

PWG

PERMANENT WORKING GROUP OF
EUROPEAN JUNIOR DOCTORS

1976, 2001



HANDBOOK OF POLICY STATEMENTS
OF THE PERMANENT WORKING GROUP
OF EUROPEAN JUNIOR DOCTORS — PWG

**HANDBOOK
OF POLICY STATEMENTS
OF THE
PERMANENT WORKING
GROUP OF
EUROPEAN JUNIOR DOCTORS
(PWG)**

UN UPDATE OF THE
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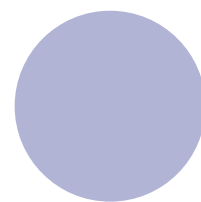
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HANDBOOK OF POLICY STATEMENTS
OF THE PWG, 1976-2001



Contents

I. Introduction

25th Anniversary of the PWG

II. PWG Statutes

Charter of the Permanent Working Group of European Junior Doctors

III. Policy Statements of the PWG

Basic Policy Statements & Studies

Education and Professional Development

- 019 Memorandum on Temporary Migration with an Educational Purpose
Helsinki 1978
- 026 Policy Statement on Postgraduate Medical Training – a European Future,
Vienna, October 1994 (PWG 94/087 Final)
- 031 Policy Statement on Continuing Medical Education/Continuous
Professional Development (CME/CPD) (PWG 99/083 Final)

Medical Workforce

- 038 Medical Manpower in Europe by the Year 2000: from Surplus to Deficit?
Florence 1991
- 042 Medical Manpower in Europe: towards a Balance between Supply and
Demand by the Year 2000. Florence 1991
- 051 Medical Manpower in Europe:
The prognosis holds true – same trend as five years ago. Copenhagen 1996
- 059 Results of Questionnaire Migration of Doctors from Eastern Europe
(PWG 93/062 Corrected)
- 070 Refugee doctors in Europe – a PWG survey and report (PWG 2001/048)

Working Conditions for Doctors in Training

- 075 HIV Infection & Hospital Doctors. London 1995 (PWG 94/089 Final)
- 082 Consequences for Doctor and Patient Care in the EU: Executive Summary
Brussels 1995
- 085 PWG Policy Statement on Future Medical Work. Cologne, 1997 (PWG
97/019 Final)

Other Policy Resolutions & Studies

Education and Professional Development

- 093 Resolution on Specialist Training (1983)
- 093 Resolution on Equal Rights of Men and Women Doctors (1983)
- 093 Resolution on the Evaluation of Specialist Training (1984)
- 094 Conclusions to the Survey on Compulsory Postgraduate Training (1987)
- 094 Comments on the "Edinburgh Declaration" on Medical Education (1989)
- 094 Provisional Statement on Quality Assurance in Clinical Medicine (1990)
- 095 Prolongation of Specialist Training (1990)
- 095 Motion about establishing European Specialty Boards by the European
Union of Medical Specialists (UEMS)
- 095 Statement on Temporary Migration with an Educational Purpose (1978)
- 096 Resolution on Transnational Training (1984)
- 096 Definition of Quality Assurance (1991)
- 097 Policy Statement on Postgraduate Medical Education in General Practice
(PWG 91/008)
- 100 Supervision (PWG 92/198)
- 101 Comments of the PWG concerning the UEMS draft charter on training of
medical specialists (PWG 92/235)
- 101 Statement on the Quality Assurance of Postgraduate Medical Training
(PWG 93/083)
- 103 On Specific Training for General Practice (PWG 93/066)
- 104 Report on Survey on Training in General Surgery 1991 (PWG 94/042)
- 106 EU/EEA Citizens with third Country Primary Qualifications (PWG 94/099
Final, 96/085 Final)
- 107 Policy Paper on Continuing Medical Education (PWG 96/049)
- 109 Presentation of PWG Policy on Postgraduate Medical Training to the
Advisory Committee on Medical Training (ACMT) (PWG 95/074)
- 115 Motion on the future of the Advisory Comm. on Medical Training (PWG 98/046)
- 114 Statement on Recertification (PWG 99/045)

- 114 Statement on the European Board examination (PWG 99/046)
- 115 Research in Postgraduate Training: a discussion paper (PWG 2000/026)

Medical Workforce

- 117 Definitions of Various Employment States (1980, revised 1989)
- 118 Recommendations on Health Manpower Planning (1982)
- 118 Resolution in Health Manpower Planning (1983)
- 119 Motion about Unpaid Posts for Medical Doctors (1990)
- 119 Main Findings of Manpower (Symposium 1991)
- 119 Statement Medical Workforce Planning (PWG 99/041)

Working Conditions

- 121 Resolution on Strike Action by Doctors, 1984
- 121 Excessive Working Hours, 1990
- 122 PWG response to EC proposed directive on working time (PWG 92/137)
- 122 Conclusions from the Questionnaire "Definition of Working Hours" (PWG 92/174)
- 125 Resolution on proposed EC Directive on Working Time (PWG 93/029)
- 125 Motion, Working Condition (PWG 93/065)
- 126 On Directive 93/104/EC, Working Time (PWG 93/082)
- 127 Final Report on the Working Hours of "Doctors in Training" in the Context
of Directive 93/104/EC (PWG 95/004)
- 138 Working Hours of Junior Doctors in Europe (PWG 95/093 Rev.)
- 141 Basis for PWG Policy on EU Regulation (PWG 93/111 Final)
- 141 Working Hours for Doctors in Training & the Implementation of the
Working Hour Directive (PWG 96/116 Final)
- 142 Opinion of the Permanent Working Group of European Junior Doctors (PWG)
and the Standing Committee of European Doctors (CP) on Council Common
Position on the excluded sectors from the working time directive (05/07/99)
- 143 Resolution on the European Working Time Directive (PWG 2000/040)

Ethics

- 145 Comments on Revision of Helsinki II (1979)
- 145 Motion on AIDS (1990)
- 146 Recommendations re Publication of HIV Document (PWG 95/048)

Organisational

- 148 Standing Committee of European Doctors, CP (1983)
- 148 Council of Europe (1986)
- 148 European Association of Medical Education, AMEE (1989)
- 148 European Union of Medical Specialists, UEMS (1989)
- 148 European Union of General Practitioners, UEMO (1991)
- 149 International Federation of Medical Student Associations, IFMSA (1994)
- 149 European Medical Students' Association, EMSA (2001)
- 149 Smoking (1990)
- 149 Criteria for membership, observer or guest status within the PWG (1991)
- 149 Motion on the European Parliament and Council Directive amending
Directive 93/16/EEC (PWG 95/049)
- 150 Additional responsibilities of PWG delegates to UEMS Boards (PWG 96/115)
- 150 PWG Support Fund Guidelines (PWG 98/108)
- 151 The management of documents submitted by the Associated
Organisations to the Board/General Assembly of the CP (PWG 2001/025)

Other documents

- 153 Resolution on the Involvement of Doctors in Health Service Management (1986)
- 154 Diagnosis Related Groups (DRGs) and other System for Cutting Hospital
Costs (1994) (PWG 94/054)
- 155 Good Pharmacy Practice in Europe (PWG 94/116 Final)
- 155 Statement on WHO draft Charter on General Practice (PWG 96/046 Final)
- 156 Motion on Medical Training Schemes for Doctors Affected by Civil Strife
and Conflict (PWG 96/044 Final)
- 156 Statement on Priority Setting in Health Care (PWG 99/105)

IV. Appendix

- 159 PWG Member Organisations
- 160 List of PWG Publications

01

INTRODUCTION





Introduction

A brief overview of the PWG after 25 years

Eduardo F. Marques

President, 1998–2001

The Permanent Working Group of European Junior Doctors (PWG) was formally created in Bad-Nauheim, Germany, in May 1976. Since then, the PWG has become the European medical organisation with the most comprehensive national membership, representing the junior doctors of 23 European countries. The PWG's initial objectives include safeguarding the interests of the junior doctors in Europe, improving relations between its member organisations and narrowing the gap between the junior doctors of the European Union and those of other European countries. Over the past quarter of a century, the PWG has actively intervened in defence of the medical profession in Europe with the purpose of contributing to the development of junior doctors' work and education and has had an important role as a background group for the organisations of junior doctors in countries preparing to join the European Union. From the beginning of the PWG's existence, it became evident that the junior doctors of the various countries have many similar experiences and difficulties. Therefore, after pooling the information and exchanging ideas, the PWG was able to identify the main areas of interest to junior doctors in Europe.

The status of the medical workforce was one of the most important issues in the PWG's early years. The PWG conducted several studies that drew the medical profession's attention to the fact that this issue is not static and that long-term planning, though difficult, is essential. The different perspectives within the European Union influence the migration of doctors as well as the working conditions, quality of training and quality of patient care. Therefore, the PWG has endeavoured to gain a better insight of the workforce policy of its member countries in order to, where necessary, influence policy makers by providing examples of more successful planning. Other major areas of interest to junior doctors, and to the PWG, have been temporary migration for educational purposes, postgraduate training, continuing medical

education, future medical work and working conditions.

In its first years, the PWG embarked on the important task of compiling information to facilitate the migration of doctors in training in Europe. The objective of this work was to provide true freedom of movement, in accordance with the principles established by the Medical Directives in 1976. The PWG's greatest contribution was the publication of a series of booklets containing relevant information for doctors wishing to seek employment or complement their training in a foreign country.

In 1995, at its conference on "Postgraduate Training: a European Future", the PWG publicly presented its most recent policy on this issue, which is still a reference for European doctors. This policy statement brings to light a significant number of principles concerning the structure and quality of this phase of medical education, which coincide with several points in one of the most important official documents on this issue, the 4th report of the Advisory Committee on Medical Training (ACMT), published in 1997. This was my first opportunity to actively participate in one of the PWG's major projects and also the first occasion that I became fully aware of the importance and potential repercussions of this work. One of the PWG's current projects, Research in Postgraduate Training, will provide a balanced development of our policy in the field of postgraduate training.

In 1997, we had the opportunity of disseminating an important new paper on "Future Medical Work", which has proven fully up-to-date. This paper concerns the organisation of work in health services and its influence on the working conditions of junior doctors. The greater expectations of patients, allied with factors such as ageing, migration and mobility, have led to a progressive increase in healthcare costs. As a result, most European countries have undermined doctors' working condi-

tions with policies of economic management and redistribution of resources. Our recommendations include concepts such as the creation of a positive workplace, organisational development, project management and other strategies that enhance the structure, process and outcomes of health promotion for patients as well as doctors.

In May 2000, the PWG published a policy statement on Continuing Medical Education/Continuous Professional Development (CME/CPD) and organised a conference in which it was possible for experts from various European medical organisations to exchange their views on CME/CPD before an expert audience. We have recently witnessed the publication of several different documents on CME/CPD that generally defend the principles that became evident during the Conference. Fundamentally, the medical profession believes that CME/CPD is both a moral obligation and a right, and that access to appropriate CME/CPD must be ensured for all doctors, including those in training. The PWG's Policy Statement opposes a system of recertification and states that it is a misconception that such a system would contribute to the identification of unsuitable doctors, hence defending the concept of quality improvement, as opposed to quality control.

The PWG was actively involved in finding a solution to the problem that was created when the European Working Time Directive (Directive 93/104/EEC) excluded doctors in training from certain aspects of the organisation of working time. In December 1995, the PWG, in collaboration with the European Commission, organised a major conference in Brussels to address the issue of junior doctors' working conditions. In the year 2000, after many years of intense negotiations with the European authorities, the European Parliament and the European Council finally agreed to include doctors in training within the scope of the European Working Time Directive (Directive 2000/034/EC). Although the PWG considers this agreement a positive step forward in protecting the health and safety of doctors and their patients, it deplores the unnecessary delays to the full implementation of the Directive. The European Parliament and the European Council established a total transition period of nine years to reach the 48-hour week, which the PWG regards as unnecessarily long because junior doctors often work until exhaustion in several European countries, jeopardising their health and safety, as well as that of their patients. The PWG continues to draw the attention of EU member states to the need for real reductions in junior doctor's working hours and the full implementation of this Directive within the shortest possible time. The PWG recently held a seminar on this issue so that countries with major problems could benefit from the input and experience of those with better working conditions.

In accordance with the text of the new Directive regulating the recognition of diplomas, published in January 2001, the minimum period for specialty training in General Medical Practice is to be extended to three years. This was welcome news after supporting the general practitioners in this objective since

1991. Curiously, our organisation was founded as the "Permanent Working Group of European Junior Hospital Doctors", which later proved inappropriate because the PWG includes doctors in training in non-hospital fields and there was no organised body of junior doctors in the field of primary care. Therefore, in 1996, during an important revision of our statutes, by a working group coordinated by Dr. Kirsi Ailus (SF), we dropped the word "hospital" and became the Permanent Working Group of European Junior Doctors.

From the beginning, the PWG has sought to develop productive relations with various European medical organisations and authorities. We have had formal relations with the Standing Committee of European Doctors (CP) since 1983 and we were granted consultative status in the Council of Europe in 1986. We also have good relations with the Regional Office of the World Health Organisation, the European Parliament and the European Commission. The PWG has regular meetings with the most important European medical and medical students' organisations to coordinate activities and increase efficacy. In November 2000, these organisations approved a protocol governing the relations between them and the CP. The PWG is now a member of a group of institutions that speak with one voice and represent the medical profession in Europe, although it is aware of the fact that it must maintain its independence and capacity of negotiation with the European authorities.

During the first 25 years of the PWG's existence, it has organised numerous plenary Assemblies all over Europe and the rotation of meetings has ensured mutual understanding and the exchange of information.

Since its beginning, in Bad-Nauheim in 1976, the PWG has been presided by Dr. Per Vagn-Hansen (DK), the first Coordinating Secretary of the PWG for the 1976-1979 triennium, followed by Dr. Anton Seiler (CH), Mr. Douglas Gentleman (UK) and Dr. Hans-Ueli Würsten (CH). Dr. Jesper Poulsen (DK) was the first person to be elected President of the PWG (1994-1997), an indication of the positive development of this organisation. My mandate, as the second President of the PWG, ends in 2001 and the PWG has chosen Dr. Nina Tiainen (SF) as my successor. Many junior doctors from all over Europe have had greater or smaller roles in the PWG's work and some are now accredited leaders in national or European medical organisations. Some non-medical participants, who have witnessed the life of this organisation from the beginning, have generously placed their knowledge on issues of medical policy at our disposal. The junior doctors of 23 European countries now have an influential organisation that defends their interests effectively and, due to the hard and dedicated work of many individuals, we are all proud of its achievements. However, there is always much to be done and we are aware that the structure of our organisation must evolve if we wish to maintain our recognised role and capacity of intervention. I see the Permanent Working Group of European Doctors as an increasingly influential and effective organisation defending the current and future interests of European Junior Doctors in these times of rapid change.

02

PWG STATUES





PWG Statues

Charter of the Permanent Working Group of European Junior Doctors

adopted at Bad Nauheim, Germany 1976;

revised in Madrid 1989 and in Copenhagen 1996

Preamble

The Permanent Working Group of European Junior Doctors was founded on 29 May 1976 by unanimous agreement of the following organizations:

Denmark:

Den Almindelige Danske Lægeforening.

Finland:

Nuorten Lääkärien Yhdistys.

France¹:

I.S.N.I.H / I.S.N.C.C.A.

Germany²:

Marburger Bund.

Iceland:

Felag Ungra Lækna.

Luxembourg:

Association des Médecins et Médecins-Dentistes.

The Netherlands:

Landelijke vereniging van Artsen in Dienstverband.

Sweden:

Sveriges Yngre Läkares Förening.

United Kingdom:

British Medical Association.

Subsequently, the following organizations were admitted as members in the year indicated:

Austria (1985):

Österreichische Ärztekammer.

Belgium (1979):

Fédération Belge de Chambres Syndicales des Médecins.

Estonia (1993):

Estonian junior Doctors' Association (EJDA)

Greece (1992):

Association of Hospital Doctors of Athens and Piraeus.

Hungary (1995):

Hungarian Medical Association.

Ireland (1977):

Irish Medical Organisation.

Italy (1978)³:

Associazione Medici Specialisti della Comunità Europea e Specialisti in Formazione.

Latvia (1993):

Latvian junior Physicians' Association.

Malta (1992):

Medical Association of Malta.

Norway (1986):

Yngre Lægers Forening.

Poland (1995):

Polish Medical Association, Junior Doctors Section.

Portugal (1977):

Ordem dos Médicos.

Slovenia (1992):

Sekcija Mladih Zdravnikov.

Spain (1977)⁴:

Consejo General de Colegios Oficiales de Médicos.

Switzerland (1977):
Verband Schweizerischer Assistenz und Oberärzte/innen
(VSAO); Association Suisse des Médecins Assistants et Chefs de
Clinique; Associazione Svizzera dei Medici Assistenti e
Capiclinica (ASMAC).

Observer(s):
Lithuania.

¹ Lapsed 1979, rejoined 1985.

² Collaborating affiliate since 1976, full member since 1980.

³ ANAAO member 1978–1996, AMSCE from 1997.

⁴ Lapsed 1979, rejoined 1986.

Article 1. Name and Purpose

- 1.1 The organization shall be called Permanent Working Group of European Junior Doctors, hereafter referred to as "the PWG".
- 1.2 The PWG shall have the following objectives:
- a.** to represent and further the interests of junior doctors in Europe;
 - b.** to exchange information and develop a common approach, and formulate common views on relevant matters such as medical manpower, postgraduate medical education, and working conditions;
 - c.** to improve relations between junior doctors in European countries;
 - d.** to improve and protect the standards of health care in Europe.

Article 2. Membership

- 2.1 Membership of the PWG shall be open to a single representative, national, nongovernmental organization representing junior doctors in each of the countries of Europe. For the purpose of this Charter, a junior doctor is defined as a doctor who has not yet attained a final senior post as an independent medical doctor within the health care system of his or her country.
- 2.2 Each national delegation shall sign the Charter of the PWG to express that it will abide by its provisions.
- 2.3. Applicants for membership of the PWG must fulfill the criteria laid down in the Charter and must be from countries eligible for membership in the Council of Europe.
- 2.4 Applicants for observer status must fulfil the criteria for membership. All observers must apply for full membership within two years of being granted observer status. Observers will have the right to speak, but not to vote.
- 2.5 Member and observer organizations will be liable to pay an annual subscription fee as levied by the PWG Plenary and set forth in the subscription key.

2.6 Withdrawal: a member may withdraw from the PWG with one year's notice. However, the withdrawal must be explained in writing to the PWG President and the withdrawing member is liable to pay all outstanding dues, including those due for the year of notice except by special dispensation of the Plenary.

2.7 Exclusion/suspension:

2.7.1 If the Plenary finds that a member organization fails to continue to fulfil the qualifications for membership, it shall be excluded in accordance with the voting procedure set forth in Article 4.7.2.

2.7.2 A member organization in serious breach of its duties as a member may be suspended by decision of the Plenary in accordance with the voting procedure set forth in Article 4.7.2. Suspension may be followed by exclusion by a decision of a later Plenary meeting in the same manner. Suspended members forfeit the right to vote or to participate in PWG meetings.

2.7.3 Except by special dispensation of the Plenary, a member organization in dues arrears for more than two years will be excluded. Any reapplication for membership will require back payment with interest in full except by special dispensation of the Plenary.

2.8 A withdrawing or excluded member will have no claim on the assets of the PWG or for dues refund.

2.9 Applications for membership or observer status will be processed by the PWG Presidency and presented to the PWG Plenary with a recommendation.

Article 3. President and Secretariat

3.1 A president shall be elected in accordance with the voting procedure set forth in Article 4.8 by the Plenary Assembly for an initial term of office of three years, and may thereafter be reelected for an additional period of one year at a time.

- 3.2 The President's duties shall include the following:
- to coordinate the activities of the PWG;
 - to maintain effective contact among PWG member organizations;
 - to represent the PWG in relations with other organizations, including the European Union;
 - to carry out the policy decisions of the Plenary;
 - to supervise the preparation and distribution of documents for Plenary meetings and, where appropriate, for meetings of subcommittees and working parties;
 - to supervise the finances of the PWG in accordance with the decisions of the Plenary;
 - to maintain the records and archives of the PWG;
 - to keep a record of representativity, analysis, address

list of delegates, and member organizations, etc.

3.3 The PWG Secretariat will be provided by the national member association of the President unless the national member association or the President requests otherwise and the Plenary so approves.

3.4 To carry out his/her function, the President may appoint such officers and arrange for such assistance and staff as he/she deems fit in keeping with the budget for the administration of the PWG Secretariat and financial management to carry out his/her function.

3.5 The President shall not have the power to vote in Plenary.

3.6 Impeachment: In the event that a president does not satisfactorily fulfill his/her duties, the Plenary may decide to remove him/her from office in accordance with the voting procedure set out in Article 4.7.2.

3.7 Succession: In the event of the President relinquishing his/her post before completing the term of office, the affairs of the PWG will be managed by the headquarters staff until the next Plenary at which time an election will be held in accordance with the procedure set forth in Article 4.7.2.

3.8. A decision as to the next national delegation to assume the Presidency and the individual to assume the office of President shall normally be made at the spring meeting prior to the rotation. The decision shall be made by vote in the Plenary in accordance with the procedure set out in Article 4.7.2.

Article 4. Plenary Meetings

4.1 The Plenary shall be the highest authority of the PWG, and shall consist of one national delegation from each member country. A national delegation will not normally consist of more than four or five representatives. Each delegation shall designate its head for the meeting in question and shall be led by its head or his/her deputy who shall vote for the delegation.

4.2 The Plenary shall normally meet twice a year, in spring and autumn; the quorum shall be two thirds of the member delegations.

4.3 The working language for PWG meetings and documents shall be English.

4.4 The agenda of each plenary meeting shall be sent to all member delegations no later than four weeks before the date of the meeting, and shall include the following items:

- election of Chairman of the meeting;
- adoption of the Minutes of the previous plenary meeting;

- report of the President;
- reports from all subcommittees and working parties;
- reports from member delegations on specific questions circulated beforehand following decisions of previous plenary meetings;
- reports on relations with other international organizations;
- discussion on topics proposed in advance by the President or member organizations;
- allocation of tasks to the President and delegations following decisions of the Plenary meeting.

4.5 The agenda of each spring meeting shall also include: a report of the PWG accounts for the previous financial year with a balance sheet and auditor's report.

4.6 The agenda of each autumn meeting shall also include: a proposed budget for the next financial year.

4.7 Decisions and Voting.

4.7.1 Policy decisions at Plenary meetings shall normally be taken only on matters which have been included on the circulated agenda of the meeting; however, with the consent of the Plenary, decisions may also be taken on other matters of a pressing nature.

4.7.2 All decisions other than elections and those covered by Article 5.3 require agreement by a vote in Plenary of three-fourths of those member organizations present and voting with a quorum as stipulated in Article 4.2

4.7.3 Decision to amend the Statutes will be in accordance with Article 7.

4.7.4 In exceptional cases, where any delegation cannot, for serious and compelling reasons, accept the majority decision, it shall have the right to invoke a veto upon explanation of its position. The veto will not apply to decisions on exclusion/suspension (Article 2.7), elections (Article 4.8), or dissolution (Article 8). In addition, non-EU/EEA members cannot veto decisions taken by the Plenary on recommendations from the EU/EEA Subcommittee.

4.8 Elections will be decided by a simple majority vote of delegations present and voting (cf. Article 4.2). In cases where there are more than two candidates, if no candidate receives a majority vote on the first ballot, the candidate with the least number of votes will be eliminated and a new ballot held. This procedure will be repeated until one candidate has received a simple majority of votes.

4.9 Proxy: a delegation not able to be present at a Plenary meeting may provide a written proxy to another del-

egation with a copy to the President concerning a specific item or items. No delegation may exercise more than one proxy. A suspended delegation has no right of proxy.

- 4.10 Guests may be invited officially by the President at his/her discretion and/or on the proposal of a member delegation. Guests will be allowed to speak at the discretion of the President and/or meeting chairman.
- 4.11 The minutes of the Plenary meeting shall be prepared by a rapporteur designated by the President and shall be provided to the President for distribution no later than eight weeks from the date of the meeting.
- 4.12 An extraordinary meeting may be called by the President or on the request of at least one-third of the national member delegations with a minimum notice of 4 and maximum of 8 weeks.

Article 5. Subcommittees and Working Parties

- 5.1 The Plenary shall establish such subcommittees and working parties as it sees fit, and shall decide their terms of reference, their chairmen, and their membership. Such subcommittees and working parties shall be subject to annual re-appointment and election.
- 5.2 There shall be a subcommittee on the European Union and EEA consisting of one member chosen by the delegation from each EU and EEA member country. Its chairman shall be elected by the Plenary from among the members of the Subcommittee in accordance with Article 4.8.
- 5.3 The Subcommittee on the European Union/ EEA will be convened as necessary to consider matters of specific relevance to the EU/EEA. The EU/EEA Subcommittee will report to the Plenary.
- 5.4 The chairmen of all subcommittees and working parties shall be responsible to the President and to the Plenary for the activities of their respective bodies and may act as spokesmen for the PWG within their terms of reference and in agreement with the President and Plenary, as relevant. The President and/or Plenary can delegate further tasks to others.

Article 6. Finances

- 6.1 Each member organization shall be responsible for the expenses of its delegation to Plenary meetings of the PWG.
- 6.2 Each member organization shall make an annual contribution to the funds of the PWG, based on a minimum amount and on the number of junior doctors which it represents. The amount of each national con-

tribution shall be decided at the autumn plenary meeting in accordance with the budget proposal and a subscription key proposed by the President or his staff for presentation to the Plenary.

