1	2	2	0	3	0	3	1	17
	AUTRICHE	0	0	0	0	0	0	0	0	1	0	1
	BELGIQUE	4	5	5	5	14	7	5	3	9	7	64
	BULGARIE	0	0	0	0	0	0	0	0	2	1	3
	DANEMARK	0	0	1	0	0	0	0	0	0	0	1
	ESPAGNE	1	0	1	5	2	1	1	0	0	1	12
	GRANDE-BRETAGNE	0	0	0	0	2	0	0	0	0	1	3
	GRECE	0	0	1	0	0	0	0	0	0	0	1
	HONGRIE	0	0	0	0	0	0	0	0	0	2	2
	ITALIE	0	1	1	1	3	2	2	1	0	0	11
	PAYS-BAS	0	0	0	0	0	0	1	0	0	0	1
	POLOGNE	0	0	0	0	1	0	0	0	0	0	1
	PORTUGAL	0	0	1	0	0	0	0	0	0	0	1
	REPUBLIQUE TCHEQUE	0	0	0	0	1	0	0	0	0	1	2
	ROUMANIE	0	0	0	0	0	0	0	22	15	20	57
	SUEDE	0	0	1	0	0	0	0	0	0	0	1
	sous-total	**9**	**7**	**12**	**13**	**25**	**10**	**12**	**26**	**30**	**34**	**178**
NPA (art L 4111-2 1 et 1bis du CSP)	BULGARIE								0	0	3	3
	ITALIE								2	1	0	3
	ROUMANIE								1	0	0	1
	SLOVAQUIE								1	0	0	1
	sous-total								**4**	**1**	**3**	**8**
TOTAL		**17**	**8**	**15**	**13**	**26**	**10**	**12**	**30**	**31**	**37**	**199**

48 – Stomatologie

Stomatologie (en activité régulière)	Diplôme	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
Diplôme d'un pays de la CEE	BELGIQUE				1				1			2
TOTAL					**1**				**1**			**2**

CYPRUS

Evaluating the Professional Qualifications Directive
Experience reports from competent authorities

QUESTIONNAIRE FOR THE MEDICAL PROFESSION

A. RECOGNITION PROCEDURE IN CASE OF MIGRATION ON A PERMANENT BASIS

1. Do you accept applications from EU citizens for the recognition of foreign diplomas sent by email or requests made on line? Under which conditions can they send documents and declarations electronically? What are your experiences in this respect?

   We do not accept applications from EU citizens for the recognition of foreign diplomas by email but we accept by mail. Requests for provisional estimation or for the issuance of letter of good standing are accepted. They can send declarations electronically if they have submitted their diplomas at least one time. Very few EU citizens submit declaration electronically.

2. What is the yearly number of positive and negative decisions of recognition from 2000 to 2009? Please submit specific data for applications for automatic recognition based on diplomas, automatic recognition based on acquired rights (as from 2005), and recognition based on the general system[1]. If available, please provide information on the average duration of the recognition process.

   No data are available before 2007. For the year 2008 we had 42 EU citizen registered based on automatic recognition. For the Year 2007 we had 40 EU citizen based on automatic recognition and for the year 2009 we had 49.
   The average duration of the recognition process is 1 month.

3. To what extent have the system of automatic recognition and the general system been a success? How do you see the costs and benefits? Specify in particular whether automatic recognition based on diploma, Annex V and the current notification system represent an efficient way to facilitate automatic recognition. Please submit comments for:

   - automatic recognition based on diploma

   Automatic recognition based on diploma is very successful and reduces both the administrative costs and recognition process.

   - automatic recognition based on acquired rights

   - recognition based on the general system. We have no experience on the general system since the Doctor Profession is a regulated profession in Cyprus.

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[1] Please provide this information unless it has already been provided to the Commission in the Database or the implementation reports.

Please specify whether there are any specific problems with Annex V.

4. Is the general system applied in your country each time the conditions for automatic recognition are not met? Are there major difficulties in the recognition procedure under the general system? Please include any comments you may have on the implementation of compensation measures. Is the migrant given the choice between an aptitude test and an adaptation period or is the choice restricted. Please explain.

   Not applicable

5. What is your experience with the recognition procedure for EU citizens with professional qualifications obtained in a third country and already recognised in a first Member State (see Articles 2(2) and 3(3))?

   Cases are examined carefully. It seems that they try to register first with EU countries that it is easier for them to register and then they use that registration to register in their own country

6. Please describe the government structure of the competent authority or authorities in charge of the recognition.

   There in only a single authority for recognition of diplomas in medicine – The Cyprus Medical Council. Registrar examines the cases and suggest to the independent committee of the CMC. The committee is appointed by the Ministerial Council.

B. TEMPORARY MOBILITY (OF A SELF-EMPLOYED OR AN EMPLOYED WORKER)

7. Are EU citizens interested in using the provisions for exercising their professional activities on a temporary and occasional basis in your Member State? How many citizens used this new system in 2008 and 2009 (per month, per year) [2]?

   There are few EU citizens interested in using the provisions for exercising their professional activities on a temporary and occasional basis in Cyprus mostly EU citizens that they cooperate with Cypriot doctors. For 2008 we had 5 doctors and for 2009 8.

8. How are the provisions of Directive 2005/36/EC concerning temporary mobility applied by the competent authorities in practice taking into account the relevant provisions of the Code of Conduct? For instance:

   - How is the "legal establishment" criteria foreseen by Article 5(1) (a) interpreted in practice? What conditions does a migrant need to fulfil in his home Member State in order to be able to provide services?

     The EU citizen must be able to practice medicine in his own country in order to be able to provide his services in Cyprus.

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[2] Please provide this information unless it has already been provided to the Commission in the Database or the implementation reports.

- How are the "temporary and occasional basis" criteria foreseen by Article 5.2 interpreted in practice? Do Member States assess duration, frequency, regularity and continuity of an activity and if so according to which criteria?

  The temporary and occasional basis depends on the Doctor. The Doctor declare that wants to provide services on a temporary and occasional basis explaining the term i.e. visit Cyprus once a month, operate whenever a case exist etc. If declare this there in no need for registration with the professional association of doctors.

9. Why is a prior declaration system necessary? What do competent authorities do with the information received? Are other possibilities conceivable? Do you have any cases – and if yes how many - whereby doctors sent the declaration after the provision of services has taken place.

   A declaration system is necessary because citizens might want to know if the person who is going to treat them is a doctor or not. There are cases whereby doctors declare after the provision of services has taken place because individuals with health problems invite them to treat them urgently while in hospital.

10. Do you charge any fee in case Article 7, § 4 applies?

    No fees are charged.

C MINIMUM TRAINING REQUIREMENTS

11. To what extent are the common minimum training requirements for specialists and general practitioners set out in Title III Chapter III of Directive 2005/36/EC and as defined in Annex V in line with scientific progress and professional needs? Furthermore, are the knowledge and skills required by the directive still relevant and up to date? Please specify. What about the conditions relating to the duration of training? Do you have many specialties training, which have a common trunk. If yes, please specify which ones.

    Minimum training requirements are still enough to ensure that the competence and skill are at least satisfactory.

12. To what extent are the common minimum requirements for training set out in Title III Chapter III of Directive 2005/36/EC in line with scientific progress and professional needs in the last ten years? Are the knowledge and skills outlined in Article 24.3 still relevant and up to date? Please specify. What about the conditions relating to the duration of training?

    The common minimum requirements for training are today enough.

13. The Directive is based on mutual trust between Member States. To what extent is such trust actually achieved? Are training programmes accredited in your country? Does accreditation of a training program in another Member State enhance trust or is it not relevant?

Actually Cyprus in based on mutual trust between Member States because there in not yet Medical School or accredited body for the accreditation of training program and is entirely depends on mutual trust.

14. To what extent are the existing Directive provisions (see recital 39 and Article 22(b) on continuous professional development (continuous training) adequate? Is continuous training mandatory in your country and what are the exact conditions?

Continuous training for Doctors is not mandatory in Cyprus because the registration is done once for the whole life but the CMC examine the case of mandatory training as soon as the Medical University will establish (year 2012).

D. ADMINISTRATIVE COOPERATION

15. To which extent does administrative cooperation, as outlined in Articles 8, 50, and 56 of the Directive, simplify procedures for the migrant professionals?

Administrative cooperation simplifies procedures for the migrant professionals and eliminates time for the examination of a case

16. Is the competent authority in your country registered with IMI? Under which circumstances does your competent authority use IMI? If not registered, why not and what would be the conditions for changing this situation?

CMC is register with IMI and when something is not easy to clarify from document I MI is used to communicate with other competent authority.

17. How could a professional card (see Recital 32 of the Directive) facilitate recognition of professional qualifications and provision of temporary services? Under which conditions could it be issued by professional associations?

We have no experience with the use of a professional card for the provision of temporary services but although it will simplify procedures we might face the problem that citizens might not have the ability to check whether the professional card valid or not or issued by the appropriate authority. It is risky. Professional association could issued that card as long as they register with them after the registration with the Medical Council

18. Are you alerted by other Member States in case of disciplinary action or criminal sanctions taken or any other serious, specific circumstances which are likely to have consequences for the pursuit of activities under this Directive? How do you share this information? Could more be done in this respect?

We are not alerted and we don't share this kind of information with other countries. If a citizen is register with the CMC and wants to register and practice in other country we provide him/her accordingly with the letter of good standing.

E. OTHER OBSERVATIONS

19. How and when are the necessary language skills of migrants checked after recognition of the professional qualifications? Are you aware of any complaints (especially from patients/clients/employers) about insufficient language skills of migrants?

The necessary language skill of migrants is checked before recognition of the professional qualifications with an interview by the council.

20. Does the application of Article 30 raise any specific problems?

It doesn't raise specific problems.

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LATVIA

Evaluating the Professional Qualifications Directive
Experience reports from competent authorities

QUESTIONNAIRE FOR THE MEDICAL PROFESSION

A. RECOGNITION PROCEDURE IN CASE OF MIGRATION ON A PERMANENT BASIS

1. Do you accept applications from EU citizens for the recognition of foreign diplomas sent by email or requests made on line? Under which conditions can they send documents and declarations electronically? What are your experiences in this respect?

   No. Latvia does not accept applications sent electronically.

2. What is the yearly number of positive and negative decisions of recognition from 2000 to 2009? Please submit specific data for applications for automatic recognition based on diplomas, automatic recognition based on acquired rights (as from 2005), and recognition based on the general system[1]. If available, please provide information on the average duration of the recognition process.

Year	number	profession	Decision	Based of ...
2008.	3	doctors	Positive	acquired rights
2008.	1	dentist	Positive	acquired rights
2008.	3	dentists	Positive	diplomas
2009.	1	dentist	Positive	diplomas
2009.	4	doctors	Positive	acquired rights
2009.	1	doctor	Positive	diplomas

3. To what extent have the system of automatic recognition and the general system been a success? How do you see the costs and benefits? Specify in particular whether automatic recognition based on diploma, Annex V and the current notification system represent an efficient way to facilitate automatic recognition. Please submit comments for:

   - automatic recognition based on diploma
   - automatic recognition based on acquired rights
   - recognition based on the general system.

[1] Please provide this information unless it has already been provided to the Commission in the Database or the implementation reports.

Please specify whether there are any specific problems with Annex V.

No comment.

4. Is the general system applied in your country each time the conditions for automatic recognition are not met?

Yes.

Are there major difficulties in the recognition procedure under the general system?

No.

Please include any comments you may have on the implementation of compensation measures. Is the migrant given the choice between an aptitude test and an adaptation period or is the choice restricted. Please explain.

We had not such cases. In accordance with the law we should give to the migrant the choice between an aptitude test and an adaptation period.

5. What is your experience with the recognition procedure for EU citizens with professional qualifications obtained in a third country and already recognised in a first Member State (see Articles 2(2) and 3(3))?

We had not such cases.

6. Please describe the government structure of the competent authority or authorities in charge of the recognition.

Latvian Medical Association is the competent authority for doctors and dentists. Recognition is made in 2 steps: 1) by the Academic Information Centre; 2) by the Latvian Medical association (final decision). Regarding recognition both of organizations are subordinated to the Ministry of the Education and Science.

B. TEMPORARY MOBILITY (OF A SELF-EMPLOYED OR AN EMPLOYED WORKER)

7. Are EU citizens interested in using the provisions for exercising their professional activities on a temporary and occasional basis in your Member State? How many citizens used this new system in 2008 and 2009 (per month, per year) [2]?

2008 – 1 per year
2009 – 8 per year

8. How are the provisions of Directive 2005/36/EC concerning temporary mobility applied by the competent authorities in practice taking into account the relevant provisions of the Code of Conduct? For instance:

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[2] Please provide this information unless it has already been provided to the Commission in the Database or the implementation reports.

- How is the "legal establishment" criteria foreseen by Article 5(1) (a) interpreted in practice? What conditions does a migrant need to fulfil in his home Member State in order to be able to provide services?

  He/she should have MD or dentist's diploma, licence to practice in home Member State and good standing in home Member State.

- How are the "temporary and occasional basis" criteria foreseen by Article 5.2 interpreted in practice? Do Member States assess duration, frequency, regularity and continuity of an activity and if so according to which criteria?

  We ask doctor or dentist to explain about duration, frequency, regularity and continuity of his professional activity, but there is no clear written criteria (except duration – until 1 year), when we should allow and when no. Until now we allowed in all cases.

9. Why is a prior declaration system necessary? What do competent authorities do with the information received?

   Yes, this is necessary to know about planned activities.

Are other possibilities conceivable? Do you have any cases – and if yes how many - whereby doctors sent the declaration after the provision of services has taken place.

We had not such cases.

10. Do you charge any fee in case Article 7, § 4 applies?

    No.

C MINIMUM TRAINING REQUIREMENTS

11. To what extent are the common minimum training requirements for specialists and general practitioners set out in Title III Chapter III of Directive 2005/36/EC and as defined in Annex V in line with scientific progress and professional needs? Furthermore, are the knowledge and skills required by the directive still relevant and up to date? Please specify. What about the conditions relating to the duration of training? Do you have many specialties training, which have a common trunk. If yes, please specify which ones.

    No comment.

12. To what extent are the common minimum requirements for training set out in Title III Chapter III of Directive 2005/36/EC in line with scientific progress and professional needs in the last ten years? Are the knowledge and skills outlined in Article 24.3 still relevant and up to date? Please specify. What about the conditions relating to the duration of training?

    No comment.

13. The Directive is based on mutual trust between Member States. To what extent is such trust actually achieved?

Are training programmes accredited in your country?

Yes.

Does accreditation of a training program in another Member State enhance trust or is it not relevant?

This is relevant.

14. To what extent are the existing Directive provisions (see recital 39 and Article 22(b) on continuous professional development (continuous training) adequate?

Is continuous training mandatory in your country and what are the exact conditions?

Yes, continuous training is mandatory to get certificate/licence to practice.

D. ADMINISTRATIVE COOPERATION

15. To which extent does administrative cooperation, as outlined in Articles 8, 50, and 56 of the Directive, simplify procedures for the migrant professionals?

It helps very much. As well we can get more credible information. This is very important to simplify procedure for specialist's temporary registration. Problems we had only in case, if the competent authority has not access to the information that we need (e.g. Italian competent authority, reached via IMI, had no information about doctors' good standing and licence to practice in Italy).

16. Is the competent authority in your country registered with IMI?

Yes.

Under which circumstances does your competent authority use IMI?

Mostly regarding specialists, who apply for temporary activities.

17. How could a professional card (see Recital 32 of the Directive) facilitate recognition of professional qualifications and provision of temporary services? Under which conditions could it be issued by professional associations?

It could be issued by the competent authority to doctors, specialists, general practitioners and dentists who want to migrate from home Member State for any professional activities (temporary or regular) abroad.

18. Are you alerted by other Member States in case of disciplinary action or criminal sanctions taken or any other serious, specific circumstances which are likely to have consequences for the pursuit of activities under this Directive? How do you share this information? Could more be done in this respect?

Information about disciplinary actions we have been received from Malta, Ireland and UK. We check this information when a specialist wants to register in Latvia.

E. OTHER OBSERVATIONS

19. How and when are the necessary language skills of migrants checked after recognition of the professional qualifications? Are you aware of any complaints (especially from patients/clients/employers) about insufficient language skills of migrants?

Language skills of migrants from EU countries are checked by employer. For migrants from third countries first indirect checking is during an aptitude test, which should be held in Latvian.

20. Does the application of Article 30 raise any specific problems?

No.

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LITHUANIA

Evaluating the Professional Qualifications Directive
Experience reports from competent authorities

QUESTIONNAIRE FOR THE MEDICAL PROFESSION

LITHUANIA

A. RECOGNITION PROCEDURE IN CASE OF MIGRATION ON A PERMANENT BASIS

1. Do you accept applications from EU citizens for the recognition of foreign diplomas sent by email or requests made on line? Under which conditions can they send documents and declarations electronically? What are your experiences in this respect?

We can not could accept applications from EU citizens by email.

2. What is the yearly number of positive and negative decisions of recognition from 2000 to 2009? Please submit specific data for applications for automatic recognition based on diplomas, automatic recognition based on acquired rights (as from 2005), and recognition based on the general system[1]. If available, please provide information on the average duration of the recognition process.

We had applications for recognition:
2007 year one for automatic recognition based on acquired rights;
2009 year one for automatic recognition based on diploma.
The average duration of the process for both automatic and general systems from 1 month till 3 months

3. To what extent have the system of automatic recognition and the general system been a success? How do you see the costs and benefits? Specify in particular whether automatic recognition based on diploma, Annex V and the current notification system represent an efficient way to facilitate automatic recognition. Please submit comments for:

   - automatic recognition based on diploma
   - automatic recognition based on acquired rights
   - recognition based on the general system.

   Please specify whether there are any specific problems with Annex V.
   Low experience and couldn't submit comments.

4. Is the general system applied in your country each time the conditions for automatic recognition are not met? Are there major difficulties in the recognition procedure under the

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1 Please provide this information unless it has already been provided to the Commission in the Database or the implementation reports.

general system? Please include any comments you may have on the implementation of compensation measures. Is the migrant given the choice between an aptitude test and an adaptation period or is the choice restricted. Please explain.

Low experience and couldn't submit comments.

5. What is your experience with the recognition procedure for EU citizens with professional qualifications obtained in a third country and already recognised in a first Member State (see Articles 2(2) and 3(3))?

We haven't such applicants from EU citizens who obtained qualification in a third country and already recognized in a first Member State.
We will accept recognized procedure, if person present to us certificate according Article 3(3).

6. Please describe the government structure of the competent authority or authorities in charge of the recognition.

Structure of competent authority:
Ministry of Health of the Republic of Lithuania
Personal Health Care Department
Health Care Resources Management Division
Responsible person: Jonas Bartlingas (Head of the division)

B. TEMPORARY MOBILITY (OF A SELF-EMPLOYED OR AN EMPLOYED WORKER)

7. Are EU citizens interested in using the provisions for exercising their professional activities on a temporary and occasional basis in your Member State? How many citizens used this new system in 2008 and 2009 (per month, per year) [2]?

Yes. This system used only two EU citizens in 2009.

8. How are the provisions of Directive 2005/36/EC concerning temporary mobility applied by the competent authorities in practice taking into account the relevant provisions of the Code of Conduct? For instance:

   - How is the "legal establishment" criteria foreseen by Article 5(1) (a) interpreted in practice? What conditions does a migrant need to fulfil in his home Member State in order to be able to provide services?

   - How are the "temporary and occasional basis" criteria foreseen by Article 5.2 interpreted in practice? Do Member States assess duration, frequency, regularity and continuity of an activity and if so according to which criteria?

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[2] Please provide this information unless it has already been provided to the Commission in the Database or the implementation reports.

The migrant have legally provided his services in his home Member State.
In Lithuania are assessed all criteria: duration, frequency, regularity and continuity.

9. Why is a prior declaration system necessary? What do competent authorities do with the information received? Are other possibilities conceivable? Do you have any cases – and if yes how many - whereby doctors sent the declaration after the provision of services has taken place.

Competent authority received information storages, share this information with supervisory institutions.

10. Do you charge any fee in case Article 7, § 4 applies?

C MINIMUM TRAINING REQUIREMENTS

11. To what extent are the common minimum training requirements for specialists and general practitioners set out in Title III Chapter III of Directive 2005/36/EC and as defined in Annex V in line with scientific progress and professional needs? Furthermore, are the knowledge and skills required by the directive still relevant and up to date? Please specify. What about the conditions relating to the duration of training? Do you have many specialties training, which have a common trunk. If yes, please specify which ones.

Lithuania harmonizes all training programs to the Directives before entry to EU and they are in line of scientific progress. The duration of all training programs are harmonized also.

12. To what extent are the common minimum requirements for training set out in Title III Chapter III of Directive 2005/36/EC in line with scientific progress and professional needs in the last ten years? Are the knowledge and skills outlined in Article 24.3 still relevant and up to date? Please specify. What about the conditions relating to the duration of training?

Lithuania is member of EU only 5 years and we have any comment to this question.

13. The Directive is based on mutual trust between Member States. To what extent is such trust actually achieved? Are training programmes accredited in your country? Does accreditation of a training program in another Member State enhance trust or is it not relevant?

Lithuania trusts other Member State fully. Training programs are accredited by Centre for Quality Assessment in Higher Education (CQAHE) of Lithuania (http://www.skvc.lt/en/?id=0). This center also evaluates training programs accredited in another Member State under suspicion.

14. To what extent are the existing Directive provisions (see recital 39 and Article 22(b) on continuous professional development (continuous training) adequate? Is continuous training mandatory in your country and what are the exact conditions?

The continuous training is mandatory in Lithuania and during 5 year each medical doctor has to collect 120 hours of continuous training.

D. ADMINISTRATIVE COOPERATION

15. To which extent does administrative cooperation, as outlined in Articles 8, 50, and 56 of the Directive, simplify procedures for the migrant professionals?

The competent authority of Lithuania cooperates with other EU competent authorities and exchange required and wanted information.

16. Is the competent authority in your country registered with IMI? Under which circumstances does your competent authority use IMI? If not registered, why not and what would be the conditions for changing this situation?

The Ministry of Health is registered with IMI. Mostly uses IMI for answers to inquiries of competent authorities of the other Member States.

17. How could a professional card (see Recital 32 of the Directive) facilitate recognition of professional qualifications and provision of temporary services? Under which conditions could it be issued by professional associations?

a) Professional card would facilitate and accelerate the movement of specialists. Depending on the provisions of data security, professional card could provide information about specialists' professional qualifications (graduated university or other institution, acquired qualification, professional experience), legal location of self-establishment, imposed penalties associated with his/her profession and data about correspondent's competent authority.
b) Professional associations could issue professional cards if the functions of issuing professional cards were delegated to them by the State.

18. Are you alerted by other Member States in case of disciplinary action or criminal sanctions taken or any other serious, specific circumstances which are likely to have consequences for the pursuit of activities under this Directive? How do you share this information? Could more be done in this respect?

We can share information about suspensions/restrictions in our country with competent authorities in other Member States by post. We had not suspensions/restrictions for medical practitioners according court decision.

E. OTHER OBSERVATIONS

19. How and when are the necessary language skills of migrants checked after recognition of the professional qualifications? Are you aware of any complaints (especially from patients/clients/employers) about insufficient language skills of migrants?

Language skills of migrants usually are checked by employer. We haven't such complaints regarding insufficient language skills of migrants.

20. Does the application of Article 30 raise any specific problems?

No.

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LUXEMBOURG

Evaluating the Professional Qualifications Directive
Experience reports from competent authorities

QUESTIONNAIRE FOR THE MEDICAL PROFESSION

A. RECOGNITION PROCEDURE IN CASE OF MIGRATION ON A PERMANENT BASIS

1. Do you accept applications from EU citizens for the recognition of foreign diplomas sent by email or requests made on line? Under which conditions can they send documents and declarations electronically? What are your experiences in this respect?

   We accept applications sent on line or by email. However some documents have to be send as originals such as the signed request the police record or the certificate of good standing issued by the Medical Council with the written request. Until now we had no negative experiences.

2. What is the yearly number of positive and negative decisions of recognition from 2000 to 2009? Please submit specific data for applications for automatic recognition based on diplomas, automatic recognition based on acquired rights (as from 2005), and recognition based on the general system[1]. If available, please provide information on the average duration of the recognition process.

   Luxembourg can only give data on the number of positive recognitions. All the recognitions are based on diplomas or acquired rights as we are unable to make recognitions based on the general system. (cf question 3). The average duration of the recognition process is about one to two months.

   2000 32
   2001 45
   2002 51
   2003 73
   2004 62
   2005 73
   2006 134
   2007 152
   2008 138
   2009 152

3. To what extent have the system of automatic recognition and the general system been a success? How do you see the costs and benefits? Specify in particular whether automatic recognition based on diploma, Annex V and the current notification system represent an efficient way to facilitate automatic recognition. Please submit comments for:

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[1] Please provide this information unless it has already been provided to the Commission in the Database or the implementation reports.

