THE EU AND THE NHS

The impact of the Working Time Directive and language requirement on doctors in the NHS
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Foreword

The NHS is rightly a treasured national institution in our Country.

Unfortunately, it is being damaged by the unforeseen consequences of EU legislation.

The Working Time Regulation, and in particular, the SiMAP and Jaeger rulings of the European Court of Justice are having a negative effect on junior doctor training, the continuity of patient care, waiting lists, NHS finances, acute specialties and doctors themselves, who report a negative impact on their working practices and fatigue.

Although valuable in promoting the exchange of healthcare professionals across the Union, The EU’s directive on professional qualifications has led on occasion to doctors with insufficient language skills being able to practice in the UK, which has led to a number of serious incidents.

This paper presents robust analysis of these issues, and proposes a number of practical solutions that the UK could deploy. It draws on the contributions of the Royal College of Surgeons, the Royal College of Physicians, the Association of Surgeons in Training, the British Medical Association, the General Medical Council and other professional bodies during a roundtable in July 2012.

It is the responsibility of all politicians to ensure our healthcare system puts patient safety as its principal objective. EU regulation is failing to do that. The irony that a piece of health and safety regulation, the Working Time Directive, is now endangering patients should not be lost. And these impacts are all unintended. The EU has no competence over healthcare.

Whether europhile or eurosphobe we must object to the unintended consequences of legislation that puts patients at risk.

Andrea Leadsom MP          Charlotte Leslie MP
Executive summary

Despite the fact that the EU treaties establish that it is the member states that have the responsibility for “the management of health services and medical care”, EU law still has a profound impact on the NHS.

EU legislation has had unintended negative consequences for the NHS, in part due to the particular structure of the NHS, which often differs to continental models of healthcare provision. The EU’s impact on the NHS is particularly significant in the areas of staff qualifications, training and continuity of care and has been shown to impinge on patient safety.

Although the NHS, like any large organisation, is affected by a broad range of EU regulations, this briefing will focus on two areas – the Working Time Directive and language testing of foreign doctors - and look at potential solutions to the problems faced.

The Working Time Directive (WTD)

The WTD’s basic provision, limiting a working week to 48 hours, was introduced in 1998, following the UK Government’s failed attempt to block the proposal in the EU’s Council of Ministers. Through subsequent amendments, the Directive now applies to almost all workers in the UK across all UK industry sectors.

As of 2009 the WTD now extends to all doctors and doctors in training except for those senior enough to set their own hours. In addition to the limit to 48 hours, the WTD also provides for mandatory break periods.

Two rulings of the European Court of Justice (SiMAP and Jaeger) have compounded the impact on the NHS by reducing doctors’ flexibility as to when they take breaks, and deciding that time spent asleep, while on call within a hospital should count as ‘working time’. These rulings have severely disrupted doctors’ working patterns and the ability of hospitals to organise rotas.

The WTD has had a serious and negative effect on the NHS in a way that even those who agreed it did not expect or intend. It has had a negative effect on junior doctor training, the continuity of patient care, waiting lists, NHS finances, acute specialities and the doctors themselves who report a negative impact on their working practices and fatigue.

The WTD has led to junior doctors finding it hard to complete the hours needed for their training, with 84% saying they have had to come in during their spare time to make up hours and 86% saying it has led their “work life balance” to deteriorate. Two thirds of surgical trainees reported deterioration in the quality of their surgical training as a result of the WTD.

The Royal College of Surgeons has estimated that the WTD has led to a loss of 400,000 surgical hours per month. Likewise, the BMA has calculated it has led to the equivalent of the loss of up to 9,900 doctors. This adds additional costs to the NHS as new doctors have to be recruited to fill these hours.

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1 Article 168(7) TFEU
2 Association of Surgeons in Training (ASiT) survey, Optimising working hours to provide quality in training and patient safety (January 2009) and British Orthopaedic Trainees Association (BOTA) survey, BOTA position statement on EQTD and training in trauma & orthopaedic surgery (January 2009); http://www.rcseng.ac.uk/policy/briefings/?searchterm=royal
3 Royal College of Surgeons briefing (August 2010); www.rcseng.ac.uk/policy/documents/RCS%20EWTD%20briefing.pdf
The application of the WTD has led to disruption in the continuity of patient care and an over reliance on handover notes. This has led to a number of publicised failings in NHS care including cases where the WTD has been cited by coroners as contributing to patient deaths.4

The UK is not alone in suffering the effects of the WTD, receiving support in raising concerns from a number of other member states. The European Commission has also realised that there is a need to remedy the worst aspects of the Directive, but due to the EU decision making process, including the intransigence of the European Parliament in relation to it, it is almost powerless to act.

The WTD’s negative effects on the NHS cannot be ignored. If action is not taken, patient care will continue to suffer, with potentially disastrous effects in terms of insufficiently trained doctors, patient care and cost.

Possible solutions

It is clear that the UK would benefit from changes to the WTD. A desired outcome could involve a limited change such as a reversal of the two ECJ court cases, a higher limit on hours (c.60 hours), or a full opt-out from EU social legislation. Possible solutions to the problems of the WTD include:

1) Continue attempting to seek agreement at an EU level to amend the WTD and/or reverse the two court cases.

2) Attempt to avoid the Directive or manage a non-compliance with the rulings.

3) Seek a treaty change to opt-out completely from EU social and employment legislation.

Language testing

The EU’s Directive on professional qualifications has led the NHS to treat doctors from the EU differently to doctors coming to the UK from outside of the EU. Whereas those wishing to practise in the UK from non-EU states have to demonstrate a use of the English language before being placed on the General Medical Council’s (GMC) register, those from the EU do not.

The current system for doctors coming in from the EU, who make up 10% of all UK doctors, is that they can automatically have their medical qualifications recognised regardless of their standard of English and are then placed on the GMC’s register. It is then up to the individual hiring hospital to ensure that the doctors they hire have sufficient English language skills. Systematic language testing is prohibited.

This has led to a number of serious incidents including death resulting from doctors with insufficient language skills slipping through the net. This is particularly the case with regard to locum doctors put forward by agencies at short notice.

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4 As in the case of the recent death of Kane Gorny, who attempted to ring the emergency services to receive a glass of water. The subsequent inquest cited the WTD as a factor leading to the lapse in care.
This problem is partly due to the system of registration in England and Wales, which differs to those in other EU member states in that there is no formal separation between registration for medical practice and recognition of qualifications.

There are a number of things that can and in some cases are being done in the UK to boost the GMC’s powers and increase accountability for language testing. Negotiations on the Directive are also underway at the EU level and could be used to improve the situation. However, these improvements would still fall short of the tests imposed on non-EU health workers. Therefore, more can and should be done to ensure patient safety.

**Possible solutions**

The UK Government could use the current renegotiation of the EU Directive on qualifications to allow the UK to impose the same language testing for EU and non-EU health workers.