- 6.3 Contributions shall be paid to the PWG within three months of the start of the financial year to which the contribution relates. Failure to pay within two years will invoke Articles 2.7.3 and 2.7.2.
- 6.4 The expenses of the President and other members of the PWG secretariat shall be borne by PWG funds. The expenses of PWG delegates shall also, at the discretion of the Plenary and/or President, be borne by PWG funds. In cases where the President exercises this discretion, such expenditure must be declared as a separate item of the financial report at the next Plenary meeting.
- 6.5 Expenses of PWG activities shall be borne via national contribution as stipulated in the budget. Expenses of Plenary meetings will be borne in accordance with the established financial guidelines.
- 6.6 The Plenary shall decide the period of the financial year of the PWG and shall take into account normal practice in the country of the PWG President/Secretariat.
- 6.7 The PWG accounts shall be submitted to the spring meeting of the Plenary each year, after they have been independently audited by a certified public accountant, and an annual proposed budget will be presented at the autumn meeting for the following year.

Article 7. Amendment of Statutes

These Statutes shall be binding from the date of ratification. They can only be amended in accordance with the procedure set forth in Article 4.7.2. Notice of proposed amendment must be given four months in advance of the meeting at which said amendment is to be voted upon and the written amendment for debate and decision must be circulated at least two months in advance.

Article 8. Dissolution

Dissolution of the PWG can only be done by the Plenary in accordance with Articles 4.7.2 and 4.7.4 and with notice of the proposal to do so at least four months in advance. In the case of such decision, the Plenary shall decide on the method of liquidating the PWG and the manner in which its assets are to be disposed of.

03

POLICY STATEMENTS OF THE PWG
Basic Policy Statements & Studies





Basic Policy Statements & Studies
Education and
Professional Development

Memorandum on Temporary Migration with an Educational Purpose

P.L. Vagn-Hansen & M.Äärimaa

Helsinki 1978

ABSTRACT

The interest of medical doctors for specialist training outside their own cultural circles has existed throughout history, but a well established European medical tradition was lost during the 20th century due to diverging national legislative and administrative traditions and increasing national organizational complexity.

With the Treaty of Bruxelles in 1949, the Treaty of Rome in 1957, and with the approval of the medical directives in 1975 the legal basis was provided for a possible revival of an ancient European medical educational tradition, and the time is now due for Europe to take over the tradition which developed since 1945 of European doctors undertaking postgraduate studies and training in the United States of America. Recent changes in federal law have drastically reduced the possibilities for European medical doctors to gain access to further medical training in the USA.

Whereas qualified doctors in specialist training represent a high degree of mobility due to their basic motivation for further education, doctors tend to become more permanently established and less mobile with time and increasing level of knowledge. But even in the presence of the necessary legal basis for temporary migration with an educational purpose, there are still difficult obstacles to be overcome as seen from the point of view of the consumer of further medical education.

A European postgraduate educational system within medicine at specialist level is proposed and outlined based on proportional reservation of small numbers of suitable hospital posts at national level – but controlled at international level to secure a suitable nature as well as the necessary quality of the system. None of the present multinational systems in Europe are designed in such a way that they provide a suitable basis for an educational system for hospital doctors in postgraduate training at specialist level.

The basic hypothesis of this paper is that doctors in further training represent a higher degree of mobility than any other group within the profession because of their ever present need for further education.

Most doctors in further training understand that education is necessary to help them to contribute fully to modern society where highly specialized functions represent the basis of our social welfare. The need for further education is constant because there are always new generations with an identical motivation.

One of the most important developments in modern times has been the development of transport. It is now possible to travel rapidly over long distances. Europe has become small during the recent past. Trade and tourism have benefitted from this development, but education only to a minor degree.

For a long time it has been appreciated that the prime obstacles to European integration are the national differences in legislation and administrative procedures. Most of these obstacles still exist, and we are only at the beginning of harmonization. It took two decades to agree to the first set of directives for a profession as a consequence of the intentions laid down in the Treaty of Rome in 1957.

The medical directives (Council Directive of 16th June 1975a + b) – as other directives affecting professions – have as their prime intention to further the free establishment and the deliverance of services by fully educated professionals across the borders of the European countries. In this respect two important points must be stressed:

1. Most academically educated people including doctors have had a long educational period behind them and tend to become more permanently established and less mobile with time and increasing level of knowledge.
2. There seems to be a general trend in most European countries towards a relative overproduction of doctors. It is not reasonable to believe that substantial numbers of doctors will reestablish themselves in a European country different to their own if the recipient country produced enough medical doctors for its own requirements. There are already reports of unemployed doctors in several European countries, but since

the systems of registration at national level differ in quality and effectiveness it is difficult to judge the situation.

While these are among the factors which may tend to diminish the importance of the medical directives for the highly educated and more established groups of professionals, the constant need for education at specialist level of the doctors in training is unchanged – and likely to increase in the future.

There would, therefore, seem to be many advantages in helping doctors at the level of specialist training moving between the European countries in small numbers. They have a solid knowledge of the health systems of their native countries, and their daily functions are so varied that their work falls within the interests of many directorate generals in Bruxelles.

Now that the medical profession has been chosen as a starting point for a production of directives for professions within the EEC, it would seem natural to further the process of European integration by creating a constant flow of hospital doctors in postgraduate training at specialist level between the European countries – thereby in reality restoring an old European tradition.

From these considerations the concept of the establishment of a broader European educational market for hospital doctors developed – in which a small number of posts for such doctors in the European countries could be reserved for qualified doctors from other member states. The purpose of such a system would be:

- A. To promote the spread of medical knowledge between European countries on the basis of the old principle "learning by doing" – and using the professional individual as a transport medium for communications.
- B. To support European medical research by creating an educational flow of hospital doctors between clinical institutions with the same research areas in several countries.
- C. To further European integration by giving a professional group the opportunity to see how their colleagues think and work in other European countries.

HISTORICAL REVIEW

The interest among doctors for further medical education outside their own cultural circles has existed throughout history. The first important European medical center was the School of Salerno ("Civitas Hippocratica") in Italy during the 11th–13th century. Here the oldest European pharmacopoea was written in 1100 A.D. by Nicolaus Salernitanus ("Antidotarium Nicolai") – which was used by European doctors for centuries.

In 1137 A.D. a medical school was founded at the University of Montpellier, France, and in 1260 A.D. a similar school was built in Bologna, Italy – the oldest university in Europe from around 1088 A.D. During the succeeding centuries more than 80 universities were established all over Europe, only a minority of which included medical schools. A unique European tradition

developed, however, where doctors of medicine of all nationalities migrated across the European borders – attracted by rumours of skill and knowledge of famous colleagues.

The Italian Lanfranchi (died 1315) carried with him a unique surgical tradition from Bologna to Paris. The English John Harvey (1578–1658) – who discovered the blood circulation – studied for a long time in Padua, Italy. The French Ambroise Paré (1510–1590) gained most of his surgical skill on the battle fields of Europe in contact with colleagues from many nations. The Dutch Vesalius (1514–1564) started his famous anatomical studies in Paris, France. The Danish Niels Steensen – who discovered the essential details of several glands – studied during his lifetime (1638–1686) in Amsterdam, Leyden, Paris, Montpellier and Florence. The Swiss Paracelsus – who perhaps more than anybody else in his time associated practice with theoretical medicine – was most of his life a wandering scholar in Europe.

Other famous doctors travelled abroad during the following centuries carrying with them medical knowledge from country to country. Some returned to their native countries after a period of study abroad – others wrote their most important scientific contributions abroad and stayed for the rest of their life in the scientific climate which inspired them to the research which became the reason for our remembering them today.

Even the incarnation of the nurse – Florence Nightingale – was born in Florence, Italy, and studied in Paris. It was during the Crimean war 1854–56 that her work earned such a reputation that it was possible for her to open "The Nightingale Training School" for Nurses at St. Thomas Hospital in London 1860.

During medieval times and up to the 20th century this educational tradition broadened and developed into a diverse and elaborate system of further education in Europe – in which single persons were the communication medium for skill and knowledge from research center to research center – from cultural circle to cultural circle – from patient to patient.

During the 20th century, however, the borders between the European countries changed character. The European nations steadily increased their organizational complexity, and a drastic increase in public service and other functions took place at national level. In the modern and complicated industrial and welfare society a need for an extensive establishment of rules and regulations developed, and this consequently created a need for public authoritative executive – administrative – management to secure that these rules and regulations served their purposes. The national diverging legislative and administrative traditions built new barriers along the borders of the European countries with the objective of protection of self-interest, and it became increasingly difficult also to gain access to studies and employment in another European country – and if one succeeded one would soon get lost in a hostile labyrinth of laws and administrative procedures.

For doctors the access to foreign patients and their health care systems became increasingly difficult – and even though their basic need for and interest in further education abroad was unaltered, the educational pulse in Europe lost its strength and volume. It was not until after World War II that current ideas of increasing European integration found their first concrete expression

in the Treaty of Bruxelles establishing the Council of Europe 1949 – and the Treaty of Rome establishing the European Economical Community in 1957. With the approval of the medical directives (Council Directive of 16th June a, b, c, d, e and f) in 1975 an important step was taken – because in the present context the legal basis was provided for a possible revival of an old European tradition.

The time is now due for Europe to take over the tradition which developed after 1945 of European doctors undertaking postgraduate training and studies in the United States of America. After the 1939–45 war this development could be justified, but not now – and this has been realized in the USA and has led to important legislative changes in federal law in January 1977, implying a drastic reduction in the possibilities for foreign medical doctors to gain access to further medical training in the USA.*

* Under federal law that took effect January the 10th 1977, the recruiting of foreign interns and residents will be phased out by 1980. Furthermore, amendments to the Immigration And Nationality Act established new requirements for the admission of alien physicians to the United States for permanent residence or for the participation in graduate medical education training programmes (Health Professions Educational Act of 1976).

PRESENT OBSTACLES TO EDUCATIONAL MIGRATION

After the approval of the medical directives concerning the EEC area all legal obstacles to educational migration have in principle been removed for hospital doctors – the Council Statement concerning Article 48,4 of the EEC Treaty having been put into effect (Council Statement on Hospital Doctors 1975).

As seen from the viewpoint of the consumer of specialist education, however, the following main obstacles still remain to be dealt with if the old European educational tradition should be re-established:

1. Information barriers
2. Administrative barriers
3. Appointment barriers
4. Economic barriers
5. Career barriers
6. Insurance barriers
7. Language barriers
8. Family barriers
9. Other barriers.

In the following these obstacles will be dealt with summarily.

Information barriers

The need for general and special information may in the individual case be felt the most difficult obstacle to overcome when seeking specialist education abroad. An elaborated informative system is, however, available as follows:

At international level

EEC: Directorate General X (Information);

CE: Directorate on Press and Information;
WHO: Information Office, Regional Center.

At national level

EEC National Information Centers;
National Health Boards;
National Professional Organizations;
National Tourist Associations;
Embassies.

A suitable information booklet – which must be kept up to date and include essential information – is needed to facilitate the access of the consumers of specialist education to these sources of information. For hospital doctors such information booklets have been developed, and a summary edition has been published.*

* Information pamphlets containing a contact system for temporarily migrating hospital doctors ("WHERE DO I ASK") have been published for 11 European countries by THE PERMANENT WORKING GROUP OF EUROPEAN JUNIOR HOSPITAL DOCTORS ("PWG"). (Co-ordinating Secretariat: The Association of Junior Hospital Doctors, Trondhjemsgade 9, DK-2100 Copenhagen, Denmark).

It must be concluded that the present potential of the above mentioned information systems could probably easily be adapted to the needs of European educational systems for most professions.

Administrative barriers

The harmonizing nature of the medical directives imply numerous changes in the national legislative and administrative systems, but this harmonization is far from being complete and may take considerable time. Even in the presence of certain documentation that such a harmonization has taken place – the actual degree of harmonization may be difficult to evaluate. An effective and current control of this development may, however, be exercised through a register of the experiences of individuals who use the systems, and this could lead to a production of a catalogue of administrative obstacles to migration. Another obvious barrier is insufficient knowledge of the administrative systems of the recipient country. It would therefore, be of interest to register what courses in legislation and administration are available to migrants – and what services could be established.

Appointment barriers

The number of obstacles to overcome by the hospital doctor who wants to gain access to a suitable hospital post abroad have by experience been found to be both numerous and difficult to deal with – and it must be remembered that most of such problems must be solved before the training can begin.

The most important elements seem to be:

A. The hospital doctors find difficulty in obtaining information concerning the suitability of relevant departments in hospitals for specialist training.

This is essential since it influences the extent to which the national authorities may acknowledge his foreign training in

his native system of specialist education. In this respect the qualitative work and the daily functions of the hospital post in question – and thereby in reality the educational value of the training – must be known.

- B. The possibility of getting temporary leave from his present hospital post in his native country is of importance – so that he does not return to unemployment having completed his foreign training.
- C. The interpretation and evaluation of qualifications of foreign medical doctors may be difficult – as these may vary from country to country. Application procedures and the needed enclosed documentation may also vary, and such problems have up till now been of major importance for hospital doctors going abroad.

Most of such problems may be solved by establishing an international control over a European postgraduate training system at specialist level based on a rather permanent use of classified hospital departments and/or hospitals in European countries.

Economic barriers

It is at present costly for the hospital doctor to move from a position in a hospital in his native country to a new position in a foreign hospital – and back again one year or more later. The average wages of the group of doctors here in question – those in the course of specialist training – are very low when compared with the average wages of fully bred specialists, heads of departments and general practitioners in nearly all European countries. If the hospital doctor also has no guarantee that he will be allowed to return to the post he left in his native country, he must in the present situation fear a period of unemployment with subsequent economic loss.

If travelling expenses and wages abroad could be secured, however, and if the transposition to a foreign training post could be planned in good time – e.g. at least one year beforehand – personal expenses could be minimized to a great extent. This probably would imply the establishment of a regular exchange system for hospital doctors.

Career barriers

Specialist education in other states must be planned well in advance in order to fit into the individual educational programme without disturbing it significantly.

Sections of the professions in several countries do not regard foreign specialist education as having the merit it deserves. This is partly due to the "we-know better-here" attitude – partly to ignorance. This attitude represents, however, a decisive factor for the hospital doctor, because it is for the time being his own responsibility to convince his colleagues, his educational advisors and the specialist degree awarding authorities that his foreign specialist education will be of a quality similar to scheduled specialist education in his native country – and this must be done before the training can begin abroad.

In an established European postgraduate training system at

specialist level classifications of departments must be made subject to regular revision. Thus the access to the system would be far more easy for candidates. Furthermore, the attitude of certain parts of the profession and the national specialist degree awarding authorities would be far more positive towards a system which carried an international stamp of quality – and this would again facilitate a situation where service abroad could be meriting by its full educational value at national level.

Insurance barriers

The main areas of insurance for hospital doctors in specialist training are the following:

- A. Professional liability (malpractice etc.)
- B. Professional ability (disability, accidents, disease etc.)
- C. Personal belongings (theft, fire etc.)
- D. Family protection and liability.

There are substantial differences between national insurance systems in Europe which create difficulties for migrating hospital doctors with regard to his juridical safety in his daily functions. His head of department and educational advisor will know this situation, and as he carries the ultimate responsibility for the professional actions of any trainee in his department, he will tend to restrict the actions of the trainee – thereby in reality reducing the educational value of the training in question. It would, therefore, be of interest if an international insurance system could be established – either as an organized collaboration between national systems and/or companies – or as a new service at international level. The first step would, however, be to assess how far the national insurance systems could cover the proposed system.

Language barriers

The current interpretation of art. 20.3 in the first medical directive implies that in principle no language barriers exist from the legal point of view between the countries of the EEC. The ability of verbal communication is, however, of prime importance when dealing with the sick and dying, and with regard to medical functions linguistic ability may be divided into

- A. Ability of oral communication (communication with patients and professional communication with colleagues).
- B. Ability of written communication.
 1. Ability to read (study of relevant legislation, regulations, rules, formulas, instructions etc.).
 2. Ability to write (prescriptions, applications, certificates etc.).

Clearly it would be reasonable to secure that a hospital doctor masters the language of the host country to a sufficient degree, if he intends to go abroad to study and learn, but it would also be of interest to register what language services were available to foreign doctors – and to consider what services could be established.

Family barriers

Such barriers include a complex of social problems emerging from the situation where a family moves from one cultural circle to another. The types of problems are legion, and a complete list cannot be established. The most significant ones seem to be the following:

- Social security
- School and kindergarten
- Housing
- Employment for the spouse
- Isolation of the spouse.

It would seem important that a local tradition in dealing with foreigners was established by using the same hospitals rather permanently over a number of years in a European system of specialist education. Such a tradition might be expected then because the same people in the host country would gain experience in dealing with the problems of foreigners – as it is the case in internationally orientated universities and schools in many places in Europe today.

Other barriers

A number of less well defined barriers are not dealt with here. Among these is the individual capacity of adaptation to new circumstances of living. Such factors are often important in the social situation of a family far away from home – and the only way to deal with such problems is to establish a local tradition in dealing with foreigners.

PRESENT EUROPEAN EDUCATIONAL SYSTEMS

The present systems within which the hospital doctor may try to seek specialist education abroad may be divided into the following categories:

- A. National systems with no specific target country.
- B. Bilateral agreements.
- C. Multinational systems.

National systems with no specific target country

A multitude of such systems exists today in most countries – being controlled at private, at university or at governmental level. By far the majority of such systems have been established to give doctors the opportunity to do specific research or to learn new medical techniques (methodology) abroad. Very few national systems have been designed to further international specialist training – this being readily explainable for the above mentioned reasons.

National systems aim at sending doctors abroad – or to invite them abroad (e.g. The British Council, Deutscher Akademischer Austauschdienst etc.).

Bilateral agreements

A number of bilateral agreements have been established

between most of the European countries. Some systems are based on regular exchange principles – others are reciprocal of nature. Also these systems are controlled at very different levels – private, at university or at governmental level.

Most bilateral systems are aimed at very specific areas of interest (research, methodology etc.) – and only in a minority of cases aimed at clinical specialist education.

Multinational systems

A number of multinational educational systems have been established in Europe during the last 40 years. Examples are:

- EEC fellowships
- CE (Council of Europe) fellowships
- WHO fellowships
- NATO fellowships
- ESRO fellowships
- ROTARY fellowships etc.

Although most of these systems are designed for research purposes, some may under special conditions be used for regular specialist education of a specific nature. The majority of these systems are controlled at governmental and at international level. The present multinational systems carry the following characteristics in the present context as a summary conclusion:

1. The majority of the systems have specific and narrow aims – most often in the fields of research and methodology – with very few exceptions.
2. The systems imply neither regularity nor the possibility of establishing a local tradition – except in certain research institutions.
3. None of the systems are designed in such a way that they provide a suitable basis for a broader educational system for hospital doctors in postgraduate training at specialist level.

A EUROPEAN POSTGRADUATE EDUCATIONAL SYSTEM AT SPECIALIST LEVEL

The general principles which should be built into a European postgraduate educational system at specialist level for hospital doctors are as follows:

- A. The relevant hospital posts should be located in departments which have been classified as suitable for specialist training within the speciality in question by professional and public authorities in the country in question. This classification should be done also at an international level – to secure that a period of service in a department within the system may be of merit equal to a period of service in a similar department in the native state of a candidate.
- B. The relevant hospital posts (or departments) should be in rather permanent use to establish a local tradition in dealing with foreigners and their needs.

- C. The national number of hospital posts in this international system should be proportional to the size of the country in question.
- D. The charge of the relevant hospital posts should be defined according to the normal functions of a similar post in similar departments in order to avoid supernumerary posts of minor educational value.
- E. The period for which a candidate may occupy a post in the system should be a set period of time with the possibility of extension – if desired by the candidate and if granted by those bodies which exercise control with the system.
- F. Priority should be given to qualified candidates from foreign member states wishing to participate in the system when advertising the posts. If suitable candidates from foreign member states do not apply, national candidates for the posts should be considered.
- G. Applicants should be qualified doctors. They should be in the course of systematic postgraduate training within a recognized speciality having demonstrated sufficient interest for their speciality. Recommendations from two independent professional sources within the speciality in question at national level should certify that the candidate is in good standing, that he is making good progress in his specialist education, and that he is considered a suitable candidate for the training in question.
- H. Candidates should be proposed and accepted by bodies recognized by governmental authorities, and the system should be controlled by an appropriate international body which includes suitable expert knowledge (e.g. panel of education-al experts) and the necessary secretariat capacity.

The following factors suggest the necessity for international control:

1. Experience has often shown that it is difficult at national level to judge a number of relevant professional qualifications and abilities of foreign doctors from a different educational system at specialist level (e.g. surgical skill, routine in diagnostic procedures, etc.).
2. It is important to secure that only posts of a certain educational value and with a solid tradition for specialist education are incorporated into the system.
3. It must be guaranteed to the national specialist degree awarding authorities that the foreign training in question is of similar quality to benefit candidates in the same way as similar training would have done in their native specialist training systems.

FEASIBILITY OF THE SYSTEM

The basic idea of a European educational system for hospital doctors training at specialist level is that even if a small number of existing hospital posts were reserved for doctors from other states in a country, the total number of posts accessible for hospital doctors in that country would not be reduced – provided that all countries participating in the system reserved a proportional number of hospital posts for doctors from other states. In other words a number of posts equal to those reserved for foreigners in one state would be accessible to nationals of that state abroad.

The system would be attractive to the member countries if it were designed in such a way that any country would offer qualified specialist training in fields (areas of expertise) especially developed in the country in question – and especially wanted by other countries where such an expertise is not readily available (or developed for the time being).

The essential precondition for the proposed system of European specialist education is a certain degree of European integration. With the approval of the medical directives the proposed system should be feasible having established the necessary legal basis for migration in the EEC area. However, the following parties should be involved in discussion of the feasibility of the system:

- Governments
- Hospital owners
- EEC commission
- Professional organizations at national and at international level.

It may be possible that the best way of gaining experience with such a system – which is completely new of type 1 Europe – would be to evaluate a pilot project based on the experience of small numbers of hospital doctors training in suitable, selected specialities – having been placed in foreign hospital posts reserved for this purpose for a limited period of time.

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The memorandum was approved for publication by the plenary assembly of THE PERMANENT WORKING GROUP OF EUROPEAN JUNIOR HOSPITAL DOCTORS on the 29th of April 1978 in Helsinki, Finland, and is the result of an extensive analysis performed by this group during 1976-1978.

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Policy Statement on Postgraduate Medical Training: a European Future

Vienna, October 1994

SECTION A:

INTRODUCTION

The community context

1. The primary purpose of postgraduate training (PGT) is to ensure that specialised doctors competently address the medical needs of the community. The Permanent Working Group of European junior Hospital Doctors (PWG) has prepared this policy paper which represents the perspective of the consumers of PGT, the trainee medical specialists in general practice, public health, and the hospital-based specialties.

The professional context

2. PGT should serve to ensure that the professional standards required of medical practitioners are attained, and that the clinical potential of every practising doctor is optimised. In attempting to achieve these goals it must be recognised that PGT is set in a legislative context, and that it is dependent on the availability of resources.
3. PGT is crucial in preparing doctors who will help develop the medical services of the future. It is therefore a matter of concern for the PWG that in many European countries the availability of resources for PGT, and of mechanisms for their effective utilisation, are inadequate, and are overridden by the demands of service provision.
4. The European Commission, through its directive 93/16/EC - the amalgamation of directives 75/362/EC and 75/363/EC - has set out the legal requirements for the mutual recognition of specialist qualifications and the minimum requirements as regards the duration of PGT in European Union member states. Consultation with the medical profession continues regarding the further development of this process.
5. The purpose of this policy paper is to draw attention to the urgent need for review of the provision and funding of PGT

on a national and European basis. The PWG hopes that this paper will stimulate further much needed discussion in order to safeguard the future quality of medical practice. In this regard it looks forward to greater cooperation with the European Commission and those bodies representing the medical profession that share an interest in these matters.

SECTION B:

BASIC PRINCIPLES AND DEFINITIONS

The continuum of medical education

6. The process of education, from medical school to retirement, should be a continuous one. For this process to be most effective it must balance common standards-based goals with the educational needs of the individual doctor.
7. Although this continuum exists in educational terms and is the most important factor in achieving quality of practice, the reality of legislative and clinical responsibilities is such that three phases of medical practice are recognised; the undergraduate phase (UGE), the postgraduate training phase (PGT), and continuing medical education (CME). Postgraduate training is the period of training and supervised clinical experience leading to the achievement of specialist status. These three phases are accommodated within educational structures specific to their outcome. Medical education is thus an ongoing process with specific goals for each phase.

The unity of methods in medical education

8. PGT is central in developing and maintaining a doctor's ability to provide a quality clinical service. The most effective means of achieving this is through a process that builds upon the knowledge and skills developed in earlier years, and utilises learning methods with which the doctor is acquainted. More can be achieved by teaching a doctor how to learn than by teaching what is prescribed in a syllabus; the former imparts skills that will always be relevant, the latter, knowledge that inevitably will decay.

9. Though the emphasis and content may vary, those techniques which are demonstrably valid for one phase of medical education should be equally applicable to the other phases.

A balance must always be ensured between the use of methods that can be applied to the broad mass of those being educated, and those that permit greater individual freedom, such as self-directed learning.

10. Greater emphasis should be placed on the continuing nature of medical education, with the goal being the unification of methods in UGE, PGT and CME.

A quality assurance-based structure

11. To provide a quality clinical service it is necessary to apply a quality assurance system to postgraduate training which must involve the following sequential steps

- Identifying criteria for the structure, process, and outcome of training and setting standards for these;
- Observing the current situation;
- Identifying deficiencies and innovations in existing practice by comparing them to the pre-determined standards;
- Implementing strategies to overcome deficiencies, and utilising innovations identified in the structure, process or outcome of training;
- Subsequently repeating observation of the situation to monitor whether or not the implemented strategies are having the required effects;
- Repeating the whole quality assurance process at regular intervals.

SECTION C:

OUTCOMES

Patients and the community

12. Patients, and the community as a whole, require that health care is delivered safely and effectively by suitably qualified practitioners. Medical services should therefore be provided by fully trained specialists and within the context of PGT, by supervised trainees.

13. It has largely been a responsibility of governments, elected to act on behalf of the community, to ensure that health care needs are met. As budgetary restraint and rationing become more prevalent it is evident that reductions in the quality of care can develop when targets are determined solely by quantity-based criteria.