- automatic recognition based on diploma
- automatic recognition based on acquired rights
- recognition based on the general system.

Please specify whether there are any specific problems with Annex V.

- **Recognition based on diplomas**

Until now we had no major problems applying the recognition based on diplomas. It allows persons with diplomas mentioned in Annexe V of the directive to get in a short time a recognition of his diploma. Problems appeared when member states changed diplomas without notifying this change to the Commission at all or in due time.

- **Recognition based on acquired rights.**

Until now we had no major problems applying the recognition based on acquired rights.

- **Recognition based on the general system**

The Luxembourg authorities are unable to make recognitions based on the general system as we have neither basic medical education nor specialized training and thus no criteria to evaluate in the frame of general system.

4. Is the general system applied in your country each time the conditions for automatic recognition are not met? Are there major difficulties in the recognition procedure under the general system? Please include any comments you may have on the implementation of compensation measures. Is the migrant given the choice between an aptitude test and an adaptation period or is the choice restricted. Please explain.

   Luxembourg does not apply the general system for the reasons mentioned above.

5. What is your experience with the recognition procedure for EU citizens with professional qualifications obtained in a third country and already recognised in a first Member State (see Articles 2(2) and 3(3))?

   Luxembourg accepts diplomas issued in a third country if the diploma has been recognized in another member state and if the holder of the diploma has a professional experience of three years in the country that has recognized the diploma.

6. Please describe the government structure of the competent authority or authorities in charge of the recognition.

   The Ministry of Health in Luxembourg is the competent authority to recognize medical diplomas.

B. TEMPORARY MOBILITY (OF A SELF-EMPLOYED OR AN EMPLOYED WORKER)

7. Are EU citizens interested in using the provisions for exercising their professional activities on a temporary and occasional basis in your Member State? How many citizens used this new system in 2008 and 2009 (per month, per year) [2]?

   EU citizens are interested in using the provisions for exercising their professional activities on a temporary and occasional basis in Luxembourg. 54 professionals used this system in the year 2008 and 49 professionals used it in the year 2009.

8. How are the provisions of Directive 2005/36/EC concerning temporary mobility applied by the competent authorities in practice taking into account the relevant provisions of the Code of Conduct? For instance:

   - How is the "legal establishment" criteria foreseen by Article 5(1) (a) interpreted in practice? What conditions does a migrant need to fulfil in his home Member State in order to be able to provide services?

The criteria is analysed individually for every application. The migrant must hold an authorization to practice in his country

   - How are the "temporary and occasional basis" criteria foreseen by Article 5.2 interpreted in practice? Do Member States assess duration, frequency, regularity and continuity of an activity and if so according to which criteria?

These criteria are reviewed on a case-by-case basis, by taking into account the individual characteristics of the service provision

9. Why is a prior declaration system necessary? What do competent authorities do with the information received? Are other possibilities conceivable? Do you have any cases – and if yes how many - whereby doctors sent the declaration after the provision of services has taken place.

   The prior declaration system is necessary for the patient's safety. It is also necessary for the patient who wants to be refunded by the social security.
   The competent authority forwards information about provisions of services to the social security authiorities. The provisions of services are mentioned and listed in a specific register.

   Until now we had no cases of ex post declarations.

10. Do you charge any fee in case Article 7, § 4 applies?

    We don't charge fees in case article 7, § 4 applies.

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[2] Please provide this information unless it has already been provided to the Commission in the Database or the implementation reports.

C MINIMUM TRAINING REQUIREMENTS

11. To what extent are the common minimum training requirements for specialists and general practitioners set out in Title III Chapter III of Directive 2005/36/EC and as defined in Annex V in line with scientific progress and professional needs? Furthermore, are the knowledge and skills required by the directive still relevant and up to date? Please specify. What about the conditions relating to the duration of training? Do you have many specialties training, which have a common trunk. If yes, please specify which ones.

    As Luxembourg has no fully fledged medical education it is unable to judge the level of knowledge and duration of training.

12. To what extent are the common minimum requirements for training set out in Title III Chapter III of Directive 2005/36/EC in line with scientific progress and professional needs in the last ten years? Are the knowledge and skills outlined in Article 24.3 still relevant and up to date? Please specify. What about the conditions relating to the duration of training?

    As Luxembourg has no fully fledged medical education it is unable to judge the level of knowledge and duration of training.

13. The Directive is based on mutual trust between Member States. To what extent is such trust actually achieved? Are training programmes accredited in your country? Does accreditation of a training program in another Member State enhance trust or is it not relevant?

    As we have no fully fledged medical education we rely on the expertise of other member states. For instance as we do not apply the general system, we recommend the holder of a diploma not mentioned in Annexe V to ask a recognition of his diploma in another member state. This recognition will then be used in his application.

14. To what extent are the existing Directive provisions (see recital 39 and Article 22(b) on continuous professional development (continuous training) adequate? Is continuous training mandatory in your country and what are the exact conditions?

    Continuous training is mandatory in Luxembourg but until now it is not evaluated and there is no supervision of this training.

D. ADMINISTRATIVE COOPERATION

15. To which extent does administrative cooperation, as outlined in Articles 8, 50, and 56 of the Directive, simplify procedures for the migrant professionals?

    The administrative cooperation between member states is of great importance for the migrant professional and the competent authorities. It facilitates and fastens the recognition procedure.

16. Is the competent authority in your country registered with IMI? Under which circumstances does your competent authority use IMI? If not registered, why not and what would be the conditions for changing this situation?

    Our competent authority is registered to IMI. It is used if there are any doubts about a diploma or another certificate.

17. How could a professional card (see Recital 32 of the Directive) facilitate recognition of professional qualifications and provision of temporary services? Under which conditions could it be issued by professional associations?

    A professional card on EU level could improve and facilitate the recognition of professional qualifications. However this card should be issued by the competent authority.

18. Are you alerted by other Member States in case of disciplinary action or criminal sanctions taken or any other serious, specific circumstances which are likely to have consequences for the pursuit of activities under this Directive? How do you share this information? Could more be done in this respect?

    Only some few countries send us information in case of disciplinary actions. We never get information on criminal sanctions.

    Luxembourg gives information in case of disciplinary actions to the competent authorities of the neighbouring countries.

    In our opinion improvements in this field have to be done. For instance it would be useful to identify the competent authority in each member state in this field.

E. OTHER OBSERVATIONS

19. How and when are the necessary language skills of migrants checked after recognition of the professional qualifications? Are you aware of any complaints (especially from patients/clients/employers) about insufficient language skills of migrants?

    The language skills of migrants are not checked on a regular base but only if there is a doubt.

    As the density of migrant doctors is rather high in Luxembourg we hear many patients who feel uncomfortable if they cannot communicate in there native language. This is especially true in emergency cases or other situations where the patient does not have the free choice of his doctor.

    This is in particular true for elderly people who have problems to communicate in a foreign language. Further more communication between healthcare professionals of different nationalities can be difficult because of the high density of migrant workers.

20. Does the application of Article 30 raise any specific problems?

Until now we had no problem applying article 30.

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HUNGARY

National implementation report for EU Directive 2005/36/EC

Medical profession

Country: **Hungary**

Organisation: Office of Health Authorisation and Administrative Procedures

The Office is responsible for the recognition of the foreign healthcare diplomas and qualifications and the registration of all the healthcare professionals.

The Office's website: www.eekh.hu

Contact details: Dr. András Zsigmond
Head of department
zsigmond.andras@eekh.hu / recognition@eekh.hu
0036-1-235-79-65

Evaluating the Professional Qualifications Directive
Experience reports from competent authorities

QUESTIONNAIRE FOR THE MEDICAL PROFESSION

A. RECOGNITION PROCEDURE IN CASE OF MIGRATION ON A PERMANENT BASIS

1. Do you accept applications from EU citizens for the recognition of foreign diplomas sent by email or requests made on line? Under which conditions can they send documents and declarations electronically? What are your experiences in this respect?

The application form can be submitted electronically as well.
The certified copies and official translations of the documents should be submitted by post, or personally. According to our experiences, our clients like the possibility of the personal consult at least when they do their application.

2. What is the yearly number of positive and negative decisions of recognition from 2000 to 2009? Please submit specific data for applications for automatic recognition based on diplomas, automatic recognition based on acquired rights (as from 2005), and recognition based on the general system[1]. If available, please provide information on the average duration of the recognition process.

Applications					
2007		2008		2009	
EEA	3rd countries	EEA	3rd countries	EEA	3rd countries
116	8	62	3	42	5

Positive decisions					
2007		2008		2009	
EEA	3rd countries	EEA	3rd countries	EEA	3rd countries
109	7	59	1	42	6

Negative decisions					
2007		2008		2009	
EEA	3rd countries	EEA	3rd countries	EEA	3rd countries
0	0	0	0	0	0

In case of the recognitions falling under the general system, the procedure (strictly the administrative procedure) takes maximum 3 months, which can be lengthened once with 22 working days if necessary. However this doesn't mean that we can issue the decision on the

[1] Please provide this information unless it has already been provided to the Commission in the Database or the implementation reports.

recognition within this period, because in case the applicant is to take an aptitude test or an adaptation period, we make a preliminary decision in which we put a deadline for the fulfilment on the condition (this depends on the length of the adaptation period or the content of the test).

3. To what extent have the system of automatic recognition and the general system been a success? How do you see the costs and benefits? Specify in particular whether automatic recognition based on diploma, Annex V and the current notification system represent an efficient way to facilitate automatic recognition. Please submit comments for:

    - automatic recognition based on diploma

This possibility simplifies the procedures also for the applicants, but for the competent authorities as well. It is a very simple procedure, if the denomination, reference date and other conditions are met.

    - automatic recognition based on acquired rights

Though the Directive's general aspect is built on the mutual trust between the competent authorities, we find the most problems concerning the certificate of acquired rights, mostly in the cases where the professional's residence MS (or his/her pursue of the medical activity) has changed several times during the last five years period.

In the Directive, it is not regulated that during the three consecutive years in the last five years in how many hours the applicant has to work in order to be able to apply for the certificate of acquired rights. (it is an extreme example, but it is possible to benefit the acquired rights even if the professional pursues his/her activities just 1 hour monthly).

We also had some problems with the interpretation of the criteria "effective and lawful practice" laid down in Article 23.1.

According to Articles 110-113. of Act CLIV of 1997 on Health (our national legislation), we have two registers of the healthcare professionals: basic register and operational registry.

Basic register functions as a register of the qualifications, which means that all the healthcare qualifications obtained/recognised (or formerly nostrificated) in Hungary are registered automatically in the basic register.

It is a requirement in case of all the regulated professions that the professional (and his/her qualification) is registered in the basic register (which means he/she holds a valid qualification).It is in accordance with Article 1 of the Directive.

The healthcare activity concerned can be pursued in Hungary with or without supervision.

The registration into the operational registry is upon the application of the professional. The registration period is valid for 5 years and can be renewed if the professional satisfies the requirements (collect points on practical and theoretical CPD activities etc.)

The valid operational registration is a condition on the pursuit of the healthcare activity without supervision. But according to the abovementioned legislation it is also possible to practise the healthcare activity with supervision if the professional does not hold a valid operational legislation.

The Commission has informed us, that according to their interpretation if in Hungary only professionals who are registered in the so called "operational registry" can exercise independently all the activities of the profession in question, only their professional experience can be considered as an "effective and lawful practice" of a profession in the sense of Article 23(1) of the Directive, and only they can receive a certificate on the effective and lawful exercise of the profession.

- recognition based on the general system.

This system works well, because we can examine the training requirements directly. Sometimes it is hard to find out if a profession is regulated profession in the Member State of origin or not.

Please specify whether there are any specific problems with Annex V.

With the Communications made by the Commission upon the national notifications it is easy to modify the Annex.

4. Is the general system applied in your country each time the conditions for automatic recognition are not met? Are there major difficulties in the recognition procedure under the general system? Please include any comments you may have on the implementation of compensation measures. Is the migrant given the choice between an aptitude test and an adaptation period or is the choice restricted. Please explain.

In all cases where not all the conditions for the automatic recognition are met we apply the general system for the procedures. When it is necessary we ask our national experts to examine the training requirements/professional experiences of the applicant, and we decide in a preliminary decision (in aware of the expert's opinion) about the conditions of the recognition. We always put a deadline to complete the conditions and inform the applicant about all the necessary information in the decision itself.

In cases falling under the effect of the general system, the applicant always has the possibility to choose between the aptitude test and the adaptation period.

We haven't got any negative feedback concerning nor the aptitude test nor the adaptation period, in some cases the applicant's had problems with their completion because they didn't have the sufficient knowledge of language.

5. What is your experience with the recognition procedure for EU citizens with professional qualifications obtained in a third country and already recognised in a first Member State (see Articles 2(2) and 3(3))?

We've some experiences in case of applicants with EU citizenship who obtained their qualifications in non member states, but recognised/nostrificated them in Hungary and wish to move to another MS. we usually issue them certificates which attest the lawful and effective pursuit of the activity concerned.

From the other side we do not have too many experiences.

6. Please describe the government structure of the competent authority or authorities in charge of the recognition.

The Office of Health Authorisation and Administrative Procedures was founded on 1st April 2003 by the Government in accordance with Hungary's preparation to join the European Union. The Office is an independent centralised national authority, with national competences regarding different administrative matters. Our Office works under the supervision of the Minister of Health.
The Department of Migration and Monitoring works - amongst others - as the Hungarian competent authority with regards to 2005/36/EC Directive on the recognition of professional qualifications for medical professional qualifications:
- this department is responsible for the recognition of most of the foreign medical professional qualifications (EEA countries and non EEA countries)
- it issues different kinds of certificates that are necessary for the recognition of the Hungarian medical professional qualifications in other countries
- it shares information concerning the conditions of the recognition and registration with other competent authorities.

The Office is also responsible for the registration: we have a so-called basic register (diploma register) and an operational registry.

A healthcare professional can only practice his/her medical activities in Hungary without supervision, if he/she holds a valid operational registration, otherwise he/she can only practise the activities under supervision.

The national coordinator and the contact point in Hungary is the Educational Authority/Hungarian Equivalence and Information Center.

B. TEMPORARY MOBILITY (OF A SELF-EMPLOYED OR AN EMPLOYED WORKER)

7. Are EU citizens interested in using the provisions for exercising their professional activities on a temporary and occasional basis in your Member State? How many citizens used this new system in 2008 and 2009 (per month, per year) [2]?

We only had some queries from doctors from the neighbouring countries, but no applications or statements were submitted in 2009.

These quieries were mainly related to organ transplant projects, or the activities of guest teachers.

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[2] Please provide this information unless it has already been provided to the Commission in the Database or the implementation reports.

8. How are the provisions of Directive 2005/36/EC concerning temporary mobility applied by the competent authorities in practice taking into account the relevant provisions of the Code of Conduct? For instance:

   - How is the "legal establishment" criteria foreseen by Article 5(1) (a) interpreted in practice? What conditions does a migrant need to fulfil in his home Member State in order to be able to provide services?

   - How are the "temporary and occasional basis" criteria foreseen by Article 5.2 interpreted in practice? Do Member States assess duration, frequency, regularity and continuity of an activity and if so according to which criteria?

We do not have too many experiences concerning temporary mobility.

9. Why is a prior declaration system necessary? What do competent authorities do with the information received? Are other possibilities conceivable? Do you have any cases – and if yes how many - whereby doctors sent the declaration after the provision of services has taken place.

As the number of the notifications concerning temporary mobility is very low, we think that the service providers do not always inform us about their service. The reason might be that they do not know about this obligation, or they find that the procedure is too complicated.

In case of healthcare we think the prior declaration/notification would be essential, because it could only guarantee the supervision of the service, and all the information could be provided concerning it later on, in case of any problems with it.

The system could work more efficiently, if its enforcement was more efficient, like developing some kind of common sanctions in case of not complying with the requirement of prior declaration.

10. Do you charge any fee in case Article 7, 4 applies?

We do not charge any fees.

C MINIMUM TRAINING REQUIREMENTS

11. To what extent are the common minimum training requirements for specialists and general practitioners set out in Title III Chapter III of Directive 2005/36/EC and as defined in Annex V in line with scientific progress and professional needs? Furthermore, are the knowledge and skills required by the directive still relevant and up to date? Please specify. What about the conditions relating to the duration of training? Do you have many specialties training, which have a common trunk. If yes, please specify which ones.

We suggest to keep the minimum requirements as simple as possible, but on the other hand they can be able to safeguard patient safety.

12. To what extent are the common minimum requirements for training set out in Title III Chapter III of Directive 2005/36/EC in line with scientific progress and professional needs in the last ten years? Are the knowledge and skills outlined in Article 24.3 still relevant and up to date? Please specify. What about the conditions relating to the duration of training?

The regulation is good, but we suggest that just the minimum requirements shall be regulated in the Directive.

13. The Directive is based on mutual trust between Member States. To what extent is such trust actually achieved? Are training programmes accredited in your country? Does accreditation of a training program in another Member State enhance trust or is it not relevant?

When we ask, or provide information concerning the recognition of professional qualifications we have experienced that the mutual trust exists. We found that the competent authorities can work effectively together mostly on a case-by-case basis.

We just had some problems concerning the certificates of acquired rights as mentioned previously.

We also have some problems with countries where the competent authorities are organized on territorial basis because it is sometimes very hard to find out who to ask to get the relevant information.

We exchange information concerning state accredited trainings and qualifications.

14. To what extent are the existing Directive provisions (see recital 39 and Article 22(b) on continuous professional development (continuous training) adequate? Is continuous training mandatory in your country and what are the exact conditions?

Requirement of the continuous professional development exists in Hungary. It would be useful, if the CPD elements could be mutually recognized or transferred in each Member States national system because the professionals could benefit a lot from this possibility. We would welcome the introduction of a common framework of the CPD in the Directive.

D. ADMINISTRATIVE COOPERATION

15. To which extent does administrative cooperation, as outlined in Articles 8, 50, and 56 of the Directive, simplify procedures for the migrant professionals?

Administrative cooperation simplifies the situation of the applicants and the authorities as well. We found it problematic that there is neither deadline nor sanction in order to answer a question. This results in some cases it is very hard to get the relevant information.

We also have some problems with countries where the competent authorities are organized on territorial basis because it is sometimes very hard to find out who to ask to get the relevant information.

16. Is the competent authority in your country registered with IMI? Under which circumstances does your competent authority use IMI? If not registered, why not and what would be the conditions for changing this situation?

The Office is registered in the IMI system we send and answers questions very often.

We find it a very useful tool to communicate amongst the competent authorities, and we would warmly welcome to make the use of the IMI compulsory for all the MS's competent authorities.

We found that using the pre-formulated questions and also the free text common boxes it is very easy to understand the individual applicant's situations, and we also have very good feedbacks from the applicants, because we are dealing these matters on a fast and effective ways, and they are not obliged to gather all the information personally.

IMI could be used more efficiently, if strict deadlines were built into the mechanism, because in some cases (and from some authorities) the answer arrives very slowly.

We'd also welcome the introduction of the alert mechanism into the IMI system also for PQ modul as it already exists for services.

17. How could a professional card (see Recital 32 of the Directive) facilitate recognition of professional qualifications and provision of temporary services? Under which conditions could it be issued by professional associations?

In Hungary a professional card exists with regards all the healthcare professionals but this card does not give any information about their training requirements.

A sophisticated system should be developed to ensure that the information accessed by using the card, or printed on the card are up-to-date.

We find that Europass CVs and certificates of good standing/current professional status are the best source to get the relevant information.

18. Are you alerted by other Member States in case of disciplinary action or criminal sanctions taken or any other serious, specific circumstances which are likely to have consequences for the pursuit of activities under this Directive? How do you share this information? Could more be done in this respect?

The Healthcare Professionals Crossing Borders initiative (HPCB) has launched some surveys and consultations on this matter to clearly see the national settings on the information sharing.

They identified two types of information sharing: reactive information sharing on case-by-case basis, and proactive information sharing.

Some countries (like Hungary) can only share information reactively, because of the national data protection legislation, until the requirement of proactive information sharing would not be introduced in the Directive itself.

Some other countries sends the information (mostly concerning fitness to practice issues) proactively, and we find it very useful to have these information, when it affects some of our registrants.

If we are informed about a case, we can investigate directly whether it has any effect on the registrant under our national law.

The HPCB has a memorandum of understanding on this matter.

We think that the IMI system could also be used as an alert mechanism in this field (it would be similar to the application of the tool with regards the services directive) if proactive information sharing would be compulsory, which would be the fastest and more secured way to inform other authorities.

E. OTHER OBSERVATIONS

19. How and when are the necessary language skills of migrants checked after recognition of the professional qualifications? Are you aware of any complaints (especially from patients/clients/employers) about insufficient language skills of migrants?

The sufficient language knowledge is not a condition during the recognition. Certainly, in the general system, if there is a compensation measure (adaptation period, aptitude test) the knowledge of the language is necessary.
In Hungary to be able to pursue the medical activity without supervision the professional should hold a valid operational registration. The sufficient knowledge of the language is one of the condition of the appplicant's registration.
We did not get any complaints concerning insufficient language skills.
The testing of the language skills are not regulated in the Directive, as the Directive doesn't let the authorities to ask language exams or any proof of evidences concerning the language knowledge. We suggest to modify this article of the Directive.

20. Does the application of Article 30 raise any specific problems?

We didn't have any problem with the application of this article concerning the GPs.

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MALTA

Evaluating the Professional Qualifications Directive
Experience reports from competent authorities

QUESTIONNAIRE FOR THE MEDICAL PROFESSION (DOCTORS & DENTISTS – MALTA)

A. RECOGNITION PROCEDURE IN CASE OF MIGRATION ON A PERMANENT BASIS

1. Do you accept applications from EU citizens for the recognition of foreign diplomas sent by email or requests made on line? Under which conditions can they send documents and declarations electronically? What are your experiences in this respect?
   Applications are primarily accepted electronically, but then, the original application form and authenticated copies of the documents requested need to be supplied. These are usually scanned and sent as attachments.

2. What is the yearly number of positive and negative decisions of recognition from 2000 to 2009? Please submit specific data for applications for automatic recognition based on diplomas, automatic recognition based on acquired rights (as from 2005), and recognition based on the general system[1]. If available, please provide information on the average duration of the recognition process.
   Applications, which are duly filled, and provide the whole checklist of documents needed, are discussed during Council Meeting, by the Subcommittee for Applications. In case the members feel the need for further verification, the Registrar goes back to the applicant for more information, or refers to other bodies; but the average duration cannot be provided.
   This information has never been recorded.
   Malta entered the EU in 2004. Even though the Medical Council has since then abided by this directive, the data requested has not been recorded, and thus it is not available. This data will be recorded as from this year.

3. To what extent have the system of automatic recognition and the general system been a success?
   No problems have been encountered

   How do you see the costs and benefits?
   Procedure followed is primarily based on the information supplied by the applicant and verification through IMI and internet with foreign regulatory bodies are quite efficient.

   Specify in particular whether automatic recognition based on diploma, Annex V and the current notification system represent an efficient way to facilitate automatic recognition. Please submit comments for:
   - automatic recognition based on diploma
   - automatic recognition based on acquired rights
   - recognition based on the general system.

   Please specify whether there are any specific problems with Annex V.

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[1] Please provide this information unless it has already been provided to the Commission in the Database or the implementation reports.

There were no problems with the lists in Annex V. This has actually created a basis for an efficient recognition.

4. Is the general system applied in your country each time the conditions for automatic recognition are not met?
   Yes, either the course of study is assessed or else applicants are asked to sit for an examination or for an adaptation period.

   Are there major difficulties in the recognition procedure under the general system? Please include any comments you may have on the implementation of compensation measures. Is the migrant given the choice between an aptitude test and an adaptation period or is the choice restricted. Please explain.
   Since the applicant will be granted registration only if one successfully passes the examination or successfully completes the adaptation period, the Medical Council ensures that the his/her qualifications are up to the standards of the Directive

5. What is your experience with the recognition procedure for EU citizens with professional qualifications obtained in a third country and already recognised in a first Member State (see Articles 2(2) and 3(3))?
   No problems have arisen to date but decisions on status on good standing should be automatically transmitted throughout the EU to ensure that migrants do not abuse of the system.

6. Please describe the government structure of the competent authority or authorities in charge of the recognition.
   The Medical Council is an independent body concerned with the registration of Medical Practitioners and Dental Surgeons, and for the recognition of qualifications.

B. TEMPORARY MOBILITY (OF A SELF-EMPLOYED OR AN EMPLOYED WORKER)

7. Are EU citizens interested in using the provisions for exercising their professional activities on a temporary and occasional basis in your Member State? How many citizens used this new system in 2008 and 2009 (per month, per year) [2]?
   The Medical Council registers these medical practitioners as temporary service. This data is not available. We started to record it for year 2010, and to date we have 26 doctors on Temporary Service

8. How are the provisions of Directive 2005/36/EC concerning temporary mobility applied by the competent authorities in practice taking into account the relevant provisions of the Code of Conduct? For instance:
   - How is the "legal establishment" criteria foreseen by Article 5(1) (a) interpreted in practice? What conditions does a migrant need to fulfil in his home Member State in order to be able to provide services?
   - How are the "temporary and occasional basis" criteria foreseen by Article 5.2 interpreted in practice? Do Member States assess duration, frequency, regularity and continuity of an activity and if so according to which criteria?