In the absence of EU agreement, the UK could formalise the separation between doctor registration and licensing that now exists, introducing language testing at the point of licensing, and extending this system to both EU and non-EU doctors to avoid discrimination.

Lastly, the UK could unilaterally extend its current system of testing non-EU health workers to all health workers and potentially face EU infraction proceedings.
The Working Time Directive

1.1. Background

The EU Working Time Directive (WTD) came into force in 1998. Its provisions are binding on the UK subsequent to the UK’s agreement to the Amsterdam Treaty in 1997, which put an end to the UK’s previous opt-out from the ‘Social Chapter’. The UK Government was opposed to the WTD’s introduction but failed in its attempt to block the proposal in the EU’s Council of Ministers. Through subsequent amendments, the Directive now applies to almost all workers in the UK.

The 48-hour working week was extended to doctors in training on 1 August 2009 and after the expiry of a number of initial derogations, the Directive has now been applied in full. The WTD was put into UK law via the Working Time Regulations, which require employers to grant most employees the following:

- A 48 hour week (by an average calculated over a four month reference period).
- Eleven hours of continuous rest in a 24-hour period.
- A 20-minute break when working time exceeds 6 hours.
- 24-hour rest every seven days (or a minimum 48 hours rest every 14 days).
- Four weeks of annual leave.
- Maximum eight hours of work in 24 hours for night workers.

Subsequent European Court of Justice Court rulings in the SiMAP and Jaeger cases have had a particular impact on the NHS.

In the 2000 SiMAP ruling, it was established that time spent resident on call in a hospital (or any other workplace) must be fully counted as working time, even if the worker is asleep for some or all of that on-call time.

The 2003 Jaeger ruling has also provoked controversy, not least because it was clearly not what was intended by the policy makers who originally agreed to the WTD. On that occasion, the ECJ ruled that the mandatory compensatory rest entailed in the WTD has to be taken immediately every time the minimum rest period is interrupted by an emergency.

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5 Directive 2003/88/EC
7 The remaining derogation relates to doctors in critical areas or rural hospitals has also lapsed http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_099150
8 There are limited exemptions for specific groups either unable to calculate their hours or senior enough to dictate their hours.
9 Case C-303/98 Sindicato de Medicos de Asistencia Publica (SiMAP) v Conselleria de Sanidad y Consumo de la Generalidad Valenciana. [2000] ECR 1-7963
10 The ECJ rulings cover both periods where the worker is working in response to a call (i.e. ‘active’ on-call time), and periods where the worker is allowed to rest while waiting for a call (i.e. ‘inactive’ on-call time), provided that he/she does not leave the workplace. See European Commission, ‘Report to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions on implementation by Member States of Directive 2003/88/EC’, 21 December 2010, p5
12 In oral evidence to the House of Lords EU Select Committee in 2004, the then Health Minister John Hutton said: “To require compensatory rest to be taken immediately would potentially have a massively destructive effect across the NHS and might mean that doctors could not work the following shift or rota that they were required to do and that would have knock-on consequences right across the hospital. At the end of the day, the only people who would be negatively affected would be the patients and that is a ridiculous result. House of Lords European Union Committee, The Working Time Directive: A Response to the European Commission’s Review, 9th report of Session 2003-04, Volume II, answer to Q259
This has meant that doctors unexpectedly required to work a longer shift have to cancel appointments the following day.¹³

In 2000, the British Medical Association estimated that the effect of the ruling would have been tantamount to losing between 4,300 and 9,900 junior doctors by 2009, when the full 48-hour limit for junior doctors was due to come into force (the UK later achieved a two year extension).¹⁴

**Individual opt-out from the Working Time Directive.**

There remains an individual opt-out from the WTD, whereby an individual staff member can give their written consent not to be bound by the 48 hour week. However, no staff member, including junior doctors, can be compelled to opt out making it impossible to plan on that basis. Senior consultants within the NHS do, however, tend to use the individual opt-out or take advantage of a separate derogation available to senior managers who set their own hours. However, the opt-out only covers the 48 hour week aspect of the WTD and does not cover other equally important aspects such as the enforced rest periods.

**Four month reference period for calculating the 48 hour week**

The WTD establishes that, when calculating limits to weekly working time, the hours worked can be averaged over a ‘reference period’. In practice, this allows staff to work longer hours during certain weeks, provided that shorter hours are worked in other weeks during the same ‘reference period’ – so that the average remains below 48 hours per week.

Under the WTD, the ‘reference period’ cannot normally exceed four months – but national governments can raise it to six months unilaterally for certain activities (e.g. training doctors, dock or airport workers, etc.). In theory, a further extension to up to twelve months is possible, but only based on collective agreements between employers and employees.

1.2. **The problem**

Although the NHS’ practices, such as the rigidity of the ‘New Deal’, have contributed to the problem, it is clear that the impact of the WTD has resulted in a serious and detrimental effect on the NHS, in terms of the continuity of patient care, the training of junior doctors and waiting times.

Although other EU states and the European Commission are aware of the problem and are willing to attempt reform, opposition from the European Parliament, and “social partners”, both given power by the EU in this area, has so far made reform impossible.

The resulting issues are addressed in turn below:

- Lower standard of training of junior doctors.
- Disrupted continuity of care.
- End to organised rotas.
- Longer waiting lists – due to doctors enforced rest period leading to cancelled appointments.
- Increased cost to NHS.
- Doctors’ welfare in terms of managing their non-working hours.

¹³ Other relevant ECJ rulings are: *Pfeiffer* (C-398/01) and *Dellas* (C-14/04)
1.2.1 Impact on the training of junior doctors:

A combination of the limiting of trainees’ hours, the counting of ‘on call’ time as working time and the unpredictability created by enforced rest periods has had a major impact on the provision of training.

Firstly, the limiting of weekly hours has reduced the time trainees have to gain experience. Secondly, disruption to the traditional rotas has made it difficult for management to schedule individual training opportunities when supervisors and trainees are both present, in addition to decreasing the chances of trainees being present when unscheduled opportunities arise in the course of routine care. It is also difficult to schedule training events where a sufficient number of trainees are present. Lastly, due to trainees spending a larger proportion of their hours on ‘out of hours’ service provision, the value of their remaining time is further reduced.

As one doctor put it:

“There is simply not enough time in the 48 hour week to get trained, particularly in the craft specialties so we all go in on our days off. If we don’t, we don’t get trained and it is us and our careers (but ultimately the patients) that suffer. Medicine is a competitive profession with only a limited number of desirable jobs in desirable locations to live so we simply have to get ourselves trained. This used to happen in our official working hours, now we work just as hard but get trained in our time off (unpaid) instead.”

This can be summed up by the diagram below.

![Diagram showing the effect of reduced hours on training time](image)

Source: A review on the impact of the EUWTD on training by Sir John Temple

This has been borne out in a number of surveys. The Association of Surgeons in Training, for instance, has found that over two-thirds of trainees reported deterioration in their surgical training due to the WTD. 47.6% of Ophthalmologist trainees have found the same with similar results for trainees in Obstetrics and Gynaecology (43%), by the BMA (43%).