Trainees

14. Trainees require service-based education within structured training schemes specifically developed to prepare them for specialist practice. These schemes should be conducted within paid posts which incorporate service and training; suitable practical and theoretical teaching; appropriate

supervised clinical experience; specialists providing models of good practice; exposure to research methodology; sufficient time for curriculum-oriented and selfdirected study; and through fair assessment, regular feedback and guidance.

15. Trainees should be required to fulfil set criteria for successful progress, as monitored by continuous assessment. These criteria should be sufficiently comprehensive to ensure that trainees develop the range of abilities required for specialist practice, and are able to demonstrate through their learning and practice the necessary knowledge and skills.

16. Setting outcomes for PGT should involve representatives of specialist trainees and other interested parties.

The alignment of outcomes with structure and process

17. PGT must be integrated with a well developed flexible manpower planning system in order to provide sufficient suitably trained specialists. This must be capable of responding to alterations in need within separate specialties, of accommodating suitable goaldirected training, and be backed up by the resources to provide these.

Requirement for resources

18. PGT is more than a means of ensuring the provision of medical services to meet patients' needs, it is also an investment in the future quality of care provided by doctors. Specific national budgets sufficient to cover all aspects of PGT must be provided as a priority.

SECTION D:

STRUCTURE AND PROCESS

Introduction

19. The PWG believes that optimum standards of medical practice can only be achieved when the structure and process of medical education meet stringent quality criteria. The PWG is therefore concerned by variations in the quality of supervision, training and assessment of trainees in existing PGT programmes.

20. A review of current practice in PGT should be performed in order to ensure that optimum standards, as determined by quality-based criteria, are achieved.

Curriculum design

21. For the foreseeable future, curriculum design will continue to be determined nationally. It is the responsibility of the bodies supervising training, in consultation with the representatives of specialist trainees, to develop and review the curriculum for PGT.

22. Trainees must acquire the knowledge base required for specialised medical practice, which is a composite of factual and conceptual learning, including basic scientific principles, and a detailed understanding of clinical practice specific to their specialty. They must also learn core and specialised medical skills for the assessment of patients, investigation and diagnosis, preventive and therapeutic methods, and the inter-personal skills necessary for a more patient-centred, team-based approach.
23. An artificial separation between the general and the specific has frequently been formalised as two distinct phases within PGT; it would be more appropriate to integrate these two aspects. Similarly, a careful balance must be achieved between knowledge and skills that are essential for everyday practice, and those less frequently called upon. Less emphasis should be placed on the learning of facts with little relevance to actual practice.
24. In order to prepare for the next generation of trainees, doctors should learn the principles required for them to supervise and train others. They should also be encouraged to achieve an understanding of quality assurance, audit and research methods – knowledge they may wish to develop further in their specialist careers.
25. The final requirement of curriculum design will be to incorporate those elements outlined above into curricula appropriate to structured training programmes.

Duration

26. For trainees in the EU/EEA, directive 93/16/EC defines the minimum duration of recognised postgraduate training demanded in each specialty in order to achieve specialist status. It is a basic principle that the duration of specialist training should be determined by the efficacy with which it achieves its outcome, competent specialists.
27. Educational criteria and their effective application must be the major determinant factors in assessing the duration of specialist training.

Training programmes

28. Postgraduate training should in all specialties occur within structured programmes which should be comprised of posts with a predominance of education over service provision and specific training goals, and in which trainees are supervised by specialists.
29. All posts accredited for training purposes should fulfil clearly defined and widely publicised criteria. These should include those detailed by the Advisory Committee on Medical Training (ACMIT) in 1978 and in 1982, which require coordinated training to occur in remunerated posts in both university centres and general teaching hospitals. Further minimum criteria must include a predominance of

training over service provision, the existence of a safe system of supervision, and instruction in the prescribed curriculum by a range of training techniques. Structured programmes will permit the construction of modular schemes with the benefits of sufficient flexibility to permit trainees to choose optional modules, and adaptation to different rates of progress.

30. Appointment to a specialist training programme should occur on the basis of open competition, with registration as a medical practitioner being a formal requirement.
31. Programmes should be responsible to the bodies supervising training for the delivery of high educational standards, and to the bodies coordinating training for the efficacy with which they achieve this. These bodies will be able either on a probationary or a permanent basis to withdraw training approval should these requirements not be met.
32. All training posts and programmes should be subject to regular inspection by these bodies. Monitoring should confirm that previously identified deficiencies have been resolved, and that no further problems have developed. Information provided confidentially by trainees should be considered in this process. High standards could also be encouraged by the development of competition between hospitals providing specialist training.

Clinical supervision

33. Clinical supervision of trainee specialists in their everyday work should be maximised in order to ensure that the quality of the specialist service received by the patient is of an optimum standard.
34. Passive supervision entails the constant availability – on request and with ease of access – of a senior more competent member of staff to deal with matters beyond the particular trainee's competence. Organising the process of this supervision should be the responsibility of a named specialist.
35. Active supervision involves the regular and consistent attendance of a named specialist to review or examine the work of the trainee in all aspects of his or her job, i.e. admissions and emergency assessment; in-patient care, including procedures and therapies, correspondence and note keeping; discharges; out-patient care; consultation, liaison and community work; working relations with other staff; organisation of clinical activity. There should be written policies on the above which should, where possible, lie standardised on a national or international basis.
36. Orientation courses should always be held for trainees commencing a new post and should include information on hospital policies. There should then be an open appraisal by a specialist, the named supervisor, of the trainees' abilities and experience to determine their initial level of responsi-

bility. The match of competence with responsibility must progress in a stepwise but flexible manner thereafter.

37. The standard of supervision should be subject to regular medical audit, and should be a criterion of accreditation of a centre of training. Clinical supervision, while intending to assure the quality and safety of patient care, is also a valuable educational experience which should be utilised fully.
38. Specialist trainees should be properly supervised in their clinical practice. Inadequate provision for this undermines the quality of patient care; the PWG believes that it is unacceptable practice to permit specialist trainees to practice without adequate clinical supervision. A system of clinical supervision, incorporating the forms described further above, should be introduced in all hospitals which engage specialist trainees.
39. Many specialists will be involved in the supervision of trainees. Clinical supervisors should provide an example of good practice in all areas of their medical practice; the manner in which they perform their clinical duties, and their interactions with other members of staff. It will be expected that through their own CME, which will itself inextricably be linked with the education of trainees, they maintain a comprehensive knowledge of their specialty.

Trainers

40. Trainers will be expected to fulfil the requirements described above for clinical supervisors, and should furthermore provide an example of good practice in the administration of their teaching activities. It is essential that these specialist trainers are themselves provided with instruction in training methods and have contractually expressed time and payment for this activity.
41. Trainers should appraise trainees, determining the clinical responsibilities that they may undertake and the need for more directed training: they should also provide suitable guidance on career progress. In a similar manner, trainers should themselves be appraised by trainees, and should be accountable for their performance to the training programme directors and to the bodies supervising training.
42. Networks of suitably qualified trainers should be established in all hospitals involved in providing PGT, their training commitments should be contractually expressed and rewarded; and through regular evaluation trainers should be encouraged to maintain high teaching standards.

Training methods

43. The majority of training should be integrated with clinical experience, since it is in this context that it will be applied. The methods employed should be varied, and may include review of clinical information, discussion of diagnostic and interventional matters, and the consideration of hypotheti-

cal case problems. Direct experience must be emphasised, since it is only through this that trainees can hope to develop competence in practical techniques. The regular audit of clinical work will provide further teaching material.

44. The full range of training methods should be employed in PGT. There should be ample contractually-determined opportunities and sufficient resources should be made available.

Evaluation of trainees

45. In a manner reflecting the training programmes, the evaluation process must itself be formally structured, precise in its delivery, and should achieve its results progressively. While it must direct itself primarily to these aims, it should also be capable of reflecting the individual trainee's needs. It should take into account previous performance in determining future needs, and provide feedback as appropriate.
46. The evaluation process should be developed in conjunction with the representatives of trainees and should be made applicable to modular training programmes. This interaction should be maintained at an operational level by ensuring that, at the outset of the relevant training period, all trainees are fully informed about the requirements made of them and the means of evaluation. This will permit the process to be robust, and will permit informed feedback from the trainees.
47. The evaluation process should be open to scrutiny; the methods used should be objective and nondiscriminatory; trainees should be required to see and comment on their evaluations without fear of prejudice; there should be an appeals procedure; and monitoring mechanisms – including feedback from trainees, reviews of results and of the evaluators, and defined lines of accountability – should be established.
48. A range of techniques should be employed, on an ongoing basis, in evaluating trainees within the PGT quality assurance system. This will ensure the evaluation of the broad range of abilities required by specialist trainees. This can be contrasted with a one-off examination-based system for evaluating competence to practice. This is neither a scientifically valid nor a reliable means of determining clinical competence, since the scope of what can be tested is limited. Trainees and trainers focus on what can be tested by such examinations rather than on the range of skills required for competent specialist practice. This may ultimately bias their clinical practice.

49. Mechanisms must be set in place to ensure that the results of individual trainee evaluations can be collated with those of their colleagues and with the results of the training programme evaluation, to provide the information required to identify deficiencies in the structure and process of the training programme.

ACCOUNTABILITY

Outcome

50. The bodies involved in PGT should individually and collectively be responsible for its delivery to doctors in training. These bodies should be accountable to the community because it has the supreme interest in high standards of medical practice.

Principles

51. It is inevitable that the bodies established to ensure the maintenance of high standards in the delivery and management of PGT will vary depending on current national provisions. A spectrum exists which ranges from bodies based entirely within government departments to those which are wholly autonomous. It must be emphasised that, though these structures and their individual responsibilities may vary, specific areas of importance can be identified. It is vital to establish bodies whose remit includes the provision, the supervision, the coordination, the regulation and the monitoring of PGT. Each of these bodies must have a clearly defined remit, constitution, lines of accountability and statutory powers where these are deemed necessary.

52. Setting aside the obvious impact on national standards, it is clear that unless effective means exist to deliver each of the above aspects of PGT, attempts at developing supranational structures for harmonising PGT are doomed to early failure by the lack of relevant and accurate information.

Bodies supervising medical education

53. The bodies supervising PGT should have the responsibility of setting the structure and content for training in each specialty. This should be performed in consultation with the representatives of specialist trainees. They should apply the principles of the educational continuum and the unity of methods in defining the goals for PGT and the duration required for specialist training.

54. These bodies should be responsible for ensuring that high standards of training are maintained. This should be done by accrediting posts and trainers suitable for training purposes, by regularly inspecting these posts and assessing the competence of the trainers, and by withdrawing accreditation should standards fall.

Bodies coordinating medical education

55. These bodies should be responsible for managing the resources available for PGT and for ensuring the development of structured programmes for its delivery.

56. They will be able, through their role in managing training programmes, to collect data regarding manpower flows in

separate specialties. It would therefore be possible for them to play a significant part informing the manpower structure which is integrated with the PGT system.

Regulatory bodies

57. In accordance with directive 93/16/EC, each EU/EEA member state must designate a regulatory body whose remit must include the registration of qualified doctors and their certification on attaining specialist status. Irrespective of the method by which these functions are carried out, the rationale for these bodies remains that of ensuring that the public interest is protected by confirming the qualifications of practising doctors. As such these bodies have a crucial role to play in monitoring the endpoint of undergraduate and postgraduate training.

SECTION F:

HARMONISATION

58. A step along the way to finding a common path for doctors in Europe was the passage of directives 75/362-363/EC, amalgamated in 93/16/EC, which developed for the medical profession principles set out in the Treaty of Rome. While ensuring equivalent recognition of qualifications, they specifically refrained from determining educational standards other than by setting minimum durations for specialist training.

59. The PWG sees the aim of harmonisation as lifting the quality of PGT all over Europe. Despite the many difficulties experienced and projected, we believe that in order to develop a profession that is most able to achieve advances in research and the quality of care, phased harmonisation will be necessary to achieve the benefits offered by greater unity in the determination of standards and outcomes, while maintaining the benefits of continued diversity.

Continuing Medical Education/Continuous Professional Development (CME/CPD)

Policy Statement of the Permanent Working Group of European Junior Doctors (PWG)

adopted in Killarney

October 1999

INDEX

Section A: Background information on CME/CPD

- Definitions
- Current approaches to CME/CPD
- CME/CPD
- Recertification
- Legal problems
- National
- International
- Methodological problems
- Resources problems
- Present situation
- The importance of CME/CPD to junior doctors

Section B: PWG Policy on CME/CPD

- General policy
- Formalisation
- Recertification
- CME/CPD activities
- Rights and duties
- Time and resources

Section C: Executive summary

SECTION A: BACKGROUND INFORMATION ON CME/CPD

Definitions

CME: Continuing Medical Education. CME is a process of life-long continuing education within the fields of knowledge of medical practice.

CPD: Continuous Professional Development. CPD embraces not only CME, but also the development of non-medical competence, such as leadership, personal and social skills, and other proficiencies. Since the term is not yet universally used, in this document we have chosen to use

the expression CME/CPD throughout.

Recertification: A process by which specified demands must be met on a periodic basis by any physician wishing to retain his or her specialist qualifications.

Current approaches to CME/CPD

The PWG has long been mindful of the challenge and importance of CME and was from the start active in the debate within the Standing Committee of European Doctors (CP) in developing its' Dublin Declaration on Continuing Medical Education.

In 1982, the Standing Committee of European Doctors (CP) adopted the Declaration of Dublin. The Declaration, which was revised in 1993, established that it is an ethical obligation for each doctor continuously throughout his professional life to participate in continuing medical education. It also established that CME is a right in which the individual doctor should be encouraged and supported. CME must be based upon actual needs and the responsibility must rest with the profession. CME must be voluntary and its exact conditions and content must arise from the demands and needs of each individual doctor.

The European Union of General Practitioners (UEMO) Declaration from 1994 is built on the principles of the Declaration of Dublin, supplemented with more precise proposals aimed specifically at general practitioners.

In 1994, the European Union of Medical Specialists (UEMS) published a charter about the individual doctor's personal obligations and right to maintain his or her professional level of competence and the obligation and right of medical organisations to influence the activity of Continuing Medical Education.

The Advisory Committee on Medical Training (ACMT) under the European Commission also in 1994 published the report Recommendations on CME (XV/E/8414/94). This report, which is the only official EU report on Continuing Medical Education,

underlines that CME is a moral obligation for each doctor, that the 'system' is obliged to offer opportunities for CME, and that the resources must be part of the Health Budget.

In 1996, after considerable debate and consideration, PWG adopted its own initial Policy Paper on CME (PWG 96/049) which, with reference to the Dublin Declaration, emphasised the importance of CME being available not only to medical specialists, but also to doctors in postgraduate training.

That document set forth PWG's belief that ensuring the availability of CME at all phases of education would inspire the education of future doctors, especially by securing the access of doctors in postgraduate training to educational activities beyond those limited to the scope of postgraduate medical training.

The previous PWG Policy paper on CME endorses the Dublin Declaration and further sets forth the essential requirement for CME as a right for all doctors, including those in training; the dynamic nature of CME and the fundamental importance of being taught how to learn in medical education; the right of doctors to CME activities in their own as well as other specialties and to educational activities in addition to the postgraduate training related to the doctor's specialty.

CME/CPD

CME/CPD comprises all of the initiatives which contribute to the maintenance and development of necessary knowledge and skills of the doctor. CME/CPD is a life-long, continuous learning process the aim of which is to ensure that the doctor is in possession of the insight, knowledge, skills, attitudes, and experience necessary to master the work, challenges and problems with which a doctor is faced daily.

The term Continuing Medical Education describes education which continues beyond that directed specifically at training as medical specialist. However, it is clear that CME/CPD, as a continuing life-long process of learning, must also apply to doctors who are undergoing specialist training.

A number of studies show that doctors achieve life-long learning by further education throughout their professional careers. This is an ethical duty for each doctor; doctors are also legally responsible for keeping themselves professionally updated. Therefore, the right of all doctors to participate in CME must be secured.

There are no valid methods to measure a doctor's clinical competence that are simple enough to be generalised nor are there any reliable measures of what constitutes a good or a bad doctor.

No clear evidence exists to prove that the introduction of new systems for quantifying CME/CPD activities or the establishment of recertification systems in their own right increase a doctor's competence. On the other hand, the general public

has a legitimate right to know how and to what extent doctors keep themselves professionally updated and develop their competence. Furthermore, the employer has a special duty to facilitate CME/CPD. The employer and the doctor are also responsible for continuous quality improvement of medical practice. CME/CPD is a prerequisite for quality improvement.

Recertification

In some European countries suggestions are being heard about introducing recertification of specialists as a method of controlling the CME/CPD activities of doctors. PWG believes that such systems have many potential pitfalls, which are outlined below.

Legal problems

Society's demand for increased evidence of doctors' continuing education is part of a general trend necessitating improved control and quality assurance within the medical profession. Most countries have laws requiring doctors to maintain their professional knowledge. This is linked to the criteria established for practising medicine.

There are two areas of legal problems relating to linking CME/CPD to recertification; national and international.

National level

The main problem is that the legal consequences of failure to meet recertification criteria are not established. It is unclear whether a doctor who fails to recertify continues to be authorised to have the right to practice. Another problem arises if the reasons for failing to meet the recertification demands are beyond the control of the individual doctor and are related, for instance, to the employer's unwillingness to provide adequate time or opportunity for CME/CPD necessary for recertification.

International level

Because of the variety of the national systems and solutions, international regulations would not be feasible or desirable for the foreseeable future. Every doctor is authorised by his or her own country. It would be impossible to envisage a set of international rules which could encompass the variety of national systems.

A specific problem related to recertification systems is that of migrant doctors converting a specialist qualification certificate in a country other than the one in which it was conferred. It is pointless for one country to introduce a system of recertification unless it co-operates closely with neighbouring countries where the doctor can convert his specialist qualifications unless the countries in question introduce a similar system. Otherwise, a situation could arise where a specialist whose recertification period is drawing to a close applies for conversion of the specialist qualification in a neighbouring country, following which it might be reconverted to his or her own country. In this way, it would be possible to avoid obligatory recertification and still maintain a specialist qualification. Although the vast majority of doctors recognise and fulfil their ethical responsibility for CME/CPD, such loopholes are a complication in any attempts to

find a mandatory legal solution to CME/CPD.

Another specific problem is involved where the recertification system is linked to the fee structure, so that those not recertified receive lower fees for service, but continue to practice as before. This hardly seems to accomplish the goal of improved quality, nor does it seem appropriate to organise patient care in a two-tiered quality system.

Methodological problems

A physician's competence (whether a doctor in training or a specialist) consists of a variety of roles and therefore cannot be measured via a simple test (for example a written examination). The examination only measures factual knowledge or theoretical competence at a given moment and does not evaluate the specialist's clinical proficiency and attitudes. Thus it is meaningless to undertake recertification with the help of such a simplified examination process.

Recertification builds upon specified requirements which must be fulfilled in order for a physician to maintain his or her specialist qualification. In some countries, recertification builds primarily upon the fulfilment of quantitative requirements about participation in activities for which points are awarded. The requirement for the accumulation of points can entail considerable participation in point-giving activities, but no evidence exists as to the quality, outcome, or relevance of these activities with regard to medical practice. The focus in such systems is directed toward formal training activities. This means that one of the greatest and most valuable parts of the professional's learning, consisting of informal activities such as collegial discussion, is not included.

Suggestions have come forward in several European countries for a possible recertification system for doctors. A recertification system could enable society to check that doctors actually participate in continuing education. The fact that a doctor takes part in courses, conferences and other CME/CPD activities does not constitute a guarantee of quality control. However, it is a common misconception that a system for recertification would contribute to the identification of unsuitable doctors.

Thus, we are faced with an important educational task vis-à-vis politicians and the general public with regard to the objective of CME/CMD.

Resource problems

Recertification is a control system involving considerable consumption of resources. In some cases, undesirable side effects have been seen where the recertification system has led to significantly increased costs and the creation of an entire industry whose exclusive aim is to prepare participants to pass obligatory tests.

Present situation

Rapid medical advances underline the importance of securing conditions that enable doctors to update their professional

knowledge and skills. This issue is on the political agenda in many European countries. The discussion is related to a general wish by politicians and the public at large to see evidence for the competence and up-to-date professional knowledge of doctors. In some countries mandatory recertification of specialists has been proposed, and even introduced.

In the Netherlands recertification, in addition to being a professional requirement, has now been enacted by parliament into a legal requirement. The Royal Dutch Medical Association is in charge of the implementation of this legal requirement.

The Swiss Medical Association has made recertification mandatory for membership.

In Norway, there is a kind of recertification system within the specialty of general practice. Specialists in general practice must be recertified every five years by taking part in different CME/CPD activities of their own choice, such as learning in groups, courses, visiting training in hospitals etc. The Norwegian Parliament has also suggested mandatory recertification in other specialties.

The Danish Medical Association is developing an Internet based system for documentation of CME activities for doctors in Denmark.

The UK General Medical Council has decided in future to revalidate all specialists, based on recognition that the existing specialist examinations cannot guarantee the competence of the specialist. Revalidation should not be an isolated examination and each individual specialty has been invited to consider how the arrangement could be implemented. All the specialist Royal Colleges have systems of CME points, which specialists are expected to achieve.

CME/CPD activities in Europe are financed in several different ways. Foundations, the pharmaceutical industry, the employers and the individual doctors all take part in funding CME/CPD activities.

In the US, recertification of specialists is on a voluntary basis, although it is required in a number of situations – e.g. as a demand for lower insurance premiums or as a condition for admitting patients to certain hospitals. Specialists pay considerable sums for study trips and examinations in order to gain recertification. The US recertification system has therefore led to the creation of a multimillion-dollar business. The many courses offered to teach doctors how to achieve recertification represent another undesired side effect.

In Canada, a voluntary CME program (Maintenance and Competence Program, MOCOMP) is practised as a training program created by the Royal College of Physicians and Surgeons in order to support the specialists' effort to secure continuous training of their own skills and knowledge. The program includes a training logbook.

The importance of CME/CPD to junior doctors

Junior doctors recognise the impact that CME/CPD will have on their working lives. As the body representing those who will have to live with the consequences of these new systems, PWG believes it has a vital role to play in the debate on CME/CPD.

One of the fundamental aims of all university education is to teach students to assume individual responsibility for their life-long learning. Further and continuing education of doctors is an ongoing process, and there is no practical or educational dividing line before or after the date of becoming a specialist. By supporting the introduction of formalised CME/CPD, PWG emphasises and promotes the right of junior doctors to take part in CME/CPD activities throughout their entire career. This will contribute positively to postgraduate (specialist) training. Employers will have to be more proactive and assume responsibility for the conditions covering the professional development of doctors. Employers will thereby become more aware of their responsibility to adapt employment conditions to both postgraduate training and continuing education.

CME/CPD is therefore a joint concern for both junior doctors and qualified specialists.

SECTION B: PWG POLICY ON CME/CPD

General policy

PWG strongly emphasises that any system of CME/CPD must be based upon a thorough understanding of the concept of quality improvement as distinct from quality control.

Processes like quality control, quality assurance and clinical audit, which are the core of accreditation systems, may be useful when addressing the issue of incompetence, but they have less to offer when discussing Continuous Professional Development. Considering the process of medical care as a whole, the concept of Continuous Quality Improvement offers greater advantages, as it combines the process of learning with peer interaction and patient care, while allowing for the development of a documentation system.

The aim of CME/CPD is to provide doctors with an opportunity to achieve and maintain a high level of competence. Therefore, CME/CPD is an essential activity in the continuous quality improvement of medical practice.

The Permanent Working Group of European Junior Doctors believes that the CME/CPD debate should focus on quality improvement in medical practice and on safeguarding the rights of the medical profession to do what it is ethically and legally obliged to do for patients: to have the necessary knowledge and skills to deliver optimal diagnosis and treatment.

The doctor should be professionally autonomous and has a duty to practice in accordance with ethical principles that include

continuous development of knowledge to meet the patient's needs. The strongest motivation for life-long learning is the aim for high professional standards, where the doctor personally defines the CME/CPD activities required in order to broaden and deepen his or her skills and competence including medical skills as well as leadership, social and personal proficiencies.

Doctors in general are capable of identifying their individual educational requirements in relation to the needs of the patient. Similarly, it is natural to define the needs for continuing education in consultation with the employer, since the employer has a responsibility for the overall activities. It is the responsibility of the profession to plan and execute CME/CPD activities in line with those needs.

CME/CPD must be lifelong and suited to the individual doctor's work situation. Continuing education must include planning for the acquisition and evaluation of knowledge to secure positive competence development. Authorities, professional organisations and employers have responsibility for establishing the framework for continuing education activities. Doctors have a particular responsibility for developing its content and form.

Each doctor is responsible for his or her actions, regardless of whether he or she is employed or in private practice and should not be held responsible for systemic faults, whether national or local, that are beyond the doctor's control. The modern demands for ever-increasing efficiency, coupled with rapid medical developments, further underline the importance of the doctor being assured of his or her right to continuous professional updating and CME/CPD.

The trust of the population in the doctor depends on his or her being perceived as constantly maintaining high professional standards and quality. The profession must continuously stress the importance of not shielding colleagues who fail to maintain sufficient professional standards, and we must adopt and publish methods that ensure the identification and removal of unsuitable doctors. This must be done in close co-operation with the relevant national authorities. In addition systems need to be developed to support colleagues who are failing. These should be aimed at preventing doctors from reaching the stage where removal from practice becomes necessary. However, systems and methods used in these instances must be completely different from those concerning formalised CME/CPD.

Formalisation

PWG recognises the importance of introducing a formalised system for CME/CPD.

The objectives of a formalised CME/CPD system are:

To ensure the opportunities for sound professional competence development and to create conditions for life-long learning for the individual doctor;

To demonstrate to the authorities and the general public that

doctors are participating in CME/CPD activities throughout their career in order to be able to provide optimal diagnosis and treatment to patients;

To secure the rights and opportunities of the individual doctor to participate in CME/CPD.