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[2] Please provide this information unless it has already been provided to the Commission in the Database or the implementation reports.

Local law follows the Directive to the letter.

9. Why is a prior declaration system necessary? What do competent authorities do with the information received? Are other possibilities conceivable? Do you have any cases – and if yes how many - whereby doctors sent the declaration after the provision of services has taken place.
   The Medical Council considers this a reliable system, since unfortunately some doctors fail to make such declarations, especially those accompanying tourist groups

10. Do you charge any fee in case Article 7 & 4 applies?
    Yes, but only with respect to Article 4.

C MINIMUM TRAINING REQUIREMENTS

11. To what extent are the common minimum training requirements for specialists and general practitioners set out in Title III Chapter III of Directive 2005/36/EC and as defined in Annex V in line with scientific progress and professional needs? Furthermore, are the knowledge and skills required by the directive still relevant and up to date? Please specify. What about the conditions relating to the duration of training? Do you have many specialties training, which have a common trunk? If yes, please specify which ones.
    This is assessed by a separate Specialist Accreditation Committee (SAC) which is a legal independent entity that assesses both the individual's specialist training and the specialist training programmes.

12. To what extent are the common minimum requirements for training set out in Title III Chapter III of Directive 2005/36/EC in line with scientific progress and professional needs in the last ten years? Are the knowledge and skills outlined in Article 24.3 still relevant and up to date? Please specify. What about the conditions relating to the duration of training?
    Conditions specified are very generic. All training programmes for primary degrees are under the supervision of the both the Education Ministry and the Medical Council to ensure adherence to stipulated standards.

13. The Directive is based on mutual trust between Member States. To what extent is such trust actually achieved? Are training programmes accredited in your country? Does accreditation of a training program in another Member State enhance trust or is it not relevant?
    The medical council accepts that trust is of vital importance. As it assumes that its decisions are not unnecessarily questioned, nor does it questions other regulatory bodies.

14. To what extent are the existing Directive provisions (see recital 39 and Article 22(b) on continuous professional development (continuous training) adequate? Is continuous training mandatory in your country and what are the exact conditions?
    It is not a legal requirement as yet but most academic professional bodies have it as a requirement for membership

D. ADMINISTRATIVE COOPERATION

15. To which extent does administrative cooperation, as outlined in Articles 8, 50, and 56 of the Directive, simplify procedures for the migrant professionals?
    The Medical Council has had no difficulty to comply with these Articles and has always found cooperation when seeking information from other regulatory bodies.

16. Is the competent authority in your country registered with IMI? Under which circumstances does your competent authority use IMI? If not registered, why not and what would be the conditions for changing this situation?
    Yes. The Medical Council replies to queries forwarded by other foreign councils. This is also a useful tool to find information and addresses of all foreign regulatory bodies, and an efficient and fast way to communicate with them, or instance, to inform them that a Medical Practitioner has been struck off.

17. How could a professional card (see Recital 32 of the Directive) facilitate recognition of professional qualifications and provision of temporary services? Under which conditions could it be issued by professional associations?
    A professional card is an ideal tool primarily for temporary service providers. It should be issued by regulatory bodies to facilitate quick communication.

18. Are you alerted by other Member States in case of disciplinary action or criminal sanctions taken or any other serious, specific circumstances which are likely to have consequences for the pursuit of activities under this Directive? How do you share this information? Could more be done in this respect?
    The Medical Council received circulars (decision circulars) from the GMC and from the Council of Ireland. We try to inform all regulatory bodies.

E. OTHER OBSERVATIONS

19. How and when are the necessary language skills of migrants checked after recognition of the professional qualifications? Are you aware of any complaints (especially from patients/clients/employers) about insufficient language skills of migrants?
    Language requirements fall under the jurisdiction of the employer. However, doctors are held responsible for any malpractice due to difficulty in communication with their patients.

20. Does the application of Article 30 raise any specific problems?
    No, acquired rights had to be taken into account locally so once the responsible regulatory council has applied this directive, the medical council trusts such decisions.

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The Netherlands
15-09-2010

THE NETHERLANDS

Evaluating the Professional Qualifications Directive
Experience reports from competent authorities

QUESTIONNAIRE FOR THE MEDICAL PROFESSION

A. RECOGNITION PROCEDURE IN CASE OF MIGRATION ON A PERMANENT BASIS

1. Do you accept applications from EU citizens for the recognition of foreign diplomas sent by email or requests made on line? Under which conditions can they send documents and declarations electronically? What are your experiences in this respect?

   Applications for the recognition of foreign diplomas sent by e-mail or otherwise electronically submitted are not accepted. Only original diplomas or certified copies of the diploma are accepted. The application form needs to be signed by the applicant, a copy is not accepted.
   These conditions are almost always met.
   Only additional information can be submitted by e-mail.

2. What is the yearly number of positive and negative decisions of recognition from 2000 to 2009? Please submit specific data for applications for automatic recognition based on diplomas, automatic recognition based on acquired rights (as from 2005), and recognition based on the general system[1]. If available, please provide information on the average duration of the recognition process.

   These are the data we can give to you.

   Automatic Recognition medical profession:

2000	*002*
2001	*290*
2002	*390*
2003	*408*
2004	*369*
2005	*350*
2006	*374*
2007	*274*
2008	*288*
2009	*322*
2010	*172 (till September)*

   Otherwise:

2000	*019*
2001	*340*

[1] Please provide this information unless it has already been provided to the Commission in the Database or the implementation reports.

2002	*414*
2003	*429*
2004	*410*
2005	*378*
2006	*386*
2007	*291*
2008	*311*
2009	*334*
2010	*181 (till September)*

For applications for automatic recognition, the duration of the recognition process is 15 days on average. For recognition based on acquired rights the process takes 30 days on average. For recognition based on the general system the process takes longer because advice by an independent professional body needs be asked. This process takes 90 days on average.

3. To what extent have the system of automatic recognition and the general system been a success? How do you see the costs and benefits? Specify in particular whether automatic recognition based on diploma, Annex V and the current notification system represent an efficient way to facilitate automatic recognition. Please submit comments for:

   - automatic recognition based on diploma

   The system is fast, simple and cost effective.

   There are major differences in the education systems of the member states. In some states the level of education is far above the minimum standards while in other states it is not. Language proficiency is essential to be able to function well in a profession.

   Since the system of automatic recognition is based on recognition of the primary qualification there is no assurance that the current knowledge and skills of the migrating professional are up to date.

   - automatic recognition based on acquired rights

   We have experienced problems concerning interpretation of the rules for automatic recognition based on acquired rights.

   In case of automatic recognition based on acquired rights it is in principle not possible to verify whether a certificate for automatic recognition was issued rightly and according to Directive 2005/36/EC. However, occasionally verification is possible using a former application file if the migrant applied in the past (before accession of the country of origin) or using information provided by the migrant unasked, like a curriculum vitae. Several times it turned out that certificates for automatic recognition were issued wrongly and not according to Directive 2005/36/EC. For example: the migrant had not been engaged in the activities in question for at least three during the five years preceding the award of the certificate; the migrant had not been engaged in the activities in question effectively and lawfully, as he had been working under supervision; the migrant had been engaged in the activities in question in a third country.

This means that the total number of wrongly issued certificates for automatic recognition must be much higher.

- recognition based on the general system.

We concur fully with the answer of Denmark in this respect.

*"Recognition based on the **general system** is good for the migrants, as they have the right to be recognised in other EU member states even though there may be substantial differences in educations. It can, however, often be difficult for the applicant to get documentation with details of the education undergone. The persons in question often have an education that goes back many years. Furthermore translation of documents will often be required, a substantial expense for the applicant.*

Compensation measures are not easily applicable. When applicants do not master the local language (Danish) they have difficulties finding positions for adaptation periods. Having to pass an aptitude test in a foreign language is equally difficult.

It is difficult to have a test system that has to take individual educational deficiencies into consideration and it is very costly."

Please specify whether there are any specific problems with Annex V.

Annex V lists the names of the diplomas that are eligible for automatic recognition. These names tend to change in the countries of origin. It is difficult and time consuming to check with the competent authorities via the IMI system whether the new name is consistent with the name registered in Annex V.

4. Is the general system applied in your country each time the conditions for automatic recognition are not met? Are there major difficulties in the recognition procedure under the general system? Please include any comments you may have on the implementation of compensation measures. Is the migrant given the choice between an aptitude test and an adaptation period or is the choice restricted. Please explain.

The option of a test is extremely expensive for professions in the health care system. For some of these professions the test would only be used in approx. ten applications per year. Therefore, in situations that there are few recognition requests, aptitude tests are not available. The choice between an aptitude test and an adaptation period should be made not by the migrating professional, but by the host member state's competent authority.

5. What is your experience with the recognition procedure for EU citizens with professional qualifications obtained in a third country and already recognised in a first Member State (see Articles 2(2) and 3(3))?

The Netherlands does not simply follow another member state in its recognition of a third country diploma. The case law supports this practice. Each state has its own recognition procedures.

There are immigrants that will file a request for recognition of their qualifications in multiple member states. There is a concern that these individuals try to use a recognition from a member state where they do not wish to settle, to get recognition in another member state.

Some member states issue ill defined declarations concerning the (educational) recognition of third country diplomas. Migrants rely on these declarations in the process of recognition.

Where third country diplomas are the issue, member states should clearly specify in their declarations whether it is a declaration as meant in article 2 (2) or article 3 (3) of the Directive.

The procedure for EU citizens with third country diplomas and at least three years professional experience in the member state that recognized the third country diploma, is clear: according to article 10(g) the general system is applicable in these cases. That is not the case if there is less than three years professional experience in the home member state: in those cases the general system is not applicable and the competent authority in the host member state can apply national law, but has to deal with the request considering the Hocsman verdict. This should be more clear by the directive, for example with an article 42c of Directive 93/16/EEC.

6. Please describe the government structure of the competent authority or authorities in charge of the recognition.

The competent authority in cases of registration of professionals with a basic qualification is the Minister of Health Welfare and Sport. The procedure of recognition of professional qualifications is carried out by the BIG-register, that is a part of the government executive agency CIBG (Central Information point Professions in Health Care).

In cases of registration of professionals with a specialist qualification the authority is in hands of Specialist Registration Committees. These committees exercise this authority by order of the Ministry of Health, Welfare and Sport in the Netherlands.

B. TEMPORARY MOBILITY (OF A SELF-EMPLOYED OR AN EMPLOYED WORKER)

7. Are EU citizens interested in using the provisions for exercising their professional activities on a temporary and occasional basis in your Member State? How many citizens used this new system in 2008 and 2009 (per month, per year) [2]?

In the Netherlands there is another possibility for professionals who wish to exercise their activities on a temporary and occasional basis. A doctor can work by order of a Dutch doctor. This Dutch doctor is fully responsible for the foreign doctor.

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2 Please provide this information unless it has already been provided to the Commission in the Database or the implementation reports.

Because of this, EU citizens do not use the 'temporary mobility' provisions to work in The Netherlands. In 2008 and 2009 there were no doctors who used these provisions.

The only instances known to us are the following; in 2006 doctors in service of the Tour de France asked about the provisions. In 2008 a doctor specialist from Czech Republic asked about the possibility, but he did not decide to use the provisions.

We agree with the answer of the General Medical Council of the UK. For "United Kingdom", you also can read "the Netherlands":
"We firmly believe that members of the public have a right to expect that the protection afforded to them by the regulatory system should be the same regardless of whether the doctor practises in the United Kingdom temporarily or permanently. We would wish to require them to provide the same information as other applicants, i.e. asking the applicant to complete a fitness to practice declaration, which enables us to follow-up any issues in relation to potential impairment. There is anecdotal information to suggest that Section 18 is seen as a 'back route' to gaining registration."

8. How are the provisions of Directive 2005/36/EC concerning temporary mobility applied by the competent authorities in practice taking into account the relevant provisions of the Code of Conduct? For instance:

   - How is the "legal establishment" criteria foreseen by Article 5(1) (a) interpreted in practice? What conditions does a migrant need to fulfil in his home Member State in order to be able to provide services?

     The migrant has to provide all the information as mentioned in Article 7 of the Directive. In The Netherlands there is an easier method in place; working under the direction of a Dutch doctor. Many migrants prefer this to the process of temporary mobility.

   - How are the "temporary and occasional basis" criteria foreseen by Article 5.2 interpreted in practice? Do Member States assess duration, frequency, regularity and continuity of an activity and if so according to which criteria?

     The temporary and occasional nature of the provision of services is assessed case by case.

     As mentioned above, the situation rarely occurs, so we have no experience to base our answer on.

9. Why is a prior declaration system necessary? What do competent authorities do with the information received? Are other possibilities conceivable? Do you have any cases – and if yes how many - whereby doctors sent the declaration after the provision of services has taken place.

   We prefer a system where a prior announcement is in place. The system in the Directive is very complicated. There are no cases in The Netherlands where the doctors have sent the declaration after the provision of services has taken place

10. Do you charge any fee in case Article 7, § 4 applies?

No

C MINIMUM TRAINING REQUIREMENTS

11. To what extent are the common minimum training requirements for specialists and general practitioners set out in Title III Chapter III of Directive 2005/36/EC and as defined in Annex V in line with scientific progress and professional needs? Furthermore, are the knowledge and skills required by the directive still relevant and up to date? Please specify. What about the conditions relating to the duration of training? Do you have many specialties training, which have a common trunk. If yes, please specify which ones.

We agree with the answer of the CMC of the UK. For "UK" you can read "the Netherlands" and for "NHS" "Dutch healthcare system":
"The minimum times for training set out in the Directive are useful, but the lack of overall consistency of approach between member states means that the level of assurance that states can draw from the training obtained by migrants is limited. We have an example of a specialist who gained recognition in the UK under the Directive but subsequently found they requires a further four years of experience to gain employment as a specialist consultant in the NHS in the UK."
(We have the same problem in the Netherlands.)

There are 33 specialities in the Netherlands. The specialities related to general internal medicine (general internal medicine, cardiology, pulmonology, rheumatology, geriatrics and gastroenterology) and to general surgery (general surgery, cardiothoracic surgery, neurosurgery, orthopaedics, plastic surgery and urology) have common trunks.

12. To what extent are the common minimum requirements for training set out in Title III Chapter III of Directive 2005/36/EC in line with scientific progress and professional needs in the last ten years? Are the knowledge and skills outlined in Article 24.3 still relevant and up to date? Please specify. What about the conditions relating to the duration of training?

The Netherlands fully concurs with the point of view of Denmark and the UK. It is very important that the content of the theoretical and practical courses are detailed. Otherwise it is impossible to make a comparison.

We agree with the answer of Denmark. For "Denmark" you can read "the Netherlands".

"The overall intentions stated in Article 24.3 a – d are still highly relevant. We find it of importance, that the hours of theory and hours of practical training in all basic and clinical subjects are well described.

Denmark could recommend, that the trans-national and/or the European dimension is more visualised in accordance with declarations from the Bologna process, i.e. the Loeven communiqué."

The Netherlands
15-09-2010

We also agree with the answer of the CMC of the UK. For "UK" you can read "the Netherlands".

"There is a lack of any information about the nature and content of medical training, and of the skills, knowledge, and competencies required of trained doctors in other member states. Without this information we cannot be assured of the quality of education elsewhere, not least given the very general nature of the standards on curriculum content and delivery required in the Directive, and the lack of information about how those standards are quality assured. In addition, comparability is largely based on length of training rather than training content or the range of competencies that medical education develops.

The overall result is a climate in which competent authorities cannot have full confidence in each other's medical training and education.

In addition, the scope of medical practice can differ between member states. What is routine treatment or procedure for a General Practitioner in the UK, for example, may not be within the normal scope of a doctor trained from another EEA country. Moreover, in some member states graduates may have strong theoretical training but less clinical experience than is deemed desirable in other member states. This can give rise to a patient safety risk where the expectations placed upon a doctor working in one jurisdiction, but trained in another, are not met.

In our view the abolition of the Advisory Committee on Medical Training (ACMT), when the Directive was revised in 2005, has lead to a situation where there is currently no European forum for the co-ordination of control of training and no satisfactory route by which the formal views of competent authorities can be made available to the Commission.

We believe there is a need for an urgent audit of basic and specialist medical qualifications in Europe as a means of identifying and confirming 'content comparability'. The findings should be used as a basis from which to develop the minimum training requirements. These should be developed in terms of learning outcomes rather than inputs (hours and length of study).

The current emphasis on inputs in terms of hours and duration of study has meant that the UK has encountered constraints in developing undergraduate medical education and training in line with the UK needs. This is not helped by the ambiguity in the Directive over whether that training should comprise 5,500 hours OR six years' training, or 5,500 AND six years' training."

13. The Directive is based on mutual trust between Member States. To what extent is such trust actually achieved? Are training programmes accredited in your country? Does accreditation of a training program in another Member State enhance trust or is it not relevant?

Trust will be achieved when competent authorities correctly implement the Directive as well as proper safeguards to prevent abuse of such trust.

Misinterpretation of the Directive can harm bilateral trust. Implementation of the Directive and its effective use is made difficult due to vast differences between national law, which can cause miscommunication between member states.

Training programmes are accredited in the Netherlands. Accreditation in other Member States could enhance bilateral trust when the legal grounds and conditions in Member States are identical. Especially relevant in this regard is that the accreditation institute checks the training programmes regularly and consistently at the at the same (high) level.

14. To what extent are the existing Directive provisions (see recital 39 and Article 22(b) on continuous professional development (continuous training) adequate? Is continuous training mandatory in your country and what are the exact conditions?

Continuous professional training is not mandatory in the Netherlands. In 2009 a system was introduced requiring renewal of registration every five years. This requirement was introduced for basic professions: nurses, midwives and physiotherapists. The same system will be introduced other professions in installments over the next years, requiring professionals to meet minimum working condition every five years. The professional that does not meet the minimum conditions is required to follow training before renewed registration.

For specialists a system of recertification was instated years ago. The registration of all specialists, including general practitioners, is valid for five years. After five years, the specialist has to prove that he/she actually did work in his/her profession for at least 16 hours per week during the period of five years and took part in accredited CME activities for at least 40 hours per year.

We agree with the answer of the CMC of the UK.

"The Directive as it currently stands does not allow competent authorities to assure themselves that the doctors and healthcare professionals they register have kept their skills and competence up to date since the award of their professional qualifications. The inability of member states to obtain such assurance at the point at which they register or license a doctor to practice inevitably weakens the level of confidence that competent authorities can have in the fitness to practice of doctors entering the host state."

D. ADMINISTRATIVE COOPERATION

15. To which extent does administrative cooperation, as outlined in Articles 8, 50, and 56 of the Directive, simplify procedures for the migrant professionals?

Administrative cooperation will likely speed up and simplify the procedure, and allows competent authorities to exchange information directly and safely – without any need for the migrant to send in his/her personal documents.

We also refer to our answer to question 16.

We prefer the direct communication between competent authorities, without involving the migrant in question. Especially where pending restrictions are concerned the IMI can perform a vital function.

16. Is the competent authority in your country registered with IMI? Under which circumstances does your competent authority use IMI? If not registered, why not and what would be the conditions for changing this situation?

Yes, the BIG-register and the specialist registration committees – the Dutch competent authorities - are registered with IMI. In case of doubt or when additional information is needed, we refer to IMI.

Our opinion is that the IMI is a useful and reliable tool to communicate with other competent authorities. Use of IMI can speed up procedures and often negates the need for further correspondence with the migrant, or for the migrant having to submit documents; IMI allows communication with competent authorities that otherwise would be difficult to reach, that would not respond within certain time limits, or with whom no communication would be possible due to language barriers.

On the other hand, IMI is not always user-friendly, and national law and discrepancies between systems of recognition (many national competent authorities exist for one profession) sometimes make the use of IMI challenging.

Suggestions for improvement of the IMI:

1. Registration with IMI should be mandatory for all competent authorities.

2. All competent authorities should be required to use IMI and respond within a given time limit.

3. IMI could be made more user-friendly, by (i) improving the interface (clustering and highlighting questions - some questions are used more often than others); (ii) implementing a system to monitor incoming and outgoing requests; (iii) improving the translation tool; (iv) implementing the option to identify competent authorities by profession (in all languages).

17. How could a professional card (see Recital 32 of the Directive) facilitate recognition of professional qualifications and provision of temporary services? Under which conditions could it be issued by professional associations?

In our opinion, a "professional card" does not have any added value to facilitate recognition of professional qualifications. The development of such a system would be very expensive, while keeping the information contained in the card up-to-date would be nearly impossible. Furthermore, developing a European database would be difficult and expensive when taking into account that every professional would need to get a card while only a few would practice their profession in another Member Stat.e

The Netherlands
15-09-2010

It seems that professional cards are meant mainly to address problems at a national level that are not prevalent in all Member States. In the Netherlands, a public, online, current directory is made available: a professional may demonstrate his/her qualifications by submitting a registration number.

Two professional card systems are imaginable with regard to recognition of professional qualifications:
1. A card that contains data, or:
2. a card that provides access to a database.

With a card that contains data, the problem arises that data may not always beup-to-date. Also, this system would be more susceptible to data fraud. With a card that provides access to a database, the problem arises that competent authorities must maintain such a database. With a European database, a few problems would likely arise, such as: language barriers, the effort of keeping the data up-to-date, and differences in interpretation with regard to data. Furthermore, there is no added value when the card is meant to be used to access data through a closed network, because of the existence of the IMI. Member States are able to provide each other with information through use of the IMI, and may incorporate such data in a national database. Subsequently, employers and civilians or patients would be able to refer to such a national database.

Even a professional card will not prevent fraud and abuse. Furthermore, the card may imply the holder of that card to be qualified when this is not actually the case.

When taking into account the number of migrants vis-à-vis the number of residents, the costs versus the benefits of introducing and maintaining a card system linked to a European database would seem disproportionate.

Maintaining both a professional card system and a public online up-to-date database would be confusing and inefficient. Employers and civilians or patients should use the register, while competent authorities should exchange information through IMI directly.

From the viewpoint of cost reductions and efficiency, we feel it would make more sense to invest in the development of public, central databases in each Member State, while using IMI for the direct exchange of data between Member States.

18. Are you alerted by other Member States in case of disciplinary action or criminal sanctions taken or any other serious, specific circumstances which are likely to have consequences for the pursuit of activities under this Directive? How do you share this information? Could more be done in this respect?

The General Medical Council of England and the Medical Council of Ireland inform us about disciplinary action or criminal sanctions taken.

Other Member States only inform us incidentally in this regard.

Dutch decisions with regard to disciplinary action or criminal sanctions are made available online, at: www.bigregister.nl.

The Netherlands
15-09-2010

The Netherlands are a partner in the Health Care Professionals Crossing Borders (HCPB) partnership. The Netherlands therefore issue Certificates of Current Professional Status (CCPS) according to the HCPB agreement. The CCPS, issued by the competent authority of the home member state, should be made a compulsory document to be carried by a migrant health professional within the EEA.

E. OTHER OBSERVATIONS

19. How and when are the necessary language skills of migrants checked after recognition of the professional qualifications? Are you aware of any complaints (especially from patients/clients/employers) about insufficient language skills of migrants?

Language skills are considered an essential part of the work quality of a professional. When a doctor, dentist, nurse, midwife or pharmacist has received recognition from the government, he or she may immediately start working in the Netherlands.

Complaints have been received by the BIG-register and the specialist registration committees about insufficient language skills of migrating health professionals who were granted registration under the Directive on a regular basis. It is incomprehensible to employers and insurance agencies that a migrant can be recognized and registered even though he or she does not speak the Dutch language.

20. Does the application of Article 30 raise any specific problems?

There are no problems in the application of article 30 (general practitioners).

HJS
2010-09-15.

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AUSTRIA

Evaluating the Professional Qualifications Directive
Experience reports from competent authorities

POSSIBLE QUESTIONNAIRE FOR EACH SECTORAL PROFESSION

A. RECOGNITION PROCEDURE IN CASE OF MIGRATION ON A PERMANENT BASIS

1. Do you accept applications from EU citizens for the recognition of foreign diplomas sent by email or requests made on line? Under which conditions can they send documents and declarations electronically? What are your experiences in this respect?

   Applications for recognition of foreign diplomas may be submitted by e-mail. Documents (like diplomas, proofs of nationality etc.) may be submitted by e-mail for a first check, but have to be submitted in paper in the course of the procedure.

   Since we experienced a number of cases where falsified documents were submitted, photocopies of the essential documents have to be certified by any authority competent to proceed the certification.

2. What is the yearly number of positive and negative decisions of recognition from 2000 to 2009? Please submit specific data for applications for automatic recognition based on diplomas, automatic recognition based on acquired rights (as from 2005), and recognition based on the general system[1]. If available, please provide information on the average duration of the recognition process.