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15 Mr Tom Palser MRSC, Surgical Trainee, email to Charlotte Leslie MP, 25 April 2012
17 Association of Surgeons in Training survey, of over 1,600 surgeons-in-training from all specialties; [http://www.asit.org/news/wtd_implementation](http://www.asit.org/news/wtd_implementation)
18 Royal College of Ophthalmologists survey of 189 trainees in October 2009.
19 A review on the impact of the EUWTD on training by Sir John Temple
20 Ibid.
The Royal College of Surgeons (66%), and by the Scottish Academy which found that 65% of trainees in England and 81% of consultants felt the WTD’s effect on training was negative.

Another serious factor resulting from the WTD is the trainee doctors’ provision of services out of hours. Whereas time spent at night unsupervised could be supplemented by supervised training opportunities during the day, under the WTD, a larger proportion of a trainee’s “training” will now be spent with inadequate supervision.

1.2.2. Continuity and quality of patient care

The overall effect of the WTD on the NHS has been to stretch staff availability to the maximum and create more and shorter shifts. This in turn has led to more handovers, less continuity of care and resulting mistakes as staff become unaware of patients’ circumstances or they fall between the gaps.

A combination of the WTD (and the financial penalties imposed by the NHS’ New Deal) has forced hospitals to move away from traditional resident on call rotas towards shorter shift working or non-resident on call rotas.

This has all affected the continuity of patient care. Patients will no longer have the same doctor who initially admitted them seeing them throughout their stay in hospital. This leads to more reliance on handover notes and patient care being broken down into individual procedures. It has also led to an expansion in the number and duration of the use of temporary locums in order to fill in gaps created by the WTD, thus breaking up patient care even further.

The decrease in the continuity of care as a result of the WTD was brought to public attention recently with the sad case of Kane Gorny, who died of dehydration, after having even called the police to be given a glass of water.

In her verdict the coroner at Westminster Coroner’s Court put the blame for the deterioration in the quality of care on hospital waiting lists and the WTD which she said had affected Gorny’s care. The Court specifically heard that many of the medical staff had not read Gorny’s notes and did not even know that he suffered from a rare condition that required daily drugs to control it.

This evidence that continuity of care has suffered as a result of the WTD is again backed up by the Association of Surgeons in Training survey, that found that 17% of trainees were aware of formally reported adverse critical incidents, directly arising from reduced working hours or increased frequency of handovers associated with WTD implementation.

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24 Telegraph, 11 July 2012; http://www.telegraph.co.uk/health/healthnews/9391899/Kane-Gorny-inquest-medics-did-not-check-pulse-for-24-hours.html

25 Association of Surgeons in Training (ASIT) and British Orthopaedic Trainees Association survey; http://www.rcseng.ac.uk/news/docs/ASiT_BOTA%20EWT%20Survey%20results.pdf/view
In this regards the SiMAP ruling over on call time has had a particularly bad effect, with one doctor writing that “the SiMAP ruling has, I think, had a devastating effect on acute care.”

1.2.3. Waiting lists

Although difficult to quantify, the rulings in the Jaeger case have an impact on NHS waiting lists. This is because enforcing a rest period if a doctor has had to work longer than scheduled will mean that he has no option other than to cancel planned appointments at short notice.

1.2.4. Cost

The combination of the Jaeger ruling and the 48 hour working week limit was estimated by the British Medical Association to amount to the equivalent of losing 4,300 to 9,900 junior doctors by 2009. The Royal College of Surgeons research and analysis of NHS workforce came up with an equivalent figure of 400,000 surgical hours lost per month due to the WTD.

In addition to this cost hospitals, as a result of the WTD, have been forced to hire more temporary locum doctors from agencies at a higher cost. These temporary doctors are not only a duplicate cost but due to demand and notice can end up costing far more. For instance as a result of the need to be WTD compliant North Cumbria University Hospitals NHS Trust has reportedly spent £20,000 on hiring a surgeon for one week and £14,000 on four days’ cover for a gynaecologist. Mid-Staffordshire NHS Foundation Trust has also reportedly paid £5,667 for a doctor to cover one 24-hour shift in casualty as the Metro newspaper points out an equivalent salary of £1.36m a year.

In addition to this is the cost of compliance with the WTD in individual hospitals, which can run into tens of thousands of pounds a year in terms of software and employee time. Responses to requests made under the Freedom of Information Act have shown, for instance, that some hospital trusts have engaged specific personnel to keep track of doctors' hours.

In 2010/11 University Hospital Aintree records having spent over £47,000 on WTD compliance, Rotherham NHS Foundation Trust over £41,000, Taunton and Somerset NHS Foundation Trust again over £36,000, to mention only three examples.

1.2.5. Doctors’ welfare

The disruption to the residential on call rota system and the introduction of shorter full shifts supplemented by enforced rest periods has paradoxically left many junior doctors with a more tiring and unpredictable working week. The Royal College of Surgeons concludes that the "move to working 48 hours a week through full shift rotas is exhausting surgical staff. We know from our members that working in a full shift pattern is more tiring when compared to working using an 'on-call' system, and creates a working environment that is impairing to patient safety.”

References:

27 Ibid
28 Royal College of Surgeon's briefing (August 2010); www.rcseng.ac.uk/policy/documents/RCS%20EWTD%20briefing.pdf
29 Metro, 18 March 2012; http://www.metro.co.uk/news/893504-20-000-spent-to-cover-doctor-for-just-1-week
30 Association of Surgeons in Training (ASiT) survey, Optimising working hours to provide quality in training and patient safety (January 2009) and British Orthopaedic Trainees Association (BOTA) survey, BOTA position statement on EQTD and training in trauma & orthopaedic surgery (January 2009); http://www.rcseng.ac.uk/policy/briefings/?searchterm=royal
Likewise the Association of Surgeons in Training, found that 67% of surgical trainees are attending work while off-duty to protect their training and gain adequate experience, and that 84% of surgical trainees are working in excess of their rostered hours to maintain the quality of the service provided.

They also reported that 86% of surgical trainees working a WTD-compliant rota have seen their work life balance deteriorate or remain unchanged with the theoretical reduction in working hours. For junior doctors in training the strictures of the WTD can force trainees to make a difficult choice: comply the WTD and fail to accumulate sufficient training hours, or come in on their days off. Many end up working in their own time off.

1.3. **Contributing factor: The NHS New Deal**

The “New Deal” is essentially an employment contract that stipulates expected hours and pay bands. Despite predating the WTD (the New Deal was agreed in 1991), the relevant parts came into force as a contract in 2000 and 2003. The New Deal awards staff financially for working more than 40 hours per week and sets a limit of 56 hours which to some extent mirrors the WTD.