A formalised CME/CPD system is one in which the individual doctor must define his or her CME/CPD requirements and thus their activities. This must be done in consultation with the principal/employer to ensure an understanding of both the needs of the individual doctor and the needs of the institution for the doctor's professional development and continuing education.

There is a need for various CME/CPD activities depending on the workplace and work situation. There are also varying needs related to whether one is a consultant, private practitioner, specialist, or a specialist temporarily not involved in clinical work, but in other areas such as administration. Continuing education must therefore be individual, and specifically tailored to the needs of the individual doctor and employer.

Furthermore, the term "formalised CME/CPD" implies that the individual doctor is capable of documenting his or her CME/CPD activities. The introduction of simple documentation systems where the individual doctor can continuously register his or her CME/CPD activities is therefore suggested.

CME/CPD documentation is concrete evidence of the individual doctor's CME/CPD activities. This could be of importance for instance in a job application. However, it is more important that the doctor utilises this system in relation to his or her employer to demand the necessary financial resources and leave of absence required to carry out CME/CPD.

Recertification

PWG opposes a system with recertification. Legal, methodological and resource problems related to recertification systems are overwhelming compared to any advantages that might be involved. As described in section 3, such systems entail a cumbersome bureaucracy with considerable financial costs, without any proof that this in itself would lead to better quality and competence for the benefit of patients.

Furthermore, recertification systems would create a number of legal problems as outlined above, which are currently unresolved. Doctors and society would be ill-advised to accept a system of CME/CPD linked to recertification. What society and patients need is an assurance of the quality of doctors' work, and a well-founded trust in the system for identifying unsuitable doctors. Furthermore, recertification is a bureaucratic and expensive system. Those resources could instead be invested in quality improvement activities, including doctors' CME/CPD.

Specialist qualifications are currently awarded without time limits, and no evidence exists to support a change in this system.

CME/CPD activities

CME/CPD activities should have a broad base to cover every need in all specialties. Traditionally, CME has relied too heavily on participating in courses and conferences. Peer reviews, audits, visiting training in hospitals, supervised group studies, research etc. also represent educationally sound methods. PWG particularly wish to stress the importance of visiting training in hospitals for privately practising specialists. Formalised continuing education is a supplement to the professional growth that takes place in practical, clinical everyday work (theoretical further education, group problem solving, the possibility of sharing experiences with colleagues, etc.)

Rights and duties

CME/CPD is both an ethical duty and a right for doctors. It is necessary to establish a system to give doctors the unequivocal rights to participate in CME/CPD.

Every doctor has an ethical responsibility to participate in CME/CPD and to maintain up to date professional knowledge and skill. The latter responsibility is also a legal requirement for the doctor in a number of countries. The current problems relating to doctors' CME/CPD are not due to lack of motivation on the part of doctors, but rather the lack of practical and financial opportunities.

A formalised CME/CPD system would guarantee the doctor the opportunity to undertake a specified amount of CME/CPD within a specified period; the responsibility for this being carried out must rest jointly with the employer and the doctor. This would also place financial demands on the employer, upon whom few obligations currently rest in this respect.

The probability of doctors, in reality, fulfilling CME/CPD is related to the individual doctor's ethical duty to maintain professional competence and the national laws on practising as a doctor.

Time and resources

A formalised CME/CPD system not only provides doctors with the opportunity to undertake CME/CPD, but also facilitates their exercising their right to do so. The responsibility for taking part in CME/CPD-activities rests jointly with the employer and the doctor. This also comprises a demand for adequate time and financial resources from the employer, who currently has limited obligations in this respect.

It should be recognised that doctors in private practice will not be able to seek direct support or remuneration. This presents particular problems for this group. It is nonetheless just as incumbent upon them to fulfil their ethical and/or legal obligations. PWG believes that if patients and insurers require the same standards from private practitioners, as employers do from their employees, then between them they must be prepared to meet the costs of so doing.

036 PWG concludes therefore that the objective of a formalised CME/CPD is to create a tool to enable the individual doctor to maintain his/her right to CME/CPD vis-à-vis the employer and others responsible for funding and facilitating CME/CPD.

SECTION C: EXECUTIVE SUMMARY

CME is a process of life-long continuing education within the fields of knowledge of medical practice.

CPD embraces not only CME, but also the development of non-medical competence, such as leadership, personal and social skills, and other proficiencies.

Any system of CME/CPD must be based upon a thorough understanding of the concept of quality improvement as distinct from quality control.

CME/CPD is a prerequisite for quality improvement.

The CME/CPD debate should focus on quality improvement in medical practice and on safeguarding the rights of the medical profession to do what it is ethically and legally obliged to do for patients

It is an ethical obligation for each doctor to continuously throughout his professional life to participate in continuing medical education

Doctors are legally responsible for keeping themselves professionally updated.

Further and continuing education of doctors is an ongoing process, and there is no practical or educational dividing line before or after the date of becoming a specialist.

CME/CPD as a continuing, life-long process of learning must also apply to doctors who are undergoing specialist training.

The right of all doctors to participate in CME/CPD must be secured.

The employer has a special duty to facilitate CME/CPD.

The general public has a legitimate right to know how, and to what extent, doctors keep themselves professionally updated and develop their competence.

CME/CPD documentation is concrete evidence of the individual doctor's CME/CPD activities.

A formalised CME/CPD system is one in which the individual doctor must define his or her CME/CPD requirements and thus their activities

The objective of formalised CME/CPD is to create a tool to enable the individual doctor to maintain his/her right to CME/CPD vis-à-vis the employer and others responsible for funding and facilitating CME/CPD.

Continuing education must be individual and specifically tailored to the needs of the individual doctor and employer.

PWG opposes a system with recertification.

It is a common misconception that a system for recertification would contribute to the identification of unsuitable doctors.

Specialist qualifications are currently awarded without time limits, and no evidence exists to support a change in this system.

The fact that a doctor takes part in courses, conferences and other CME/CPD activities does not constitute a guarantee of quality control.

Legal, methodological and resource problems related to recertification systems are overwhelming compared to any advantages that might be involved.



Basic Policy Statements & Studies

Medical Workforce

Medical Manpower in Europe by the Year 2000: From Surplus to Deficit?

Florence 1991

Foreword

From the beginning, medical manpower has been one of the dominant items on the PWG agenda. Reports at the end of the 1970s of large-scale medical unemployment in Europe led to the PWG conference on health manpower planning in Maastricht in April 1982, bringing together politicians, planners, and the profession in an attempt to solve this problem. This led to a general interest in planning the future supply of doctors to match the anticipated demand for their services.

The PWG then commissioned a further study of medical manpower in Western Europe which culminated in the congress held in Florence, Italy on 31 October 1991: "Medical Manpower in Europe: From surplus to deficit?". This conference was based on the manpower study conducted by Peter Saugmann Jensen of Denmark in cooperation with the PWG Medical Manpower Subcommittee and the 17 national delegations.

This booklet reviews the results of that conference, which has made it clear that manpower questions are not static and that long term planning, difficult as it may be, is a necessity.

The European medical manpower picture will be a varied one as we enter the new millennium, and the PWG prognosis set forth in this booklet as well as the country by country analysis produced for the conference in Florence can be expected to serve well in this future planning.

Hans-Ueli Würsten,
Coordinating Secretary,
PWG

The myth of future mass unemployment

The physicians "glut" is not going to last forever. It is a myth that Europe will be facing mass unemployment among physicians in the late 1990s and that a progressive worsening of the situation will ensue if a further reduction in intake to medical school is not speedily effected in most European countries.

A major reversal of long-standing trends in medical manpower supply will occur shortly after the year 2000. The number of physicians leaving the active ranks will rise to match, possibly

More females are entering the medical profession

Fraction of workforce

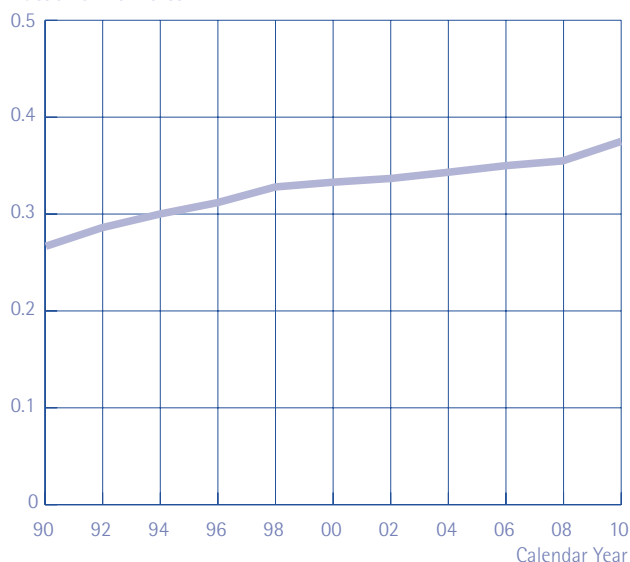


Figure 1. Predicted change in proportion of European women physicians of all European physicians (percent of workforce).

surpass the number of newcomers to the profession. This change will already begin to be felt in the nineties. Therefore, there will be a near balance between supply and demand of physicians in most countries in Western Europe by the turn of the century. Some countries will even experience a shortage of doctors. Countries that currently have full employment of physicians can expect that status to continue. Those countries presently experiencing unemployment can look forward to improved employment conditions, although at varying rates.

These conclusions are the result of a comprehensive investigation of the medical manpower situation in Western Europe carried out under the auspices of the Permanent Working Group of European junior Hospital Doctors (PWG).

The investigation was conducted by Peter Saugmann Jensen (DK) with a number of national collaborators.

The PWG survey provides detailed, specific analyses of 15 individual countries as well as a general overview of the Western

European labor market for physicians.

Some countries will find it necessary to educate more physicians if they want to avoid a shortage. Other countries will likely choose to reduce the number of medical students to hasten full employment of physicians.

Effects of "The big bang"

The supply of physicians in Western Europe will stop growing by the end of the 1990s. This is one of the striking conclusions of the PWG survey.

In the 1960s and early 70s, the number of physicians grew explosively in all of Europe, with the single exception of the United Kingdom. Universities educated and sent out more and more physicians into the labour market each year. This phenomenon has been described in the PLUG study as "the big bang".

After the turn of the Century, we will witness an enormous departure of physicians from the medical labour market as those from "the big bang" period reach retirement age or die in service. Many countries will then experience a decrease in the number of physicians for the first time in history, unless intake to medical schools rise somewhat by the late nineties.

Another consequence of "the big bang" period is the graying of the ranks of physicians. A typical physician around the year 2000 will be a person around 45-50 years old. There will also be an increase in the proportion of female physicians. These changes may affect the way the health care sector is organized.

Graying of the ranks of physicians

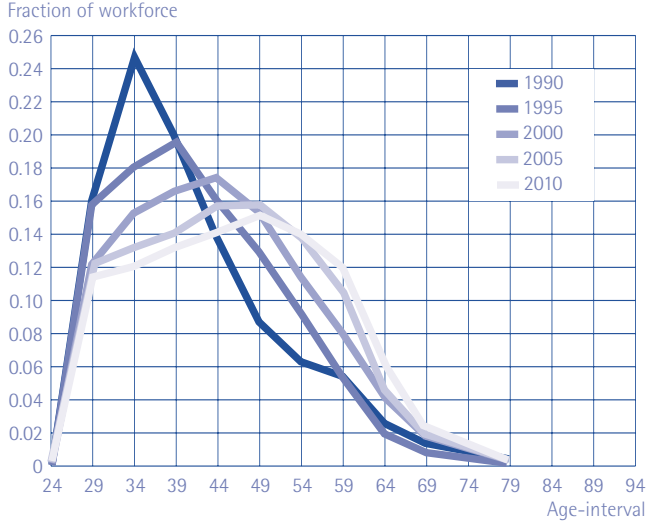
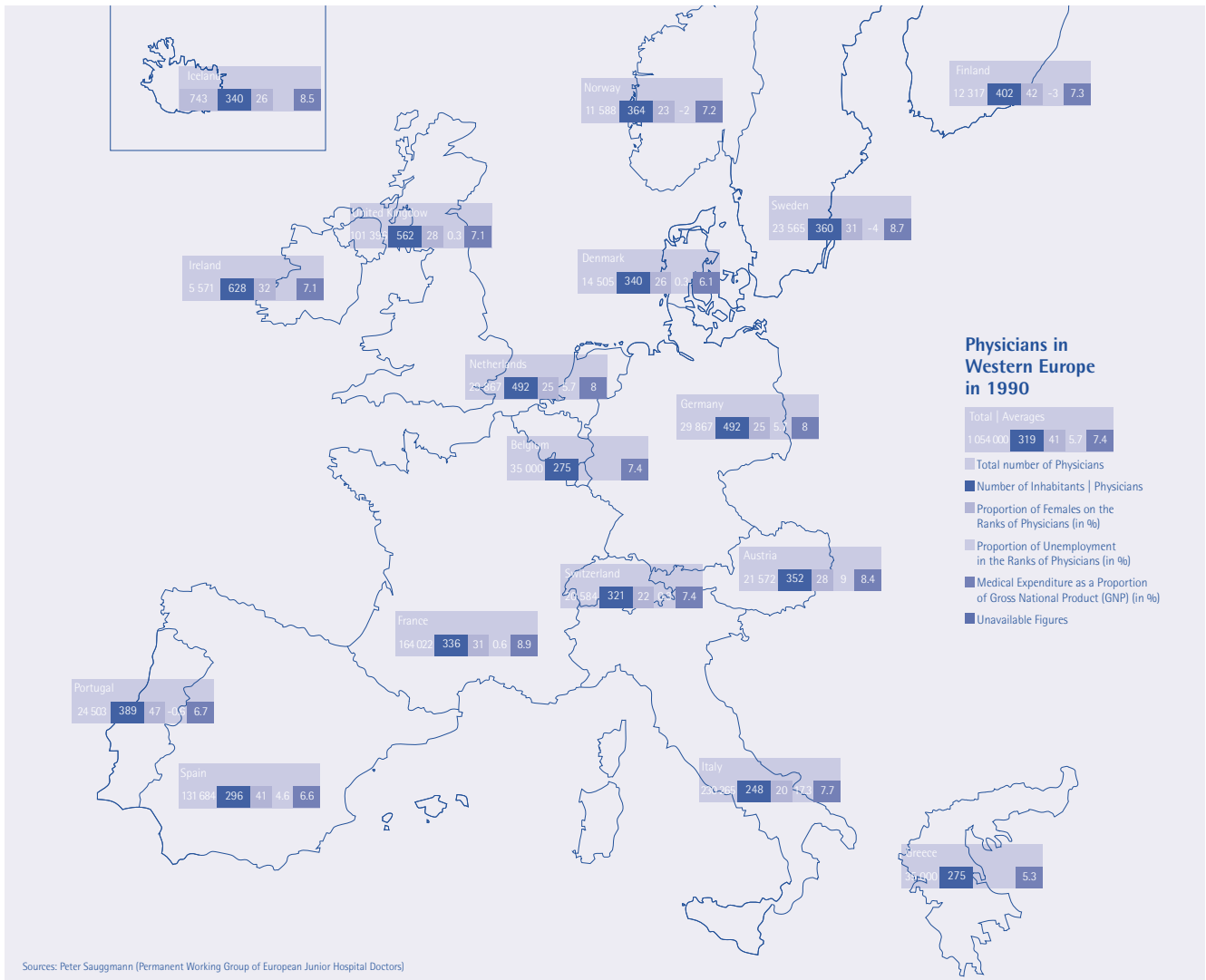


Figure 2. Predicted age distribution of professionally active physicians.

Employment of physicians

Unemployment will probably not appear in those countries that have full employment today. On the other hand, in those countries where it is currently a problem, unemployment will remain



Sources: Peter Sauggmann (Permanent Working Group of European Junior Hospital Doctors)

on the same level or increase in the first half of the 1990s. But in the second half, conditions will also improve there.

At present Europe has 1.05 million active physicians and about 40–60,000 unemployed. Unemployment is a considerable problem in five countries. In 1990, 60% of the unemployed physicians in Europe were Italian, 23% German, 9% Spanish, 2,9% Austrian, and 2,6% Dutch. The physicians in these five countries represent 57% of the total number of physicians in Western Europe.

During the 1990s the number of physicians will grow at an increasingly slower rate. The 1990 growth rate of 2,7% will go down to 1,85% in 1995, which is less than half of the average yearly growth in the 1980s. For the year 2000, the projected growth rate is 0,5%.

To eliminate unemployment it is necessary that the yearly demand for physicians increase by an average of 2,3% each year until the year 2000. In those countries that have the highest unemployment, the average growth in demand must be from 2% to 35% to keep pace with the supply of physicians.

Factors deciding supply and demand for physicians

The ten years it takes to educate a physician gives us the opportunity to project the number of physicians entering the future labour market. We can also project the demographic development among currently practising physicians. We are therefore on reasonably firm ground when we estimate the supply of medical manpower for the next ten years.

However, the possible migration of physicians from eastern

Decrease in number of active physicians

Physicians (mill.)

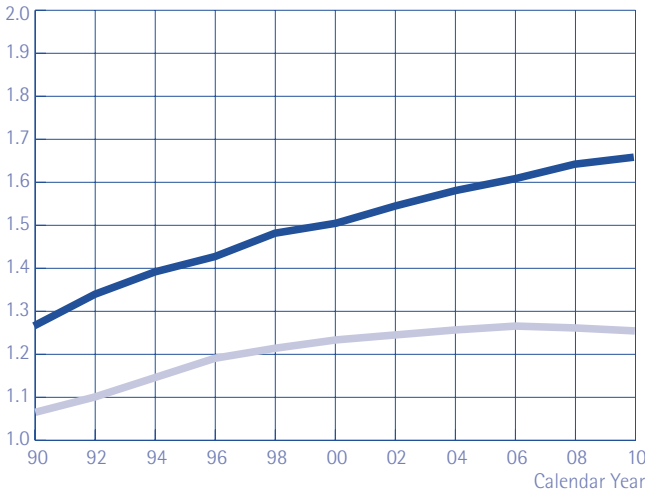


Figure 3. Predicted growth of European physician supply 1990–2010. Upper line: total medical population. Lower line: professionally active medical population.

Europe to western Europe is an unknown factor that can influence the supply. Will the language barrier and the cultural barrier work effective obstacles to migration, as they have in the past reduced migration between the EC countries?

It is also difficult to forecast the demand for medical manpower due to the many factors which have an impact on it. But a generally very safe assumption is that health care expenditure will not grow more slowly than national income (BNP). By implication, one would then expect physician average demand

Decreasing annual growth in supply

Percent annual growth of supply

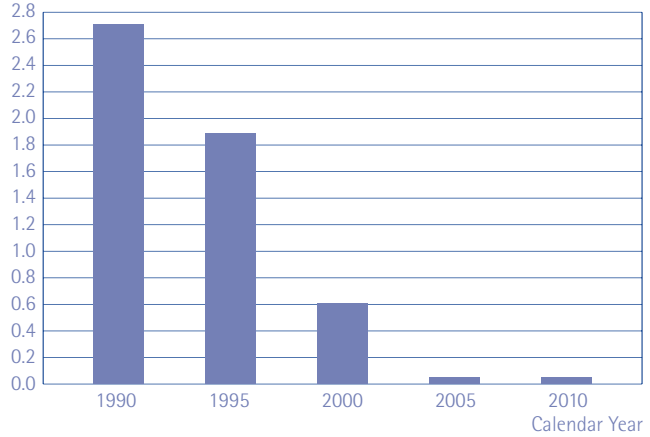


Figure 4. Predicted annual growth rate (percent p.a.) of European medical manpower, selected calendar years within the period 1990–2010.

growth over the long-term to be at least 1–2 percent p.a., which also seems borne out by past experience.

Other factors tend to raise the demand for physicians. For exam-

Physicians in the next 20 years — surplus or deficit

Physicians | surplus or deficit ('000)

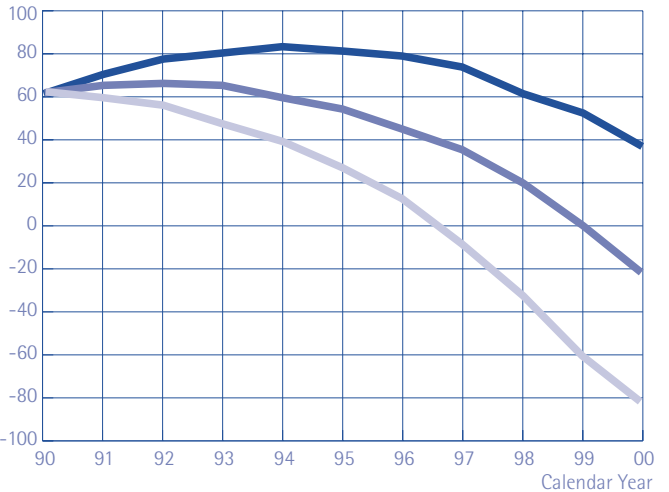


Figure 5. Predicted surplus or deficit of Physicians 1990–2000 on various demand growth assumptions: 2,0% p.a. (upper), 2,5% p.a. (middle) and 3,0% p.a. (lower).

Physicians | surplus or deficit ('000)

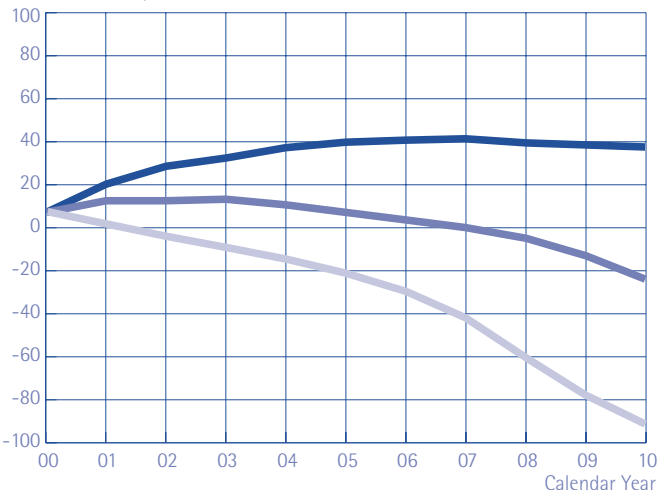


Figure 6. Predicted surplus or deficit of physicians 2000–2010 on various demand growth assumptions: 0,0% p.a. (upper), 0,5% p.a. (middle), and 1,0% p.a. (lower).

ple, employment of physicians is affected by continuing medical advances. Although ongoing innovations in medicine can at times reduce the need for physicians, the general tendency is that innovations create extra jobs for physicians. The net effect is a tendency toward an increased demand for physicians.

Another factor that will increase the demand for medical manpower is the aging of the entire western European population. Some estimates indicate that the growing number of elderly people will add 0.5% to the demand for physicians.

Physicians mobility across border: the Scandinavian and Italian experiences

The realization of the EC internal market is not likely to have any significant effect on mobility across borders in western Europe, according to the PWG-study. The intra-European mobility of physicians is of interest because it affects the supply of doctors in individual countries.

Since the beginning of the 1970s free movement of physicians has been assured in principle by the EC Medical Directives. But the migration we have witnessed has in general been small.

The PWG survey found however that mobility in Scandinavia has been remarkably large, but this mobility is due to specific reasons. Danish physicians would have faced major unemployment in the 1970s and 80s had it not been for mobility within Scandinavia's common labour market. This mobility allowed full employment of Danish physicians within Scandinavia.

The Scandinavian labour market for physicians is closely linked by language and cultural similarities. The connection is strengthened by the fact that Scandinavian hospitals and health care systems function similarly.

In stark contrast to the Scandinavian experience, Italy has been experiencing major unemployment – currently approximately 40,000, although the precise number of unemployed and underemployed doctors is unknown.

Some basic factors behind this situation are:

- unregulated admission to Italian medical schools.
- an already high ratio of physicians to general population, the highest in Europe.
- lack of opportunity for employment in neighbouring countries.
- language and other cultural barriers to migration.

Medical Manpower in Europe: Towards a Balance between Supply and Demand by the Year 2000

Peter Saugmann

Florence 1991

SUMMARY

The aims of this study were (1) to discover how many physicians there are in West Europe, how they are distributed on age and sex, and how many are unemployed (2). To make forecasts of European manpower supply with a particular view to the prospects for supply-demand balance year 2000 (3). To compare countries.

Profession insiders in each of 15 countries reported key national parameters in accordance with a standard format. A computerized supply algorithm which is described was used to establish a 1990–2010 projection of collective West European manpower supply. The same algorithm was used to set up a 1990–2000 prognosis for each country separately. The comprehensive analysis, including main results from the national studies, is reported in this article. The detailed prognostics for each country are being submitted to national journals and may presently be obtained from a data repository in Copenhagen (1).

Presently, we give the comprehensive results of the study.

The European medical workforce comprised (1990) 1.05 million physicians, corresponding to 338 heads of population per physician (nations range 296–628). Women comprised 28% (nations range 1647). 6,1% of the workforce = 64.500 were unemployed (nations range 0–17,3). Of the unemployed, 60% were Italian, 23% German, 9% Spanish, 2,9% Austrian and 2,6% Dutch. Unemployment was thus confined mainly to five countries. Medical manpower will increase in the nineties by an average 1,85% p.a., which is less than half of average annual growth in the eighties. The average demand growth required to consume all unemployment before year 2000 is 2,3% p.a. However in the countries most affected by unemployment it will be 2–3,5% p.a. The growth rate (supply) is sharply declining from 2,7% p.a. (1990) to 1,85% p.a. (1995) and 0,5% p.a. (2000). By the year 2000, the workforce will comprise 1.24 million physicians, 33 percent of whom will be women. The workforce will also display a progressive "seniorisation". Beyond year 2000, supply growth will be almost nil. A profound change in the dynamics of the manpower situation thus will occur, which begins to make itself felt in the latter half of the nineties. The hidden variable which explains these findings is that loss of active manpower due to

death-in-service and retirement increases steeply as the decade draws to an end. This reflects that the large influx to the profession which began in the sixties, is beginning to be converted into an efflux.