   In our register of doctors, we do not differentiate between diplomas which were recognized automatically based on diplomas, or on acquired rights, or on the general system without any compensation measures. Therefore we can only provide an overall number of EU diplomas that were recognized in Austria either automatically or based on the general system, but without any compensation measures.

   2009: 150
   2008 163
   2007 215
   2005/2006 (2years) 374

   Since the Directive 2005/36/EC was only implemented into the Medical Act in July 2009, rather few diplomas were recognized according to the general system so far. So far all applicants proved sufficient training or professional experience and were thus recognized without any compensation measures. The first procedure in which compensation measures are being imposed on an applicant is pending at the moment.

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[1] Please provide this information unless it has already been provided to the Commission in the Database or the implementation reports.

Concerning the duration of the recognition procedure, we can only give an estimate, since there is no structured documentation. Automatic recognition procedures (either based on diplomas or acquired rights) normally last between one and four weeks after receipt of completed documentation. Naturally, the procedure may last longer in cases where documents or data have to be verified with the competent authority of another Member State, depending on the time it takes until we receive an answer to our request.

We have no sufficient experience yet to give an estimate on the duration of procedures based on the general system. The duration of these procedures will differ widely, depending on whether it is obvious that an applicant's training and/or professional experience are sufficient in order to recognize his or her diploma without imposing any compensation measures, or whether a medical expert has to be consulted, and a compensation measure is imposed. Whereas in the first case, most procedures will be concluded within a few weeks, in the latter case they might last for several months, within the time limits set by the Directive 2005/36/EC.

The duration of procedures of any kind also depends on the development of the number of applications. If the number of applications rises significantly, procedures will last longer than the periods stated above.

3. To what extent have the system of automatic recognition and the general system been a success? How do you see the costs and benefits? Specify in particular whether automatic recognition based on diploma, Annex V and the current notification system represent an efficient way to facilitate automatic recognition. Please submit comments for:

   - automatic recognition based on diploma

   Generally speaking, the system of automatic recognition works very well. In our view, automatic recognition is a very effective way of recognition, and saves time and costs. However, the system is somewhat prone to fraud: The fact that only one or two documents (i.e. diploma and certificate of conformity) are sufficient to be granted automatic recognition seems to be a temptation to produce falsified documents.

   Another pitfall might be that the system can be used for "qualification shopping". E.g. physicians who were already awarded a specialist qualification by one Member State have parts of their medical training periods accredited by another Member State with the goal to be awarded another specialist qualification, which then has to be recognised by the Member State that issued the first diploma (and would have required a much longer training period for the second one). Hence, due to the same periods of medical training being accredited twice in order to gain another specialist qualification, the minimum training period is shortened to a large extent. As a consequence the physician in question possesses two specialist qualifications, although he did not undergo the full amount of training periods required for these two specialist qualifications.

   In this context, difficulties exist in particular with regard to medical specialties that differ widely between individual Member States. Two examples:

Cardiac and thoracic surgery are combined into one medical specialty in a great number of Member States, but are two separate specialties in Austria and some other Member States. However, only thoracic surgery is listed in Annex 5.1.3. of Directive 2005/36/EC. This means that a medical doctor from a country where cardio-thoracic surgery is one medical specialty can only be recognized as a specialist in thoracic surgery in Austria, but not as a specialist in cardiac surgery. (Further recognition as a specialist in cardiac surgery based on the general system is not possible, since the general system is only applicable to diplomas that are either not listed in Annex 5.1.3. of the Directive or not subject to the system of automatic recognition.) Vice-versa Austrian specialists in thoracic surgery are recognized automatically in countries where cardio-thoracic surgery is one medical specialty, even though they may lack training in cardiac surgery. By contrast, Austrian specialists in cardiac surgery are not subject to automatic recognition at all, even if they want to migrate to a country where cardio-thoracic surgery is one medical specialty and want to engage in the field of cardiac surgery there.

The same is the case with orthopaedics and trauma surgery, which are two different specialties in Austria (the former being subject to automatic recognition, the latter not). However, in a number of other Member States orthopaedics and trauma surgery are combined into one specialty (see also below).

It would be useful in this context to clarify Consideration 12 of the Directive, which aims at preventing unlawful qualification shopping, and move it into the body of the Directive.

Another potential problem related to automatic recognition of diplomas is the fact that Member States have to recognise diplomas that meet the formal requirements of the Directive, regardless of the applicant's current status of knowledge and skills. The Austrian Medical Chamber presently promotes a change in the Austrian law that would enable us to demand evidence of up-to-date knowledge and skills of doctors who have not performed medical activities for several years before registering them. As soon as such a mechanism is introduced by law, it should apply to all doctors, regardless of whether they have qualified in Austria or another EU country. Patients treated in Austria expect to be treated only by doctors who meet the standards set by the Austrian law for the sake of patient safety. We regard it a right of patients that those standards are being applied to all doctors providing medical services in Austria. In our view it should be clarified in the Directive that the recognition of diplomas is without prejudice to the competence of Member States to lay down preconditions for the registration of doctors on their territory, as long as those preconditions do not, either directly or indirectly, discriminate against nationals of other Member States.

- automatic recognition based on acquired rights

Also in this case, our experience is overall positive. It does make sense that a medical doctor who has been working for years is recognized automatically in another Member State, even if his or her diploma does not fully correspond with EU law.

The new provision of article 23 which requires effective and lawful engagement in the activities in question for at least three consecutive years in the past five years not only for basic, but also for specialist training is an important simplification in comparison with the regime of Directive 93/16/EEC as regards acquired rights for specialist doctors.

In this context we would like to point out that the wording of Article 23 par. 3, 4 and 5 of the Directive is outdated. In many cases, doctors from Eastern European countries migrate to a Western European country and want to move on to another EU Member State after several years of medical practice in the first host country. Upon their first migration to another EU country, they are able to submit a certificate according to Article 23 par. 3, 4 or 5, issued by the competent authority of the successor state of their original country of origin. But after having worked in another EU Member State for several years, their acquired rights' certificate is issued by the first host Member State, and not, as laid down in Article 23 par. 3, 4 or 5 of the Directive, by the competent authority of the Member State that issued their diploma. We therefore recomment to adapt the wording of Article 23 par. 3, 4 and 5 insofar as the acquired rights' certificate can be issued by the competent authority of the Member State or Member States where the applicant has acquired professional experience.

- recognition based on the general system.

The application of the general recognition system to doctors' diplomas that are not subject to automatic recognition is a major improvement compared to the procedure foreseen by Directive 93/16/EEC. Procedures according to the general system are much less time consuming for doctors than a detailed evaluation and accreditation of individual training periods.

However, since any documents can be used to prove professional experience and knowledge, it might turn out extremely difficult for the competent authorities to assess the reliability, and in some cases also the authenticity of documents submitted.

We have also experienced cases where Austrian doctors tried to abuse the system of recognition of diplomas in order to circumvent Austrian training regulations. For example a doctor who acquired the Austrian diploma of a specialist in orthopaedics applied for a German diploma in orthopaedics and trauma surgery. After having undergone a short period of additional training, he obtained this combined diploma. After that he returned to Austria and applied for recognition of his German diploma of a specialist in orthopaedics and trauma surgery towards the Austrian specialty of trauma surgery, on the basis of the general system. In this case, the European Commission informed us that the general system was not applicable, since the diploma acquired by the doctor was listed in Annex 5.1.3. of the Directive and subject to automatic recognition (even if in the area of orthopaedics and not of trauma surgery). So in this case, the doctor did not succeed in circumventing the Austrian training regulations.

However, in another case, qualification shopping by a doctor could not be prevented by the Austrian Medical Chamber: In the latter case the doctor acquired the Austrian diploma of a specialist in trauma surgery, which is not listed in Annex

5.1.3. of the Directive. In addition, he wanted to acquire the diploma of a specialist in orthopaedics, which would have required several years of additional training in Austria. So he went to Germany and applied for recognition of his diploma on the basis of the general system there. After additional training of only about 1.5 years, he acquired the German diploma of a specialist in orthopaedics and trauma surgery. Since this diploma is listed in Annex 5.1.3. of the Directive under the heading of orthopaedics, the doctor had to be recognized automatically as a specialist in orthopaedics in Austria, thus having successfully reduced the required period of training by about two years.

Please specify whether there are any specific problems with Annex V.

See above. Furthermore, more frequent updates of the Directive's Annexes would be helpful in order to avoid misunderstandings and delays in recognition procedures resulting from outdated information in the Annexes.

4. Is the general system applied in your country each time the conditions for automatic recognition are not met? Are there major difficulties in the recognition procedure under the general system? Please include any comments you may have on the implementation of compensation measures. Is the migrant given the choice between an aptitude test and an adaptation period or is the choice restricted. Please explain.

The general system is applied in the cases set out in Article 10 par b, d and g of Directive 2005/36/EC and implemented in the Austrian Medical Act. If the conditions specified there are not met, the general system is not being applied. However, training periods underwent in other EU Member States and third countries can always be credited towards training required according to the Austrian training regulations, if regarded as equivalent to training undergone in Austria.

To our experience, it sometimes proves rather difficult to obtain an applicant's complete documentation as required for assessing his or her professional qualification and experience and determining whether recognition is possible without any compensation measures, or if compensation measures have to be imposed, and what exact fields they would have to cover.

In Austria, migrants are not given the choice between compensation measures, but an aptitude test is foreseen as the only possibility.

5. What is your experience with the recognition procedure for EU citizens with professional qualifications obtained in a third country and already recognised in a first Member State (see Articles 2(2) and 3(3))?

Problems might arise in the following respect:

In some countries doctors with third country diplomas are entitled to exercise the medical profession under supervision due to a provision of national law without a formal recognition procedure. In other Member States doctors with a third-country diploma benefit from facilitated or rather automatic recognition procedures due to bilateral agreements. Such way of recognition of third country diplomas

without a formal procedure does not satisfy the requirements of Article 2(2) of the Directive. The diplomas concerned are therefore not subject to recognition under Article 3(3). However, it is almost impossible for the competent authority of a Member State to examine whether the conditions of Articles 2(2) and 3(3) are met, especially if the Member State who first recognised a third country diploma issues a certificate according to Article 3(3).

Most of the cases we had to handle so far concerned basic medical diplomas issued in South America and recognized in an EU Member State. In most of these cases, the doctors underwent training to become a specialist doctor in the Member State that recognised their basic medical diploma, and then moved on to Austria to work as a specialist doctor there. Since these doctors did not work independently in the Member State that first recognised their basic medical diploma, but under supervision within the framework of specialist training, they would presumably not be able to submit a certificate issued by the competent authority according to which they have three years' professional experience (which, according to our understanding, means independent medical practice) in the first host Member State. In order to enable these doctors to profit from the general recognition system nevertheless, the Austrian law has been worded in a way that does not require proof of three years' independent medical practice, but just three years of effective and lawful medical practice. According to our interpretation, accredited practical training in a medical specialty fulfils this requirement.

We have so far experienced no case of recognition of a third country specialist diploma on the basis of the general system.

6. Please describe the government structure of the competent authority or authorities in charge of the recognition.

The Austrian Medical Chamber is a public body established by law and enshrined in the Austrian constitution. It is the competent authority for licensing and operating the register of doctors, recognition of foreign diplomas, issuing of certificates of good standing and of certificates stating that a doctor's evidence of formal qualifications is that covered by Directive 2005/36/EC. Furthermore it supervises the postgraduate training of doctors, issues the diploma listed in Annex 5.1.2. of the Directive 2005/36/EC and is in charge of disciplinary law and procedures. The Austrian Medical Chamber is subject to supervision by the Austrian Ministry of Health.

B. TEMPORARY MOBILITY (OF A SELF-EMPLOYED OR AN EMPLOYED WORKER)

7. Are EU citizens interested in using the provisions for exercising their professional activities on a temporary and occasional basis in your Member State? How many citizens used this new system in 2008 and 2009 (per month, per year)[2]?

   The number of declarations made to the Austrian Medical Chamber was very low so far (our documentation provides only numbers per year):

2005	**33**
2006	**35**
2007	**31**
2008	**55**
2009	**57**

   These numbers do not include declarations of temporary and occasional services which were not accepted by the Austrian Medical Chamber since due to their duration, frequency, continuity or regularity, these medical activities would have required establishment.

   On the other hand, we presume that there are a considerable number of cases where no declaration was made at all.

   Among doctors established in Austria, there seems to be very little interest in providing temporary and occasional services abroad, since we do not receive any applications for the certificate foreseen in Article 7 par. 2 b by Austrian doctors.

8. How are the provisions of Directive 2005/36/EC concerning temporary mobility applied by the competent authorities in practice taking into account the relevant provisions of the Code of Conduct? For instance:

   The time frames for checking the professional qualifications of service providers which do not benefit from automatic recognition do pose a severe problem as they are very tight (Article 7 par 4). These tight time frames do not allow the Member States to duly examine the qualification of a service provider not benefiting from automatic recognition. Subsequently, this poses a problem of quality assurance and lastly patient safety.

   Another issue which, in our view, poses a risk to patient safety, is the fact that there is no possibility to check the fitness to practice of a potential service provider. Austrian citizens rely on the fact that medical doctors practising in Austria have proven their physical and mental fitness to practice according to the standards set by Austrian law. This trust is undermined by temporary service providers, whose fitness to practice is not subject to examination by the Austrian Medical Chamber. For the benefit of patients and public health, we recommend to

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[2] Please provide this information unless it has already been provided to the Commission in the Database or the implementation reports.

change Article 7 insofar as Member States should be able to require that the declaration be accompanied by the documents and certificates listed in Annex VII, point 1, (d), (e) and (f).

- How is the "legal establishment" criteria foreseen by Article 5(1) (a) interpreted in practice? What conditions does a migrant need to fulfil in his home Member State in order to be able to provide services?

According to our interpretation, "legal establishment" means that the migrant is legally entitled to independent medical practice (either in an employed or a self-employed status) as a doctor with basic medical training, a general medical practitioner or a specialist doctor, depending on which kind of medical activities he intends to perform in Austria.

The conditions the migrant needs to fulfil are to be defined by his home Member State. The Austrian Medical Chamber only requires the attestation foreseen by Article 7 par 2.b of Directive 2005/36/EC.

- How are the "temporary and occasional basis" criteria foreseen by Article 5.2 interpreted in practice? Do Member States assess duration, frequency, regularity and continuity of an activity and if so according to which criteria?

The Austrian Medical Act does not contain any legal definition apart from that set out in Article 5 par. 2 of the Directive. Accordingly, there are no concrete criteria, or limits in periods or time, neither in theory nor in practice, but assessment is carried out case by case. If a medical activity is being planned by both the service provider and the recipient of the service (or often an employer established in Austria) in a way that it shall be delivered repeatedly and based on a continuous cooperation, even if the intervals between the provision of individual services differ (e.g. in the case of emergency services), we tend not to classify this activity as a temporary and occasional provision of services, but as establishment.

To our experience, in many cases it proves enormously difficult to differentiate between temporary and occasional provision of services and establishment, which leads to insecurity on the part of the authority as well as on the migrants and their potential employers. The lack of clear provisions in the Directive causes considerable legal uncertainty and definitely deters potential service providers from making a declaration at all, thus inducing unlawful behaviour. This is an area where we see an urgent need to amend and improve the Directive.

Furthermore, in order to enable the competent authority of a Member State to determine whether an intended medical activity is to be assessed as temporary and occasional provision of services, or as establishment, it must have the possibility to ask the migrant for information on the duration, frequency, regularity and continuity of the intended medical activities. We strongly recommend a clarification of the Directive in this regard.

9. Why is a prior declaration system necessary? What do competent authorities do with the information received? Are other possibilities conceivable? Do you have any cases – and if yes how many - whereby doctors sent the declaration after the provision of services has taken place.

Prior declaration is crucial in order to enable the competent authority to protect patients from service providers who lack the qualification necessary or are not entitled to perform the services in question for whatever reasons, including a criminal background. Without a prior declaration, the competent authority would not even know about the planned provision of services, thus lacking any possibility of examining the migrant's aptitude or entitlement to perform the relevant medical activities.

In addition, in order to be able to assess whether an intended medical activity can be classified as a temporary and occasional provision of services, or requires establishment, the Austrian Medical Chamber has to be informed about the intended service beforehand.

When the Austrian Medical Chamber receives a declaration of a planned provision of services, it checks the migrant's professional qualifications and legal entitlement to medical practice as laid down in Article 7.

We have no information on cases where declarations were made subsequent to the provision of services. As mentioned above, we assume that in such cases, no declaration is made at all.

10. Do you charge any fee in case Article 7, § 4 applies?

In case the migrant submits a diploma subject to automatic recognition, and possibly (on a voluntary basis) a certificate of conformity issued by the competent authority of his home Member State, no fee is charged for the processing of his declaration.

In all other cases, i.e. if the service provider does not submit a diploma subject to automatic recognition, the real costs incurred by the Austrian Medical Chamber are charged to the applicant. So far, we have not experienced such a case.

C MINIMUM TRAINING REQUIREMENTS

11. To what extent are the common minimum training requirements for specialists and general practitioners set out in Title III Chapter III of Directive 2005/36/EC and as defined in Annex V in line with scientific progress and professional needs? Furthermore, are the knowledge and skills required by the directive still relevant and up to date? Please specify. What about the conditions relating to the duration of training? Do you have many specialties training, which have a common trunk. If yes, please specify which ones.

As far as general medical practice is concerned, a minimum training period of three years constitutes a lower limit. In Austria, there are current discussions about a revision of the training regulations for general medical practice. The Austrian Medical Chamber promotes a training period of four years in hospital and

one additional year in an approved general medical practice or approved primary care centre.

Regarding specialist training, nearly all medical specialties require a minimum training period of six years in Austria. In our view, a training period of three years is definitely insufficient; a four year training curriculum constitutes the lower limit. We recommend that for specialties that still require a minimum training period of three years according to Annex 5.1.3. of the Directive, the minimum training period should be extended.

General medical practitioners as well as specialist doctors have to undergo a comprehensive examination, which covers the whole field of expertise of their respective profession, after having completed their practical training. Successful completion of this examination is an obligatory prerequisite to be awarded the diploma of a general medical practitioner or specialist doctor. According to our knowledge, obligatory exams are foreseen in a considerable number of other Member States, as well. However, this is not the case in all Member States. In the view of the Austrian Medical Chamber, it is vital in respect of patient safety that before being awarded a diploma, a future doctor proves to be competent with regard to his whole field of activities. This is not guaranteed by smaller exams which cover only part of the medical specialty. In real life doctors are confronted with a broad variety of situations in which they have to prove competence and knowledge.

For these reasons, the Austrian Medical Chamber advocates the introduction of obligatory final exams for general medical practitioners and specialist doctors in the Directive. The European Board assessments provided by the UEMS should serve as a model in this regard.

The Austrian Medical Chamber strongly supports the UEMS in its ambition to define common criteria for specialist training according to high medical standards. In the long run, international accreditation of specialist training by the European Boards of UEMS could be a goal worthwile to pursue.

A common trunk for specialist training is currently not foreseen in Austria.

In this context, we would like to utter our regret about the abolition of the former Advisory Committee on Medical Training (ACMT). This has reduced the possibility of direct input from the professions concerned, whose medical expertise as well as practical experience could contribute significantly to the co-ordination of training and its adaptation to scientific developments and practical needs. The Austrian Medical Chamber strongly promotes the establishment of a new mechanism that enables the continuous, intensive involvement of and co-operation with representatives of the professions concerned.

12. To what extent are the common minimum requirements for training set out in Title III Chapter III of Directive 2005/36/EC in line with scientific progress and professional needs in the last ten years? Are the knowledge and skills outlined in Article 24.3 still relevant and up to date? Please specify. What about the conditions relating to the duration of training?

    We have no comments or recommendations regarding basic medical training.

13. The Directive is based on mutual trust between Member States. To what extent is such trust actually achieved? Are training programmes accredited in your country? Does accreditation of a training program in another Member State enhance trust or is it not relevant?

    In our view, mutual trust is being achieved in practice. However, there are cases that undermine such trust. For example, the following happened repeatedly during the last months:

    A doctor worked in an Austrian hospital that is not an approved training institution for several years. Medical activities performed at this hospital could not be credited towards medical training in Austria. Nevertheless, the doctor applied for a diploma in another EU Member State on the basis of his working experience in Austria. The competent authority of the other EU Member State accepted the Austrian working periods as medical training, without having consulted the Austrian Medical Chamber or having demanded a certificate issued by the latter and confirming that training had been undergone by the doctor. Instead, a diploma was issued on the basis of the assumed "training" undergone in Austria, and subsequently a certificate according to Annex VII. 2 of Directive 2005/36/EC was issued to the doctor, stating that his evidence of formal qualifications was that covered by this Directive. On the basis of this certificate, the doctor applied for automatic recognition in Austria, thus gravely infringing Austrian training regulations. Requests made by the Austrian Medical Chamber to the competent authority of the Member State concerned asking for clarification regarding the training undergone by the doctor were answered by a general statement according to which the medical training undergone by the doctor was in line with EU law.

    In Austria, hospitals and practices that provide medical training have to be approved by the Austrian Medical Chamber, and in addition, individual training posts have to be assigned according to quality criteria set by law. Medical activities undergone in a hospital or practice or at a post that does not fulfil these criteria must not be credited towards medical training. Upon request of a doctor or the competent authority of another Member State, the Austrian Medical Chamber certifies whether a certain hospital or practice or an individual training post satisfy the legal requirements to be credited towards medical training in Austria.

    We do appreciate accreditation of training programmes in other Member States, which definitely does enhance our trust.

14. To what extent are the existing Directive provisions (see recital 39 and Article 22(b) on continuous professional development (continuous training) adequate? Is continuous training mandatory in your country and what are the exact conditions?

In our view, the existing provisions are sufficient. In Austria, doctors are legally obliged to undergo CPD. CPD is organised by the medical chambers and the Austrian Academy of Physicians and accredited according to stringent quality criteria. The CPD programme provided by the Austrian Academy of Physicians comprises a minimum of 150 credit points within three years.

In Austria, there is no system of compulsory recertification/revalidation for doctors who perform their profession on a continuous basis, since this is considered unnecessary bureaucracy with no added value for the patient.

D. ADMINISTRATIVE COOPERATION

15. To which extent does administrative cooperation, as outlined in Articles 8, 50, and 56 of the Directive, simplify procedures for the migrant professionals?

The Austrian Medical Chamber is in intense cooperation with the competent authorities of other Member States. To our experience, direct communication between competent authorities simplifies procedures to a great extent, since it saves time and costs for the migrant and reduces bureaucracy. In cases of uncertainty about a migrant's professional qualification or professional status, administrative cooperation between authorities can spare the migrant from providing another certificate or (translated) document, while at the same time providing the competent authority with the required information or certainty.

16. Is the competent authority in your country registered with IMI? Under which circumstances does your competent authority use IMI? If not registered, why not and what would be the conditions for changing this situation?

The Austrian Medical Chamber is registered with IMI and uses the service regularly for:

- identification of competent authorities
- verification of authenticity of documents in cases of doubt
- questions on the duration of medical training
- requests for supplementary information in cases of incomplete documentation
- questions in cases of denominations differing from those in Annex V
- questions in cases where certificates of good standing are older than 3 months

The average time until we received a response was 12 days (the period ranging from answers received within the first day and after 107 days), with no response at all in 4 % of cases.

Questions posed to the Austrian Medical Chamber via IMI were answered after 7,5 days on average, the period ranging from 1 to 20 days. 13 % of requests

made to the Austrian Medical Chamber via IMI were recalled by the requesting authority.

IMI certainly facilitates cooperation among Member States. It is a very good and effective tool for identifying competent authorities, obtaining information from authorities who do not answer e-mail requests, quickly clarifying doubts regarding qualifications and exchanging information in a secure manner.

However, in order to ensure the good functioning of the system, it is important that IMI includes all authorities which are in charge of the application of Directive 2005/36/EC in each Member State, as there might be more than one authority dealing with these matters. Furthermore, in order to tap the full potential of IMI for the benefit of free migration, there should be a legal obligation for competent authorities to use IMI.

The main drawbacks of IMI are the fact that it is rather time-consuming and complicated to use, and its structure is not very user-friendly. It often takes considerable time to log on to the system, and to identify the relevant questions among the standardized ones. Since the latter are often not compatible with our practical needs, we frequently use the free text facility. Also the documentation of requests posed and answered and the searching within requests is unsatisfactory at the moment.

It is presumably for these practical reasons that we have experienced a decrease in the use of IMI since 2010. To our experience, after successful identification of relevant contact persons through a first IMI contact, it normally proves easier and quicker to contact these persons directly by telephone or e-mail the next time a question occurs.

We propose the following improvements of IMI:

- mandatory registration of all competent authorities
- more user-friendly structure
- obligatory time limits for replies
- possibility to send a reminder after expiry of the time limit
- automatic documentation of all requests made and received
- alert mechanism for cases of suspension of doctors (see question 18)

17. How could a professional card (see Recital 32 of the Directive) facilitate recognition of professional qualifications and provision of temporary services? Under which conditions could it be issued by professional associations?