<table>
<thead>
<tr>
<th>Key Features</th>
<th>EWTD</th>
<th>New Deal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authority</td>
<td>Health and safety legislation</td>
<td>Contract of employment including pay and conditions</td>
</tr>
<tr>
<td>Average maximum number of hours worked per week</td>
<td>48 hours (unless use of opt out agreed)</td>
<td>56 hours (plus up to 16 extra duty hours)</td>
</tr>
<tr>
<td>Maximum period of work in 24 hour period</td>
<td>13 hours</td>
<td>16 hours</td>
</tr>
<tr>
<td>Minimum rest period in 24 hour period</td>
<td>11 hours</td>
<td>8 hours</td>
</tr>
<tr>
<td>Minimum break period and duration of time worked before it is available</td>
<td>Approximately 20 minutes after six hour work</td>
<td>30 minutes after approximately four hours work</td>
</tr>
</tbody>
</table>

Although the WTD is the main factor contributing to the disruption of doctors’ working hours, the NHS’ own New Deal is a contributing factor. Absent the WTD, the New Deal would continue to put cost and time restraints on the NHS.

1.4. **Is the WTD a problem in other EU states?**

It is important to understand that the implementation of the WTD and the ECJ rulings is not solely a UK problem - it has caused problems for healthcare providers across the EU. In addition, the European Commission has recognised this in its review of the directive. It is therefore interesting to see how other states have coped with the WTD. To take a few examples below:

Belgium only enforced the 48-hour cap for training doctors into national legislation from February 2011. Until then, training doctors were working up to 79 hours per week on average in Belgium.

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31 The New Deal: [http://www.dhsspsni.gov.uk/scujuniordoc](http://www.dhsspsni.gov.uk/scujuniordoc)
Despite transposing EU working time rules for training doctors into national law in 2004, Ireland is still failing to apply them – and was last year threatened to be taken to the ECJ. At the beginning of this year, the Irish government laid down a plan to ensure compliance with EU rules over the next three years – meaning that Ireland may not be fully applying the rules before the end of 2014.

The following table outlines the level of compliance in Ireland:

<table>
<thead>
<tr>
<th>Grade</th>
<th>Daily breaks</th>
<th>Daily rest</th>
<th>Weekly/fortnightly rest</th>
<th>Average 48-hour week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intern</td>
<td>79%</td>
<td>77%</td>
<td>97%</td>
<td>43%</td>
</tr>
<tr>
<td>Senior House Officer (SHO)</td>
<td>72%</td>
<td>69%</td>
<td>93%</td>
<td>30%</td>
</tr>
<tr>
<td>Registrar</td>
<td>73%</td>
<td>67%</td>
<td>92%</td>
<td>31%</td>
</tr>
<tr>
<td>Specialist Registrar</td>
<td>73%</td>
<td>65%</td>
<td>94%</td>
<td>37%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>73%</strong></td>
<td><strong>69%</strong></td>
<td><strong>93%</strong></td>
<td><strong>33%</strong></td>
</tr>
</tbody>
</table>

Source: Irish Department for Health

In other words, the Irish government estimates that last year only one third of training doctors across the country were working less than 48 hours a week on average.

In France, the relevant national law only says that doctors in training are obliged to work “eleven half-days” a week – two of which must be devoted to “academic formation”. In other words, neither is the 48-hour limit explicitly mentioned nor does any legal upper limit to junior doctors’ working hours appear to be in place. In addition, French law does not even formally fix the length of a ‘half-day’. However, based on the length of day and night shifts in France, the European Commission estimated that French junior doctors were, on average, required to work about 51 hours a week.

In the Netherlands, the government has sought to get around the problem, by deciding that “training” of junior doctors is not “work” in violation of EU law.

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33 Loi du 12 décembre 2010 fixant la durée du travail des médecins, dentistes, vétérinaires, candidats médecins en formation, candidats dentistes en formation et étudiants stagiaires se préparant à ces professions, see http://www.emploi.belgique.be/defaultTab.aspx?id=33092
39 In principle, there is no law which would prevent French junior doctors being asked to work longer than the eleven half-days. For further details, see European Commission staff working paper, ‘Detailed report on the implementation by Member States of Directive 2003/88/EC concerning certain aspects of the organisation of working time’, 21 December 2010, p33-34
40 NHS, Medical Education England, the impact of the EU WTD; http://www.mee.nhs.uk/pdf/LiteratureReviewFINAL.pdf p.26
another attempt in the Netherlands to classify all workers earning over three times the national minimum wage as exempt as being defined as “persons with autonomous decision-taking power”.41

In Poland, it has been reported that the Polish health union complained after an anaesthesiologist died after working five days in a row, suggesting a low level of compliance.42

1.4.1. How do others deal with the issue of “On-call time”

According to the European Commission’s report from December 2010, the UK is one of the only nine EU member states43 which treat on-call time entirely as working time – in line with the ECJ rulings. All other member states have exemptions in place, in breach of EU law.

In particular, the Commission noted, there is no law in Greece establishing that even ‘active’ on-call time should be counted as working time for public health service doctors. In the report, Greece was also pointed out for excluding public sector doctors from the right to rest periods altogether.44

Last September, the European Commission issued Greece with a ‘reasoned opinion’ threatening to take the Greek government to the ECJ over its failure to apply the WTD to public sector doctors. The Commission noted:

“Doctors working in public hospitals and health centres often have to work a minimum average of 64 hours per week and over 90 hours in some cases, with no legal maximum limit. There is no legal ceiling to how many continuous hours they can be required to work at the workplace, and they often have to work without adequate intervals for rest or sleep.”45

Interestingly, Greece had received the first warning from the Commission almost three years before – but substantially ignored it.46

1.4.2. How do other states cope with the “Reference period”

In its review of the WTD, the Commission noted that Germany, Hungary, Poland, and Spain allow a twelve-month reference period without a collective agreement, again in breach of EU law. This is still the case in Spain, although the maximum working week under Spanish law is fixed at only 40 hours.47

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43 The other eight are: Cyprus, Czech Republic, Estonia, Italy, Latvia, Lithuania, Malta and the Netherlands
44 European Commission, ‘Report to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions on implementation by Member States of Directive 2003/88/EC’, p4
45 See European Commission press release, ‘Commission requests Ireland and Greece to comply with the EU rules on limits to working time in public health services’, 29 September 2011, http://ec.europa.eu/social/main.jsp?langId=en&catId=89&newsId=10883&furtherNews=yes
1.5. **UK doctors’ non-compliance with WTD**

Despite the disruption caused by the implementation of the WTD, it is interesting to note that compliance with the WTD remains patchy within the UK.