The results are interpreted to show that unemployment is unlikely to emerge where it is presently absent. In those countries where unemployment is presently high, the situation will remain unchanged or worsened in the first part of the decade, followed by progressive amelioration of conditions in the latter half.

INTRODUCTION

The present study concludes a comprehensive investigation of the medical manpower situation in Western Europe, carried out under the auspices of the Permanent Working Group of European junior hospital doctors (PWG). The main purpose of that investigation has been to establish an internally consistent manpower data base, and to set up a 10-year manpower prognosis with a particular view to the prospects of balance between physician supply and demand at the European level. This would appear to be what is required to either verify or falsify the opinion, now widespread in medical circles, that Europe

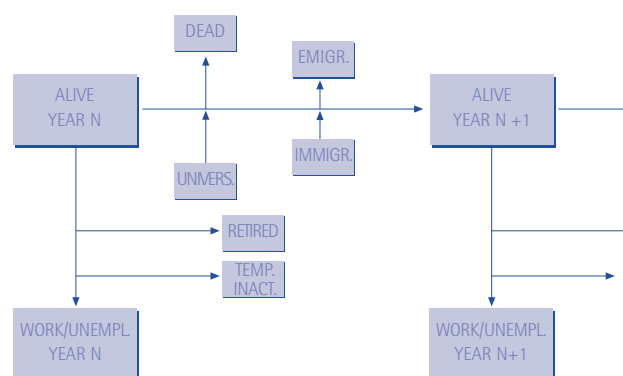


Fig. 1. The supply-algorithm adopted in this study. Alive = Total pop. Work/Unempl. = Workforce.

Table 1. Prospective annual additions to European manpower stock (University output). All entrants assumed to be aged 25–29

Year	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
University Output ¹	45017	43760	41732	39348	38286	34616	33776	33845	31471	31471
Woman fraction	0.47									
Emigration ²	–	–	–	–	–	–	–	–	–	–
Immigration	–	–	–	–	–	–	–	–	–	–

¹ Sum over all countries.

² Assumed negligible.

Note: all "internal" migration between European countries cancel out in the comprehensive prognosis.

* For Greece and Belgium, which did not partake, a sustained annual 1500 (each) was assumed.

will be facing mass unemployment amongst physicians in the nineties, and that a progressive worsening of the situation will ensue if a further reduction in intake to medical school is not speedily effected in most of the countries. However, there are several obstacles to such an undertaking.

It is a recognized problem with cross country studies of health care related issues that data are not readily comparable. This was deplored only recently by the O.E.C.D. which pioneered a very valuable retrospective health data file (2), and inspection of their data illustrates the nature of the problem. For instance, their finding of a surprisingly low number of physicians in Switzerland reflects, as far as we can judge, the fact that this country traditionally only included senior physicians in their statistics, while their findings with Italy presumably reflect that only employees of the National Health Service were reported to them. These examples together with other examples of similar nature serve to illustrate the importance for cross country comparisons of rigidly defined and identical criteria for being included or excluded. However such generally accepted criteria do not currently exist. When it comes to comparing, between countries, future trends in the evolution of manpower supply and demand, the situation is further complicated by the fact that prognostic studies of medical manpower are not done or (as evidenced by the result of a computerized search in literature) not published with a number of European countries. Even where they are found, their method and basic underlying may not always be exactly stated. To overcome such difficulties as stated above, we found it necessary to adopt uniform definitions and to apply the same prognostic algorithm to all countries studied.

METHODS

Data Collecting, and "default" criterium for truth Raw data for the study were obtained from "profession insiders" with good access to manpower data in their respective countries. They were elected representatives of their national associations to the Permanent Working Group, and also practicing physicians. Their task was, as field analysts (and co-authors on national studies), to do a critical review of home data sources, and to compute and recast them in accordance with definitions contained in a written protocol issued Jan. 1990. Information was sought on the total number of live physicians, their age and sex distribution,

mortality rates, retirement and temporary inactivity trends, university in- and output (prospective and retrospective) distributed on age and sex, study duration and completion rates, emi- and immigration trends, and vacancies and un- and underemployment. Data were reported to a single compilation Unit in Copenhagen, where the central analyst would feed them to the computer program to be described below. Various checks on the internal consistency of the data were done, e.g. whether reported age distribution of manpower was consistent with reported outputs from Universities over the last decade. After the first run, the central analyst would often request additional information from the field analyst(s), and the process was repeated until all spots were covered. With countries where only piecemeal information on one or more main parameters could be given in the first run, the central analyst would suggest values or sets of

Table 2. Population description 1990: assumed values for initialising the prognosis

Total Medical Population (TMP), January 1990	1.254 million
Women fraction	–
Professional active Manpower (PAM), January 1990	1.05 million
Women fraction	0.28
Physician unemployment as fraction of PAM	64.500 0.061
Temporary inactivity, fraction	approx. 0.03

Table 3. Assumed age-dependt decrease in compound activity ratio of total medical population (TPM)

Age interval	Men	Women
55–59	0.894	0.835
60–64	0.672	0.577
65–69	0.299	0.183
70–74	0.114	0.023
75–79	0.024	0.002
80–84	0.0	0.0

values based on backwards computation from other data or based on findings from other countries – e.g., mortality rates for doctors. In practice, the field analyst would reject suggestions only in case he or she could produce better values in a new search. The procedure described thus supplied a default criterium for "soft" truth when "hard" truth could not be ascertained.

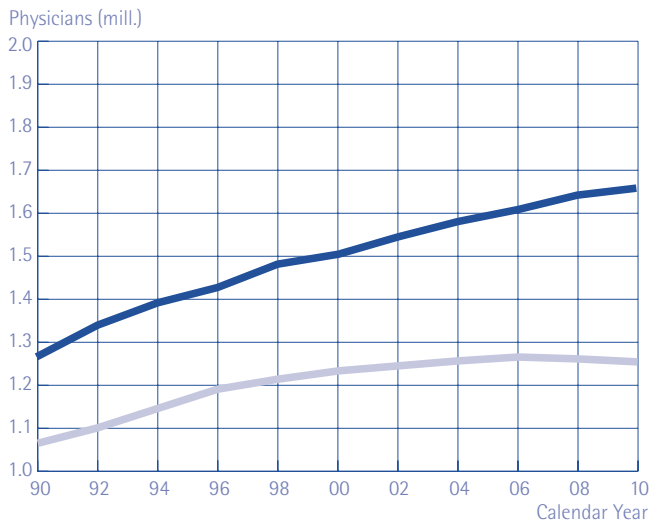


Fig. 2. Predicted growth of European physician supply 1990–2010. Upper line: total medical population (TMP). Lower line: Workforce (PAM).

Standard format definitions

The Total Medical Population (TMP) in a country was defined to include all holders of a University degree in Medicine who were alive and residing in that country by the time, whether professionally active or not, and regardless of their nationality. This count is, by definition, a headcount, thus being directly comparable from country to country. It was broken up on 5-yr. age intervals and on sex. Professionally active manpower (PAM) which we shall refer to in short as the workforce was defined as the "ready supply", i.e. after subtracting, from TMP, those permanently retired and those temporarily retired from the marketplace. Retirement (permanent) trends may reflect compulsory retirement age or optional retirement age. In the latter case, doctors may often choose to retain professionally active status indefinitely, although their working hours decline as a function of age. A compound estimate of age dependent decrease in activity ratio was therefore adopted, estimating average activity of physicians of age $60 + i$ ($i = 0, 5, 10 \dots 30$), expressed as fraction of average activity of physicians of age 50, and broken up on sex. These data were used as nodal points in the fitting of sigmoidal trend curves, whose limiting slopes were estimated from the shape of retirement trend curves in more well

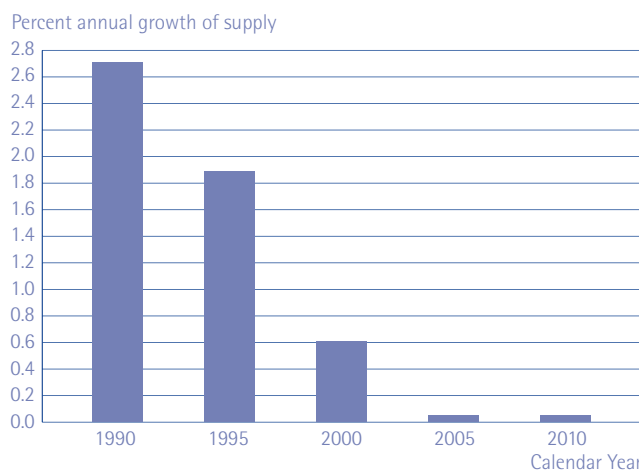


Fig. 3. Predicted annual growth rate (per cent p.a.) of European medical manpower, related to selected calendar years within 1990–2010. Compare fig. 2.

described countries. Point estimates were defined in units of professionally active manpower, cf. below. Temporary absence (TA) was defined, for each sex, as the proportion of all physicians of that sex who, on any date, would be estimated to be on prolonged leave due to, e.g. maternity, draft service, study leave in other country, sabbatical leave, fixed term appointments in other country, e.g. arab peninsula, third world projects, or any other cause, but not including absence due to short term illness or ordinary holidays.

Units of "supply" and "demand"

The supply of physicians in the sense of "ready supply" of professionally active manpower, cf. above, was expressed in units of present average working time physicians in a country (PAT-equivalents). We note that it is possible to comply with this definition even where average working hours are not known, as in the initial state PAT-equivalents simply equal a head count of the ready supply. Where data are sufficiently detailed, PAT-equivalents may be easily transformed into whole time equivalents. The demand for physicians is expressed also in PAT-equivalents. 1990-demand was estimated by adding supply and number of vacancies, and subtracting number of unemployed physicians. An unemployed physician was defined as any physician who, on a particular time is eligible to work, is actively seeking a medical post and yet does not work as a physician (PWG-definition).

West Europe was defined by us as comprising the seventeen countries which appear in table 4, excluding Luxembourg. Only Belgium and Greece did not participate in the study.

Computer processing of data

Data were analyzed in a DOS-supported spread-sheet with printgraph application (Lotus Symphony), on an Olivetti M211V personal computer adapted with a 2 MB RAM-expansion. An algorithm was designed which takes TMP as the fundamental variable, and calculating $TMP_n \approx TMP_{n+1} \approx TMP_{n+2} \dots$ ($n =$

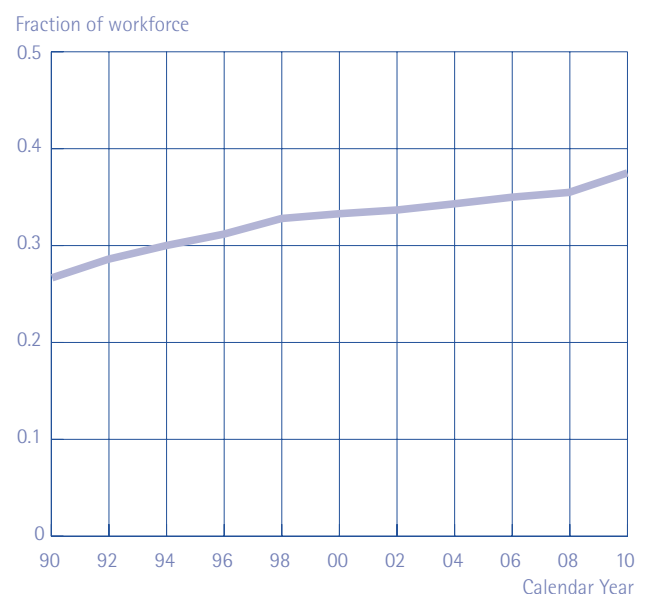


Fig. 4. Predicted change in proportion of European women physicians to all European physicians (per cent of workforce).

calendar year) by adding, at each arrow, expected 1-year input of newly qualified physicians and immigrants, and subtracting calculated mortalities and expected emigrants. Professionally active manpower = workforce was obtained from TMP in a subsequent step, calculating $TPM_n \div PAM_n$; $TPM_{n+1} \div PAM_{n+1}$.. by subtracting, at the arrows, permanently inactive and temporarily inactive persons in accordance with the trends reported. The algorithm has been illustrated in Figure 1. Where the total number of live physicians (i.e., including those retired) could not be given with sufficient accuracy, the algorithm was used to "repair" the stock so as to yield consistency with reported retirement trends and workforce, including age distribution of the latter. This may be regarded as a purely technical thing which does not, of course, affect the calculation of prospective loss due to retirement or death-in-service. All calculations were done on male and female doctors separately, integrating results in the last step.

The algorithm was further branched to yield other desired parameters than the above mentioned, e.g. unemployment ratio forecasts on various demand growth assumptions. The spreadsheet was programmed to yield an instant display, including graphical display, of 12 analytical windows, thus being a handy tool for studying a wide range of possible scenarios.

Mortality Rates

The mortality rates used throughout this study were those established separately for Danish male and female physicians (2), which differed not appreciably from mortality rates in those countries where they were known with some accuracy (Sweden, France, United Kingdom, Netherlands).

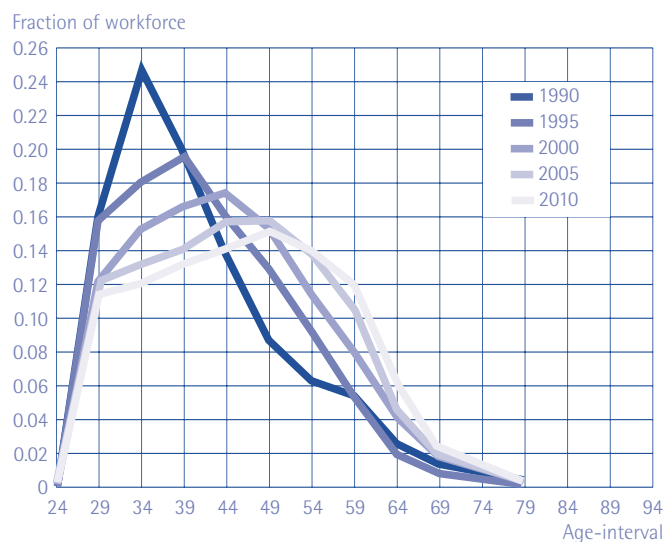


Fig. 5. Predicted distribution of manpower (workforce) on 5-year age intervals 1995, 2000, 2005, 2010 compared with 1990-distribution.

RESULTS AND EXPLANATION

Description of European Medical Manpower 1990

The findings which are pertinent to a description of the collective European stock of physicians as of January, 1990, have been summarized in tables 1-2-3; some of these findings have

been further detailed on individual countries in table 4. These values are all either directly such as they were reported by the field analysts, or such as could be obtained from their data by summing over countries (e.g., university outputs, number of unemployed) or, where relevant, by calculating average values (e.g., on retirement trends). Average values were calculated as weighed arithmetical means, using the size of each country's workforce as weight.

By January 1990, the number of professionally active physicians was 1.05 million. Of these, 294,000 (28%) were women physicians and 64,500 (6.1%) were unemployed physicians (table 2). In order to predict future growth of the medical workforce, it is indispensable to know the annual output from universities/medical schools. Assessment of this parameter was for each country based on knowledge of government targets for student intake or the passing of examination after first year (numerus clausus), and consideration of student intake 1980-89 and graduate output for the same period, the latter making an assessment of study completion rate possible. Table 1 gives the sum total of the expectations on each country and thus represents the expected total annual addition to the European manpower stock, excluding the contribution from a possible positive net immigration factor, which we assume to be negligible. It appears from the table, that the annual addition to the stock is, on these expectations, going to decrease slowly during the present decade. It further appears that the proportion of women graduates to male graduates will be close to unity in the nineties.

The annual addition to the stock will be to a lesser or greater extent counterbalanced by loss of active manpower due to death-in-service or retirement from all causes. The former can be calculated with accuracy once the age distribution of active manpower is known and reliable mortality rates are at hand (as in this study). To calculate the latter, one must know the retirement trends. Table 3 gives the weighed average of the trends that were reported with individual countries.

Based on the information contained in tables 1-2-3, projections of the collective European manpower supply may be obtained by the algorithm described earlier.

Prognosis for manpower supply 1990-2010

In Figure 2, European medical manpower supply has been projected using the data described in the foregoing section as input to the prognosis model (supply algorithm). Both the total stock of live physicians including those retired, and the active workforce, are going to increase further, although it is visible from the slope of the curves, that growth of supply is getting progressively slower during the prognosis period. This is perceptibly more pronounced with the workforce, than with the total stock. By the year 2000, the lower curve (workforce) becomes almost horizontal, indicating complete arrest of growth. In Figure 3, the prospective annual rate of growth of the workforce has been calculated on selected calendar years. The figure displays a rapid decline from 2,8 per cent p.a. in 1990, over 1,85 per cent p.a. in 1995 to less than a half per cent p.a. by the turn of the century. Thereafter, the annual growth rate attains zero value.

The decline in growth rate is so pronounced that it obviously cannot be explained solely by the rather modest decline in the annual addition of fresh physicians which appears from table 1. The proportion of women physicians to all physicians will increase steadily (Figure 4). By the year 2000 just over 1 in 3 physicians will, according to the projection, be female, up from present approximately 1 in 4.

In Figure 5, the projected age-distribution of the workforce is displayed as a function of 5-year intervals in time, and compared with present (1990) age distribution. The curves display a pronounced "right-shift" with time, which reflects progressively decreasing numbers in the lower age intervals, and progressively increasing numbers in the higher age intervals. This might aptly be termed progressive "seniorisation" of the physician stock. The predicted annual loss of professionally active physicians due to either death-in-service or retirement due to all causes appears from Figure 6. This represents, statistically speaking, the number of new opportunities that would be at disposal annually, even at zero demand growth, to those entering the profession from universities or from abroad. A steep increase in this number can be discerned from the mid-nineties onwards. By the year 2000, the figure will be approx. 50 per cent higher, than today, and by the year 2010 it will have reached more than double its present value. This is the "hidden" variable which explains mathematically, together with the more modest expected decrease in university output, the steep decline in annual growth rates observed in Figure 3.

The balance between supply and demand

In Figure 7, the conditions for the emerging equilibrium between supply and demand during the course of the nineties have been analyzed by studying the effect of various demand-growth alternatives (2,0; 2,5 and 3,0 per cent p.a.) against the projection for supply growth which we obtained in this study. The graph displays, as a function of time, the result of the calculation $x = (\text{supply} - \text{demand})$. If $x > 0$, there is an excess of supply over demand, i.e. unemployment. If $x < 0$ there will be unfilled posts (vacancies). If $x = 0$, demand equals supply. There is a present (1990) excess of supply over demand corresponding to just over 62.000 physicians which is reflected at the origin of the curves.

One may conclude from inspection of Figure 7, that, e.g., an average annual 2 per cent demand growth would lead to a moderate rise in the physician surplus (unemployment) before 1995. However thereafter such growth would be sufficient to get unemployment figures down. A 2,5 per cent annual growth in aggregate demand for physicians would initially only suffice to stave off a further rise, but if sustained would consume all unemployment before the end of the decade. The critical growth, i.e. the average annual demand growth which would exactly be enough to achieve balance by the year 2000, appears to be a little less than 2,5 per cent p.a. (2,3%). An important lesson to be taken from Figure 7 is, however, that the effect of a given annual demand growth in bringing down unemployment becomes much more pronounced in the latter half of the nineties than in the first half. Again, this only becomes understandable

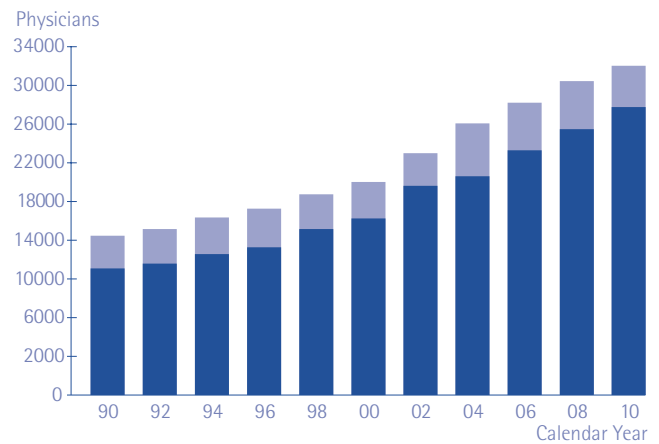


Fig.6. Predicted annual loss of professionally active physicians due to either death-in-service (top bars) or retirement due to all causes (bottom bars).

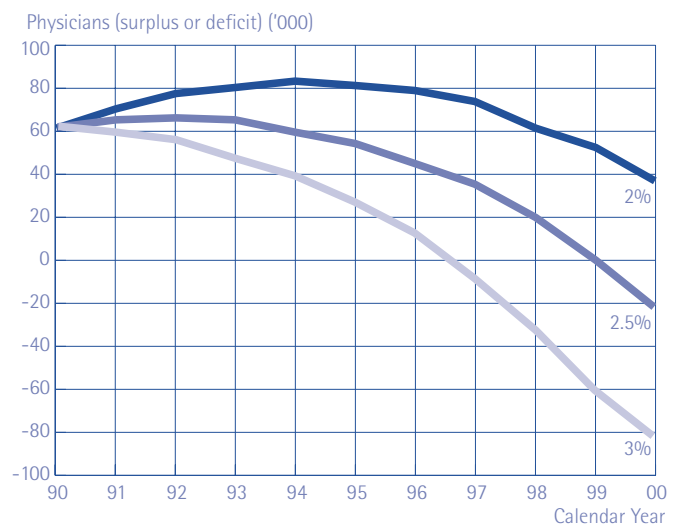


Fig.7. Predicted surplus or deficit of physicians 1990–2000 on various demand growth assumption: 2.0% p.a. (upper), 2.5% p.a. (middle) and 3.0% p.a. (lower).

when the combined effect of the findings reported in table 1 and Figure 6 is taken into consideration.

A further proof that the underlying dynamics of the manpower situation changes profoundly as the century draws to an end may be taken from consideration of Figure 8. The figure illustrates that beyond year 2000, a balance between supply and demand could be maintained at an annual demand growth in the range 0–0.5 per cent p.a. For these calculations the program was fed the assumption of a surplus corresponding to 10,000 physicians by the year 2000, which might be considered arbitrary; however, the principal findings of the figure is very little influenced by the exact size of that surplus. The prediction hinges on the further assumption that university output in the period studied will remain stationary and equal outputs 1997–1999, however again the principal finding that much lower growth rates would be required after year 2000 to absorb a given supply growth, than would be required in the first half of the nineties, would not be altered by a change in that assumption.

A comparison between individual countries

So far, we have treated the European medical manpower as one

collective stock, using weighed means of reported parameters (where relevant) to yield the supply projection. The results are the same or almost the same as would be obtained by first doing the prognostics on each country in isolation, and afterwards calculating weighed means of the projected results,

although the latter would be more tedious. As we did, however, during the course of this study, calculate individual supply projections for the first half of the prognosis period (1990–2000), we were able to verify that the two procedures yield results which differ only insignificantly between them.

Notwithstanding this, there remains to be decided to what extent individual countries differ from each other and from the main trend.

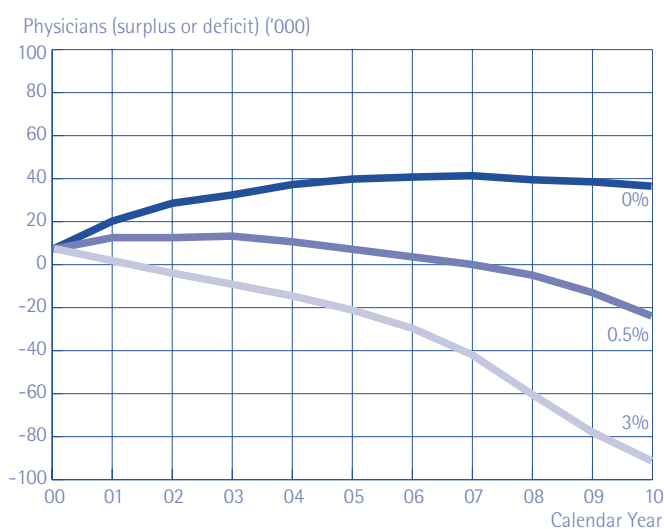


Fig.8. Predicted surplus or deficit of physicians 2000–2010 on various demand growth assumptions: 0.0% p.a. (upper), 0.5% p.a. (middle), and 1.0% p.a. (lower).

PHYSICIAN UNEMPLOYMENT

In table 4 a number of pertinent findings concerning the countries we studied have been summarized. From these findings it is obvious that physician unemployment is extremely unequally distributed amongst the countries, ranging from a modest shortage of physicians in several nordic countries, to the very high unemployment figures in Italy, Germany, Spain, Austria and the Netherlands. These five countries between them account for almost all of the unemployed physicians which has been illustrated in Figure 9. It should be observed, however, that the medical populations in those five countries amount to a combined 57% of the physicians in West Europe, as may also be calculated from table 4.

Table 4. Synopsis of data concerning individual countries

	Manpower ¹	Pop doc ²	Supply Intensity ³	Unemployed ⁴	Critical demand gr. 1990–1999 ⁵
The Nordic Region					
Denmark	14505	340	2.55	0.5	0.9
Finland	12317	402	4.10	-3.0	2.0
Iceland	743	340	5.07	0	2.5
Norway	11588	364	2.69	-2.0	1.0
Sweden	23565	360	3.23	-4.0	1.5
The North-West Region					
Ireland	5571	628	3.05	0	1.0
United Kingdom	101396	562	3.73	0.3	1.0
Netherlands	29867	492	3.61	5.7	2.0
The West Region					
France	164022	336	2.88	0.6	1.5
Belgium	35000 est*	290 est	–	–	–
The Central Region					
Austria	21572	352	4.33	9	3.5
Germany	192480	332	5.49	8	3.5
Switzerland	20584	321	3.67	0.3	2.0
The South Region					
Italy	230265	248	2.46	17.3	3.1
Portugal	24503	389	1.76	-0.6	0.5
Spain	131684	296	3.19	4.6	2.5
Greece	35000 est*	290	–	–	–
All Countries	1.054 mio.	338 (w) ⁶	3.46 (w)	6.1 (w) ⁷	2.3 (w)

¹ Workforce, incl. unemployed physicians.