The Austrian Medical Chamber issues a professional card for doctors. This ID card, which is issued for doctors entitled to independent medical practice or medical practice under supervision, is recognized as a public legitimate document and is used as proof of the professional qualification vis-à-vis health care institutions, pharmacies and other informed third parties. Depending on the respective status of registration with the Austrian Medical Chamber, the ID card for doctors contains a hologram which identifies its holder either as fully licensed doctor, as a doctor in training, a specialist doctor or a general medical practitioner.

This kind of information on the card has proven to be worthwhile and sufficient in practice.

From our point of view a professional card for doctors at a European level with the aim of facilitating recognition of professional qualifications is not deemed to be useful, as the card's content could not exceed the current provisions as set out in Directive 2005/36/EC. In the procedures for the recognition of foreign diplomas in the case of migration or the provision of temporary services it showed that diplomas subject to automatic recognition, as outlined in the Directive, can easily be examined upon direct presentation by the migrant and the procedures for recognition or temporary provision of services can thus be handled efficiently and quickly.

On the other hand diplomas which are not subject to automatic recognition have to be examined thoroughly. The provision of written evidence of these diplomas is indispensable in order to avoid mistakes in the process of recognition of professional qualifications. Detailed examination of documentation is in the interest of patient safety and in the interest of public safety in the health care sector. Unfortunately we experienced cases in the past where doctors tried to establish in Austria without sufficient professional qualifications, or tried to gain recognition on the basis of forged documentation.

Also, it is as easy to provide information on professional qualifications like university diplomas, qualifications and professional experience in paper as on a card, but the quality of the documentation is better if presented in original or certified copy. Questionable data would have to be checked in any way with the competent authority even if a professional card was provided.

Furthermore, information on the rightful establishment and disciplinary and criminal sanctions as well as other information to be provided by the competent authority are subject to constant updating, as according to Article 50 of the Directive, this information must not be older than 3 months. This fact immediately raises the question of who should be responsible for the updating of such information. In order to have a well functioning sound and secure system providing up-to-date information, a European server solution connecting all the competent authorities would be necessary. This would definitely bring about a high burden of bureaucracy and would also be very costly. This high bureaucratic burden and costs would not reflect the time that might be saved in the recognition procedure by providing a professional card for the purpose of migration or the provision of temporary services. Furthermore, this professional card would also have to contain elements of a public legitimate document, which prove the authenticity of the holder in order to eliminate the risk of misuse.

From our point of view it is very likely that such a professional card will not come up to the quality desired by the European Commission, which would be necessary to lead to an actual increase and facilitation of mobility of professionals. Our experience when it comes to exchanging necessary information, also via electronic means, between the competent authorities of the host country and the country of origin are excellent. Furthermore, the maximum duration for the procedure of recognition is limited by law in any way. In cases of

doubt regarding the professional qualification of or current professional sanctions imposed on a doctor, where detailed information is required from the competent authority, a professional card cannot replace detailed inquiries with the competent authority in the country of origin.

18. Are you alerted by other Member States in case of disciplinary action or criminal sanctions taken or any other serious, specific circumstances which are likely to have consequences for the pursuit of activities under this Directive? How do you share this information? Could more be done in this respect?

Since a reform of the Austrian Medical Act in 2009, the Austrian Medical Chamber has been entitled to inform the competent authorities of other EU Member States about disciplinary action or criminal or administrative sanctions taken or any other serious, specific circumstances which are likely to have consequences for the pursuit of the medical profession. We provide this information on request to the competent authority of another Member State, or on our own initiative if we know that a doctor subject to such disciplinary action etc. is planning to move to a certain Member State of the EEA (or Switzerland). Information is shared in writing, via e-mail and/or regular mail.

As regards doctors moving to Austria, we experience great differences in the handling of such cases by other Member States. There are some Member States that pro-actively inform us about any suspension of any doctor on their territory, others that inform us in case the doctor concerned has any connections with Austria (e.g. acquired his professional qualification there or migrated from Austria to the Member State in question), and others that are extremely restrictive in providing information on disciplinary sanctions or criminal actions, even if on request, for reasons of national data protection law.

According to our experience, doctors who are suspended in a Member State for disciplinary or criminal reasons, or else for reasons of lacking physical fitness to practice, very often try to migrate to another Member State. If the competent authority of this Member State is not alerted, it might (have to) recognise the doctor's qualification and entitle him or her to work on its territory, thus putting the patients at risk. Therefore, for the benefit of patient safety, we regard it as crucial to extend the cooperation between Member States in this respect, and make them share information on disciplinary or criminal action etc. taken against doctors, or lack of doctors' physical or mental fitness to practice, in a pro-active and coordinated manner. It should be examined whether IMI could serve as an instrument for implementing such an alert mechanism.

E. OTHER OBSERVATIONS

19. How and when are the necessary language skills of migrants checked after recognition of the professional qualifications? Are you aware of any complaints (especially from patients/clients/employers) about insufficient language skills of migrants?

In our view migrating physicians should have sufficient language skills enabling them to safely practice medicine in the respective Member State. In this respect, it is vital that their language skills are not only sufficient for general conversation, but cover the whole range of medical language.

In Austria, in order to be able to register as medical doctors, physicians of non-German language have to undergo an assessment of their language skills before a commission of medical and linguistic experts, unless they have attended a German-speaking school or university, have trained or practised in a German speaking country, have completed university studies of the German language, or else can prove sufficient knowledge of German.

20. Does the application of Article 30 raise any specific problems?

There was the case of a doctor who obtained a basic medical qualification in South America. This was automatically recognized in an EU Member State on the basis of a bilateral agreement, and the doctor was issued a licence to practice by this Member State. On the basis of transitional law of the Member State in question, doctors who had obtained a licence to practice before a specific date were granted the right to pursue the activities of a general practitioner in the framework of its national social security system. Subsequently, the doctor in question applied for automatic recognition as a general medical practitioner in Austria on the basis of acquired rights.

Since the doctor did not possess an EU diploma, but a third country basic medical qualification which had been recognized, on the basis of a bilateral agreement, in an EU Member State for the purpose of pursuing the activities of a general practitioner in the framework of its national social security system, automatic recognition in Austria was not possible. The fact that the competent authority of the host Member State issued a certificate correctly stating the facts and mentioning that the diploma in question was not subject to automatic recognition, decisively facilitated the procedure.

Since the doctor had worked in the EU Member State that recognized her basic medical qualification for less than three years, Articles 3 (3) and 10 (g) of Directive 2005/36/EC did not apply, either.

In spite of individual cases like this, in which doctors face difficulties in migrating between Member States, the Austrian Medical Chamber thinks that Article 3 (3) is a useful provision which ensures that doctors with third country diplomas acquire sufficient professional experience within the health care system of an EU Member State before they are able to freely migrate throughout the EU.

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POLAND

Evaluating the Professional Qualifications Directive
Experience reports from competent authorities

QUESTIONNAIRE FOR THE MEDICAL PROFESSION

A. RECOGNITION PROCEDURE IN CASE OF MIGRATION ON A PERMANENT BASIS

1. **Do you accept applications from EU citizens for the recognition of foreign diplomas sent by email or requests made on line? Under which conditions can they send documents and declarations electronically? What are your experiences in this respect?**

Currently applications are to be made personally at the regional chamber of physicians and dentists (or by proxy) or sent by regular post as the main documents have to be provided in original hard copy versions and the application and certain statements have to be hand signed by the applicant.
In the course of the recognition process applicants often send additional documents by e-mail or by fax and later provide originals, this way shortening the duration of the proceedings.
The Polish administrative law envisages that applications may be made online or by e-mail with the use of a secure electronic signature. The application should include at least the applicant's name, address and request and be accompanied with the secure electronic signature. The competent authority is eligible to communicate with the applicant via internet as an official channel, including official correspondence, provided that the applicant has agreed to it. In fact this method has not yet been used by the doctors applying for recognition. However the competent authorities commonly use e-mails to provide information in the field of recognition of qualifications.

2. **What is the yearly number of positive and negative decisions of recognition from 2000 to 2009? Please submit specific data for applications for automatic recognition based on diplomas, automatic recognition based on acquired rights (as from 2005), and recognition based on the general system[1]. If available, please provide information on the average duration of the recognition process.**

According to the data submitted by the regional chambers of physicians and dentists the number of positive and negative decisions of automatic recognition of qualifications of doctors between 2007 and 2009 was the following:

	2007		
	Basic training	Specialist training	General medical practice
Positive decisions	12	6	-
Negative decisions	2	3	-

[1] Please provide this information unless it has already been provided to the Commission in the Database or the implementation reports.

	2008		
	Basic training	Specialist training	General medical practice
Positive decisions	22	12	-
Negative decisions	-	-	-
	2009		
	Basic training	Specialist training	General medical practice
Positive decisions	23	29	1
Negative decisions	1	2	1

The above indicated decisions include recognition based on diplomas and based on acquired rights.
As regards recognition based on the general system, in 2008 and 2009 the Minister of Health received 3 applications from physicians – proceedings in these cases are not accomplished yet.

We have no analysis of the average duration of the recognition process. It varies between cases, often depending on how promptly the applicant provides additional documents or competent authorities form other Member States provide requested information.

3. **To what extent have the system of automatic recognition and the general system been a success? How do you see the costs and benefits? Specify in particular whether automatic recognition based on diploma, Annex V and the current notification system represent an efficient way to facilitate automatic recognition. Please submit comments for:**

   - automatic recognition based on diploma

   System is efficient and provides no real problems – good administrative co-operation between competent authorities is the key for smooth operation of this system.

   - automatic recognition based on acquired rights

   Doubts may come up as to which competent authorities should certify that the migrant meets the requirements for the recognition based on acquired rights – migrants are not always aware which authority in their member State may issue this certificate and on which basis.
   There should be more clarity as to the definition of "effective" and "lawful" exercise of the profession as these terms may be differently interpreted between Member States.

   - recognition based on the general system.

   See response to question 4.

Please specify whether there are any specific problems with Annex V.

Annex V indicates only documents that are currently issued by Member States and is not always fully up-to-date as the notifications of changes are sometimes submitted and published with delay. Hence there are problems with denominations of diplomas that are not indicated in the Annex.
A solution could be to elaborate additional Annex with "historical" information, i.e. including denomination of documents that have been issued in the past and indication of the period of their issuance.

4. **Is the general system applied in your country each time the conditions for automatic recognition are not met? Are there major difficulties in the recognition procedure under the general system? Please include any comments you may have on the implementation of compensation measures. Is the migrant given the choice between an aptitude test and an adaptation period or is the choice restricted. Please explain.**

The general system is applied in Poland in relation to those situations that are set out by art. 10 (b), (d) and (g) of the Directive 2005/36/EC, i.e. when:
- migrant does not meet the requirements of effective and lawful professional practice for recognition based on acquired rights,
- migrant applies for recognition of qualifications as a specialist in the field not covered by automatic recognition,
- migrant meets the requirements set out in Article 3(3) of the Directive (evidence of formal qualifications issued by a third country recognised by a Member State and three years' professional experience).
In other cases not covered by automatic recognition a different procedure is in place (nostrification of a diploma by a Polish medical university, completion of post-graduate internship and passing the State Medical Exam).

The competent authority for recognition of qualifications of doctors falling under the general system is the Minister of Health (exception from the general rule that the competent authorities are regional medical councils). The Minister of Health acts in accordance with the provisions of the law of 18 March 2008 on the rules governing recognition of professional qualifications acquired in EU Member States. A task force of experts (including a representative of the medical self-government) is set up in relation to every application and on the basis of its opinion the Minister of Health makes a decision on the recognition.
The choice between an aptitude test and an adaptation period is restricted – the choice is made by the Minister according to the findings of the experts.

To date the Minister of Health has not received any application for recognition within the general system of qualifications of doctors with basic training. The Minister of Health has received a total of six applications for recognition of a specialist title within the general system
Hence, we are not yet in a position to provide general comments on the recognition procedure under the general system.

As an example we would like to point the case of a doctor who applied for recognition of a specialty. The applicant has submitted a document issued by the Joint

Committee of Paediatric Urology (JCPU) as an evidence of formal qualifications in the field of paediatric urology. JCPU is the European Board of Paediatric Urology settled in Belgium. Applicant's training has been provided in institutions within the EU and the examination has been held in Nice.
In this case there were concerns whether such a document may be treated as evidence of formal qualifications' falling under the Directive 2005/36/EC as a specialist, in particular whether it has been issued by the competent authority body within the meaning of the Directive 2005/ 36/ EC.
The Polish Chamber of Physicians and Dentists is of the opinion that this document is not an evidence of formal qualifications as a specialist and has not been issued by the competent authority. Hence qualifications confirmed by this document are not subject to recognition on the basis of the Directive.

5. What is your experience with the recognition procedure for EU citizens with professional qualifications obtained in a third country and already recognised in a first Member State (see Articles 2(2) and 3(3))?

Professional qualifications of EU citizens obtained in a third country and already recognised in a first Member State who meet requirements set out in art. 3 (3) are recognised under the general system. The main aim of the general system for the recognition of evidence of training is to compare whether education profile completed abroad is similar to Polish, including duration and curriculum of the training. The application should be submitted together with appropriate documents certifying the doctor's training and qualifications, as the Minister of Health bases his decision on the evidence provided by the physician. The Minister of Health makes decision on recognition the physician's qualifications only when he is convinced that the duration of the training and forms of acquisition of knowledge and practical skills correspond to the Polish program of medical training. Otherwise, the Minister of Health refuses the recognition. When justified, final decision may depend on completing compensatory measures.

This procedure may seem to foreign physicians as complicated. Especially, when compared with the procedure of automatic recognition. To date not much experience in this regard. We receive many requests for information on recognition of professional qualifications obtained outside the EU and already recognized in one of the Member States. However no application has been filed so far. It appears that complicated procedure discourages possible applicants in this situation.

When requirements of art. 3 (3) are not met, e.g. not enough professional experience, the other procedure, mentioned in response to question 4, is applied.

6. Please describe the government structure of the competent authority or authorities in charge of the recognition.

In Poland the competent authorities in charge of the recognition of qualifications of doctors are the bodies of the professional self-government of physicians and dentists – the regional medical councils (organs of the regional chambers of physicians and dentists).
There are 23 regional medical councils in Poland (and in addition a Military Medical Council with nationwide competence; further on the term "regional medical council"

will include the Military Medical Council as it has the same scope of tasks as regional medical councils).
The regional medical councils receive applications for recognition of qualifications obtained in other Member States. They make decision on the recognition and award the right to practice the profession in Poland.
The regional medical councils receive declarations related to the exercise of professional activities on a temporary and occasional basis and maintain a register of doctors temporarily exercising the profession in Poland.
The regional medical councils also provide certificates envisaged by the Directive 2005/36/EC to physicians who qualified in Poland and seek recognition in other Member States.
Within the Polish Supreme Chamber of Physicians and Dentists a Centre of Recognition of Qualifications has been established in order to co-ordinate the actions in the field of recognition and to support the regional medical councils and individual physicians. Regional medical councils in the course of proceeding with applications may ask for the opinion of the Centre regarding the documents submitted by the applicant. Regional medical councils also contact the Centre with other questions regarding application of the system of recognition of qualifications.
The Centre collects information related to recognition system, stays in contact with competent authorities in other Member States (often asking for specific information or clarifications on behalf of the regional councils or individual doctors), as well as provides information to doctors seeking recognition in Poland or in other Member States.

As an exception, in case of qualifications of doctors falling under the general system the competent authority is the Minister of Health (see information under question 4).
A migrant provides the regional medical council the decision of the Minister and on its basis the council awards the right to practice the profession (when basic training is recognised) or indicates the right to use the specialist title (when specialist qualifications are recognised).

B. TEMPORARY MOBILITY (OF A SELF-EMPLOYED OR AN EMPLOYED WORKER)

7. Are EU citizens interested in using the provisions for exercising their professional activities on a temporary and occasional basis in your Member State? How many citizens used this new system in 2008 and 2009 (per month, per year) [2]?

In 2009 regional medical councils received declarations only from 4 doctors intending to exercise their professional activities in Poland on a temporary and occasional basis. This number of doctors who had declared their professional activities in Poland on temporary and occasional basis is minimal and it is, therefore, evident that exercising professional activities on a temporary and occasional basis in Poland is not popular among doctors established in other Member States.

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[2] Please provide this information unless it has already been provided to the Commission in the Database or the implementation reports.

We have no data on the number of doctors established in Poland who exercise profession in other Member States on temporary and occasional basis. However, the regional medical councils have not been requested to issue certificates confirming that the doctor is legally established in Poland and is not prohibited from practising, as envisaged by art. 7 (2) (b) of the Directive. This would imply that doctors established in Poland are not availing themselves of this system.

8. **How are the provisions of Directive 2005/36/EC concerning temporary mobility applied by the competent authorities in practice taking into account the relevant provisions of the Code of Conduct? For instance:**

   - How is the "legal establishment" criteria foreseen by Article 5(1) (a) interpreted in practice? What conditions does a migrant need to fulfil in his home Member State in order to be able to provide services?

     The doctor intending to exercise the profession in Poland on temporary and occasional basis has to hold the evidence of formal qualifications obtained in a Member State and has to be entitled to practice the profession in another Member State without limitations.

   - How are the "temporary and occasional basis" criteria foreseen by Article 5.2 interpreted in practice? Do Member States assess duration, frequency, regularity and continuity of an activity and if so according to which criteria?

     The regional medical councils are aware that they should assess the "temporary and occasional basis" criteria in every individual case. However, to date we have no practical experience with that. In some cases when the doctor intends to practice the profession in Poland in a way that seems to be establishment rather than temporary and occasional (e.g. the doctor intends to practice as a full time employee, but concludes a work contract for the beginning valid for limited time period) the regional medical councils suggest the applicant to apply for recognition of qualifications and the right to practice the profession in Poland and the applicants have been up to now accepting that.

9. **Why is a prior declaration system necessary? What do competent authorities do with the information received? Are other possibilities conceivable? Do you have any cases – and if yes how many - whereby doctors sent the declaration after the provision of services has taken place.**

The prior declaration system is necessary, as it enables the competent authorities to be aware of the individuals intending to exercise the regulated profession of doctor in its territory.
Firstly, the competent authority may check – by contacting the authorities in other Member State when necessary – whether the given professional indeed has the necessary professional qualifications and is entitled to exercise the profession in the other Member State. Thus the competent authority may take appropriate actions in order to prevent exercise of the medical profession in its territory by professionals who are not entitled to this, and that is most of all in the interest of patients' safety.

Secondly, on the basis of a declaration the regional medical council runs a register of doctors temporarily and occasionally exercising the profession in Poland (a kind of automatic temporary registration envisaged in art. 6 (a) of the Directive). This way the council may supervise the exercise of the profession and if needed apply disciplinary provisions.

We have so far not received declarations sent after the doctor had provided medical services in Poland.

We also have no information about doctors temporarily exercising the profession in Poland without sending any declaration whatsoever.

10. Do you charge any fee in case Article 7 § 4 applies?

Not applicable to doctors.

C. MINIMUM TRAINING REQUIREMENTS

11. To what extent are the common minimum training requirements for specialists and general practitioners set out in Title III Chapter III of Directive 2005/36/EC and as defined in Annex V in line with scientific progress and professional needs? Furthermore, are the knowledge and skills required by the directive still relevant and up to date? Please specify. What about the conditions relating to the duration of training? Do you have many specialties training, which have a common trunk. If yes, please specify which ones.

In Poland medical specialties are divided into specialties in basic fields of medicine and specialties in specific fields of medicine. To commence training in a specific field of medicine the doctor has to hold a specialist title in an appropriate basic field (e.g. training in allergology may be commenced by holders of specialist titles in internal medicine, paediatrics, dermatology or in otolaryngology). As regards basic fields, doctors holding specialist titles in a given field may, in other appropriate basic field, commence training of shorter duration (e.g. a holder of specialist title in general surgery may take up training in thoracic surgery that takes 4 and a half years instead of 6 and a half years).
These regulations reflect a common trunk of various specialties existing in Poland.

One of the problems related to harmonization of specialist training in certain fields is that scope of specialties varies between Member States. Therefore, even though given specialties are indicated in the Annex V as equivalent and subject to automatic recognition, in fact the knowledge and skills obtained during the training in different Member States may differ substantially. As a result migrant doctor may find out in the host Member State that being a specialist in the given field he is expected to practice in an area that he is not in fact trained in.

12. To what extent are the common minimum requirements for training set out in Title III Chapter III of Directive 2005/36/EC in line with scientific progress and professional needs in the last ten years? Are the knowledge and skills

outlined in Article 24.3 still relevant and up to date? Please specify. What about the conditions relating to the duration of training?

13. **The Directive is based on mutual trust between Member States. To what extent is such trust actually achieved? Are training programmes accredited in your country? Does accreditation of a training program in another Member State enhance trust or is it not relevant?**

The standards of undergraduate medical training in Poland are laid down in a regulation of the Minister of Science and Higher Education. Medical universities are supervised by the Minister of Health. The State Accreditation Commission evaluates the quality of higher education.
The curricula of specialist training are elaborated and updated by a group of experts nominated by the Minister of Health. The Supreme Chamber of Physicians and Dentists gives an opinion on the draft curriculum. Finally it is endorsed by the Minister of Health and published by the Medical Centre of Postgraduate Education. Specialist training may be delivered only by institutions approved by the Minister of Health.
As regards continuing medical education, the providers and programmes are accredited by the chambers of physicians and dentists.

14. **To what extent are the existing Directive provisions (see recital 39 and Article 22(b) on continuous professional development (continuous training) adequate? Is continuous training mandatory in your country and what are the exact conditions?**

Continuing professional development is an essential component of professional qualifications of doctors. Therefore the provision of art. 22 (b) and the recital 39 requiring Member States to make arrangements for the continuing education for doctors has to be maintained.

In Poland continuous medical education is mandatory for doctors by virtue of the law. A credit-points system is applied over a 4-year period - every 4 years doctors have to collect 200 credit points by attending practical courses, lectures, seminars and congresses.
Continuing education is administered by the chambers of physicians and dentists. The contents and quality of continuing education courses are supervised by regional chambers. Some institutions in Poland are entitled to provide continuing professional education by virtue if the law (e.g. medical universities, institutions entitled to provide specialist training). As regards other providers of continuing professional education events, they have to be registered by the chambers.
The chambers also confirm that a doctor has fulfilled the obligation of collecting the credit points. Educational events attended abroad may be recognized in Poland and the points accredited according to the Polish points scale.

Another problem relates to doctors who have not been practising the profession for a longer period of time and intend to recommence their professional practice. It is clear that a doctor with an extensive break in his professional practice should undergo some sort of verification of his current professional knowledge and skills.
In a case of a doctor who had not been practicing the profession and applies for recognition and the right to practice in another Member State, it is not clear what

actions may be taken by the competent authority in that State. For example under Polish law a doctor who had not been practising the profession for more than 5 years and intends to recommence professional practice is required to complete additional "refreshment" training before taking up again the exercise of the profession. The duration and curriculum of the training is determined by the regional medical council on a case-by-case basis. In our opinion this procedure should also apply to a doctor from another Member State.

D. ADMINISTRATIVE COOPERATION

15. To which extent does administrative cooperation, as outlined in Articles 8, 50, and 56 of the Directive, simplify procedures for the migrant professionals?

Administrative co-operation is of the utmost importance in the process of recognition of qualifications – quick exchange of reliable information helps to speed up the procedure and that is in the interest of the migrant. Good administrative cooperation helps to obtain necessary information. For instance, the Minister of Health requested an opinion on the recognition of specialist title in the field of paediatric urology and received helpful responds from other authorities.
Generally, we are experiencing proper administrative co-operation with authorities from other Member States. Most of our enquiries are thoroughly responded to, although sometimes with delay, which in turn has a negative effect for the applicant. It is often possible to gather the relevant information promptly in direct contact with the competent authority without involving the applicant.

In case where for a given profession there is more than one competent authority in a Member State their tasks and territorial competence should be clearly indicated. This would facilitate easier and faster contact.

16. Is the competent authority in your country registered with IMI? Under which circumstances does your competent authority use IMI? If not registered, why not and what would be the conditions for changing this situation?

All the regional chambers of physicians and dentists as well as the Supreme Chamber are registered with IMI and use it on regular basis, both responding to (more often) and sending out requests for information. To date 40 requests were sent to the chambers in Poland, whereas the chambers themselves sent out 12 requests. 39 requests are closed, 13 are still being processed (the data comprises requests related to the professions of a doctor and a dental practitioner).

The IMI is in many cases useful tool to gather necessary information. However, in more complex cases it is more convenient to use other tools of communication (e-mail, post, telephone) in order to clarify the matter. The pre-defined questions in IMI are sometimes not suitable and there is not enough space to put additional remarks.
Anyway, the big advantage of IMI is the easily accessible updated database of competent authorities.