For instance:

- 10% of trainees said they had falsified their hours (PMETB survey)\(^{48}\)
- 51.9% said they had worked more than 48 hours (RCO survey)\(^{49}\)
- 63% said that rotas that complied on paper did not in fact.\(^{50}\)

Non-compliance is also difficult to ascertain because the Department of Health in England has decided to stop the central collection of data. A spokesman explained this in 2010,

> “As part of the government’s commitment to reduce bureaucracy in the NHS, the secretary of state has stopped the central collection of new deal compliance data which was used as a proxy to demonstrate compliance with the working time directive. Local organisations are still required to ensure compliance with the working time directive and to monitor that compliance.”\(^{51}\)

In summary, the WTD has caused great disruption within the NHS as well as within heath care systems across Europe. Faced with this major challenge to their delivery of services many countries have chosen not to comply with the Directive and / or the ECJ rulings.

1.6. **Solutions**

1.6.1. **What would we like to do?**

Although organisations such as the College of Surgeons believe that the 48 hours limit is the problem and wish to extend it to 65 hours,\(^{52}\) there is some agreement that the major immediate issue is the inflexibility imposed by the ECJ’s court cases. It is worth noting that, if the UK managed to extend the maximum working week to 65 hours, it would also have to renegotiate the New Deal that currently limits doctors’ hours to 56.

1.6.2. **UK only remedy: Renegotiate the NHS “New Deal”**

It would potentially be possible to renegotiate the “New Deal” to remove the financial penalties imposed on the NHS by doctors working longer hours. At present, the NHS has to pay supplements to all staff working over 40 hours a week in a complex system of “pay banding” that can double a doctors’ pay for the most “anti-social” hours. The financial implication of this has had an effect on hospitals' design of rotas, forcing them to err on the side of caution.

A renegotiated New Deal could improve the provision of junior doctor training by allowing more flexibility to hospital management in the design of rotas. However, although renegotiating the New Deal could help, it would not escape the problems imposed by the WTD and so would at best provide for a limited mitigation of its effects.

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\(^{48}\) A review on the impact of the EUWTD on training by Sir John Temple

\(^{49}\) Ibid

\(^{50}\) Ibid

\(^{51}\) BMJ Careers, 1 September 2011, [http://careers.bmj.com/careers/advice/view-article.html?id=20004425](http://careers.bmj.com/careers/advice/view-article.html?id=20004425)

\(^{52}\) Royal College of Surgeons, Impact of the EU Working Time Directive on Surgery, [http://www.rcseng.ac.uk/policy/briefings/?searchterm=royal](http://www.rcseng.ac.uk/policy/briefings/?searchterm=royal)
1.6.3. Use loopholes to avoid the regulations

A number of "loopholes" have been developed by health care managers around Europe in order to escape the effects of the WTD. These have included:

- Arguing that training is not "work". In the Netherlands, it has been argued that training is not work for the purposes of the WTD, prior to that it was stated that all those earning over three times the minimum wage were also exempt as "autonomous workers". This could potentially be attempted in the UK but would face two immediate problems. Firstly, the European Commission is attempting to tighten implementation and, secondly, the greater provision of services by UK trainee doctors would make this a difficult argument to make.

- Say that doctors are "Self-employed" or manage their own hours: It could be possible to argue that UK junior doctors are senior enough to decide their own hours and training schedules. If this was the case, they could take advantage of an exemption within the directive available to senior staff. This would, however, be difficult to argue, not least with the trainees themselves, and would likely be challenged by the European Commission at the ECJ.

- Dual Employment contracts: As the European Commission itself admitted, the WTD fails to specify whether the 48-hour cap relates to the worker or to employment contract. In order to avoid the WTD, it could potentially be possible to place all junior doctors on two employment contracts each below 48 hours, one for training and one for hospital work. However, again this might be challenged by the European Commission and so would not be a permanent solution.

1.6.4. Continue to seek a deal at EU level to reform the WTD by reinterpretting the cases?

Faced with complaints from a number of EU states, the European Commission, supported by the UK and other EU states, has itself tried to remedy the worst effects of the SiMAP and Jaeger rulings.

Attempt 1) EU Member States and European Commission attempts at reform are blocked by the European Parliament

Background: The European Commission had an obligation to look at two derogations incorporated in the original directive in 1993 within seven years from its introduction. The two derogations are:

- the individual 'opt-out' from the 48-hour week used by the UK and 15 other states
- the four-month reference period for calculating the 48 hours (extendable to one year on the basis of collective bargaining).

The Commission used this review to look at the implications of the SiMAP and Jaeger rulings. They published a consultation on the impact of the ruling, and eventually a political

compromise among the member states was reached on 10 June 2008 involving a separate concession by the UK on the implementation of the Agency Workers Directive.\footnote{55 Member States reach a compromise in 2008 in the Employment, Social Policy, Health and Consumer Affairs Council on 10 June 2008; \url{http://www.eu2008.si/en/News_and_Documents/Press_Releases/June/0609MVZTdeo.html}}

The draft amended WTD would have removed the effects of the ECJ cases by distinguishing between active and inactive ‘on-call’ time, where time spent on call but not at work would not be counted as working time. The European Parliament subsequently voted to unpick the compromise on 17 December 2008 by insisting on the removal of the UK’s individual opt-out as the price of its agreement and ‘conciliation talks’ subsequently failed, leaving the status quo in place.

\textit{Attempt 2) Attempt to bypass European Parliament’s Approval by concluding a “Social Partner Agreement” at the EU level.}

Following the failure to gain MEPs’ approval, the European Commission launched a consultation in March 2010 among the EU-level “social partners” on a review of the WTD looking again at the two ECJ cases.\footnote{56 The consultation, launched under Article 154 of the Treaty on the Functioning of the European Union (TFEU), asks the social partners for their views on the possible direction of action regarding the directive. \url{http://europa.eu/rapid/pressReleasesAction.do?reference=IP/12/903&format=HTML&aged=0&language=EN&uiLanguage=en}} The benefit of asking the social partners to come to an agreement was that the European Parliament would not be able to veto the deal under EU law.

On 14 November 2011, the EU-level social partners agreed to start negotiations. The original nine months given to reach a compromise was extended again on 16 August 2012 to 31 December 2012.\footnote{57 However, it seems unlikely that agreement could be reached, due to the entrenched positions of both sides.} However, it seems unlikely that agreement could be reached, due to the entrenched positions of both sides.

\textit{The main umbrella organisations recognised as “Social Partners” are:}

- The European Trade Union Confederation
- The European employers’ organisation Business Europe

The ETUC’s public position is to oppose any change to the interpretation of the ECJ cases and scrapping the UK’s individual opt-out.\footnote{58 The EU Trade Union Confederation has the following as its negotiating mandate: \textit{“Backed by the impact assessment the Commission should:}\\ - End the opt-out from the 48 hour limit on weekly working time;\\ - Keep the current reference periods in place;\\ - Codify the ECJ jurisprudence on on-call time in the workplace;\\ - Codify for all workers that the Directive has to apply per worker.\\ The ETUC would enter into negotiations with the social partners at European level with a mandate which had the following objectives:}\\ - a comprehensive revision of the WTD which can serve the health and safety of workers;\\ - the end or phasing-out of the individual opt-out in the near future;\\ - keeping the status quo concerning reference periods;\\ - and ensuring compliance of the ECJ judgments on on-call time and compensatory rest.”}
1.6.5. A “social partners” deal in the UK?