² Ratio: heads of general population per head of physicians in workforce.

³ Mean annual prospective (1990–2000) addition to stock as per cent of workforce of 1990.

⁴ Expressed as percent of workforce.

⁵ Defined as the average annual demand growth 1990–2000 which would be necessary to consume prospective supply growth as well as existing surplus of manpower by the year 2000.

⁶ "w"= weighed average, using manpower size as weight.

⁷ Observe: negative values (= vacancies) not included in the weighed average.

* Est. on the basis of WHO-and OECD-data for 1987.

CRITICAL PROSPECTIVE DEMAND GROWTH

As might be expected from these findings, the critical demand growth in the nineties – i.e., the demand growth that might just consume all existing unemployment as well as new additions to the stock before the year 2000 – also varies considerably from the weighed average (2,3 per cent p.a.) which was found with the projection of the collective stock (cf. also Figure 10). Thus, in Italy, Germany and Austria the critical demand growth would have to be 3–3.5 per cent p.a. in the nineties, and this conceals the fact that the growth requirement would be higher in the first part of the decade, than in the latter.

SUPPLY INTENSITY

By "supply intensity" we shall understand the annual input of new physicians to a country's manpower stock, expressed as a percentage of the existing stock (it thus depends mainly on student intake to universities). Other things held equal, one would expect countries where unemployment runs high to reduce the supply intensity either through restrictions at the university level or through the market mechanism. However, when prospective average supply intensity for the period 1990–2000 were calculated for those countries and compared with a weighed estimate of supply intensity in all countries studied, the results shown in Figure 11 were found. Excepting the Netherlands, they all displayed higher intensities than the European average.

PHYSICIAN DENSITY

We found that, on average, there were by 1990, 338 heads of general population per head of physician (table 4). However the nations range was wide. A group of low density countries (Ireland, United Kingdom and Netherlands), as well as a group of high density countries (Italy, Spain – probably also Greece and Belgium), could be discerned. The remaining ten countries (The Nordic countries, France, Germany, Switzerland and Portugal) scatter around 350 heads of population per physician. The five countries hit by gross physician unemployment were distributed on all three groups (Figure 10).

WOMEN PHYSICIANS

An increasing proportion of women physicians to all physicians was found with all countries studied. In almost all countries, the

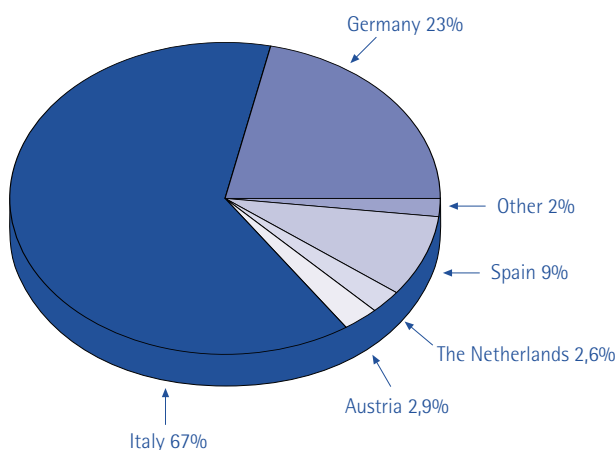


Fig. 9. Distribution of unemployed physicians (1990) according to country.

percentage of women in the workforce attained 25–30 (not shown). The exceptions were Finland, Portugal and Spain, where that percentage was close to 40.

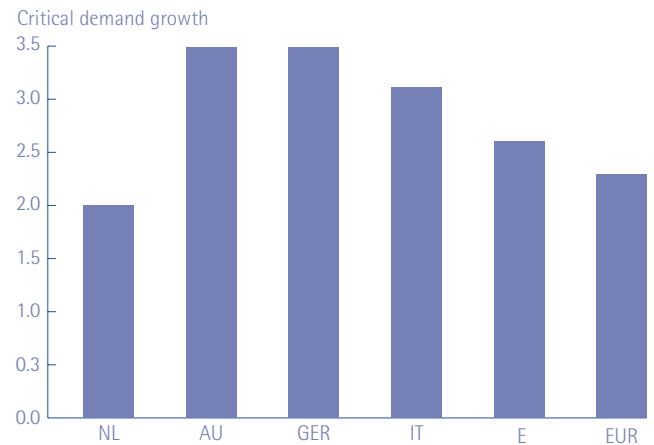


Fig. 10. Prospective critical demand growth in countries affected by unemployment, compared with European weighed average.

AGE DISTRIBUTION OF WORKFORCE

The trends towards increasing "seniorisation" of the workforce, which is shown in Figure 5, were also found in most countries (not shown). The exceptions were Iceland, Ireland and the UK where large fluctuations in student intake have not occurred in the past, and no great reduction is expected in the nineties.

DISCUSSION

Any conclusions to be drawn from our findings would have to take into account the uncertainty which might be attached to the raw data concerning each country. With some countries, e.g. Italy and Spain this uncertainty is probably large on some parameters. With Italy, an age distribution of the workforce had to be estimated on the basis of 5-annual output of laureati 1960–86, and prospective output of physicians on the basis of reported number of students of 32 medical schools. The reason for accepting such estimates is simply that no better estimates seem to be at hand presently. With this exception, however, data concerning the size and coarse age- and sex distribution and approximate number of unemployed physicians should

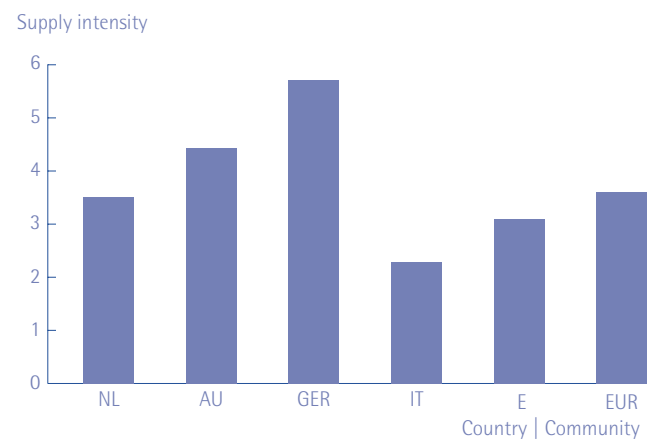


Fig. 11. Prospective annual average 1990–2000 supply intensity in countries affected by unemployment, compared with European weighed average.

probably cause no great concern. They stem in all instances from the single most representative medical association in the country and they are not, to our knowledge, contested to a significant degree at home. Retirement patterns are known with considerable accuracy on publicly employed physicians, but a greater uncertainty would generally attach to retirement of self-employed physicians. However, an error on this estimate cannot alter the shape of the future, which is often overlooked – it can only, so to speak, act to "contract" or "expand" the time axis and probably, as the estimate is accepted by the national association, the magnitude of the error would probably not exceed $\pm 1-2$ years. Finally, errors of estimate would probably not go all in the same direction in different countries.

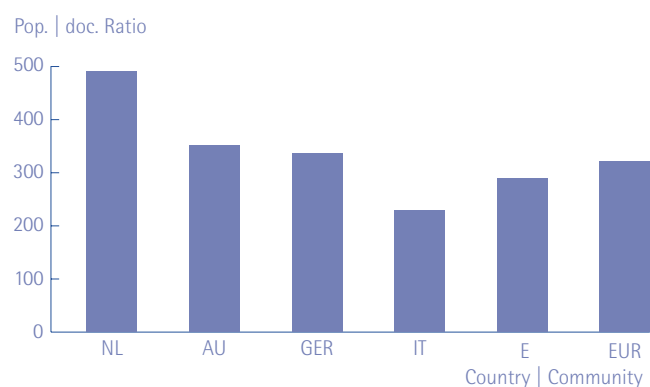


Fig. 12. Population/physician ratio in countries affected by unemployment, compared with European weighed average.

With regard to estimates of future output from medical schools, it should be observed that targets are now operated by governments in all of the fifteen countries which participated in this investigation, which – other things equal – should better the estimate. However to what extent such targets might be circumvented by universities in some countries is probably not yet settled. Notwithstanding this, as we were generally able to obtain the retrospective numbers on student intake 1980–1989, as well as output numbers for that same period which allowed for estimates of past study completion rates to be made, we feel entitled to attach a certain confidence to our assumptions of prospective outputs at least running up to and including 1996–97. Neither can any present or future government decision to alter intake change output in that period, owing to the long production time for a doctor.

With the reservations stated above, we venture the following interpretation of our findings.

REVERSAL OF FUNDAMENTAL TRENDS

The study indicates, that a major reversal of long standing trends on the manpower supply side will occur shortly after year 2000: ever since the second world war, annual input of new physicians has by far exceeded the annual output from the system, meaning manpower has been steadily growing bigger. By the turn of the century, however, annual growth of the European workforce will have dropped to one half per cent by year 2005, and input and output will tend to cancel each other out in the equation. The European medical manpower would

then, probably for the first time in its history, stop growing. This is the lesson to be taken from the findings shown in Figure 2 and Figure 3. Were nothing changed, the workforce would even after that begin to contract. Of course it will never come so far in reality, because university output will probably not remain fixed at the level which we could project for the end of the nineties, but the projection of what will happen on the "no change" assumption serves to reveal the force of an underlying change which is going to be increasingly felt in the second half of the present decade: the rising tide of efflux from the system (Figure 6). We are here witnessing a late effect of the big bang which began when, in the sixties, increasing numbers moved out of university and into the profession's ranks.

Practically all of the countries we studied will discover reversal of trends described above – some a little later, some a little sooner – the notable exception being the United Kingdom where manpower has ever been strictly controlled, and its growth slow.

MORE WOMEN, AND AGEING OF THE PROFESSION

Other basics that were discovered in our investigation were that everywhere the proportion of women physicians is increasing, and almost everywhere the profession is undergoing increasing "seniorisation".

Today, one-in-four physicians is a woman, in ten years that will be one-in-three. Both developments may influence the demand-supply equation. However this was not considered in more detail.

TOWARDS A BALANCE BETWEEN SUPPLY AND DEMAND?

Our study found, that unemployment is very unequally distributed on countries. In none of the five countries found to be affected by gross unemployment (Italy, Germany, Austria, Spain, Netherlands) could a regaining of balance be calculated to occur in the first half of the decade. Nothing can be done, regrettably, to rectify that, owing to the long production time of physicians at the university level. In all but one of them, the finding of a prospective supply intensity well above the average European level clearly indicates that planning and control is lacking efficiency. To achieve balance there by the year 2000, demand growth in the nineties would have to be sustained at close to the levels experienced in the nineties which we think would at best be a very uncertain expectation. To reduce student intake by a further 10–15 per cent 1992–1996 accompanied by a close monitoring of the situation would obviously be a no-risk operation to society, and would seem to be what is required to achieve balance in the course of this decade. In the absence of such further regular' On balance will very probably only be achieved at some point in the time interval 2000–2005, however it is difficult to see what any party could gain from prolonging the agony.

The final observation to be made from our findings would appear to be, that in those ten countries where unemployment is presently not significant, it is likely not going to emerge in the nineties on the existing of assumptions.

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The Prognosis Holds True: same trend as five years ago

Steen Poulsen & Bo Rahbek Christensen

Copenhagen 1996

1. SUMMARY

In an attempt to establish a comprehensive presentation of the medical manpower situation in Europe, the PWG conducted a study in 1991 in which professionals from the field of medicine in seventeen countries were given the task of reporting key parameters on the medical manpower situation in their country according to a standard format. The same procedure has been applied in this update of the previous study.

In 1994, the European medical workforce amounted to 1.148 million physicians, corresponding to 314 patients per active physician (nation range 231–610). Women physicians comprised 31% of that total. 7,56% of the workforce (87.950 physicians) were unemployed (nation range 0–24,4%). Of the unemployed doctors, 67% were Italian, 17% German, 7% Spanish, 3% Austrian and 2% Dutch. Unemployment was mainly confined to these five countries accounting for 96% of unemployed physicians in Europe.

The average demand growth rate required to absorb all unemployed doctors before year 2000 is 2,7% per annum. In the countries most affected by unemployment, the growth rate would have to be between 2,96% and 5.5%.

The supply growth rate (production of physicians) is expected to sharply decline from 1,98% in 1995 to 0,72% in 2000 and 0,09% in 2005. By the turn of the century, the physician workforce will be approximately 1.25 million. The workforce will also show an increasing "seniorisation".

The prognosis established in 1991 has shown to be very accurate and a valid tool. It calculated that the required growth rate should be 2,3% in order to establish equilibrium by the turn of the century. The actual growth rate was approximately 0,2% p.a. from 1990–1994; therefore, a demand growth rate of 2,7% p.a. is needed to secure balance by the year 2000.

2. INTRODUCTION

The present study is an update of the PWG Manpower study conducted under the auspices of the Permanent Working Group of European junior Hospital Doctors in 1991, which was pub-

lished in various national medical journals in 1991 and in a single publication by the PWG the same year. The purpose of this study is primarily to examine whether the model used in 1991 is still applicable and to investigate whether it produced a valid and confident manpower prognosis. Secondly, the PWG wished to update the 1991 study to get a current picture of the manpower situation in Europe.

The main purpose of the 1991 study was to establish an internally consistent manpower database and to set up a 10-year prognosis with a particular view to the prospects of balance between physician supply and demand at European level.

At the beginning of the nineties, the opinion was widespread that to avoid mass unemployment, it was necessary to reduce intake in the medical schools; the intention of the 1991 study was to contribute to the discussion by investigating whether it was realistic to expect mass-unemployment at all.

When initiating a cross country investigation, it is important to be aware of the existing difficulties when comparing the data of healthcare related issues which are not readily comparable. As with the previous study, it is a recognized problem in the literature of manpower studies and planning that data are not readily comparable. Most manpower registers have been produced to serve an administrative or planning purpose. For this reason, even country comparisons between databases can cause problems, and with cross country comparisons the problems only increase. There are different examples of comparisons between different databases. For instance, the certifying body's file may or (more often) may not reveal the extent to which a person is professionally active, or indeed whether he or she is alive.

Professional organizations (scientific societies, medical associations, medical trade unions) may each target only part of the medical population. Even a simple sum may cause problems, because of possible overlap, and the problems of target coverage and policy considerations still remain.

One may also find examples of only the chief physicians being counted, not their postgraduate apprentices, which presumably is left over from ancient guild traditions.

Apart from the above, there is also the problem that prognostic studies of medical manpower being unavailable or unpublished in a number of European countries. When they are found, their method and underlying assumptions often are not specified. Therefore, to overcome such difficulties, it was necessary to harmonize definitions and to apply the same prognostic algorithm for all countries included in the study.

3. METHOD

Data collection and "default" criteria for data. Raw data for the study were obtained from professionals in the field of medicine with good access to manpower data in their respective countries. The contact persons were appointed by the national member associations to the PWG. Their task was as field analyst (and co-authors of the national studies) to critically review national data sources, and to compute and recast them in accordance with definitions contained in a protocol issued in 1994.

Information was sought on the total number of live physicians, their age and sex distribution, mortality rates, retirement and temporary inactivity trends, university input and output (prospective and retrospective) distributed according to age and sex, study duration and completion rates, emigration and immigration trends, and vacancies and both underemployment and underemployment. Data were reported to a single compilation unit in Copenhagen, where central analysts would feed them into the computer program described below.

Various checks on the internal consistency of the data were conducted, e.g. whether reported age distribution of manpower was consistent with reported outputs from universities over the last decade. After the first run, the central analysts would often request additional information from the field analyst(s), and the process was repeated until all areas were covered.

With countries where only piecemeal information on one or more main parameters could be given in the first run, the central analyst would suggest values or sets of values based on backwards computation from other data or based on findings from other countries e.g., mortality rates for doctors. In practice, the field analyst would reject suggestions only in case he or she could produce better values in a new search. Thus, the described procedure supplied a default criterium for 'soft' data when 'hard' data could not be ascertained.

3.1. Standard format definitions

The Total Medical Population (TMP) in a country is defined to include all holders of a university degree in medicine who were alive and residing in that country by the time of data collection, whether professionally active or not, and regardless of their nationality. This count is, by definition, a head count, thus being directly comparable from country to country. It was broken down according to 5-year age intervals and sex.

Professionally Active Manpower (PAM) was defined as the "ready supply", i.e. after subtracting from TMP those permanently or temporarily retired from the labor market.

Retirement (permanent) trends may reflect compulsory retirement age or optional retirement age. In the latter case, doctors may choose to maintain professionally active status indefinitely, although their working hours decline as a function of age. A compound estimate of age-dependent decrease in activity ratio was therefore adopted estimating average activity of physicians of age $60 + i$ ($i = 0, 5, 10 \dots 30$), expressed as a fraction of average activity of physicians of age 50, and divided up by sex. These data were used as nodal points in the fitting of sigmoidal trend curves, whose limiting slopes were estimated from the shape of retirement trend curves in more well described countries. Point estimates were defined in units of professionally active manpower.

Temporary absence (TA) is defined, for each sex, as the proportion of all physicians of that sex who, on any date, would be estimated to be on prolonged leave due to e.g. maternity, military service, study leave in another country, sabbatical leave, fixed term appointments in another country. Temporary absence does not include absence due to short term illness or ordinary holidays.

3.2. Units of "supply" and "demand"

The supply of physicians, in the sense of "ready supply" of professionally active manpower, cf. above, was expressed in units of present average working time of physicians in a country (PAT-equivalents). We are aware that it is possible to comply with this definition even where average working hours are not known, as in the initial state PAT-equivalents simply equal head count of the ready supply. Where data are sufficiently detailed, PAT-equivalents may easily be transformed into full time equivalents. The demand for physicians is also expressed in PAT-equivalents. It was obtained by adding supply and number of vacancies and subtracting number of unemployed physicians. An unemployed physician was defined as any physician who, on a particular date is eligible for work, is actively seeking a medical post and yet is not working as a physician (PWG-definition). Europe was defined to comprise the seventeen countries which appear in table 4. Only Belgium and Greece did not participate in the study. As explained below, the data for France and Italy are estimates based on the 1991 Manpower study.

3.3. Computer processing of data

Data were analyzed in a DOS and WINDOWS-supported spreadsheet with print graph application (Excell 5.0) on a Personal Computer. An algorithm was designed using TMP as the fundamental variable, calculating $TMP-n \mp TMP-n+1 \mp TMP-n+2 \dots$ ($n =$ calendar year) by adding, at each arrow, expected 1-year input of newly qualified physicians and immigration while subtracting those who had died and emigrees. Professionally active Manpower (PAM) was obtained from TMP in a subsequent step, calculating $TMP-n \mp PAM-n$; $TMP-n+1 \mp PAM-n+1$; .. by subtracting, at the arrows, permanently inactive and temporarily inactive persons in accordance with the trends reported.

Where the total number of live physicians (i.e. including retired) could not be given with sufficient accuracy, the algorithm was used to "repair" the stock as to yield consistency with reported

retirement trends and workforce, including age distribution of the latter. This may be regarded as a purely technical thing which does not affect the prospective loss due to retirement or death-in-service.

For France and Italy, for various reasons, it was not possible to obtain new data, so the prospective calculation of the 1991 study has been used as the best alternative.

All calculations were done on male and female doctors separately, integrating results in the last step. The algorithm was further branched to yield other desired parameters than the above-mentioned e.g. unemployment ratio forecasts on various demand growth assumptions.

3.4. Mortality rates

The mortality rates used in this study were those established separately for Danish male and female physicians, which did not differ substantially from mortality rates in those countries where they were known (Sweden, United Kingdom and The Netherlands).

4. RESULTS AND EXPLANATION

4.1. Description of European Medical Manpower 1994

The findings which are pertinent to a description of the collective European stock of physicians as of January 1994 have been summarized in tables 1, 2 and 3; some of these findings have been further detailed on individual countries in table 4.

By January 1994, the number of professionally active physicians was 1.158 million (which includes two new countries Estonia and Lama) of which 34% were women and 87.950 (7,53%) were

a possible net-immigration factor, which we assume to be negligible. It appears from the table that the annual addition to the stock, *ceteris paribus*, will decrease slowly during the present decade. Further, it is remarkable how well the prediction from the 1991 study is in accordance with the real 1994 increase (In 1991, the expected increase was 38.286 and the real figure is 38.838).

Table 3. Assumed age-dependent decrease in compound activity ratio of total medical population

Age interval	Men	Women
55–59	0.894	0.835
60–64	0.672	0.577
65–69	0.299	0.183
70–74	0.114	0.023
75–79	0.024	0.002
80–84	0.0	0.0

The retirement trends in Europe are similar to the figures from the 1991 study. It is acceptable to use the same figures again because the actual situation probably will show a generally decreasing retirement age. By using the old figures, we probably have a too low retirement frequency and, thereby a marginally higher manpower stock.

Based on the information contained in tables 1, 2, and 3, projections of the collective European manpower supply may be obtained by the algorithm described earlier.

4.2. Prognosis for manpower supply 1994–2004

In figure 2, European medical manpower supply has been projected by using the data described in the previous section as

Table 1. Prospective annual additions to European manpower stock (University output). All entrants assumed to be aged 25–29

Year	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
University output	38.883	37.077	35.796	34.098	32.951	29.313	29.526	26.561	26.194	25.833

Table 2. Population description 1994: assumed values for initialising the prognosis

Total Medical Population (TMP), Women fraction	1.357 million —
Professional active Manpower (PAM), Women fraction	1.148 million 0.31
Physician unemployment as fraction of PAM	87.950 0.075
Temporary inactivity, fraction	0.03

unemployed physicians.

In order to predict future growth of the medical workforce, it is indispensable to know the annual output from universities/medical schools. Assessment of this parameter for each country was based on knowledge of government targets for student intake or the passing of an examination after the first year (*numerus clausus*). Table 1 gives the total sum of the expectations for each country and thus represents the expected total annual addition to the European Manpower stock, excluding the contribution from

input to the prognosis model. Both the total stock of live physicians including those retired, and the active workforce is going to increase further. However, it is evident from the slope of the curves that the growth of supply is getting progressively slower during the period. Again, it is remarkable how well the prognosis of the 1991 study predicted the actual situation in 1994.

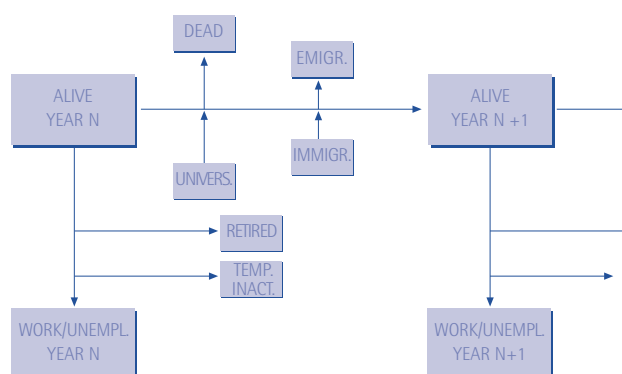


Figure 1. The supply algorithm applied in the PWG Manpower Study.

The manpower curve of the 1991 study predicts that the manpower stock in 1994 will be around 1.14 million, which is absolutely correct calculating the 1994 stock to be 1.148 million. The growth in manpower stock is still expected to be almost zero after the year 2000. The curve gets almost horizontal after year 2000, indicating almost non-growth.

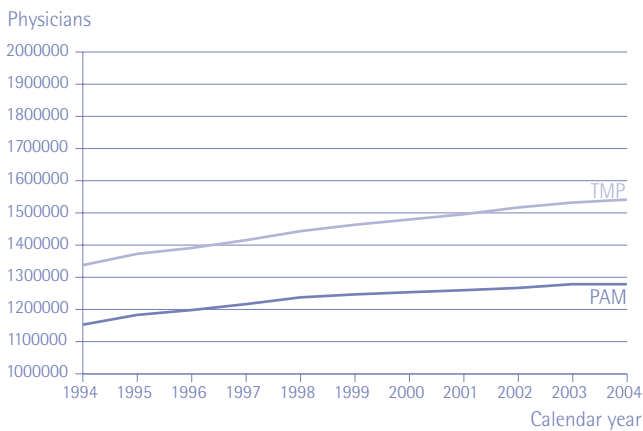


Figure 2. Predicted growth of European physician supply 1994–2004.

In Figure 3, the prospective annual rate of growth of the workforce has been calculated on selected calendar years. The figure displays a rapid decline from 1,98% in 1995 over 0.72 by the turn of the century and 0.09 by the end of the prognosis period. The figures of the 1991 study for the same years were 1,85%, 0,6% and less than 0,1%. Again we must conclude that the 1991 prognosis seems to hold.

The fraction of women physicians will continue to increase from 31% to around 34%.

Figure 4 shows the projected age distribution of the workforce as a function of 5-year intervals in time, compared with the present (1994) distribution. The curves show a pronounced "right" – shift with time, which reflects the progressively decreasing numbers in the lower age categories, and progressively increasing numbers in the higher age categories. This trend can be termed the "seniorisation" of the medical workforce.

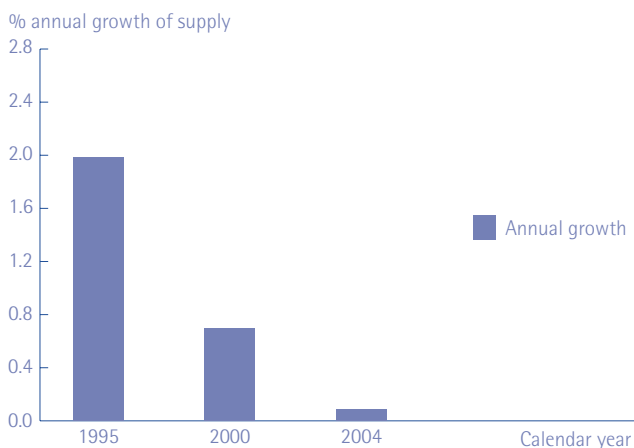


Figure 3. Predicted annual growth rate of European medical manpower related to selected calendar years.