17. How could a professional card (see Recital 32 of the Directive) facilitate recognition of professional qualifications and provision of temporary services? Under which conditions could it be issued by professional associations?

A professional card could facilitate recognition of professional qualifications and provision of temporary services in case of doctors who fulfil all the conditions for recognition or temporary provision of services, i.e. hold the evidence of formal qualifications indicated in the relevant annexes and meet the requirements regarding good repute and character.
In other cases the migrant would still need to provide additional documents – certificates issued by competent authority. And sometimes direct contact between competent authorities in order to clarify certain doubts would still be inevitable.

It should be possible for a professional card to carry all the data necessary for the recognition procedure (qualifications, good standing etc.) and this data should be updated by the competent authorities on regular basis. That however might be problematic, given the number of various possible situations.

In Poland the professional self-government (chambers of physicians and dentists) by virtue of the law maintains a register of physicians and dentists with all the relevant professional data on each professional registered in Poland. This way, the chambers are in possession of all the data that would have to be contained in a professional card. Hence from a formal point of view the chambers in Poland are in a position to issue professional cards to Polish doctors.

18. Are you alerted by other Member States in case of disciplinary action or criminal sanctions taken or any other serious, specific circumstances which are likely to have consequences for the pursuit of activities under this Directive? How do you share this information? Could more be done in this respect?

We are alerted, but only by a small number of the Member States (usually the UK and Ireland).
Such an information about disciplinary action, criminal sanctions or other serious circumstances regarding a doctor registered in Poland is forwarded to the regional chamber wherewith the doctor is registered.
On this basis the regional chamber should take up actions to determine whether this could be a basis for disciplinary action in Poland under the Polish law. However, it is often problematic to proceed in a case like this, as it is difficult (and could be costly as well) to gather the evidence which is available only abroad.

With regard to a doctor registered in Poland pending disciplinary actions, imposed disciplinary or penal sanctions or other limitations to the right to practice the profession are always indicated by the regional medical council in the so called Certificate of Good Standing (issued on the basis of Annex VII point 1 (d) of the Directive). This way competent authorities in other Member States are aware at this at the point of registering the doctor, as they always require submission of this certificate.

There is, however, a problem when the action is commenced or the sanctions or limitations imposed after the doctor has also been registered in another Member State. The regional medical council may send such an information only to the competent authority of a Member State wherein the doctor practices or intends to practice the profession. And usually doctors do not inform their respective regional chambers in which other Member State they are also exercising the profession.
A solution to this could be, when competent authorities in Member States would be informing each other on regular basis that they have registered a doctor coming from another Member State.

E. OTHER OBSERVATIONS

19. How and when are the necessary language skills of migrants checked after recognition of the professional qualifications? Are you aware of any complaints (especially from patients/clients/employers) about insufficient language skills of migrants?

In order to be awarded the right to practice the profession of a physician in Poland an applicant has to declare in writing the knowledge of Polish language to the extent necessary to practice the medical profession. The regional medical councils are not entitled to require any additional proof. However, when the statement made by the applicant seems to be clearly false (the applicant does not speak Polish at all or very poorly) the council, having awarded the right to practice, may commence the sort of fitness to practice proceedings that could lead to limiting the doctor's entitlement to practice the profession until the language skills are developed to a satisfactory level.

We are not aware of complaints about insufficient language skills of migrants.

In general, as regards the language skills, there should be more clarity as to the application of the language requirement in various Member States. The authorities should clearly know what level of language skills can be demanded and how it can be tested and the applicants should be aware what can be required from them.

20. Does the application of Article 30 raise any specific problems?

No.
Acquired rights in the field of general medical practice for doctors in Poland have been specified in the law regulating the general health insurance.
Doctors meeting those requirements may request a certificate from the regional medical council confirming their acquired rights in the field of general medical practice that can be used both domestically (to conclude contract with the National Health Fund) and in other Member States (for recognition of qualifications in this field).

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PORTUGAL

Evaluation of Directive 2005/36/CE

Answer to questionnaire

A – Recognition procedure in case of migration on a permanent basis

1 – No, the Portuguese Medical Association does not accept any documents submitted through IT/internet means, since we do not fully trust them as far as transmission security and document reliability are concerned.
Requests can be submitted electronically as long as the necessary documents are submitted in paper format, according to all formalities.

2 – The following diplomas have been recognized:

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Degree recognition										
EU National doctors with EU degree	251	266	197	177	145	138	181	89	81	63
Non EU national doctors with EU degree	18	9	13	13	18	17	23	14	17	17
Speciality recognition										
EU national doctors with EU specialty	124	101	120	48	124	43	29	34	23	14

No enrolment requests were denied.

3 – The application of the automatic recognition system allows a swifter handling of qualification recognition requests and warrants increased security in the attribution of equivalences. The implementation of Annex V did not raise any difficulties, and several entries were corrected on the basis of request changes delivered by the Portuguese Medical Association.
Both the automatic based on diplomas recognition and the recognition of acquired rights became easier through the implementation of the Directive rules on this matter.
Implementation of the common recognition system leads to some issues, as those described on paragraph 4.

4 – The Portuguese Medical Association has problems in implementing articles 11 and 13 of the Directive, since the base medical training is so specific that it cannot be replaced by any other equivalent training. In any case, those principles may be applied to submit the candidate to medical internship. The candidates are not given the option to choose their compensation.

5 – If the candidate submits a document issued by the State-member that has recognized the foreign qualification ensuring title equivalence to those issued by that same State, the request is accepted. Should the equivalence not be certified, the process is analyzed on the basis of the common system rules and is subject to detailed assessment, namely regarding the training underlying the title.

6 – Support Service – Juridical Department, when necessary – Competent Regional Council

B – Temporary mobility (of a self-employed or an employed worker)

7 – Yes, the Portuguese Medical Association receives some requests from service providers that are not interested in establishing themselves in our territory. Throughout the year 2008, 23 requests were delivered and 19 during the year 2009.

8 – The Portuguese Medical Association only demand as proof is a certificate from the State-member of origin clearly stating that the candidate legally and effectively practices the profession in the State of origin, as well as the documents stated in article 7, paragraph 2 of the Directive.
Temporary and occasional provision of services is evaluated on a case by case basis, according to its duration, frequency and eventual continuity. For instance, the practice of one isolated act or a set of actions to one patient in one particular institution, in a specific date, is clearly a provided service. This may also be the case of someone practicing Medicine for a period of 6 months for a specific program, without the candidate actually moving into Portugal and for as long as the practice is not reiterated, i.e., repeated every year.

9 – The previous statement is a way to control those who practice medical acts in Portugal, evaluate their reliability and to take, if needed, disciplinary measures.

10 – No.

C – Minimum training requirements

11 –

12 –

13 – Every time a diploma certifies that a candidate fulfils the minimum training requirements, the Portuguese Medical Association recognises it, which means we trust the equivalency determined by the Directive. In Portugal, training programs are legally recognized and defined.

14 – The continuous training is an essential part in the quality of medical acts, and therefore should be promoted. It is a deontological duty for doctors to keep up to date with the progress of Medicine and its respective techniques, to ensure better medical care for their patients.

D – Administrative cooperation

15 – Cooperation between different competent authorities allows processes to become more agile and dynamic, and therefore it is not necessary that the candidate requests and delivers a new document, since the Portuguese Medical Association can clarify any doubts directly with the competent authority from the origin State-member.

16 – Yes, it is registered and regularly uses the system, as a way to clarify doubts regarding qualifications or professional reliability of any candidate, and also as a way to reply to requests delivered by other entities.

17 – State-members inform us of any disciplinary sanctions if a doctor intends to register with the Portuguese Medical Association or if there is any record that he practices Medicine in Portugal. This information exchange is a direct procedure between the competent authorities or is verified on the documents delivered by the candidate.

E – Other observations

18 – Language knowledge is evaluated every time the candidate does not fully master the Portuguese language and such a situation may become an obstacle to the adequate practice of his/her activity.

19 – No.

SLOVENIA

Evaluating the Professional Qualifications Directive
Experience reports from competent authorities

QUESTIONNAIRE FOR THE MEDICAL PROFESSION

A. RECOGNITION PROCEDURE IN CASE OF MIGRATION ON A PERMANENT BASIS

1. Do you accept applications from EU citizens for the recognition of foreign diplomas sent by email or requests made on line? Under which conditions can they send documents and declarations electronically? What are your experiences in this respect?

In the procedure of professional qualification an application can be also sent by email. The certificated copies and official translations of documents should be submitted by post or personally.

2. What is the yearly number of positive and negative decisions of recognition from 2000 to 2009? Please submit specific data for applications for automatic recognition based on diplomas, automatic recognition based on acquired rights (as from 2005), and recognition based on the general system[1]. If available, please provide information on the average duration of the recognition process.

Ministry of Health is competent authority for recognition of qualification from November 2008.
In year 2009 we received 13 applications, 10 for recognition of qualification of physician, one for recognition of physician specialist of general surgery, one for recognition of physician specialist of clinical genetic.
In the year 2009 we recognized 9 qualification of physician, from this 4 based on diploma, and 5 based on acquired rights.

For recognition of qualification of physician specialist of general surgery and for recognition of physician specialist of clinical genetic general system is applied, but because one candidate did not submit required documents within the prescribed period, his application was rejected. The other procedure is still in progress.

The average duration of recognition progress is 2 months.

3. To what extent have the system of automatic recognition and the general system been a success? How do you see the costs and benefits? Specify in particular whether automatic recognition based on diploma, Annex V and the current notification system represent an efficient way to facilitate automatic recognition. Please submit comments for:

   - automatic recognition based on diploma
   - automatic recognition based on acquired rights

[1] Please provide this information unless it has already been provided to the Commission in the Database or the implementation reports.

- recognition based on the general system.

Please specify whether there are any specific problems with Annex V.

In the Republic of Slovenia we currently have lack of physicians. The system of automatic recognition is the fastest way for employment of qualified persons, but we noticed that there are major differences in knowledge of foreign physicians from other EU Member states in comparison with Slovene one.

And of course the knowledge of language is on of the biggest problem and barrier to the mobility on internal market.

Also the automatic recognition based on acquired rights is an advantage, while person can benefit from automatic recognition only if he has the certificate of working experience. But because Directive doesn't specify how many hours person has to work in order to get the certificate of working experience, person can get it also if he works part time.

The benefit of the general system is that competent authority can assess knowledge and competences of a person.

4. Is the general system applied in your country each time the conditions for automatic recognition are not met? Are there major difficulties in the recognition procedure under the general system? Please include any comments you may have on the implementation of compensation measures. Is the migrant given the choice between an aptitude test and an adaptation period or is the choice restricted. Please explain.

In the procedure under general system, compared with procedure under automatic system, Ministry always consult professional organisation for doctors, Medical chamber of Slovenia. The compensation measures are determined together.

The migrant is given the choice between an aptitude test and an adaptation period, but lately we have problems with same specialisation, where in aptitude test the migrant would have to make presentation of cases of his patients, which can't be done, if person did not perform profession in the Republic of Slovenia.

5. What is your experience with the recognition procedure for EU citizens with professional qualifications obtained in a third country and already recognised in a first Member State (see Articles 2(2) and 3(3))?

In the procedure of professional qualification we recognized qualification obtained in EU member state, irrespective of nationality. If person possess document of qualification mentioned in Annex V, we recognized it irrespective of her nationality.

In the year 2010 we have received 2 applications from candidates, who have obtained qualification in a third country and were already recognised in one of the Member State. In both cases the requirement for three years working experience has not been met, nevertheless we examine the knowledge and qualifications already recognised from another member state and recognised them under general system.

6. Please describe the government structure of the competent authority or authorities in charge of the recognition.

Ministry of Labour, Family and Social Affairs is responsible for the coordination of the implementation and the uniform application for the procedures of recognizing and regulations issued for the implementation of the directives
The procedure for recognising qualifications of doctors is conducted by Ministry of Health of Republic of Slovenia which is competent authority for all of health professions. The procedure of recognition of a qualification is initiated by a candidate lodging an application with the competent authority for a particular regulated profession or professional activity.

After the receipt of the application, the competent authority informs the candidate about any missing certificates and asks for additional documentation, as necessary. After the receipt of a complete application, the competent authority must issue a decision within two months.
In the course of the procedure, the competent authority may request a competent professional chamber or organisation to submit their opinion; if the latter is not provided, the competent authority shall issue its decision without it. An opinion of a competent professional chamber or organisation shall not be binding for a decision issued by the competent authority.

In the case of an automatic recognition procedure the applicant's documents are compared with the evidence requested in Annex V and if they meet the qualification is automatically recognized.

In the procedure, the competent ministry compares written documentation on the applicant's professional qualifications with the professional qualifications required by regulations in the Republic of Slovenia for the pursuit of the regulated profession or professional activity. If based on the comparison, the competent authority assesses that the applicant's professional qualifications are not adequate, it issues a provisional decision and calls on the applicant to take one of the following supplementary actions, depending on the circumstances, in order to obtain recognition of his/her professional qualifications:

- an aptitude test; or
- an adaptation period, during which the applicant will satisfy the conditions for recognition of professional qualifications which he/she initially failed to meet.

The competent authority issues a decision on the recognition of the candidate's professional qualification regarding the pursuit of a particular regulated profession or activity in the Republic of Slovenia:
a) when it is assessed –based on the application – that the candidate's professional qualifications comply with the qualifications required for the pursuit of a particular regulated profession or professional activity in the Republic of Slovenia;
b) when the candidate submits evidence of a successfully completed adjustment period or aptitude test ,
c) in case of automatic recognition on the basis of evidence that meets the evidence in Annex V.

On the basis of a decision on the recognition of professional qualifications, the candidate is enabled to pursue a regulated profession for which he/she has been qualified in a Member State of the EU, EEA or the Swiss Confederation under the same conditions that apply to Slovenian nationals, provided that the activities covered by that profession are comparable.

B. TEMPORARY MOBILITY (OF A SELF-EMPLOYED OR AN EMPLOYED WORKER)

7. Are EU citizens interested in using the provisions for exercising their professional activities on a temporary and occasional basis in your Member State? How many citizens used this new system in 2008 and 2009 (per month, per year) [2]?

   We received only two declarations, but none of them was complete.

8. How are the provisions of Directive 2005/36/EC concerning temporary mobility applied by the competent authorities in practice taking into account the relevant provisions of the Code of Conduct? For instance:

   - How is the "legal establishment" criteria foreseen by Article 5(1) (a) interpreted in practice? What conditions does a migrant need to fulfil in his home Member State in order to be able to provide services?

For attesting legal establishment the migrant has to attach next documents:
- certificate from competent authority,
- certificate of the professional licence,
- certificate of good standing,
- registration certificate

   - How are the "temporary and occasional basis" criteria foreseen by Article 5.2 interpreted in practice? Do Member States assess duration, frequency, regularity and continuity of an activity and if so according to which criteria?

For determination of "temporary services" in declaration the migrant has to indicate how much time and how often will perform services. And than the competent authority decides whether it is "temporary and occasional basis" or not.

9. Why is a prior declaration system necessary? What do competent authorities do with the information received? Are other possibilities conceivable? Do you have any cases – and if yes how many - whereby doctors sent the declaration after the provision of services has taken place.

The competent authority collects information for statistical and analytical purposes., they are also used for annual reports to the European Commission.
On the basis of the information we supervise the professionals pursuing services in our country.

Ministry of Health submits complete application to Medical chamber of Slovenia, which temporary registers migrant in the register of physicians.

10. Do you charge any fee in case Article 7, § 4 applies?

We charge fee in amount of 17,73 EUR.

Fee in amount of 17,73 EUR is also charged for recognition of professional qualification.

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[2] Please provide this information unless it has already been provided to the Commission in the Database or the implementation reports.

C MINIMUM TRAINING REQUIREMENTS

11. To what extent are the common minimum training requirements for specialists and general practitioners set out in Title III Chapter III of Directive 2005/36/EC and as defined in Annex V in line with scientific progress and professional needs? Furthermore, are the knowledge and skills required by the directive still relevant and up to date? Please specify. What about the conditions relating to the duration of training? Do you have many specialties training, which have a common trunk. If yes, please specify which ones.

The Directive only determines framework without any content in it, which is not enough for mutual trust to be achieved. We understand that because of scientific problems it is hard to determine the content of training, but some of it should be put in the Directive.
For instance we could follow other sectoral professions where the programme of training is described in the Directive.

In Annex V of Directive only minimum training requirements for different specialization are determined. Some countries have specialization which have come trunk, others have specialization which are "independent".
In the Republic of Slovenia we have two groups of specialities training with common trunk. In the first are so called surgical specializations that include: abdominal surgery, general surgery, urology, trauma and orthopaedic surgery, plastic surgery, cardio vascular surgery, thoracic surgery
and in the second are so called internal medicine specializations that include: internal medicine, respiratory medicine, gastroenterology, rheumatology, haematology, renal medicine, internal oncology.

12. To what extent are the common minimum requirements for training set out in Title III Chapter III of Directive 2005/36/EC in line with scientific progress and professional needs in the last ten years? Are the knowledge and skills outlined in Article 24.3 still relevant and up to date? Please specify. What about the conditions relating to the duration of training?

The requirements set in the Article 24.3 of Directive are very general and very broad.

13. The Directive is based on mutual trust between Member States. To what extent is such trust actually achieved? Are training programmes accredited in your country? Does accreditation of a training program in another Member State enhance trust or is it not relevant?

The mutual trust is not achieved, therefore in the procedure of professional qualification Ministry of Health always requires certificate of obtained qualification, issued by competent authority.
Basic medical training and also specialist medical training are accredited first by Medical University, second by Medical Chamber of Slovenia. The contents of specializations are prepared by Slovenian Medical Association in conjunction with the Medical University and than adopted by the Medical Chamber of Slovenia.

14. To what extent are the existing Directive provisions (see recital 39 and Article 22(b) on continuous professional development (continuous training) adequate? Is continuous training mandatory in your country and what are the exact conditions?

According to national law all (Health service act) health workers and health associates have the right and obligation of further professional training, thus an institution must enable them to:

- regularly to follow the development of health sciences;
- occasional practical further training in appropriate health institutions;
- occasional verifying of theoretical and practical knowledge.

Physicians in the Republic of Slovenia need a licence to practice, which is conferred after completion of specialisation. The licence is conferred for 7 years. Physicians must, prior to the expiry of their licence, submit evidences of their fulfilment of the conditions for renewing the licence. Licence is renewed on the basis of evidence of participations in seminars, conferences, ... For the renewing of licence physician must collect 75 credit points during the past licensing period. 1 hour is one credit.

D. ADMINISTRATIVE COOPERATION

15. To which extent does administrative cooperation, as outlined in Articles 8, 50, and 56 of the Directive, simplify procedures for the migrant professionals?

Administrative cooperation simplifies and fastens procedure for the migrant professionals, while some information about migrants qualifications can be obtained directly from competent authority.

16. Is the competent authority in your country registered with IMI? Under which circumstances does your competent authority use IMI? If not registered, why not and what would be the conditions for changing this situation?

Ministry of Heath is registered in IMI. Till now we only replied to inquires of another Member State.

17. How could a professional card (see Recital 32 of the Directive) facilitate recognition of professional qualifications and provision of temporary services? Under which conditions could it be issued by professional associations?

We think that professional card is not relevant in the procedure of professional qualifications.

18. Are you alerted by other Member States in case of disciplinary action or criminal sanctions taken or any other serious, specific circumstances which are likely to have consequences for the pursuit of activities under this Directive? How do you share this information? Could more be done in this respect?

Ministry of Health as well as Medical Chamber of Slovenia are alerted by some countries. We do not inform others yet, but are planning to do so in near future.

IMI is the right tool for sharing the information with competent authorities about suspensions/restrictions. It could also be the right toll for sharing other relevant information.

E. OTHER OBSERVATIONS

19. How and when are the necessary language skills of migrants checked after recognition of the professional qualifications? Are you aware of any complaints (especially from patients/clients/employers) about insufficient language skills of migrants?

According to The act on the performance of medical professions in the Republic of Slovenia by citizens of other Member States of the European Union the employer specify in its employment regulations the level of knowledge of the Slovene languages and the method of its assessment, that are required in relation to individual work posts. The Government has set the standards for the level of Slovene language skills for typical work posts.

Because of insufficient language skill one of the migrant could not manage to get true the specialization process.

20. Does the application of Article 30 raise any specific problems?

Yes.
A few years ago (till 2007) we had a specific postgraduate training which was called "sekundarijat"-basic postgraduate training. This training lasted for 2 years, first 6 months was internship that ended with exam and at the end of the two years was the final exam. Doctor who passed this final exam has received the licence for general practitioner. In the Republic of Slovenia he can perform the activity of general practitioner.

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Valvira
Sosiaali- ja terveysalan
lupa- ja valvontavirasto

21 June 2010

FINLAND

European@gmc-uk.org

Evaluating the Professional Qualifications Directive
Experience reports from competent authorities
Doctors

QUESTIONNAIRE FOR THE MEDICAL PROFESSION

A. Recognition procedure in case of migration on a permanent basis

1. The Finnish National Supervisory Authority for Welfare and Health (Valvira) accepts only applications for the recognition of foreign diplomas that have been signed by the applicant. Valvira accepts only certified copies of diplomas and other official documents. No documents or declarations are accepted electronically.

2. The yearly number of positive decisions:
   2000 100
   2001 133
   2002 110
   2003 140
   2004 342
   2005 316
   2006 215
   2007 245
   2008 226
   2009 324

   Very few negative decisions have been made. The exact yearly number of negative decisions is not available.

   The information whether the decision has been based on automatic recognition (diplomas, acquired rights) or general system is not available.

   The average duration of the automatic recognition based on diplomas and acquired rights is one month.

3. *Automatic recognition based on diploma* is a simple procedure for applicants and the competent authority. It is also a fast way to get a recognation.

   Diplomas are not always named exactly the same as mentioned in the Annex V. This may cause some confusion.

   Automatic recognition based on acquired rights is also a simple procedure and a fast way to get a recognition. Valvira has always accepted certificates stating that the applicant has been effectively and lawfully engaged in the activities in question for at least three consecutive years during the five years preceding the award of the certificate. However, it is not defined what effectively and lawfully means. Definitions may vary between Member States.

   Recognation based on the general system
   If one fails an aptitude test, is it possible to retake it. How many times?

PL 210, 00531 Helsinki | Lintulahdenkuja 4, 00530 Helsinki | Puhelin (09) 772 920 | Faksi (09) 7729 2138 | www.valvira.fi | kirjaamo@valvira.fi (registry office)

4. When the conditions for automatic recognition are not met, Valvira always applies the general system. The adaptation period as well as the aptitude test is implemented in national law (Act on Healthcare Professionals 559/1994). The decision on the compensation measure is made by the Valvira.

5. If the applicant has been working in the Member State that has already recognised the professional qualifications for 3 years, Valvira has almost every time recognised the professional qualifications based on the working experience. If the applicant doesn't have the working experience required in Article 3 (3) of the Directive 2005/36/EC the recognition procedure is similar to the recognition procedure for non-EU citizens who have obtained their qualifications in a non-Member State.

6. When the recognition concerns healthcare professionals according to the Finnish Act on Healthcare Professionals, the competent authority is Valvira. Valvira is an independent office under the Ministry Of Social Affairs and Health.

B. Temporary mobility (of a self-employed or an employed worker)

7. Valvira has not received any questions or declarations according to the Art. 7 of the Directive 2005/36/EC of applicants concerning the exercising of their professional activities on a temporary and occasional basis.

8. No practice.

9. It is important for patient safety reasons that the national supervisory authority is aware of who plans to practice in Finland.

10. The fee is 170 €.

C. Minimum training requirements

11. It has not come to Valviras knowlegde that the minimum training requirements would not be in line with the provisions of the Directive. The Ministry of Education and Culture is the competent authority when it comes to educational requirements.

The following specialties training have common trunk:
gastroenterological surgery, hand surgery, paediatric surgery, orthopaedics and traumatology, plastic surgery, cardiothoracic surgery, urology, vascular surgery, general surgery

The following specialties training have common trunk:
endocrinology, gastroenterology, clinical haematology, infectious diseases, cardiology, nephrology, rheumatology, internal medicine

The following specialties training have common trunk:
child psychiatry, adolescent psychiatry, forensic psychiatry, psychiatry

The following specialties training have common trunk:
general practice, occupational health, geriatrics

12. See question number 11. The duration of training is appropriate.

13. Valvira does not question the authenticity of proofs issued by other competent authorities according to Annex VII 2. However, there has been uncertainty when it comes to proofs about compliance with the directive issued by some Member States. In these cases the training has been completed much before the reference date.

14. Continuous professional development (continuous training) is mandatory in Finland. According to Section 18 of the Act on Health Care Professionals (559/1994) health care professionals must maintain and improve their professional knowledge and skills required to carry on their professional activity and familiarise themselves with the provisions and regulations concerning them. Employers of health care professionals shall create opportunities for participation in necessary further training for the profession.