The original Directive allows for certain limited derogations subject to “agreements concluded between the two sides of the industry at the appropriate collective level.” This could arguably be done at a national level and could be done for the NHS or parts of the NHS in isolation. However, this is unlikely to work for two reasons:

1) The derogations allowed under the Directive do not cover the 48 hour week per se, and seem unlikely to overcome the ECJ rulings.
2) Even if it was possible to override the rulings with a UK deal, reaching an agreement would still be difficult. In case of the NHS, this would probably have to include the BMA, which is largely opposed to changing the rulings. However, a limited deal for trainee doctors or the College of Surgeons might be possible.

Solution?: One possibility could be to argue in the EU Council for a limited change to the Directive to explicitly allow collective deals to be agreed at a member state level. This could potentially be narrow enough to gain approval by the European Parliament (although this runs a risk of linkage to another subject) but would still require agreement within the UK and the further introduction into UK practice of the EU’s social partner concept.

1.6.6. Tell the NHS to ignore the judgements?

The UK could tell the NHS not to comply with the ECJ rulings. In this case, the UK would open itself to NHS employees or Unions challenging particular cases in UK courts which are under an obligation to follow EU law, unless the UK Parliament explicitly tells them not to.

Unfortunately for the Government, any case taken to a UK Court would either be lost, or referred by the UK court straight back to the ECJ, which presumably would uphold its previous decision. This new ruling would then have to be followed by the UK courts. This is because under the European Communities Act 1972 the UK courts are obliged to follow EU law unless directed by the UK Parliament not to.

If the UK wished to ignore the ECJ’s rulings it should therefore devise a strategy:

In order to mitigate the political and legal fallout from refusing to comply with EU law the UK could take the following steps. Firstly it could seek as wide as an agreement as possible amongst employees’ representatives within the NHS and among other EU states facing similar problems. It could then legislate in the UK to clarify the WTD and prevent UK courts sending cases directly to the ECJ. This approach could be framed as a temporary measure pending a final agreement to implement the Commission’s revisions.

If the European Commission decided to take this breach of EU law to the ECJ and the ECJ ruled against the UK, the UK could then decide to ignore the enforcement proceedings and “pay the fines”. This is not as rare as it might sound, other states such as Germany have also ignored rulings. The likely effect would be:

1) The UK’s failure to comply with the ECJ ruling would result in the Commission taking the UK back to court and asking the ECJ to impose a lump sum and/or a daily penalty payment on the UK. The maximum fine that can currently be imposed on the UK is €703,104 a day or €256.6m (£225.6m) a year.

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59 Assuming the WTD is directly applicable or even indirectly applicable.
60 Germany has not yet implemented the Data Retention Directive and is currently defying the ECJ on the issue of “Golden shares” in Volkswagen.
61 The ECJ can either impose a daily penalty payment or a lump sum penalty. The basic flat-rate penalty payment is €640 a day. This is multiplied by a coefficient for seriousness (ranging between 1 and 20) and a
2) It is unclear what happens if the UK refuses to pay the fines.

1.6.7. Attempt treaty change

Ultimately, to fully remove the problem of ECJ jurisdiction in this area it would be necessary to change the EU treaties to remove the UK from this area of competence. This would require unanimous agreement of all EU member states and a separate treaty amendment. This would ultimately be a part of a larger discussion over the UK’s EU membership terms. This issue was recently dealt with by Open Europe in its report “Repatriating EU social Policy,” 62 and is one of the options considered in the Fresh Start Project Green Paper “Options for Change”, published in July 2012. 63

Language testing

2.1. Background

The EU’s Recognition of Professional Qualifications Directive64 was adopted to facilitate the free movement of nationals of EU member states by making it easier for professionals qualified in one member state to practise their profession in another. The Directive covers all sectors of the labour market, not simply healthcare professionals.

Health professionals who hold certain qualifications and are currently registered with a regulatory body in one member state can register to practise in any other member state under the Directive’s “automatic recognition” procedures. Automatic recognition of qualifications is simply about granting access to professional registration, not about an individual’s suitability to undertake a particular job.

Under the current rules as they apply in the UK, it is up to employers to ensure, as part of the recruitment process, that the applicant has the necessary skills and competences to perform the role for which they are applying.

Approximately 10% (23,550) of doctors currently on the UK medical register (245,000 in total), qualified in other parts of the EU/European Economic Area (EEA)65. While these people play a valuable role in providing healthcare in the UK, the safety of patients must remain the prime concern of UK policymakers and regulators.

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The law on the recognition of qualifications for medical professionals in the UK is set down in statutory regulations\(^6\) which have been incorporated into the 1983 Medical Act.\(^{67}\)

In December 2011, the European Commission tabled a proposal to amend the Directive,\(^{68}\) which is currently under negotiation between national governments and the European Parliament. The Commission anticipates that a new Directive will be agreed by the end of 2012, but is unlikely to be implemented in the UK before 2014 (two years after its adoption by the EU institutions).

2.2. The Problem

Communication and language skills are an essential part of healthcare professionals’ ability to practise effectively and safely. Doctors, nurses, dentists, midwives and pharmacists not only need to be able to communicate effectively with patients but also understand precise medical terminology, which can often be particular to a given field of medicine.

Healthcare regulators in the UK, chiefly the General Medical Council, are currently prevented from systematically testing language skills of EU/EEA nationals at the point of registration. In the UK, the automatic recognition of qualifications is part of the registration process. Once registered, EEA doctors are free to seek work in the UK. In contrast, non-EU/EEA nationals must pass a language test (known as the IELTS test) to a specified level before being allowed on to the UK’s Medical Register.\(^69\)

The European Commission’s Code of Conduct for the implementation of the Directive states that systematic testing of EEA nationals is “unacceptable practice” for national regulators.\(^70\)

In its 2011 Green Paper on modernising the Directive, the Commission outlined its interpretation of the rules:

“Currently, Member States can control that professionals have the language knowledge necessary for performing their activities, but they must do it in a proportionate way. This means that they cannot subject systematically foreign professionals to language tests. Professionals should be able to prove their language knowledge by other means (e.g. diploma acquired in the relevant language, professional experience in the country, language certificate etc.). This means also that the level of language knowledge required varies according to the type of activity and the framework in which it will be conducted. Also the language control can only take place after the end of the recognition procedure and cannot be a reason for refusing recognition of professional qualifications as such.”\(^71\) (emphasis added)

\(^6\) European Communities (Recognition of Professional Qualifications) Regulations 2007 and European Qualifications (Health and Social Care Professions) Regulations 2007
The House of Lords EU Select Committee’s inquiry into doctor mobility stated that, “The general understanding among our witnesses was that regulators could check language only on an ad hoc basis when they were alerted to an issue and therefore had reasonable doubt about an individual’s language competence.”