4.3. The balance between supply and demand

In Figure 6, the conditions for an emerging of equilibrium between supply and demand during the nineties have been analyzed by studying the effect of various demand-growth assumptions (1,5; 2; 2,5 and 3% p.a.) against the projection of

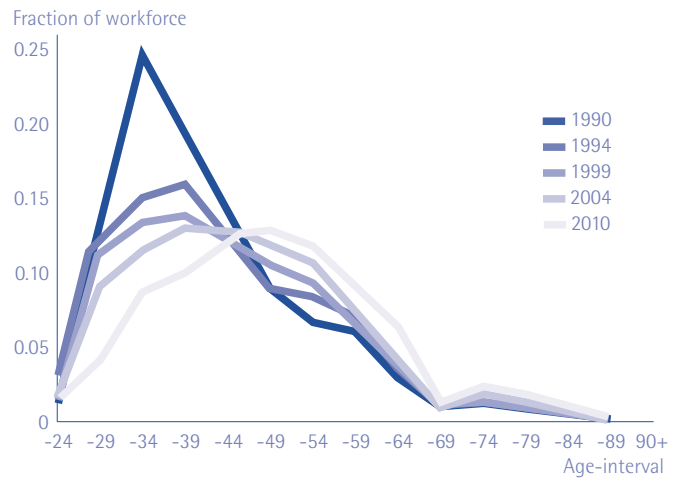


Figure 4. Predicted distribution of manpower on 5-year intervals for 1999, 2004 and 2010 compared with 1990 and 1994 distributions.

supply growth which we obtained in this study. The graph displays, as function of time, the result of the calculation $x = (\text{supply} - \text{demand})$. If $x > 0$, there is an excess of supply over demand, i.e. unemployment. If $x < 0$ there will be unfilled posts (vacancies). If $x = 0$ demand meets supply (equilibrium). There is at present (1994) an excess of supply over demand corresponding to approximately 87.950 physicians which is reflected at the origin of the curves.

With an average growth of 1,5% p.a., unemployment will increase, but after approximately 4 years (1998–1999) will decline. An aggregated demand growth rate of 2% p.a. will immediately diminish the surplus of doctors and will eventually establish balance between demand and supply at the beginning of the next century. The critical growth rate which would establish equilibrium by the year 2000 was, in the 1991 study, calculated to be approximately 2,3%. However, the growth in employment in the period was approximately 2,0%¹ which resulted in an increase of unemployment (the physician surplus increased from 64.500 in 1991 to 87.950 in 1994), which was also predicted would happen if growth was only 2% p.a. If this growth continues, equilibrium will be reached in 2003.

The annual critical demand growth rate necessary to secure equilibrium by the end of the century is increased from the previous study until now. The necessary demand growth rate p.a. has been calculated to be 2,7% p.a., a slight increase from the 2,3% p.a. in the earlier study. This increase is explained by the fact that the actual growth between 1990 and 1994 never reached the necessary level as described above.

¹ The European Commission: Employment in Europe, Luxembourg 1995, p. 60 (graph 49).

4.4. A comparison between individual countries

4.4.1 Physician unemployment

In Table 4, a number of findings concerning the countries included in the study are summarized. Physician unemployment is very unequally distributed amongst the countries studied ranging from shortage and modest unemployment in the Baltic region to relatively high unemployment figures in Germany, Spain, The Netherlands, Austria and Italy. These countries account for almost all unemployed physicians (Figure 7). However, they also account for the major part of physicians in Europe – approximately 62%.

As a result of the very unequal distribution of physician unemployment in Europe, it is interesting to investigate how the situation would develop not including the unemployed Italian physicians (Figure 8).

Figure 8 reveals that an annual critical demand growth of 2,3% will establish equilibrium by the turn of the century.

4.4.2 Critical prospective demand growth

As with unemployment, the critical demand growth (i.e. the demand growth that might consume all existing unemployment as well as new additions to the stock before the end of the investigated period) varies considerably from the weighed average (2,7% p.a.).

In Italy, Finland, Austria and Spain the critical demand growth p.a. would have to be between 2,76% p.a. and 5,5% p.a. for the remainder of the nineties to secure equilibrium by the year 2000, while Sweden, Germany and The Netherlands would all need a critical demand growth under the European weighed average in order to achieve near-balance by the end of the century. Although Germany would require an annual demand growth rate just above the EUR16 demand growth rate (Figure 9).

Table 4. Synopsis of data concerning individual countries

	Manpower	Pop doc ¹	Supply Intensity ²	Unemployed (% or workforce)	Critical demand gr. 1994–2000 ³
The Baltic Nordic region					
Estonia	5.255		1.6	–	-3.3
Latvia	7.992		3.9	–	1.8
Denmark	15.000	358	3.1	- 2.6	0.6
Finland	13.809	368	3.25	2.6	2.76
Norway	10.658	384	2.8	0.1	1.6
sweden	26.153	335	2.6	2.2	1.8
Iceland	811		3.46	0	1.73
The North-West Region					
Ireland	5.858	610	0.9	0	-4.6
United Kingdom	113.136	510	2.46	-0.9	0.08
Netherlands	37.179	414	2.26	4.6	1.5
The West Region					
France (est.)	180.322	321	–	0.5	1.6
Belgium	–	–	–	–	–
The Central Region					
Austria	25.663	313	3.1	8.9	3.6
Germany	285.923	282	2.65	5.2	2.5
Switzerland	24.793	–	5.9	1.3	3.7
The South Region					
Italy (est.)	247.021	231	–	24.5 ⁵	5.5
Portugal	22.621	437	1.4	0	-0.2
Spain	126.017	310	2.8	4.7	2.96
Greece	–	–	–	–	–
All Countries	1.148.211	314 (w)	2.72 (w)⁶	7.56 (w)⁴	2.7 (w) 2.3 (w)⁷

¹ Ratio: heads of general population per head of active physicians.

² Mean annual prospective (1994–2004) addition to stock as percent of workforce 1994.

³ Defined as the average annual demand growth 1994–2000 which would be necessary to consume prospective supply growth as well as existing surplus of manpower by the year 2000.

⁴ Vacancies are not included in the average.

⁵ The Lancet, vol. 346, December 9, 1995. p.1552

⁶ Excluding France and Italy (figures not available).

⁷ Calculating the critical demand growth rate excluding the Italian figures.

Negative values can occur concerning the critical demand growth. When the number of professionally active is declining (Estonia, Ireland and Portugal).

4.4.3 Supply intensity

By "supply intensity" is understood the annual input of new physicians to a country's manpower stock, expressed as percentage of existing stock. *Ceteris paribus*, it is to be expected that countries with high unemployment figures will reduce the supply intensity either through restrictions at university level or market mechanisms.

4.4.4 Physician density

We found the European average doctor-patient ratio by 1994 to be 314. It is possible to identify a set of high density countries: Austria, Germany, Italy and Spain. Low density countries are United Kingdom, Ireland, The Netherlands and Portugal. The rest of the countries vary between 320–400. The density in

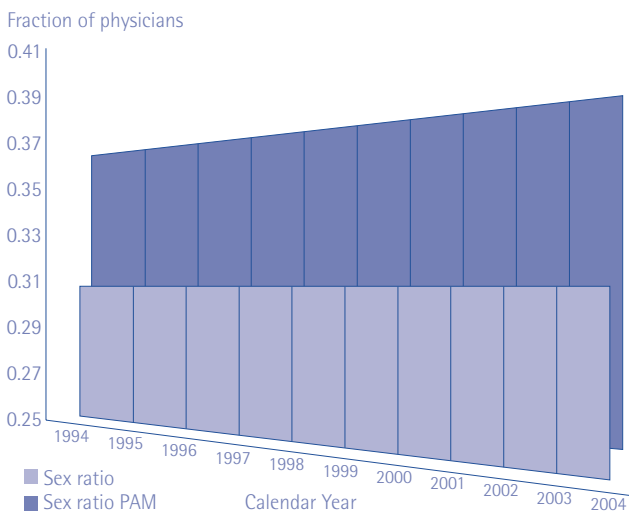


Figure 5. Predicted change in proportion of women physicians to all physicians 1994–2004.

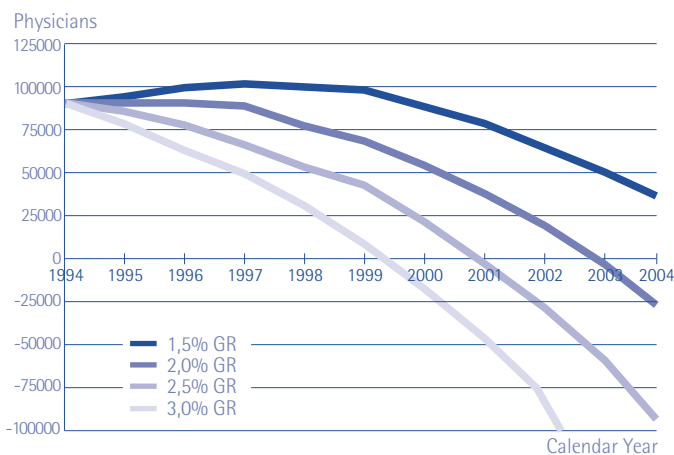


Figure 6. Predicted surplus/deficit of physicians 1994–2004 on various demand growth assumptions.

Germany increased drastically in the period between the previous study and this study. This is due to the relative increase of physicians as a result of the reunification of Germany.

4.4.5 Women physicians

An increasing proportion of women physicians was found in all

countries with the exception of Lama and Estonia which due to former Soviet Union policies and traditions already have a high proportion of women physicians and predictably will experience a decline in their proportion.

In almost all countries the percentage of women in the workforce reached 30–35%, while in some countries the proportion was above 40%, namely Spain and Finland, and in Portugal even above 50%.

5. DISCUSSION

Any conclusions to be drawn from our findings would have to take into account the uncertainty which might be attached to the raw data concerning each country. With some countries, e.g. Italy and France, there is a degree of uncertainty because the data are based on the projections made in the 1991 study. The reason for accepting such estimates is simply that no better estimates were available and it has been shown that the prognosis model is very exact.

In addition to these concerns, the fact that data are missing from Belgium and Greece is, of course, a problem. Their participation would obviously make the results more valid, but on the other hand, all considered, their inclusion would only have a limited effect on the overall picture. The remaining data concerning the size and age and sex distribution of the medical population should not cause any problems. They stem from the single most representative association in the country and the data are not contested to any significant degree at home.

Retirement patterns all over Europe are generally known for the publicly employed physicians. For self employed physicians the trend is more uncertain. In any event, the errors occurring as a result of these uncertainties will be marginal. In some countries,

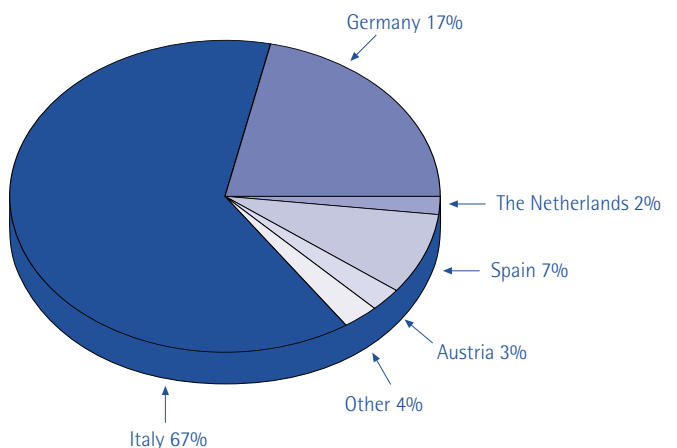


Figure 7. Distribution of physician unemployment according to country 1994.

the most recent trend is that the retirement age is falling and by using the "old" retirement trends, we tend to underestimate the effect of an earlier retirement trend, thereby only expanding the time axis (Reaching equilibrium at a later stage).

In most of the countries involved in this study, the input and output of universities is administered and regulated by the government. It is of course very difficult to be sure that the policies

on the intake and output are not changed, but if policies are changed, the effect will take place at a later stage because of the long production time of a doctor.

5.1. Evaluation of the prognosis model

One of the main purposes of updating the previous PWG manpower study was to investigate the predicted trend of a decline in the supply of physicians and whether it is realistic to expect equilibrium, nearbalance or even a shortage of physicians by the turn of the century. When trying to answer these questions, we would automatically evaluate the prognosis model developed by PWG in 1991. To our satisfaction, it seems that the predictions/projections made in 1991 can be confirmed by the actual figures for 1994.

The growth of the medical manpower stock is very close to the one expected in 1991. The annual growth rates of the manpower stock for the years 1995, 2000 and 2004 are along the lines proposed in 1991. The age distribution is following the "right" – movement predicted in the previous study and finally the curves showing the decrease of the medical manpower surplus and eventually establishing equilibrium. However, it seems that the equilibrium will not be reached by the turn of the century, but has been postponed approximately 3 years. The critical demand growth rate calculated in 1991 was to be 2,3% in order to establish equilibrium by the turn of the century. The actual demand growth rate has been approximately 2%² resulting in an increase of unemployment from 1991–1994, thereafter decreasing, thus postponing equilibrium to 2003 with a continued demand growth rate of 2% p.a. When excluding Italy from the calculation, a continued annual demand growth of 2,3% will secure equilibrium by the end of this century (Figure 8).

² Ibid p. 60

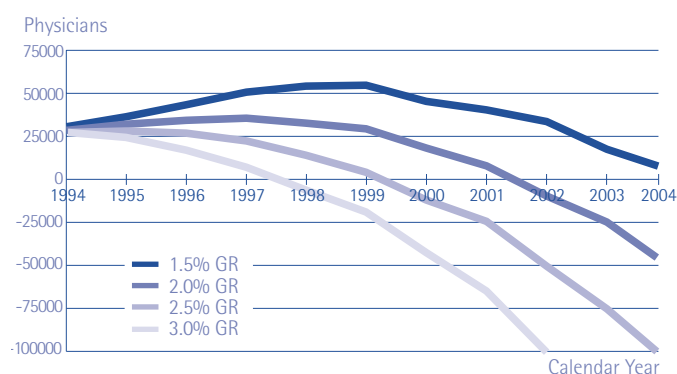


Figure 8. Estimated surplus/deficit of physicians on various demand growth assumptions 1994–2004, excluding the Italian figures.

The conclusion drawn from the study in 1991 seems still to be valid. The trend is that for the first time since World War II, there is a possibility of having equilibrium at the beginning of the next century. The growth of the manpower stock by the end of the prognosis period will be close to zero (0,09%). That a negative growth should occur is highly unlikely because the output from the universities will not remain at the same level. There are countries in which the size of the medical manpower

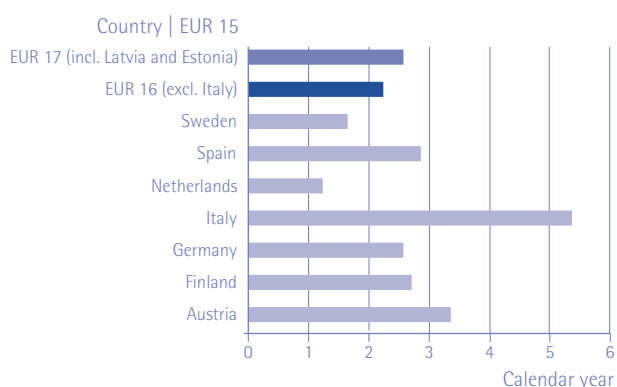


Figure 9. Prospective critical demand growth in countries affected by unemployment (above 2%), compared with European weighed average.

will be reduced in the coming years, *ceteris paribus*, Portugal, Ireland and Estonia.

The increase of women physicians will continue and be very close to 35% by the end of the investigated period. In every country, there is an increasing trend, except for the two newly included countries Estonia and Latvia, where, due to policies and traditions in the former Soviet Union, the fraction of women is above 80%, but falling. Together with the increasing fraction of women, every country is experiencing an "aging" of the medical population.

For each of the countries still suffering from high unemployment rates, reaching equilibrium is still a distant dream. It is the same countries which suffer from mass unemployment in 1994 as in 1991 (Italy, Spain, Austria and Germany) and it will demand high demand growth rates to establish equilibrium within the next ten years. The Netherlands also has a mass unemployment problem, but contrary to the above countries, it seems that an expectable demand growth rate of 1,5% will reduce the problem in the near future. The latter change can be explained by the reduced supply intensity from 1990 to now (from 3.61 to 2.26).

During the recession from 1990–1994, other countries experienced an increase in unemployment (Finland and Sweden), but with a demand growth rate below 2% p.a., it is probable they will restore equilibrium within a short term period.

For countries with a current minor unemployment, it is very unlikely that they will experience a drastic growth in unemployment within the medical profession.

6. CONCLUSION

The previous manpower study concluded that it would be reasonable to expect a reversal of fundamental trends.

1. The supply of physicians would no longer outnumber the exit from the manpower stock. The 1991 study predicted a decline in the growth of the supply of physicians. This prediction has been confirmed by this second study.
2. The expected aging of the medical manpower population has been confirmed by this study.

- 058 3. The previous manpower study recommended countries with gross unemployment to reduce the intake to, medical schools. A reduction has taken place in Germany and The Netherlands resulting in an improved situation where annual demand growth rates below the weighed European average will secure equilibrium by the turn of the century.

Thus the long established trend of oversupply of physicians in Europe is changing and equilibrium can be expected, as predicted by the 1991 study. If a demand growth of 2% p.a. is anticipated to continue, Europe will experience a declining unemployment rate among physicians. If the Italian figures are excluded, it is realistic to expect equilibrium close to the turn of the century.

Corrected

Results of Questionnaire Migration of Doctors from Eastern Europe

February 1994

INTRODUCTION

At the PWG meeting in Dublin in October 1992, it was decided to issue a questionnaire concerning migration of East European Doctors to Western Europe.

18 out of 19 delegations answered the questionnaire – we have not heard from the delegates of Portugal – and 2 among the 18 delegations stated that they were at the moment not able to answer the questionnaire (Switzerland and Sweden). The rest of the delegates have answered the questionnaire with the figures they were able to obtain.

The questionnaire posed 3 main questions:

1. How many authorizations were granted to doctors with diplomas from Eastern Europe in the period 1989–1992.
2. If possible, state how many of these authorizations were permanent and how many were temporary.
3. Indicate the number of authorizations from each of the East European countries.

In the following section we will reproduce the figures from each country with a few comments.

RESULTS

Country: **AUSTRIA**

Country/Year	89	90	91	92	89–92	90–92
East Euro. Auth.					0	0
Permanent Auth.					818	614
Temporary Auth.					390	293
Albani					0	0
Bulgaria					31	23
Czechoslovakia					263	197
Croatia					0	0
Estonia					0	0
Hungary					97	73
Latvia					0	0
Lithuania					0	0
Poland					221	166
Rumania					86	65
Russia					0	0
Serbia					0	0
Slovenia					0	0
Ukraine					0	0
(former) USSR					25	19
White Russia					0	0
(former) Yugoslavia					95	71
Total	0	0	0	0	818	614

- Manpower according to PWG Manpower Report **21.572**
- East European Authorizations in % of manpower (90-92 permanent East auth./manpower) **2,84%**
- East European Authorizations in % of manpower (90-92 temporary East auth./manpower) **1,36%**

Note: The Austrian delegates have been unable to specify the figures for each of the years 1989–92. The figures in the 90–92 column are calculated on the basis of the 82–92 figures.

Comment: The level of immigration of East European doctors is about 1–3 %, especially from Czechoslovakia and Poland.

Country: **BELGIUM**

Country/Year	89	90	91	92	89-92	90-92
East Euro. Auth.					0	0
Permanent Auth.					0	0
Temporary Auth.					0	0
Albani					0	0
Bulgaria					0	0
Czechoslovakia					0	0
Croatia					0	0
Estonia					0	0
Hungary					0	0
Latvia					0	0
Lithuania					0	0
Poland					0	0
Rumania					0	0
Russia					0	0
Serbia					0	0
Slovenia					0	0
Ukraine					0	0
(former) USSR					0	0
White Russia					0	0
(former) Yugoslavia					0	0
Total	0	0	0	0	0	0

- Manpower according to PWG Manpower Report **35.000**
- East European Authorizations in % of manpower (90-92 permanent East autho./manpower) **0,00%**
- East European Authorizations in % of manpower (90-92 temporary East autho./manpower) **0,00%**

Comment: The information gathered by the Belgian Ministry of Public Health cannot be related to East European doctors.

Country: **DENMARK**

Country/Year	89	90	91	92	89-92	90-92
East Euro. Auth.	4	8	5	9	26	22
Permanent Auth.	4	8	5	9	26	22
Temporary Auth.					0	0
Albani					0	0
Bulgaria					0	0
Czechoslovakia		1			1	1
Croatia					0	0
Estonia					0	0
Hungary					0	0
Latvia					0	0
Lithuania					0	0
Poland	2	5	2	5	14	12
Rumania	1	2	2	1	6	5
Russia					0	0
Serbia					0	0
Slovenia					0	0
Ukraine					0	0
(former) USSR	1		1	1	3	2
White Russia					0	0
(former) Yugoslavia				2	2	2
Total	4	8	5	9	26	22

- Manpower according to PWG Manpower Report **14.505**
- East European Authorizations in % of manpower (90-92 permanent East autho./manpower) **0,15%**
- East European Authorizations in % of manpower (90-92 temporary East autho./manpower) **0,00%**

Note: Number of temporary authorizations not available.

Comment: The level of immigration from East European countries is low and insignificant.

Country: **FINLAND**

Country/Year	89	90	91	92	89-92	90-92
East Euro. Auth.		100	175	178	453	453
Permanent Auth.		10	10	10	40	30
Temporary Auth.		90	165	168	423	423
Albani					0	0
Bulgaria				6	6	6
Czechoslovakia					0	0
Croatia					0	0
Estonia		41	81	85	207	207
Hungary		10	10	8	28	28
Latvia					0	0
Lithuania			2	0	2	2
Poland		23	32	30	85	85
Rumania					0	0
Russia		30	54	49	133	133
Serbia					0	0
Slovenia					0	0
Ukraine					0	0
(former) USSR					0	0
White Russia					0	0
(former) Yugoslavia					0	0
Total		104	179	178	461	461

- Manpower according to PWG Manpower Report **12.317**
- East European Authorizations in % of manpower (90-92 permanent East auth./manpower) **0,24%**
- East European Authorizations in % of manpower (90-92 temporary East auth./manpower) **3,43%**

Note: Data from 1989 not available.

Note: Data from each year are status – not newcomers.

Comment: As mentioned above, the figures from Finland do not give the annual number of authorizations granted. Still, it is possible to state that there are no significant changes over the years i.e. no growth during the last 2-4 years. This may be due to the current serious unemployment situation.

Country: **FRANCE**

Country/Year	89	90	91	92	89-92	90-92
East Euro. Auth.						0
Permanent Auth.	17	4	4	4	29	0
Temporary Auth.						0
Albani						0
Bulgaria						0
Czechoslovakia						0
Croatia						0
Estonia						0
Hungary						0
Latvia						0
Lithuania						0
Poland						0
Rumania						0
Russia						0
Serbia						0
Slovenia						0
Ukraine						0
(former) USSR						0
White Russia						0
(former) Yugoslavia						0
Total						0

- Manpower according to PWG Manpower Report **164.022**
- East European Authorizations in % of manpower (90-92 permanent East auth./manpower) **0,01%**
- East European Authorizations in % of manpower (90-92 temporary East auth./manpower) **0,00%**

Note: Temporary authorizations are never issued.

Comment: The level of immigration is very low and insignificant.

Country: **GERMANY**

Country/Year	89	90	91	92	89-92	90-92
East Euro. Auth.	1445	1453	1414	1437	5749	4204
Permanent Auth.				0	0	0
Temporary Auth.				0	5749	4304
Albani					0	0
Bulgaria					0	0
Czechoslovakia	290	276	247	150	1084	794
Croatia					0	0
Estonia					0	0
Hungary	143	149	148	144	587	444
Latvia					0	0
Lithuania					0	0
Poland	419	426	418	428	1684	1265
Rumania	203	225	237	261	887	684
Russia					0	0
Serbia					0	0
Slovenia					0	0
Ukraine					0	0
(former) USSR				105	0	0
White Russia					0	0
(former) Yugoslavia	390	377	364	359	1508	1118
Total	1445	1453	1414	1447	5749	4304

- Manpower according to PWG Manpower Report **192.480**
- East European Authorizations in % of manpower (90-92 permanent East autho./manpower) **0,00%**
- East European Authorizations in % of manpower (90-92 temporary East autho./manpower) **2,24%**

Comment: In general, authorizations are temporary – a small part of them may be permanent. Germany is the CP country with the highest number of East European doctors, with a level of about 2-3%, primarily from Czechoslovakia, Poland, and the former Yugoslavia.

Country: **GREECE**

Country/Year	89	90	91	92	89-92	90-92
East Euro. Auth.			10	11	21	21
Permanent Auth.				0	0	0
Temporary Auth.			10	11	21	21
Albani					0	0
Bulgaria				2	2	2
Czechoslovakia				1	1	1
Croatia					0	0
Estonia					0	0
Hungary					0	0
Latvia					0	0
Lithuania					0	0
Poland				1	1	1
Rumania			10	4	14	14
Russia					0	0
Serbia					0	0
Slovenia					0	0
Ukraine					0	0
(former) USSR					0	0
White Russia				3	3	3
(former) Yugoslavia					0	0
Total			10	11	21	21

- Manpower according to PWG Manpower Report **35.000**
- East European Authorizations in % of manpower (90-92 permanent East autho./manpower) **0,00%**
- East European Authorizations in % of manpower (90-92 temporary East autho./manpower) **0,06%**

Note: The numbers are only from the Medical Association in Athens. The numbers from the other parts of Greece – particularly from the North – are supposedly larger.