D. Administrative cooperation

15. Active administrative cooperation is crucial for the functioning of the Directive. Administrative cooperation simplifies and quickens the procedure.

16. Valvira is registered with IMI. Valvira uses IMI whenever it needs clarifications from a competent authority concerning an application.

17. A professional card can only work if the competent authority could be sure that the information on the card is reliable and up to date. The professional card could be issued by professional associations if they are a competent authority or they issue the cards in co-ordination with the national competent authorities.

18. Valvira shares information about suspensions/restrictions with the competent authorities of the other Nordic countries.

19. According to Section 18a of the Act on Health Care Professionals health care professionals must have adequate language skills that are required by the work tasks of this particular health care professional. Checking the necessary language skills is left to employers. Valvira is aware of complaints about insufficient language skills of migrants from patients as well as from managers of places of employment. In latter cases doctors have mostly been employed by companies providing medical staff.

20. Specific problems haven't raised.

SWEDEN

Evaluating the Professional Qualifications Directive
Experience reports from competent authorities

QUESTIONNAIRE FOR THE MEDICAL PROFESSION

A. RECOGNITION PROCEDURE IN CASE OF MIGRATION ON A PERMANENT BASIS

1. Do you accept applications from EU citizens for the recognition of foreign diplomas sent by email or requests made on line? Under which conditions can they send documents and declarations electronically? What are your experiences in this respect?

   We accept applications sent by email, but most applicants send in an application form by post. We demand that certified copies of diplomas and other official documents are sent in by post.

2. What is the yearly number of positive and negative decisions of recognition from 2000 to 2009? Please submit specific data for applications for automatic recognition based on diplomas, automatic recognition based on acquired rights (as from 2005), and recognition based on the general system[1]. If available, please provide information on the average duration of the recognition process.

   Yearly number of applications with positive decisions 2003-2009

2003	2004	2005	2006	2007	2008	2009
576	882	765	802	1134	993	750

   In 2009 there were 3 negative decisions.

   We can at present not submit specific data for applications for automatic recognition based on diplomas, automatic recognition based on acquired rights and recognition based on the general system. In 2009 approximately 10 % of the positive decisions were on basis of acquired rights.

3. To what extent have the system of automatic recognition and the general system been a success? How do you see the costs and benefits? Specify in particular whether automatic recognition based on diploma, Annex V and the current notification system represent an efficient way to facilitate automatic recognition. Please submit comments for:

   - automatic recognition based on diploma

   When the applicant has the qualification listed in Annex V and the training began after the reference date the recognition process is quick and cost-effective.

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[1] Please provide this information unless it has already been provided to the Commission in the Database or the implementation reports.

- automatic recognition based on acquired rights

In some cases we have received certificates stating that the applicant has been working in the Member State of origin when the CV shows that the applicant has been residing in Sweden during that time.

We have also experienced difficulties in certifying professional experience in Sweden since the applicants sometimes do not provide us with the relevant documentation.

- recognition based on the general system.

Recognition based on the general system can be quite complicated, time-consuming and cost-intensive. It is often difficult to get relevant documentation regarding the content of the training and the professional experience. Furthermore translation of the documents will often be required, a substantial expense for the applicant.

Please specify whether there are any specific problems with Annex V.

The information in Annex V is not always up to date. The process of recognition could be quicker if the Annex was updated more frequently. It would also be useful to include historical information, including the denomination of the documents that have been issued in the past and when they have been issued.

4. Is the general system applied in your country each time the conditions for automatic recognition are not met? Are there major difficulties in the recognition procedure under the general system? Please include any comments you may have on the implementation of compensation measures. Is the migrant given the choice between an aptitude test and an adaptation period or is the choice restricted. Please explain.

Yes, the general system is applied each time the conditions for automatic recognition are not met. When the training is more than one level below in article 11 in the directive there will be a negative decision.

We look at every case individually when deciding upon compensatory measures.
When the applicant has chosen an adaptation period he must himself find a place. Knowledge of the Swedish language is normally necessary to successfully go through the adaptation period. No one has yet chosen to take an aptitude test.

5. What is your experience with the recognition procedure for EU citizens with professional qualifications obtained in a third country and already recognised in a first Member State (see Articles 2(2) and 3(3))?

When the professional qualifications obtained in a third country are recognised in a Member State they are automatically recognized in Sweden, thus the three years of experience is not mandatory.

We have experienced difficulties in certifying professional experience in Sweden since the applicants sometimes do not provide us with the relevant documentation.

6. Please describe the government structure of the competent authority or authorities in charge of the recognition.

The National Board of Health and Welfare (Socialstyrelsen) is an authority under the Ministry of Health and Social Affairs. The National Board of Health and Welfare is responsible for the registration and supervision of all regulated health care professionals in Sweden.

B. TEMPORARY MOBILITY (OF A SELF-EMPLOYED OR AN EMPLOYED WORKER)

7. Are EU citizens interested in using the provisions for exercising their professional activities on a temporary and occasional basis in your Member State? How many citizens used this new system in 2008 and 2009 (per month, per year) [2]?

No one has yet used this system. We believe that they instead apply for permanent recognition. There might also be persons exercising their professional activities on a temporary and occasional basis in Sweden that are unaware of the procedure or for other reasons refrain from informing Socialstyrelsen.

8. How are the provisions of Directive 2005/36/EC concerning temporary mobility applied by the competent authorities in practice taking into account the relevant provisions of the Code of Conduct? For instance:

- How is the "legal establishment" criteria foreseen by Article 5(1) (a) interpreted in practice? What conditions does a migrant need to fulfil in his home Member State in order to be able to provide services?

We do not have any practise since no one has used the provisions. In the regulation incorporating the provisions it is stated that the applicant has to meet all the conditions for practising that profession in the host Member State and is not prohibited from practising that profession.

- How are the "temporary and occasional basis" criteria foreseen by Article 5.2 interpreted in practice? Do Member States assess duration, frequency, regularity and continuity of an activity and if so according to which criteria?

9. Why is a prior declaration system necessary? What do competent authorities do with the information received? Are other possibilities conceivable? Do you have any cases – and if yes how many - whereby doctors sent the declaration after the provision of services has taken place.

To ensure patient safety it is important for the supervisory authority to know when health care professionals are exercising professional activities.

10. Do you charge any fee in case Article 7, § 4 applies?

We would not charge a fee.

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[2] Please provide this information unless it has already been provided to the Commission in the Database or the implementation reports.

C MINIMUM TRAINING REQUIREMENTS

11. To what extent are the common minimum training requirements for specialists and general practitioners set out in Title III Chapter III of Directive 2005/36/EC and as defined in Annex V in line with scientific progress and professional needs? Furthermore, are the knowledge and skills required by the directive still relevant and up to date? Please specify. What about the conditions relating to the duration of training? Do you have many specialties training, which have a common trunk. If yes, please specify which ones.

There are a total of 56 specialities in Sweden, of which 31 are basic specialities, 23 sector specialities and 2 supplementary specialities. An individual undergoing training in Sweden must hold a qualification in a basic speciality to be able to obtain specialist qualification in a sector speciality or a supplementary speciality. The minimum training period to obtain a qualification in a basic speciality is five years. We believe that a training period of three years is insufficient and that the minimum training requirements should be changed.

12. To what extent are the common minimum requirements for training set out in Title III Chapter III of Directive 2005/36/EC in line with scientific progress and professional needs in the last ten years? Are the knowledge and skills outlined in Article 24.3 still relevant and up to date? Please specify. What about the conditions relating to the duration of training?

It has not come to the attention of The National Board of Health and Welfare that the minimum training requirement regarding basic medical training would not be in line with scientific progress and professional needs.

13. The Directive is based on mutual trust between Member States. To what extent is such trust actually achieved? Are training programmes accredited in your country? Does accreditation of a training program in another Member State enhance trust or is it not relevant?

Mutual trust is achieved when competent authorities correctly implement the directive. Misinterpretation of the directive and wrongly issued certificates can harm bilateral trust.

Training programmes are not formally accredited in Sweden, but they must follow nationally regulated curricula, supervised by the Swedish National Agency for Higher Education. There are also regulations stating the responsibility of every caregiver to secure that all their employees have adequate competence and training. Those regulations are supervised by the National Board of Health and Welfare. The high specialization of health-care and the various conditions in the different countries makes it necessary to have this local training. All newly employed health-care personnel should therefore get an introduction to secure that he or she is adequately skilled.

14. To what extent are the existing Directive provisions (see recital 39 and Article 22(b) on continuous professional development (continuous training) adequate? Is continuous training mandatory in your country and what are the exact conditions?

All health-care personnel have a responsibility to maintain and improve their professional knowledge and skills required to carry out their profession. As stated under 11 it is also

the responsibility of every caregiver to secure that all their employees have adequate competence and training.

D. ADMINISTRATIVE COOPERATION

15. To which extent does administrative cooperation, as outlined in Articles 8, 50, and 56 of the Directive, simplify procedures for the migrant professionals?

Active administrative cooperation simplifies the procedure considerably. The process is quicker and simpler for the applicant as well as for the competent authority

16. Is the competent authority in your country registered with IMI? Under which circumstances does your competent authority use IMI? If not registered, why not and what would be the conditions for changing this situation?

Yes the National Board of Health and Welfare is registered with IMI. We use it when we need clarification concerning an application. It is a useful tool to communicate with other competent authorities. However not all professions are included in the IMI system and some competent authorities are not in the system. Registration with IMI should be mandatory and more widely used. IMI could be improved to be more user-friendly.

We would also welcome the introduction of an alert mechanism in the IMI system. The system could also be used to proactively share information about suspension/prohibition to pursuit the profession.

17. How could a professional card (see Recital 32 of the Directive) facilitate recognition of professional qualifications and provision of temporary services? Under which conditions could it be issued by professional associations?

In order for a European card for health care professionals to work effectively the competent authorities must be sure that the information on the card is reliable and up to date. We believe that public registers, e.g. web-based searchable lists of authorisation/registrations and/or exchange of information via IMI would be better tools.

18. Are you alerted by other Member States in case of disciplinary action or criminal sanctions taken or any other serious, specific circumstances which are likely to have consequences for the pursuit of activities under this Directive? How do you share this information? Could more be done in this respect?

We believe that the administrative cooperation in this regard could be improved. At present we inform the Nordic countries when a registered health personnel has been suspended, disqualified or prohibited from practicing the profession. We also receive information from the UK.

E. OTHER OBSERVATIONS

19. How and when are the necessary language skills of migrants checked after recognition of the professional qualifications? Are you aware of any complaints (especially from patients/clients/employers) about insufficient language skills of migrants?

It is the employer that is responsible for checking the necessary language skills. We have gotten complaints from employers and patients regarding insufficient language skills.

In order to ensure patient safety we believe that it should be possible, when appropriate, to require minimum language skills as part of the recognition procedure regarding health care personnel.

20. Does the application of Article 30 raise any specific problems?

No, we have not had any problems.

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UNITED KINGDOM

General Medical Council

Regulating doctors
Ensuring good medical practice

Evaluating the Professional Qualifications Directive
Experience reports from competent authorities

The General Medical Council (GMC) is the independent regulator for doctors in the UK and the competent authority responsible for the mutual recognition of medical qualifications in the UK. The GMC believes the fundamental purpose of medical regulation is to ensure safety and quality of care for patients.

The GMC supports the free movement of doctors in the EU and the principle of recognition of professional qualifications; for decades the UK health system has benefited from EU and overseas qualified doctors practising in the UK. Approximately 37% of those doctors on the register gained their primary medical qualification in countries other than the UK.

There are currently over 239,170 doctors on the UK Medical Register. Of those 151,280 (63.3%) received their primary medical qualification in the UK; 22,263 (9.3%) qualified in other parts of the European Economic Area; and 65,627 (27.4%) are international medical graduates (IMGs).

The specific requirements that doctors have to satisfy before being granted entry to the medical register vary depending under which category they fall. UK legislation ensures that are more stringent system of checks is in place for IMGs wishing to join the UK medical register to ensure patient safety is not compromised. Given the higher proportion of IMGs on our register, these checks do not appear to act as a barrier to movement.

Recent events in the UK have highlighted some of the regulatory gaps that have the potential to harm patients and undermine confidence in healthcare. In an environment where health professionals and patients are encouraged to move across member states a risk to patient safety in one member state is potentially a patient safety risk in another member state. It is therefore essential that EEA doctors and healthcare professionals, exercising their rights of free movement, are only granted registration when they are known to be appropriately qualified and fit and safe to practise.

We welcome the opportunity to respond to the European Commission evaluation of Directive 2005/36/EC on the mutual recognition of professional qualification and remain committed to working with the Department of Health (England), devolved administrations, employers and the European institutions to ensure that the free movement of doctors in the EU does not compromise patient safety in Europe.

QUESTIONNAIRE FOR THE MEDICAL PROFESSION

A. Recognition procedure in case of migration on a permanent basis

1. Do you accept applications from EU citizens for the recognition of foreign diplomas sent by email or requests made on line? Under which conditions can they send documents and declarations electronically? What are your experiences in this respect?

In the majority of cases, doctors applying for registration in the UK make an application using our online facility. Since 2009, 85% of applications were made online (5,400). A hard copy application form is available if required.

Applicants are required to submit photocopies of documents to enable us to recognise their European qualifications. They can choose to send these by post or email. Inevitably there can be problems sending information electronically – problems with security, file size etc.

The GMC has concerns about the Code of Conduct[1] as adopted by the European Coordinating Group in April 2010. The Code prevents competent authorities from requiring original and officially translated copies of documentation and from requesting doctors to verify their identity. We understand that these provisions are in line with the outcome of ECJ Case C-298/99[2] which refers to the case of architects but, given the risk to patients and the public that would inevitably arise from a fraudulent recognition and registration, we believe that special provisions should be made for healthcare professionals in line with Recital 6 in the Directive. It states that: "The facilitation of service provision has to be ensured in the context of strict respect for public health and safety and consumer protection".

We believe that original documentation, officially translated copies, and verification of identity of the applicant are essential in the prevention of fraud and identity theft. In our view they do not impose any unnecessary barrier to free movement upon applicants who are appropriately qualified and fit to practise. The GMC has experienced a number of cases of fraud and identity theft. These include:

- Thomas Nassier, who was admitted to the GMC register based on documentation that was subsequently found to be fraudulent. The doctor had never worked in France as a doctor nor had he studied medicine. After investigation we found the qualification documentation, as well as the confirmations (including those from the medical regulatory authority about his good standing), were forgeries.

- Barian Baluchi, a former mini cab driver, stole the identity and documents of a Spanish doctor. He claimed to have trained at Harvard, Colombia, Newcastle and Sussex Universities, and Leeds Medical School but in reality had no medical

[1] Code of conduct as approved by the Group of Coordinators, 30 April 2010
[2] Case C-298/99 Judgment of the Court (Fifth Chamber) of 21 March 2002 - Commission of the European Communities v Italian Republic-Failure by a Member State to fulfil its obligations-Directive 85/384/EEC-Mutual recognition of formal qualifications in architecture-Access to the profession of architect -Article 59 of the EC Treaty.

experience. He worked as a consultant psychiatrist and committed fraud in relation to asylum applications. He was jailed for 10 years.

2. **What is the yearly number of positive and negative decisions of recognition from 2000 to 2009? Please submit specific data for applications for automatic recognition based on diplomas, automatic recognition based on acquired rights (as from 2005), and recognition based on the general system[3]. If available, please provide information on the average duration of the recognition process.**

The GMC has submitted the yearly number of positive and negative decisions to the European Commission through the UK National Coordinator.

It is not possible to provide specific data for applications for automatic recognition based on acquired rights.

The average duration of the recognition process is between 2 and 16 days upon receipt of a complete application.

3. **To what extent have the system of automatic recognition and the general system been a success? How do you see the costs and benefits? Specify in particular whether automatic recognition based on diploma, Annex V and the current notification system represent an efficient way to facilitate automatic recognition. Please submit comments for:**

   - **Automatic recognition based on diploma**

Where a doctor has a European qualification that is listed in the Directive, we have some assurance that the training leading to the award of those qualifications meets certain standards.

However, we have recently had an application for registration from a former Sudanese national who obtained British citizenship and had recently qualified in another EEA country. This qualification was listed in the Directive. Although not a requirement for registration for EEA doctors, this doctor elected to sit an exam in the UK, run by the GMC, which is known as the Professional and Linguistic Assessments Board (PLAB). This test is the main route by which international medical graduates demonstrate that they have the necessary skills and knowledge to practise medicine in the UK. Despite three attempts, this doctor failed to pass the exam. This indicates that, although he has a qualification that is listed in the Directive, and therefore is entitled to registration, he does not appear to have the requisite knowledge and skills to practise safely as a fully registered doctor in the UK.

We also have evidence of 83 applicants who have in the past failed our PLAB test and have subsequently gained recognition and registration with the GMC under the Directive after they acquired EC rights or following EU enlargement. We have grave concerns that these doctors although eligible for recognition and registration with the GMC under the Directive, may pose a risk to patient safety.

[3] Please provide this information unless it has already been provided to the Commission in the Database or the implementation reports.

We believe that the current recognition system does not offer competent authorities and patients the assurance that doctor's current knowledge, skills and experience are at the levels required to practise safely. Since 1 January 2009, we have received applications from 29 doctors who have had extensive breaks in their medical practice (some spanning 10 years) and yet automatic right to registration allows them to practise medicine in the UK.

The automatic recognition process also relies on competent authorities only issuing documentation in accordance with the Directive. We have seen examples of certificates issued under Article 23.1 when we have evidence that the applicant has worked outside the EEA since 1996. We have also received certificates that have been issued in compliance with Directive 92/16/EEC when the country in question was not subject to that Directive. This is a cause for concern.

In the majority of cases, automatic recognition based on diploma is successful for applicants, in that their qualification is recognised and they gain registration to practise medicine in the UK.

- **Automatic recognition based on acquired rights**

If an EEA qualification was obtained before the reference date in Annex V and the training does not meet the minimum training requirements, Article 23.1 in the Directive specifies that the applicant can benefit from automatic recognition if they can show, via an attestation from the member state of origin, that they have been effectively and lawfully practising the profession in question for at least three consecutive years during the five years prior to the attestation being issued. However, in some cases, competent authorities, cannot confirm that the doctor has been working for at least three consecutive years during the five years prior to the attestation being issued. This is because the competent authority does not hold information on an applicant's practice. In these cases, the GMC would seek to obtain alternative evidence, such as employment references. We would welcome clarification from the European Commission on whether the competent authority in the member state of origin is obliged to provide the requisite certification, or whether the GMC should continue to accept and require alternative evidence.

Whilst Article 23.1 specifies the total duration of professional experience as three years, this is open to interpretation and may allow for minimal experience (such as part-time work) or experience confined to highly restricted forms of practice. Therefore, it is possible that an applicant, whose training does not meet the minimum training requirements laid out in the Directive, may have acquired rights to recognition and registration based upon working one locum shift per month over a period of three consecutive years during the five years prior to the attestation being issued. This scenario offers competent authorities like the GMC little assurance that applicants can practise safely in the UK.

There are also no provisions in the Directive that allow competent authorities to satisfy themselves that the professional experience certified by the member state of origin has been completed satisfactorily.

- **Recognition based on the general system.**

EEA doctors with European qualifications

The GMC has not experienced any difficulties when dealing with applicants with European qualifications under the general system. In most cases the applicant cannot provide evidence that they hold the accompanying certificate (to their medical qualification) listed in the Directive and instead submit an alternative compliancy letter. The compliancy letters issued by the member state of origin are easy to obtain and make the applications straight forward.

EEA doctors with third country qualifications

The GMC has not experienced any difficulties with the applicant's member states of origin confirming that the applicant's third country qualification has been recognised. This route to registration (under S19A of the Medical Act) presents a simpler application process for the applicant and the GMC. It is easier to obtain the relevant documentation from a competent authority in a member state than it would be for the applicant to provide documentation from overseas.

However, for all general systems cases, we have the same reservations as with acquired rights cases, when it comes to accepting the duration and extent of professional experience as outlined in Article 3.3.

We do not experience many difficulties with applicants undergoing a general systems assessment for specialist or GP recognition.

We are aware that in some cases doctors with EC rights have obtained their primary medical qualification outside of the EEA and have become recognised by another European competent authority before obtaining registration with the GMC. In these situations we are reliant on the rigour of another competent authorities' procedure in awarding recognition and registration in their country. This gives us cause for concern. For example, we are aware of a case involving an applicant who failed the GMC's PLAB test twice before being given registration in another EEA country. By virtue of their recognition in this country, they were eventually given UK registration, under EC rules, and subsequently became the subject of GMC fitness to practise action.

- **Please specify whether there are any specific problems with Annex V.**

We are aware that the Annexes of the Directive are out of date. It would be beneficial if these were updated more frequently (annually as a minimum), with input from the relevant authoritative bodies, and if the dissemination of new versions of the Directive was facilitated in a more structured and timely fashion to all competent authorities either through the national coordinator or via direct communication from the European Commission. It would also be helpful for effective dates to be included as well as historic information. For example for the UK, the specialist qualification was a certificate of completion of specialist training up to 16 January 1996 and certificate of completion of training from 17 January 1996.

4. **Is the general system applied in your country each time the conditions for automatic recognition are not met? Are there major difficulties in the recognition procedure under the general system? Please include any comments you may have on the implementation of compensation measures. Is the migrant given the choice between an aptitude test and an adaptation period or is the choice restricted. Please explain.**

We apply the general system where the conditions for automatic recognition are not met. The GMC has not experienced any major difficulties in the recognition procedure under the general system.

The process involves a comparison of the applicant's training with our national training to check whether there are any substantial differences. In accordance with the Directive, we define 'substantial differences' as major differences with regard to the subjects which are essential for the safe practise, If differences are identified we have three options: we can recognise the qualification; refuse to recognise the qualification; or apply compensation measures, and require the applicant to undertake an aptitude test or an adaptation period.

The GMC sought a derogation to require EEA doctors whose applications fall under the general system to undergo an adaptation period. This period can be of a maximum of three years and the applicant is responsible for payment of costs.

The GMC has not had any cases of applicants requiring compensation measures for basic medicine. However, initial estimates indicate that the financial cost of developing an adaptation period will be high. This will need to cover the services of an expert to assess the applicant's experience, determine the content of the adaptation period required, and decide if the shortfall has been met.

For those applicants undergoing a general systems assessment for specialist or GP recognition, the recommendations made for the adaptation period are very specific and provided in line with the requirements of the relevant curriculum. At the end of our assessment, we provide a clear recommendation to the applicant, the time in which it can be achieved, as well as suggesting what evidence can be provided to the GMC to demonstrate that the requirements have been fulfilled.

From time to time, applicants may not agree with the recommendations. In these cases we invite applicants to supply further evidence to allow us to review the application further.

5. **What is your experience with the recognition procedure for EU citizens with professional qualifications obtained in a third country and already recognised in a first Member State (see Articles 2(2) and 3(3))?**

EEA nationals with an overseas primary medical qualification that has been recognised by a competent authority of another EEA member state (or Switzerland) and have been allowed to work in that country as a doctor for at least three years can be assessed under general systems. This route to registration (under Section 19A of the UK Medical Act) presents a simpler application process for the applicant and for the GMC. It is easier to obtain the relevant documentation from an EEA country than it would be for the applicant to provide documentation from overseas.

However, as already outlined under question 3, we would welcome further clarity about the definition of 'professional experience' which is to be relied upon as the basis for recognition by other member states. This definition is open to interpretation and may allow for minimal experience or experience confined to highly restricted forms of practice. We would also welcome further provisions to enable competent authorities to satisfy themselves that the professional experience certified by the member state of origin has been completed satisfactorily.

We would also welcome further provisions to enable competent authorities to be provided with details of the standard against which the professional qualifications obtained in a third country were recognised in the first member state.

6. Please describe the government structure of the competent authority or authorities in charge of the recognition.

The General Medical Council (GMC) is a statutory body established under the UK *Medical Act 1858*. We are a charity registered with the Charity Commission for England and Wales, and the Office of the Scottish Charity Regulator.

The GMC is the independent regulator of doctors in the UK. We are independent of government, as the dominant provider of healthcare in the UK, free from domination by any single group and publicly accountable for the discharge of our functions. This means that we:

a. put patient safety first

b. support good medical practice

c. promote fairness and equality and value diversity

d. respect the principles of good regulation: proportionality, accountability, consistency, transparency.

Our purpose is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine.[4]

The *Medical Act 1983* sets out our four core functions:

a. keeping up-to-date UK registers of qualified doctors

b. fostering good medical practice in the UK

c. promoting high standards of medical education in the UK

d. dealing firmly and fairly with doctors practising in the UK whose fitness to practise is in doubt.

[4] For more information about the role of the GMC, please see our website at http://www.gmc-uk.org/about/role.asp

The Council[5] is the governing body of the GMC. It is comprised of 24 members, 12 lay and 12 medical, all appointed by the UK's Appointments Commission. Members are appointed for a four year term.