The problem is compounded by the fact that the Article 53 of the Qualifications Directive, which concerns language competency, has not been transposed into UK law, which limits the GMC’s legal powers to test language competency even after the recognition of a professional qualification. The 1983 Medical Act therefore does not currently permit the GMC to institute ‘fitness to practise proceedings’ against a doctor solely on grounds of poor knowledge of English.

Putting Article 53 into UK law would increase the GMC’s powers post-recognition of qualifications but would not solve issue regarding adequate pre-registration language testing.

The responsibility for assessing whether an EEA doctor or a nurse’s language competence is satisfactory therefore falls on individual employers, e.g. the NHS trust where the applicant seeks employment.

At the level of employers, guidance from NHS Employers on language competency states that complying with Article 53 of the Directive,

“…does not wholly rule out the use of tests, but employers must not systematically test all applicants from the EEA. For example, making all applicants sit the same test, even though they may be able to demonstrate their competence in other ways, is not permitted…

…Decisions by the employer about what evidence it requires to be satisfied about the applicant’s English language knowledge must be made on a case by case basis and be proportionate in all the circumstances, depending on the work the individual is going to undertake.”

A 2010 report by Pulse, a weekly magazine for GPs, found that only 23% of EU doctors in the NHS had their competence checked and 17% had been tested for language skills, with a follow up report finding that only 4% of doctors untested in 2010 had undergone checks since then.

This problem is exacerbated by the disruption to rota patterns caused by the WTD, which often means extra or locum staff have to be taken on to provide sufficient cover. In the case of locums, NHS Employers advises trusts appointing medical locums and other agency staff

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73 Article 53 of the current directive states that “Persons benefiting from the recognition of professional qualifications shall have a knowledge of languages necessary for practising the profession in the host Member State.”
77 Pulse, ‘Revealed: How PCTs have ignored call to test EU doctors’, 28 March 2012; [http://www.pulsetoday.co.uk/newsarticle-content/-/article_display_list/13681468/revealed-how-pcts-have-ignored-call-to-test-eu-doctors](http://www.pulsetoday.co.uk/newsarticle-content/-/article_display_list/13681468/revealed-how-pcts-have-ignored-call-to-test-eu-doctors)
to ensure that their agreements with contractors or locum agencies include obligations to supply employees who have the required level of communication skills to carry out the role. However, the ultimate responsibility to ensure that a locum has suitable language skills falls on the trust appointing the doctor. This can be a particular challenge to trusts as locums are often recruited on an ad hoc basis and flown in to fill a particular shift at short notice.

In addition to locums, self-employed health professionals are another area of concern. As the House of Lords EU Committee’s inquiry noted:

“There were concerns that giving employers the primary responsibility for ensuring that language requirements are met meant that there were no provisions in place to ensure that self-employed professionals met the required standards. This was of particular concern in professions which had a high proportion of self-employed individuals, for example pharmacy or osteopathy.”

(emphasis added)

2.3. The impact

The risks associated to doctors from other EU member states not having sufficient language skills to work in the UK received huge attention from the media following the case of Nigerian-born German Doctor Daniel Ubani.

During his first out-of-hours shift in the UK, Dr Ubani caused the death of a patient by injecting him ten times the recommended dose of diamorphine. William Morris, the coroner who carried out the inquest, concluded that the patient had been “unlawfully killed” and described Dr Ubani as “incompetent – not of acceptable standard.”

Among other things, the coroner found that Dr Ubani was obliged to drop his application to go on the ‘Performers List’ of the West Yorkshire NHS Central Services Agency because he had failed an English language test. However, he then successfully applied to go on the Performers List of the Cornwall and Isles of Scilly Primary Care Support Agency, which also enabled him to practise elsewhere in the UK. The Cornwall and Isles of Scilly authority “demanded no passing of any IELTs language test – nor did it make enquiries as to whether Dr Ubani had ever failed such a test.”

The coroner recommended to the Health Secretary that the application of EU rules on foreign doctors in the UK be reviewed and guidance be given to all Primary Care Trusts.

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82 See ‘Inquest into the deaths of David Gray and Iris Edwards – Coroner’s summing up, decisions and announcements’, February 2010, p8, http://www.hardwicke.co.uk/media/06/206-inquestverdict-gray.pdf
83 See NHS Devon / Torbay & Plymouth Performer Lists; http://www.devonpct.nhs.uk/Performer_Lists/Performer_Lists.aspx
84 ‘Inquest into the deaths of David Gray and Iris Edwards – Coroner’s summing up, decisions and announcements’, p18-19
85 The coroner specifically mentioned Council Directive 93/16/EEC
(PCTs) that foreign doctors need to have a “sufficient knowledge of English” to be able to operate in the UK.

2.4. **The Solution**

There are currently policy developments underway at both the UK and EU levels that are likely to determine the issue of language competency in the future, which present opportunities to find a workable solution that prioritises patient safety.

2.4.1. **UK-level measures:**

On the domestic front, the Government has recently embarked on a number of measures within the UK designed to address the issues surrounding language competency. In April 2012, it launched a consultation on proposals to give Responsible Officers\(^{86}\) in England the responsibility to check the language competence of doctors under their supervision.\(^ {87}\) The Government has proposed that:

> “An assessment of language skills would need to be carried out in a proportionate way which took account of the circumstances in which the doctor would be working before they were able to take up post. This would include in certain circumstances the proportionate use of language tests.”\(^ {88}\)

The outcome of the Responsible Officers’ assessment would then be fed back to the GMC, allowing the regulator to either “register a general level of assurance on language competence” or be alerted to where the responsible officer has “significant concerns on the language competence of an individual.”\(^ {89}\) It should be noted, however, that the GMC has stated that it does “not think it would be helpful” to keep a running register of doctors’ language competences as “the significance of the inclusion or absence of an annotation in a particular case may impact unfairly on doctors if those consulting the register are unclear about the correct inference to be drawn.” The GMC has, though, said that it thinks it should be notified where Responsible Officers have significant concerns about the language competence of an individual.\(^ {90}\)

In addition, in March 2012, Parliamentary Under-Secretary of State at the Department of Health, Lord Howe stated that the Government was working with the GMC to amend the Medical Act to enable the GMC to be “better able to take action where language concerns arise as part of the registration process and when a licence to practise has already been issued.”

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\(^{86}\) Responsible Officers are senior doctors within a healthcare organisation with specific and personal responsibility for those aspects of clinical governance linking to medical revalidation and to the conduct and performance of doctors working in or for the organisation.

\(^{87}\) The new duty could only apply to responsible officers working in England because the assessment of language skills is a clinical governance function, and clinical governance has been devolved to Wales, Scotland and Northern Ireland.