The GMC is responsible for the recognition of primary and specialist medical qualifications – automatic recognition and general system. From April 2010, the General Medical Council (GMC) is the single organisation responsible for the regulation of medical education and training. Until April 2010, the Postgraduate Medical Education and Training Board (PMETB) was the independent regulatory body responsible for postgraduate medical education and training.

B. Temporary mobility (of a self-employed or an employed worker)

7. Are EU citizens interested in using the provisions for exercising their professional activities on a temporary and occasional basis in your Member State? How many citizens used this new system in 2008 and 2009 (per month, per year)[6]?

Under temporary and occasional provisions the rules that apply are more flexible compared to recognition on a permanent basis mainly because there is no requirement for evidence of good standing or a registration fee.

The GMC has not experienced any difficulties in this area. However, we are concerned that before granting temporary registration, we cannot perform our standard fitness to practise checks. We believe that members of the public have a right to expect that the protection afforded to them by the regulatory system should be the same regardless of whether the doctor practises in the United Kingdom temporarily or permanently. We would wish to require them to provide the same information as other applicants, i.e. asking the applicant to complete a fitness to practise declaration, which enables us to follow-up any issues in relation to potential impairment. There is anecdotal evidence to suggest that Section 18 is seen as a 'back door route' to gaining registration. This could seriously undermine confidence in the provision of public health services. In our view, Title II of the Directive should be amended to provide guarantees for the safety of patients and include separate provisions for those professionals who have contact with patients.

In 2008, we received 49 applications from European doctors requiring temporary registration. We granted 38 of these applications.

In 2009, we received 68 applications and 46 were granted.

[5] For more information on the Council of the GMC, please see our website at http://www.gmc-uk.org/about/council.asp

[6] Please provide this information unless it has already been provided to the Commission in the Database or the implementation reports.

8. **How are the provisions of Directive 2005/36/EC concerning temporary mobility applied by the competent authorities in practice taking into account the relevant provisions of the Code of Conduct? For instance:**

   - **How is the "legal establishment" criteria foreseen by Article 5(1) (a) interpreted in practice? What conditions does a migrant need to fulfil in his home Member State in order to be able to provide services?**

To benefit from temporary mobility, the applicant must be legally established in one of the EEA countries, i.e. they meet all the conditions for practising that profession in the host member state and are not prohibited from practising that profession either permanently or temporarily.

A visiting practitioner who proposes to provide occasional medical services for the first time in the UK is entitled to registration if they provide the following documents:

1. A written declaration that:

   a. States the practitioner's wish to provide occasional medical services, and

   b. Contains details of the insurance cover, or other means of personal or collective protection, that the practitioner has with regard to professional liability.

2. If the practitioner is a national of a relevant European state, proof of nationality in the form of a passport or ID card. If the practitioner is not a national of a relevant European State, proof of the Community right by virtue of which the practitioner is an exempt person.

3. A European recognised medical qualification that is listed in Annex V of the Directive. In addition to this, where the visiting practitioner proposes to provide any services as a general practitioner or a specialist medical practitioner, they must provide the European recognised qualifications which entitle them to provide those services in their home state.

4. A certificate, dated within the last 12 months, issued by a competent authority in the practitioner's home State confirming that:

   a. The practitioner is lawfully established in medical practice in that state, and

   b. The practitioner is not prohibited either on a permanent or temporary basis from practising as a medical practitioner there.

An applicant who has previously held temporary registration may apply again. They are entitled to further periods of registration if they provide new declarations (as detailed in paragraph 1.a and 1.b above) and a certificate as described in paragraph 4.

The conditions a migrant needs to fulfil in the UK in order to be registered with a licence to practise and thus able to provide services and be legally established are as follows:

a. They need to provide evidence of having completed a primary medical qualification and the requisite training obtained while provisionally registered. This is normally evidenced by a degree certificate and a certificate of experience, as detailed in Annex V of the Directive.

b. Their fitness to practise is not impaired.

c. They have to pay a registration fee on application and then continue to pay their annual retention fee.

To remain on the register, and therefore legally established, doctors have to maintain an effective address. Whilst registered, doctors are also bound by Good Medical Practise. Serious or persistent departure from which may lead to action being taken against their registration through our fitness to practise procedures

- **How are the "temporary and occasional basis" criteria foreseen by Article 5.2 interpreted in practice? Do Member States assess duration, frequency, regularity and continuity of an activity and if so according to which criteria?**

Most new applicants when making initial enquiries about temporary and occasional registration, voluntarily state their intentions. To date, in nearly all cases, applications could be clearly defined as 'temporary and occasional'. The majority of doctors require this type of registration to allow them to participate in highly specialised surgical procedures or training. The duration of their stay typically ranges from a couple of days to a week.

With regard to renewals, we make registration decisions on a case by case basis as it is not always clear in what circumstances a renewal would be considered temporary and occasional. While we have had no difficulties to date, it is possible that applicants may attempt to use this route to registration because we can only undertake limited fitness to practise checks and no registration fee is payable.

The term 'temporary and occasional' is ambiguous and we would welcome further clarification from the European Commission about the length of time envisaged by the use of this terminology.

9. **Why is a prior declaration system necessary? What do competent authorities do with the information received? Are other possibilities conceivable? Do you have any cases – and if yes how many - whereby doctors sent the declaration after the provision of services has taken place.**

Section 18 of the Medical Act, with reference to Schedule 2A, makes provision for registering visiting EEA practitioners from relevant European states so that they can provide medical services in the UK on a temporary and occasional basis. To ensure patient safety, we verify the applicant's qualification before they start the temporary provision of services.

Prior to December 2007, in exceptional cases, doctors could supply the documentation required for temporary and provisional registration after the services have been rendered. Declarations had to be provided as soon as possible and no later than 15 days after the provision of the service. These cases were rare.

The practice allowing retrospective submissions was ceased in 2007. Since then, there have been no cases of declarations submitted after the provision of services.

We believe that the prior declaration system is essential to patient safety and effective regulation of the profession.

10. Do you charge any fee in case Article 7, § 4 applies?

We have not received any applications where Article 7(4) applies. It would, however, be our intention to charge a fee in these cases.

C Minimum training requirements

11. To what extent are the common minimum training requirements for specialists and general practitioners set out in Title III Chapter III of Directive 2005/36/EC and as defined in Annex V in line with scientific progress and professional needs? Furthermore, are the knowledge and skills required by the Directive still relevant and up to date? Please specify. What about the conditions relating to the duration of training? Do you have many specialties training, which have a common trunk. If yes, please specify which ones.

The minimum times for training set out in the Directive are useful, but the lack of overall consistency of approach between member states means that the level of assurance that states can draw from the training obtained by migrants is limited. We have an example of a specialist who gained recognition in the UK under the Directive but subsequently found they required a further four years of experience to gain employment as a specialist consultant in the NHS in the UK. All GMC approved curricula are required to state and demonstrate achievement of the EU minimum time requirements, where applicable. All approved curricula have to make the time period expected explicit and reflected in the programmes delivered.

There is no obvious rationale why some specialties do not have a minimum time requirement.

There are 61 specialties and 34 subspecialties recognised in the UK. Of the 61 specialties, eight have a common surgical trunk; 29 have a common medical trunk; 33 have an option to undertake an acute care common trunk; six of the psychiatric specialties have a common psychiatry trunk. There is no universal common trunk covering all specialties. Other developments for a common trunk are in progress.

12. To what extent are the common minimum requirements for training set out in Title III Chapter III of Directive 2005/36/EC in line with scientific progress and professional needs in the last ten years? Are the knowledge and skills outlined in Article 24.3 still relevant and up to date? Please specify. What about the conditions relating to the duration of training?

The mutual recognition of professional qualifications assumes comparability of medical education across the EEA. It is on the basis of medical qualifications that are deemed to have met certain minimum standards, that doctors can exercise their right of free movement within the EEA.

The specific requirements of article 24.3 of the Directive remain relevant and up to date. However, in many respects they are so broadly drawn and general that they are of limited practical value in providing assurance for other member states about the standards of medical education and training of migrants. At the same time, their focus on time served in training rather than the outcomes of training has imposed constraints which have impeded us in developing undergraduate medical education in line with the UK's needs.

There is a lack of any information about the nature and content of medical training, and of the skills, knowledge, and competencies required of trained doctors in other member states. Without this information we cannot be assured of the quality of education elsewhere, not least given the very general nature of the standards on curriculum content and delivery required in the Directive, and the lack of information about how those standards are quality assured. In addition, comparability is largely based on length of training rather than training content or the range of competencies that medical education develops. The overall result is a climate in which competent authorities cannot have full confidence in each other's medical training and education.

In addition, the scope of medical practice can differ between member states. What is routine treatment or procedure for a General Practitioner in the UK, for example, may not be within the normal scope of a doctor trained from another EEA country. Moreover, in some member states graduates may have strong theoretical training but less clinical experience than is deemed desirable in other member states. This can give rise to a patient safety risk where the expectations placed upon a doctor working in one jurisdiction, but trained in another, are not met.

In our view, the abolition of the Advisory Committee on Medical Training (ACMT), when the Directive was revised in 2005, has led to a situation where there is currently no European forum for the co-ordination of training and no satisfactory route by which the formal views of competent authorities can be made available to the Commission.

We believe there is a need for an urgent audit of basic and specialist medical qualifications in Europe as a means of identifying and confirming 'content comparability'. The findings should be used as a basis from which to develop the minimum training requirements. These should be developed in terms of learning outcomes rather than inputs (hours and length of study).

The current emphasis on inputs in terms of hours and duration of study has meant that the UK has encountered constraints in developing undergraduate medical education and training in line with the UK's needs. This is not helped by the fact that although the Directive is quite clear that training should comprise 5,500 hours or six years' training, there have been attempts in some quarters to impose a much more restrictive interpretation on what the Directive requires.

13. The Directive is based on mutual trust between Member States. To what extent is such trust actually achieved? Are training programmes accredited in your country? Does accreditation of a training program in another Member State enhance trust or is it not relevant?

The GMC is responsible for the regulation of medical education and training in the UK. Our responsibilities are divided into three areas; undergraduate education, postgraduate education, and continued practice.

This function provides assurance to the public on the quality of medical education and training doctors receive throughout their careers. This contributes to the overall standard of care that doctors provide.

Undergraduate medical education
We have a statutory duty to set the standards and outcomes for undergraduate medical education in the UK. These are outlined in *Tomorrow's Doctors* 2009. *Tomorrow's Doctors* sets the framework within which medical schools must plan their curricula. Students must meet all the outcomes within it before they graduate.

We run a quality assurance programme for UK medical schools delivering the undergraduate programme to ensure they are meeting the standards in *Tomorrow's Doctors*. We hold a list of universities that can award a UK medical degree and have the power to remove universities from that list if standards are not met.

Postgraduate medical education
Following the merger of the Postgraduate Medical Education and Training Board (PMETB) with the GMC on 1 April 2010, we also have statutory responsibility for:

a. Setting the standards and requirements for postgraduate medical education and training. This includes the Foundation Programme, which is a two-year period of generic training completed prior to commencing specialty training.

b. Ensuring that the standards and requirements we set are met (including the standards for curricula and assessment systems).

c. Developing and promoting postgraduate medical education and training in the UK.

Our core responsibilities for postgraduate medical education also include the prospective approval of training posts and programmes that lead to the award of a Certificate of Completion of Training (CCT) that is necessary to work in the NHS as a

GP or NHS consultant, and approving specialty training curricula and assessment systems.

Following the merger with PMETB, the GMC has also become the competent authority to approve and decommission subspecialties in the UK.

Continued practice
The GMC's role in education also covers continued practice for doctors. We publish Guidance on Continuing Professional Development, which sets out the principles on which continuing professional development should be based, and the roles of the relevant organisations involved in its delivery and quality assurance.

Quality assurance
We operate three quality assurance processes – quality assurance of basic medical education (QABME), quality assurance of the foundation programme (QAFP), and the Quality Framework (QF).

- QABME is the system we use to ensure that the 32 medical schools in the UK are meeting the standards and outcomes for undergraduate medical education set out in *Tomorrow's Doctors*.

- QAFP is a quality assurance mechanism that monitors whether the Standards for Training for the Foundation Programme contained within *The New Doctor*, are being met.

- QF links together all the GMC's quality assurance of specialty including GP training. The aim of the QF is to measure quality of training, using a range of evidence, against our published standards and requirements, and then to promote and maintain improvement.

Following PMETB's merger with the GMC, which has brought responsibility for the quality assurance of the whole of medical education and training under the auspices of the GMC, work is underway to integrate the quality assurance of the Foundation Programme and specialty including GP training.

We believe that trust only comes from knowledge in each other's legal systems, education systems and the quality assurance processes applied to those systems. A recent study commissioned by the European Parliament Internal Market Committee suggested that regular meetings between the National Contact Points in the various member states would facilitate cooperation across and between member states and the EU institutions and improve trust. Whilst we do not doubt that cooperation and further meetings between National Contact Points may be beneficial, we believe that the emphasis should be on the establishment of better cooperation between competent authorities as this is where the expertise and knowledge of professional regulation and recognition of qualifications lies. This, more than networking between Contact Points, would help facilitate the implementation of the Directive.

In light of the GMC's extended education responsibilities, we are keen to learn from our colleagues across Europe, about the challenges and issues they face in regulating medical education and training. Following some work we carried out in

2009, the GMC is planning to host a meeting of interested parties on 13 October to discuss issues related to:

- Undergraduate standards and quality assurance
- Postgraduate standards and quality assurance
- The education and training aspects of Directive 2005/36/EC, and its upcoming review
- The Bologna Process.

We envisage this meeting to be an opportunity to share perspectives on how different countries respond to these issues and to improve mutual understanding of our education system and the regulation of it.

14. To what extent are the existing Directive provisions (see recital 39 and Article 22(b) on continuous professional development (continuous training) adequate? Is continuous training mandatory in your country and what are the exact conditions?

The GMC is working on plans to change the way doctors in the UK are regulated to practise medicine. All doctors in the UK are required by law to hold a licence to practise if they wish to undertake certain activities, for example holding certain posts, prescribing medicines and signing statutory certificates. In future, licences to practise will require periodic renewal (referred to as 'revalidation'). This means doctors must undertake the periodic renewal of their licence by demonstrating that they continue to be up to date and fit to practise. We anticipate that the new arrangements will come into force around 2013.

To revalidate, doctors will need to collect evidence about their practice which shows how they are complying with the professional standards set by the GMC. The information required will vary depending on the nature of the doctor's practice, but will include material such as audit data, outcome data, and evidence of participation in appropriate Continuing Professional Development (CPD).

We do not believe that revalidation should set prescriptive requirements for CPD in terms of structured packages of learning delivered by accredited providers. Our professional guidance, *Good Medical Practice* requires doctors to keep their 'knowledge and skills up to date' and 'regularly take part in educational activities that maintain and further develop [their] competence and performance'. To support doctors and those appraising them we have identified core principles[7] that should guide doctors in their CPD activity.

We have recently completed a public consultation on our proposals for revalidation and are currently analysing the results. These will be available in October 2010.

[7] To view the GMC's guidance on CPD, visit: http://www.gmc-uk.org/education/continuing_professional_development/cpd_guidance.asp

The Directive as it currently stands does not allow competent authorities to assure themselves that the doctors and healthcare professionals they register have kept their skills and competence up to date since the award of their professional qualifications. We do not consider that the Directive should impose minimum CPD or revalidation requirements of the kind used in relation to medical education and training for the purposes of mutual recognition. However, the inability of member states to obtain assurance of an individual's continuing fitness to practise at the point at which they register or licence a doctor to practise inevitably weakens the level of confidence that competent authorities can have in the competence and fitness to practise of doctors entering the host state.

D. Administrative cooperation

15. To which extent does administrative cooperation, as outlined in Articles 8, 50, and 56 of the Directive, simplify procedures for the migrant professionals?

Administrative cooperation enables the GMC to exchange information directly with other competent authorities. The exchange can take place without the doctor's involvement. Although this is mainly done for security reasons, it also minimises the number of requests for information that we make to the doctor and makes the process simpler for the applicant.

16. Is the competent authority in your country registered with IMI? Under which circumstances does your competent authority use IMI? If not registered, why not and what would be the conditions for changing this situation?

The GMC is registered with IMI. We use IMI in cases of justified doubts. IMI enables us to get answers and obtain information from competent authorities who would not normally respond to routine correspondence. However, as registration with IMI is not mandatory, sometimes we find it difficult to receive replies to our requests and therefore to verify compliance with the Directive.

It would be beneficial if registration with IMI was mandatory for competent authorities, if IMI was more widely used, and regulators responded within the relevant timescales. It would be helpful to allow users to follow up when a response is not received within the timelines stated. It would also be helpful if there was a reporting facility to allow users to track how many requests are made and the timeline for responding – on both incoming and outgoing requests. IMI also has some limitations given that many organisations, such as medical schools or organisations responsible for investigating and taking regulatory action against doctors, are not linked to it.

The IMI system might benefit from the use of a more sophisticated translation tool such as Google Translate as automatically translated questions are problematic, particularly when legal and regulatory terms are used.

Improving the extent to which competent authorities proactively share disciplinary information should be a priority to ensure that competent authorities can take effective action under their own fitness to practise rules if a doctor is registered in more than one jurisdiction. Existing differences in data protection and privacy

legislation in other EEA countries pose a challenge and a potential threat to patient safety. We believe that having a secure means to exchange information when regulatory action is taken against a doctor's registration has the potential to improve significantly the information that competent authorities will be prepared to share.

We strongly suggest that the European Commission strengths the legal basis for IMI so that the system can be used for the proactive sharing of information. IMI could provide a secure password protected tool for the effective sharing of information and enable those competent authorities not currently able to exchange information, due to domestic privacy legislation, to do this more effectively. The Services Directive (Directive 2006/123/EC) currently provides for such sharing of information, via an alert mechanism provided by IMI (Article 29 and Article 32). We believe that similar provisions should be included in a revised 2005/36/EC Directive.

17. How could a professional card (see Recital 32 of the Directive) facilitate recognition of professional qualifications and provision of temporary services? Under which conditions could it be issued by professional associations?

The Directive refers to the possible introduction at European level of professional identity cards. At first sight the development of a European card for health professionals appears a useful tool to facilitate the free movement of healthcare professionals throughout the EEA. Considered more deeply, however, such a card brings with it some potential risks.

We believe that there must be clarity about the problems that such a card seeks to solve. In recent years, various aims for a proposed card have been stated, such as the harmonisation of existing card-based record/identification systems, the facilitation of exchange of information between regulators, and the identification of healthcare professionals for employers.

A card that serves only as a basic photo identity card, rather than a secure chip card containing electronically readable data, is open to fraud and forgery and could present a serious risk to patient safety.

Whilst the card could in principle store further information we believe that the IMI system already provides a cost effective tool for the secure information exchange between competent authorities and that it will be essential to avoid duplication. IMI provides for improved regulatory information exchange between competent authorities without some of the risks potentially brought about by a card system.

A professional card containing microchip-based data would need to be interoperable across all regulatory jurisdictions of the EEA. Information would need to be uploaded effectively and efficiently on the card and would need to be readable in a format and language accessible and understandable by every competent authority. As some professionals will be simultaneously registered in more than one jurisdiction it would also need to be usable by more than one competent authority concurrently. This is to ensure a complete record of the professional is provided and to avoid the risk that professionals only use their 'clean' card to obtain registration as a basis from which to secure employment.

The information being suggested as the basis of the European professional card is already held by competent authorities. Any additional source of this data arguably presents a level of duplication and additional regulatory burden and could become a disproportionate and costly response to the challenge of effective information exchange between competent authorities.

We also believe that efforts in the short term would be better focused on supporting competent authorities to share information directly and more effectively and enabling them to make the information they hold publicly available.

The GMC has a web-based searchable list of registration and disciplinary information freely available on its website. In the UK this not only supports the information that competent authorities exchange on a bilateral basis but also enables patients to make more informed choices about the practitioners they consult or may choose to consult. A positive way of improving transparency would be for European level cooperation to promote similar publicly available web-based information.

The GMC will continue to consider the implications of a professional card but remains cautious about the introduction of such an initiative at European level on basis of proportionality and costs.

18. Are you alerted by other Member States in case of disciplinary action or criminal sanctions taken or any other serious, specific circumstances which are likely to have consequences for the pursuit of activities under this Directive? How do you share this information? Could more be done in this respect?

Our Fitness to Practise Directorate discloses details of all disciplinary action proactively to other competent authorities. This is done by email via our monthly decisions circular and sent to nearly every regulator worldwide. The circular includes details of all doctors who have been subject to fitness to practise proceedings and sanctions (conditions attached to their registration, erasures, suspensions etc).

In addition to this, after a fitness to practise hearing is concluded, we write to the regulator in the country where the doctor originally graduated, the regulator in the country where the doctor currently resides and, if known, the country to where the doctor has moved.

We also have agreements in place governing electronic exchange of Certificates of Good Standing / Certificates of Current Professional Status with a limited number of competent authorities and are a signatory to the Healthcare Professionals Crossing Borders Memorandum of Understanding on case-by-case and proactive information sharing[8].

[8] Healthcare Professionals Crossing Borders (HPCB) is an informal partnership of professional healthcare regulators in Europe, established to work collaboratively on a range of regulatory issues. The purpose is to contribute to patient safety in Europe through effective regulatory collaboration in the context of cross-border healthcare and free movement of healthcare professionals. For more information about the HPCB MoU, see: http://www.hpcb.eu/activities/information_sharing.asp

Only a small number of European countries proactively notify us of disciplinary decisions taken, most notably Ireland, Norway, and Sweden. We receive less than six notifications per year. We understand that different data protection regimes prevent some countries from sharing information but we believe that it essential that fitness to practise information is shared to ensure that patient safety is not comprised.

When alerts are received, we check to see if the doctor is registered. If the doctor is registered with the GMC they would enter our Fitness to Practise procedures. Our rules allow us to rely on the decision from other regulatory bodies as conclusive evidence of the relevant facts so we would not need to reinvestigate. However, based on those facts, we would make our own decision on whether the doctor is impaired and what sanction on the doctor's UK registration would be appropriate. For example, we may be referred a determination from another regulatory body which has imposed a major sanction in relation to a doctor. The country in question may consider the actions of that doctor a serious matter. We would accept the determination by the body as evidence of the facts but we may choose to impose a different sanction based on the fact that we treat the issue differently in the UK.

If the doctor is not registered, we make a record of the information we receive in case the doctor makes an application for registration with us in the future.

To ensure patient protection across Europe we have for some time called for legal duty on competent authorities to share information effectively and proactively when regulatory action is taken against a doctor's registration.

It would also be helpful to identify which organisations in the member states are responsible for taking action against a doctor's registration (suspensions, conditions, warnings, erasures) when their fitness to practise is impaired. Our experience shows that in many countries recognition and fitness to practise functions are carried out by separate organisations, sometimes at regional and local level. This provides confusion and potentially a risk to patient safety, especially if information about a doctor's fitness to practise is not communicated effectively and efficiently to the relevant organisation(s). For the IMI alert mechanism to be effective, it would be essential that all organisations responsible for recognition, registration and fitness to practise are registered on IMI.

E. Other observations

19. How and when are the necessary language skills of migrants checked after recognition of the professional qualifications? Are you aware of any complaints (especially from patients/clients/employers) about insufficient language skills of migrants?

Currently, EEA applicants to the GMC register do not need to pass a language assessment.

Whilst we recognise the Directive's reference to language knowledge, the provision proves to be problematic. It is unclear whether article 53 enables competent authorities to assess the level of language proficiency of migrants at the point of registration. It remains our view that the ability of the professional to communicate

effectively in the language of the host member state should be a prerequisite for registration and that we should be able to assess the knowledge of language where appropriate. We understand that a test may be applied in cases of doubt – as long as it is proportionate, appropriate, and not systematic.

According to *Good Medical Practice*, doctors must be able to communicate effectively with their patients, other member of their healthcare team and colleagues in the healthcare system. If they are to provide high quality and safe care and ensure informed consent is acquired before treatment, effective communication is essential regardless of where they practise.

We have examples of fitness to practise cases brought before the GMC where the lack of English language competence has been identified as a concern. These cases indicate that it is not sufficient for employers to assess the language competence of EEA trained doctors. We believe that language provisions for doctors in the Directive should be strengthened to ensure that competent authorities are allowed to check the language knowledge of applicants at the point of registration to ensure patient safety is not compromised.

20. Does the application of Article 30 raise any specific problems?

We receive no more than five applications per month. Generally they do not raise any problems. It is surprising, however, that this provision still exists. Providing an automatic right to someone who qualified before 1994, without any subsequent check on their capability for practice, seems to be at odds with patient safety.

We have come across the following scenario a few times – where a member state has awarded a GP qualification that is listed in the Directive *and* has issued the doctor with an Article 30 letter. A doctor who has a Directive compliant qualification does not have an acquired right. We have to contact the member states that issued the documents to determine why they have been issued an Article 30 letter which can take time. The result is always that the letter was issued incorrectly (often in place of an Article 28).

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