\(^{90}\) GMC, ‘Response to Department of Health consultation on Responsible Officers’, Q3.3 & Q3.4.; [http://www.gmc-uk.org/GMC_response__DH_consultation_on_ROs_in_the_new_health_architecture.pdf_49678166.pdf](http://www.gmc-uk.org/GMC_response__DH_consultation_on_ROs_in_the_new_health_architecture.pdf_49678166.pdf)
Giving responsible officers the role of checking language competency and using this as a feedback alert mechanism to the GMC is likely to increase accountability for ensuring satisfactory standards in hospitals. Self-employed doctors would also be included as the new system will cover all doctors, including the self-employed. Amending the Medical Act could also boost the GMC’s power to take action where doubts are raised about a doctor’s language skills during the registration process. However, as GMC Chief Executive Niall Dickson told a House of Lords Committee, “The question is: what is a doubt?”

It should be noted that the BMA has suggested that the proposals for Responsible Officers to check language competency are “unworkable”, due to time constraints and potential conflicts of interest.

Nevertheless, these improvements would still fall short of the systematic language testing at the point of registration applied to non-EEA nationals, which the GMC has stated is its preferred option for all healthcare professionals.

2.4.2. EU-level measures:

The Commission’s 2011 Green Paper on revising the Qualifications Directive recognised the problems caused by the current rules on language testing and the proposed revision to the Directive, tabled in December 2011, expands the section on language testing. Inserted into Article 53 is a reference to “professions with patient safety implications”. The revision would allow member states to:

“…confer to the competent authorities [i.e. the GMC] the right to carry out language checking covering all professionals concerned if it is expressly requested by the national health care system, or in case of self-employed professionals not affiliated to the nationals health care system, by representative national patient organisations.”

However, this clarification would not much improve a situation that could be achieved through the domestic initiatives, discussed above, already being taken by the Government. There remain two fundamental concerns under the new proposal:

- Firstly, the Commission’s 2011 proposal effectively restates the existing situation whereby the “checking of language knowledge is to take place only after the host Member State has recognised the qualification.”

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91 See the GMC’s oral evidence given to the HoL’s EU Committee’s inquiry on doctor mobility on 30 June 2011, Q80; http://www.parliament.uk/documents/lords-committees/eu-sub-com-g/healthcare/evidencevolumemobhealthcare.pdf
93 See the GMC’s written evidence to the HoL’s EU Committee’s inquiry on doctor mobility, 17 June 2011, p96; http://www.parliament.uk/documents/lords-committees/eu-sub-com-g/healthcare/evidencevolumemobhealthcare.pdf and oral evidence given to the Committee on 30 June 2011, Q81; http://www.parliament.uk/documents/lords-committees/eu-sub-com-g/healthcare/evidencevolumemobhealthcare.pdf
Lord Howe said that the Government’s interpretation of the proposal was that “while the proposal would not allow language checks by a competent authority before recognition of the qualification of a professional, they do make it clear that controls on language checks would be permissible and could be undertaken before a professional was able to practise”.

The issue is that the UK system of registration does not distinguish between the recognition of the qualification and access to the profession as many other EU member states’ systems do. In Germany, for example, there is a distinction between the recognition procedure and the granting of a licence to practise:

“Proficiency in the language is not part of the recognition procedure…In practice, this difference can mean that an applicant’s evidence of formal qualifications must be recognised but the applicant still does not have a right to be granted a licence due to lack of proficiency in the language. How language proficiency is verified is a matter of administrative practice in each of the German Länder.” (emphasis added)

Since November 2009, the UK law has changed to require doctors wishing to practise in the UK to hold both registration and a licence to practise with GMC. This new format could potentially allow the UK to adopt a two-stage approach similar to that of Germany.

- There is, however, a second area of concern: the nature of the testing permitted under the new proposals. The NHS European Office notes that the Commission’s proposed text remains ambiguous on this point. While one paragraph gives national regulators the “right to carry out language checking covering all professionals concerned if it is expressly requested by the national health care system”, an earlier paragraph implies the caveat that testing can only take place “if there is a serious and concrete doubt about the professional’s sufficient language knowledge in respect of the professional activities this person intends to pursue.”

Indeed, Lord Howe has suggested the proposals would only permit testing where there is a doubt about language competency,

“…the Commission’s proposed draft would not appear to allow the GMC to undertake systematic language testing at the point of registration. The GMC would be required, as it is now, to consider the recognition of the qualification and, if accepted, to register the EEA migrant. However, the proposals appear to give greater scope for the GMC to be able to apply language checks after registration where serious concerns are identified, which is a positive development. We believe that what the Commission is proposing would be consistent with the proposed model for a strengthened system of checks, overseen by responsible officers, that we are working up in conjunction with the GMC.” (emphasis added)

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101 Hansard, 22 Mar 2012 : Column 1114
Once again, the question is: what is to be considered a doubt or concern?

2.4.3. What more could be done?

- **Push for language testing at the point of recognition to be set out in the Directive:**
  While the Commission’s proposals, in combination with domestic legal changes, would mark an improvement on the current situation, they would still fall short of the ideal situation whereby the GMC would be able to test the language competency of EEA doctors in the same manner as all other foreign non-EEA doctors are tested.

  The UK could therefore take a tougher stance in the ongoing negotiations to ensure that the new Directive allows language testing to be applied to all foreign doctors at the point of registration. The free movement of doctors is clearly unlike the free movement of other professionals and therefore exceptions in this case are not unreasonable.

  However, this may be politically difficult, as the Commission and the other EU institutions, such as the European Parliament, clearly feel that the mutual recognition of qualifications set out in the Directive is integral to upholding the principles of free movement and non-discrimination between nationals of EU member states.

- **Separate recognition and licensing:** Failing the preferred outcome being incorporated into the new Directive, the UK could formalise the separation between doctor registration and licensing that now exists, introducing language testing at the point of licensing, and extending this system to both EEA and non-EEA doctors to avoid discrimination.

  This would seemingly satisfy the Commission’s desire for language testing to happen after the recognition of qualifications. The remaining doubt would be whether the UK language tests currently applied to non-EEA doctors would be permissible under the Commission’s caveat that language controls should only be undertaken “if there is a serious and concrete doubt about the professional’s sufficient language knowledge in respect of the professional activities this person intends to pursue.”

  The UK tests for foreign non-EEA doctors do provide some flexibility in that foreign doctors who have trained in the UK or in other English-speaking countries do not necessarily have to sit the IELTS language test, which might enable the UK to argue that they are not ‘systematic’ but assessed on a case-by-case basis.

- **Unilateral introduction of testing at the point of registration:** If neither of the above options are forthcoming, the UK could simply unilaterally apply its current language testing for all foreign doctors, non-EEA or EEA. This would probably result in the UK being in breach of EU law, but this could be justified in the context of patient safety and maintaining the integrity of the UK’s system of medical regulation.

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102 GMC language qualification: [http://www.gmc-uk.org/doctors/registration_applications/13676.asp](http://www.gmc-uk.org/doctors/registration_applications/13676.asp)