Country: ICELAND

Country/Year	89	90	91	92	89-92	90-92
East Euro. Auth.					4	4
Permanent Auth.					0	0
Temporary Auth.					4	4
Albani					0	0
Bulgaria					0	0
Czechoslovakia					0	0
Croatia					0	0
Estonia					0	0
Hungary					0	0
Latvia					0	0
Lithuania					0	0
Poland					0	0
Rumania					0	0
Russia					0	0
Serbia					0	0
Slovenia					0	0
Ukraine					0	0
(former) USSR					0	0
White Russia					0	0
(former) Yugoslavia					0	0
Total					0	0

- Manpower according to PWG Manpower Report **743**
- East European Authorizations in % of manpower (90-92 permanent East auth./manpower) **0,00%**
- East European Authorizations in % of manpower (90-92 temporary East auth./manpower) **0,54%**

Comment: The level is low and insignificant.

Country: IRELAND

Country/Year	89	90	91	92	89-92	90-92
East Euro. Auth.	2	3	1	2	8	6
Permanent Auth.					0	0
Temporary Auth.	2	3	1	2	8	6
Albani					0	0
Bulgaria	1				1	0
Czechoslovakia				1	1	1
Croatia					0	0
Estonia					0	0
Hungary		2		1	3	3
Latvia					0	0
Lithuania					0	0
Poland		1	1		2	2
Rumania	1				1	0
Russia					0	0
Serbia					0	0
Slovenia					0	0
Ukraine					0	0
(former) USSR					0	0
White Russia					0	0
(former) Yugoslavia					0	0
Total	2	3	1	2	8	6

- Manpower according to PWG Manpower Report **5.571**
- East European Authorizations in % of manpower(90-92 permanent East auth./manpower) **0,00%**
- East European Authorizations in % of manpower (90-92 temporary East auth./manpower) **0,11%**

Comment: The level is low and insignificant.

Country: ITALY

Country/Year	89	90	91	92	89-92	90-92
East Euro. Auth.					0	0
Permanent Auth.					0	0
Temporary Auth.					0	0
Albani					0	0
Bulgaria					0	0
Czechoslovakia					0	0
Croatia					0	0
Estonia					0	0
Hungary					0	0
Latvia					0	0
Lithuania					0	0
Poland					0	0
Rumania					0	0
Russia					0	0
Serbia					0	0
Slovenia					0	0
Ukraine					0	0
(former) USSR					0	0
White Russia					0	0
(former) Yugoslavia					0	0
Total	0	0	0	0	0	0

- Manpower according to PWG Manpower Report **220.265**
- East European Authorizations in % of manpower (90-92 permanent East autho./manpower) **0,00%**
- East European Authorizations in % of manpower (90-92 temporary East autho./manpower) **0,00%**

Comment: The delegation from Italy has noted that there are no exact data on migration of doctors from Eastern Europe into Italy.

A rough estimate gives a number around 800, primarily from Hungary, Slovenia, and Albania.

Country: LUXEMBOURG

Country/Year	89	90	91	92	89-92	90-92
East Euro. Auth.					0	0
Permanent Auth.					0	0
Temporary Auth.					0	0
Albani					0	0
Bulgaria					0	0
Czechoslovakia					0	0
Croatia					0	0
Estonia					0	0
Hungary					0	0
Latvia					0	0
Lithuania					0	0
Poland					0	0
Rumania					0	0
Russia					0	0
Serbia					0	0
Slovenia					0	0
Ukraine					0	0
(former) USSR					0	0
White Russia					0	0
(former) Yugoslavia					0	0
Total	0	0	0	0	0	0

- Manpower according to PWG Manpower Report not available
- East European Authorizations in % of manpower (90-92 permanent East autho./manpower) **ERR**
- East European Authorizations in % of manpower (90-92 temporary East autho./manpower) **ERR**

Note: To date, we have been unable to get figures for the entire medical population.

Note: No authorizations have been issued to East European doctors in the stated period.

Country: **MALTA**

Country/Year	89	90	91	92	89-92	90-92
East Euro. Auth.	4	3	2	4	13	9
Permanent Auth.					0	0
Temporary Auth.	4	3	2	4	13	9
Albani					0	0
Bulgaria					0	0
Czechoslovakia	3	2		1	6	3
Croatia					0	0
Estonia					0	0
Hungary					0	0
Latvia					0	0
Lithuania					0	0
Poland	1	1	2	2	6	5
Rumania					0	0
Russia					0	0
Serbia					0	0
Slovenia					0	0
Ukraine					0	0
(former) USSR					0	0
White Russia					0	0
(former) Yugoslavia		1			1	1
Total	4	4	2	3	13	9

- Manpower according to PWG Manpower Report not available
- East European Authorizations in % of manpower (90-92 permanent East auth./manpower) **ERR**
- East European Authorizations in % of manpower (90-92 temporary East auth./manpower) **ERR**

Note: To date, we have been unable to get figures for the entire medical population.

Country: **THE NETHERLANDS**

Country/Year	89	90	91	92	89-92	90-92
East Euro. Auth.						18
Permanent Auth.						18
Temporary Auth.						0
Albani						0
Bulgaria	1					1
Czechoslovakia		2	1			3
Croatia						0
Estonia						0
Hungary						0
Latvia						0
Lithuania						0
Poland	2	4	3			9
Rumania			2			2
Russia						0
Serbia						0
Slovenia						0
Ukraine						0
(former) USSR						0
White Russia	2		1			3
(former) Yugoslavia						0
Total	5	6	7	0	18	13

- Manpower according to PWG Manpower Report **29.867**
- East European Authorizations in % of manpower (90-92 permanent East auth./manpower) **0,06%**
- East European Authorizations in % of manpower (90-92 temporary East auth./manpower) **0,00%**

Comments: The Netherlands have issued surprisingly few authorizations to East European doctors. The level is low and insignificant.

Country: **NORWAY**

Country/Year	89	90	91	92	89-92	90-92
East Euro. Auth.	0	49	50	8	107	107
Permanent Auth.	0	0	0	0	0	0
Temporary Auth.	0	49	50	8	107	10
Albani					0	0
Bulgaria		1			1	1
Czechoslovakia		3	2		5	5
Croatia					0	0
Estonia					0	0
Hungary			1		1	1
Latvia				1	1	1
Lithuania					0	0
Poland		40	41	3	84	84
Rumania		1	3	1	5	5
Russia					0	0
Serbia					0	0
Slovenia					0	0
Ukraine					0	0
(former) USSR			1		1	1
White Russia					0	0
(former) Yugoslavia		4	2	3	9	9
Total	0	49	50	8	107	107

- Manpower according to PWG Manpower Report **11.588**
- East European Authorizations in % of manpower (90-92 permanent East autho./manpower) **0,00%**
- East European Authorizations in % of manpower (90-92 temporary East autho./manpower) **0,92%**

Comments: Only relatively few authorizations have been issued, mainly to Polish doctors. In general, the level is low and insignificant.

Country: **PORTUGAL**

Country/Year	89	90	91	92	89-92	90-92
East Euro. Auth.						0
Permanent Auth.						0
Temporary Auth.						0
Albani						0
Bulgaria	1	1	1		3	2
Czechoslovakia			1		1	1
Croatia					0	0
Estonia					0	0
Hungary					0	0
Latvia					0	0
Lithuania					0	0
Poland					0	0
Rumania					0	0
Russia	1	4	4	4	13	12
Serbia					0	0
Slovenia					0	0
Ukraine					0	0
(former) USSR					0	0
White Russia					0	0
(former) Yugoslavia	1				1	0
Total						18
						15

- Manpower according to PWG Manpower Report **24.503**
- East European Authorizations in % of manpower (90-92 permanent East autho./manpower) **0,00%**
- East European Authorizations in % of manpower (90-92 temporary East autho./manpower) **0,00%**

Note: The Portuguese delegates have been unable to specify the figures for each of the years 1989-1992. The figures in the 90-92 column are calculated on the basis of the 82-92 figures.

Country: **SPAIN**

Country/Year	89	90	91	92	89-92	90-92
East Euro. Auth.	1	3	3	11	18	17
Permanent Auth.					0	0
Temporary Auth.					0	0
Albani				1	1	1
Bulgaria					0	0
Czechoslovakia			1		1	1
Croatia					0	0
Estonia					0	0
Hungary			1		1	1
Latvia					0	0
Lithuania					0	0
Poland	1	1		1	3	2
Rumania				7	7	7
Russia		1		2	3	3
Serbia					0	0
Slovenia					0	0
Ukraine					0	0
(former) USSR					0	0
White Russia					0	0
(former) Yugoslavia		1	1		2	2
Total	1	3	3	11	18	17

- Manpower according to PWG Manpower Report **131.684**
- East European Authorizations in % of manpower (90-92 permanent East auth./manpower) **0,00%**
- East European Authorizations in % of manpower (90-92 temporary East auth./manpower) **0,00%**

Comments: The level is very low and insignificant.

Country: **SWEDEN**

Country/Year	89	90	91	92	89-92	90-92
East Euro. Auth.						0
Permanent Auth.						0
Temporary Auth.						0
Albani						0
Bulgaria						0
Czechoslovakia						0
Croatia						0
Estonia						0
Hungary						0
Latvia						0
Lithuania						0
Poland						0
Rumania						0
Russia						0
Serbia						0
Slovenia						0
Ukraine						0
(former) USSR						0
White Russia						0
(former) Yugoslavia						0
Total	0	0	0	0	0	0

- Manpower according to PWG Manpower Report **23.565**
- East European Authorizations in % of manpower (90-92 permanent East auth./manpower) **0,00%**
- East European Authorizations in % of manpower (90-92 temporary East auth./manpower) **0,00%**

Comments: The Swedish delegation informs that it is not possible to obtain this kind of information in Sweden.

Country: **SWITZERLAND**

Country/Year	89	90	91	92	89-92	90-92
East Euro. Auth.					0	0
Permanent Auth.					0	0
Temporary Auth.					0	0
Albani					0	0
Bulgaria					0	0
Czechoslovakia					0	0
Croatia					0	0
Estonia					0	0
Hungary					0	0
Latvia					0	0
Lithuania					0	0
Poland					0	0
Rumania					0	0
Russia					0	0
Serbia					0	0
Slovenia					0	0
Ukraine					0	0
(former) USSR					0	0
White Russia					0	0
(former) Yugoslavia					0	0
Total	0	0	0	0	0	0

- Manpower according to PWG Manpower Report **20.584**
- East European Authorizations in % of manpower (90-92 permanent East autho./manpower) **0,00%**
- East European Authorizations in % of manpower (90-92 temporary East autho./manpower) **0,00%**

Note: Data only available from cantons.

Note: National data will probably follow.

Country: **UNITED KINGDOM**

Country/Year	89	90	91	92	89-92	90-92
East Euro. Auth.		79	98	121	298	298
Permanent Auth.						
Temporary Auth.		79	98	121	298	298
Albani					0	0
Bulgaria		3	6	4	13	13
Czechoslovakia		8	7	11	26	26
Croatia					0	0
Estonia					0	0
Hungary		11	18	21	50	50
Latvia					0	0
Lithuania					0	0
Poland		26	30	25	81	81
Rumania		10	10	15	35	35
Russia					0	0
Serbia					0	0
Slovenia					0	0
Ukraine					0	0
(former) USSR		14	15	29	58	58
White Russia					0	0
(former) Yugoslavia		7	12	16	35	35
Total	0	79	98	121	298	298

- Manpower according to PWG Manpower Report **101.396**
- East European Authorizations in % of manpower (90-92 permanent East autho./manpower) **0,00%**
- East European Authorizations in % of manpower (90-92 temporary East autho./manpower) **0,0029%**

Note: Number of permanent authorizations not available. Data from 1989 are not available.

Comment: The level is low and insignificant.

CONCLUDING REMARKS

Many of the delegates have raised questions as to the validity of the data deriving from their own country – and the problem of validity is evident in this survey. E.g. some of the countries are not able to give data on the permanent authorizations, others not for the temporary. Some seem not to register whether the data concerns one or the other etc.

The conclusions of this survey, therefore, have to be made with this enormous spread in data quality in mind.

TOTAL:

Country/Year	89	90	91	92	89-92	90-92
East Euro. Auth.	1456	1698	1758	1721	6693	5237
Permanent Auth.	21	22	19	23	85	64
Temporary Auth.	6	224	326	314	6619	5168
Albani	0	0	0	1	1	1
Bulgaria	3	5	7	12	27	24
Czechoslovakia	293	292	259	164	1008	715
Croatia	0	0	0	0	0	0
Estonia	0	41	81	85	207	207
Hungary	143	172	178	174	667	524
Latvia	0	0	0	1	1	1
Lithuania	0	0	2	0	2	2
Poland	425	527	529	495	1976	1551
Rumania	205	238	264	289	996	791
Russia	1	35	58	55	149	148
Serbia	0	0	0	0	0	0
Slovenia	0	0	0	0	0	0
Ukraine	0	0	0	0	0	0
(former) USSR	1	14	17	135	167	166
White Russia	2	0	1	3	6	4
(former) Yugoslavia	390	390	379	380	1539	1149
Total	1464	1718	1775	1794	6747	5283

- Manpower according to PWG Manpower Report **1.054.662**
- East European Authorizations in % of manpower (90-92 permanent East auth./manpower) **0,01%**
- East European Authorizations in % of manpower (90-92 temporary East auth./manpower) **0,08%**

What can be said about the issue of East European doctors in the West European countries seems to be the following:

- most of the authorizations are given on a temporary basis. Relatively many countries simply do not give permanent authorizations to doctors from East Europe;
- if all doctors who have obtained a temporary authorization in 1989-1992 are still authorized at the moment, there would seem to be about 510.000 East European doctors working in the Western PWG-countries;
- estimated in percentage, this means that less than 1 percent of the doctors in Western Europe derives from Eastern Europe;
- the East European doctors are spread over many countries, the vast majority (almost two thirds) though being in Germany;
- in 10 of the 19 countries, the number of East European doctors is so small (nill or less than 1/2%) that it is hardly worth mentioning;
- there does not seem to be any growth in migration from the East European countries in the stated period;
- the East European doctors primarily derive from Czechoslovakia, Hungary, Poland, Rumania and former Yugoslavia.

Refugee Doctors in Europe

a PWG Survey and Report

by Kate Adams

The 20th century has seen populations displaced on an unprecedented scale. One country's displaced person is another country's asylum seeker and many European countries are struggling to cope with increased numbers of asylum seekers and refugees. Among the asylum seekers and refugees, are a number of doctors. Surely we should be helping these doctors use their skills in their adopted country? It makes not only moral but good economic sense to help this group of doctors. A number of European countries have shortages of doctors.

Refugee doctors share the problems of all asylum seekers and refugees. They have been forced to flee their homes, families and friends and arrive in a new country where they are isolated by language, culture and subject to unprovoked adverse publicity and racism in an increasingly xenophobic Europe. Many are forced to live in poverty. Due to the sheer numbers of asylum seekers, states such as the UK have adopted dispersal policies which means that asylum seekers and refugee doctors may be far from established national communities and support networks.

Problems faced by refugee doctors hoping to re-establish their medical careers are identified as follows

- Language difficulties
- Difficulty accessing appropriate information
- Documentation may have been lost
- Difficulty in securing references
- Training may have been interrupted
- They may be well advanced in their careers and have difficulty adjusting to the training and language requirements which will allow them to practise
- Poverty, isolation, no contact with family members or other support networks

These difficulties add to the trauma they may have experienced in their personal lives and which has led them to seek refuge. Refugee doctors are motivated professionals who want to contribute to the country that has given them shelter rather than depend on it.

Most refugee doctors when they first arrive in a new country feel they will never be able to practice as a doctor again.

PWG Survey on Refugee Doctors

This survey was initiated by the resolution made at the PWG meeting in Utrecht (October 2000), stating that the PWG "will develop a policy statement on the support and integration of refugee doctors into the medical workforce in the EU by using examples of best practise"

The following survey was sent to 15 countries in Europe. 10 replies.

The Survey

In the UK we define a refugee as being "Someone who has applied for asylum on the basis of a well-founded fear of being persecuted on the basis of race, religion, nationality, membership of a particular social group or political opinion, and who has been granted asylum under the terms of the 1951 UN Convention relating to the status of refugees or has been given exceptional permission to stay in the UK". We estimate there to be between 500 and 2000 refugee doctors currently in the UK.

1. Approximately how many refugee doctors are there in your country?
2. What process do refugee doctors need to go through in order to register and work as a doctor?
3. Are there any special initiatives to help refugee doctors in your country? If so please give details.

Table of Results

Country	Refugees Dr. Numbers	Doctor U/E Y/N	Registration process	Initiatives
AUSTRIA	20–100	Yes	Proof of medical studies / sufficient knowledge of German Surveillance bodies, medical training examined by specialist from AMA? Formal exam	No
DENMARK	200–300	? No	Danish National Board of Health is responsible for the evaluation of doctors' qualifications	DMA / Association of County Councils are establishing language courses for refugee doctors Local branch associations of DMA setting up clinical attachments Other initiatives at municipality / county level
FINLAND	20	Yes	3 part exam: I. Administration & legislation of Finnish health system II. Clinical medicine III. Practical medicine Exams are in Finnish. Then 6/12 practical training period	Ministry of Education provides help Help with linguistic skills
FRANCE	No specific concept of refugee Dr. Many overseas doctors from Sub Saharan / C Africa	Yes	Can work without MD in France but limited opportunities Discrimination	None
GERMANY	? However Germany has many refugees	Yes	Proof of qualification / evidence of work. Evidence of proficiency in German Exams for non EU doctors to be introduced 2001	Marburger Bund offers advice
HOLLAND	No exact data. 370 refugees doctors being supported by University Assistance Fund	No	Diploma must be recognised by Ministry of Health I. Recognition granted II. Nearly equivalent III. Non equivalent MSRC propose content / length of training required (6 month – 2 years). May be required to retrain. Once diploma recognised need permit which depends on status	UAF invests in refugees with good prospects. "Job support", a support fund to help find jobs for graduates SIBIO helps all foreign doctors find posts for additional training Barriers: • Language courses not adapted for doctors. Cultural input not valued
PORTUGAL	Drs from East / C. Europe not working as Drs. 1998 Drs. from ex-Portugal Guinea requested asylum	?	No details	None
SWEDEN	1000	Yes	Exams to test language, medical knowledge and clinical skills. Then enter pre-reg grade. If specialist must successfully complete a probationary 6/12 clinical placement	Courses to help refugee doctors pass exams. help for specialists to find probation period placements
SWITZERLAND	?	Yes	Required to pass federal medical exams although possibility of getting a job if haven't passed the federal exam	None
UK	500–2000	No	2 routes for Non EU doctors I. Pass exams testing language medical knowledge and clinical skills (IELTS and PLAB) Gain limited registration – equivalent to 1 st year SHO II. If have 5 years postgraduate experience in a specialty, can work in UK if sponsored by Royal Colleges / Need offer of job. Little flexibility	<ul style="list-style-type: none"> • Provision of information • Careers advice / mentoring • Support for exams, practical and financial • Clinical attachments • Exploring funded designated training post

Issues arising from results

- Poor data collection on refugee doctor numbers. Most countries do not collect data on the professional status of asylum seekers on arrival. Once in the country refugee doctors may be difficult to locate. People seeking asylum may be suspicious of data collection.
- Distinguishing refugee doctors as a separate group with special needs from "overseas doctors" i.e. non-EU. Refugee doctors may be viewed as part of the "overseas doctor" group. However they have separate needs and require added support to put them on a "level playing field" with other overseas doctors
- Language course provision and examination is hugely variable between countries. There are formal written and verbal examinations in some countries and no formal exams in others. Few specialist language courses are available in countries.
- Very few initiatives to help this group of doctors. However countries with significant numbers of refugee doctors and shortages of doctors i.e. Denmark, Holland, UK all have initiatives for refugee doctors.
- Difficulty in getting jobs/discrimination post registration.

Integrating Refugee Doctors — A Framework

1. Identification.

At the port of entry, most applicants are not recognised by profession.

Unless refugee doctors are identified, need cannot be highlighted. So that refugee doctors have the best chance of being able to re-establish their medical careers, this should be done at the earliest opportunity. Any database should be voluntary. National refugee groups and national medical associations are perhaps in the best position to co-ordinate this.

2. Information

It can be extremely difficult for refugee doctors to obtain information about routes to registration/exams. Their needs for information are similar to those of overseas doctors from non-EU countries. Refugee doctors also benefit from information about the national health system and career structure and opportunities for doctors in general in that country. In countries where there are a number of study groups and initiatives to help refugee doctors, then these should be promoted. Access should be linked to the database.

Orientation 1

Ideally a mentor for every refugee doctor to provide information, careers advice and informal one to one support to the refugee doctor.

This person is well placed to carry out needs assessment and honest appraisal of the refugee doctor's chance of re-establishing their career as a doctor

Preparation

On average it takes 2 years to obtain registration in the UK. Achieving language competency is key. Refugee doctors benefit from language courses, structured teaching programmes and

access to self – help study groups. At this stage refugee doctors may benefit from a short clinical attachment in a hospital or primary care setting.

Examinations

Most refugee doctors will be required to sit exams, which test language and medical skills. For many refugee doctors these prove a major financial and personal hurdle.

Registration

On successful completion of exams most refugee doctors will be in a position to register with the appropriate medical body. Some countries will require refugee doctors to do a further period of supervised clinical practice.

Orientation 2

Many refugee doctors will not have practised medicine for some years and need to build up their confidence in a supportive environment. During clinical attachments refugee doctors should have the opportunity to work alongside a team of doctors in a hospital or primary care setting, and have an opportunity to develop an understanding of the particular country's medical practice and health service "culture".

Clinical attachments should be free and proper learning contracts and feedback arrangements drawn up between the refugee doctor and the clinical supervisor. For many refugee doctors these attachments present an opportunity to acquire that all important first reference.

Employment

Despite having completed the registration requirements, refugee doctors still find it extremely difficult to obtain a job. They may experience prejudice against their age, experience, their status and race. In some European countries, with doctor unemployment, it may prove a greater hurdle. Countries may wish to consider developing a career advice service for refugee doctors, helping refugee doctors find posts. Countries may consider funding and setting up special one off designated training posts for refugee doctors.

Refugees make valuable contributions to the cultural and economic life of a country. It is vital that the potential contribution of refugee doctors is acknowledged and that all efforts are made to ensure that their talents and enthusiasm are nurtured and developed, for the benefit of the refugee doctor, for the national state health service and for the community as a whole. All medical associations should initiate efforts to integrate refugee doctors into the professional workforce.

Ideas for PWG activity

- Each member country should raise the issue of refugee doctors with their medical associations, profession and Governments. Members of the PWG may wish to place articles in medical journals highlighting the needs of this special group of doctors.
- Adopt/amend the framework on integrating refugee doctors as a model of best practice in member countries. Access to

appropriate language tuition is crucial.

- Individual countries / PWG / CP could approach/lobby the European Union for special funds to support initiatives that re-integrate refugee doctors into the workforce.
- Take this issue to CP/other European medical organisations.

The PWG may wish to consider broadly the issue of overseas doctors (i.e. training needs, career prospects, discrimination).



Basic Policy Statements & Studies
Working Conditions
for Doctors in Training

Final

HIV Infection & Hospital Doctors**A Policy Statement****London 1995****FOREWORD I**

Blood borne infection has always been a threat to the medical profession, but it was not until HIV entered the scene that the potential problems for infected health care workers were widely discussed. Due to the moral and ethical issues involved, irrational fear and prejudice have complicated further the professional response to this challenge. Several years ago the Permanent Working Group of European Junior Hospital Doctors (PWG) saw the need for a clear evidence based policy regarding the question of HIV and other blood borne infections in health care workers, and a working party was established. The present policy document is the result of this work, which has been achieved to a large extent because of the contribution of the British Medical Association Foundation for AIDS. It has been a pleasure to take part in the development of this document, and I want to thank all the members of the working party, and the various national delegations who provided data from their country. Hopefully, the policy statements can help on a national level to prevent unnecessary fear or problems, and to ensure both future patients and health care workers their rights and security.

Guttorm Brattebø MD
Chairman of working party

FOREWORD II

It is incumbent on all professionals to keep themselves updated on everything that influences the safety of the practice of their profession. So also with physicians and other health workers. This Policy Statement is an important document towards that end, and especially since the production of it was conceived by junior doctors themselves.

International health authorities, and national authorities in most countries, may not, because of the relative small risks involved for exchange of blood between health workers and patients, have found it cost-beneficial to have used time and resources yet on reviewing the problem and expressing a policy and strategy for coping with the questions it raises. Since in excess of 80 per cent of HIV-infection worldwide is caused by sexual transmission, such an attitude may be explicable. However, to health workers their own safety and the safety of their patients are of paramount importance, as is, of course, their legal rights in those few, but not less tragic, cases when transmission may be traced to professional exposure.

This PWG Policy Statement on HIV Infection and Hospital Doctors is a model of clarity and applicability. An added benefit is that it is equally applicable to other blood-borne infections such as the hepatitis viruses.

Oslo, 20 September 1995

Svein-Erik Ekeid MD MA
formerly Director
Division of Technical Cooperation
WHO Global Programme on AIDS

Introduction and basic principles

The Permanent Working Group of European junior Hospital Doctors (the PWG) is an association of European national organisations representing postgraduate trainees in hospital medical specialities and general practice. Its aims include improving and protecting standards of health care and furthering the professional interests of junior doctors in Europe. In line with these aims, when considering issues related to the employment and careers of doctors who may be infected with HIV the PWG acknowledges the need to ensure the highest standards of safety and welfare for patients, while seeking to ensure doctors' rights to privacy and freedom from unwarranted discrimination on the basis of actual or presumed HIV infection status.

A basic principle is that patients are entitled to know that effective policies and practices are in place to protect them from infection risks, but they are not entitled to know details regarding the personal health status of doctors or other health professionals. Health workers who have HIV infection are entitled to the same rights to confidentiality as any other patients.

The risk of transmission of HIV infection in health care settings is low, provided routine infection control procedures are observed. Worldwide, only one case of a health worker transmitting HIV to patients has been reported, that of the Florida dentist. Although the exact mode of transmission from the dentist remains obscure, it is known that he did not observe all recommended precautions. Other studies of large numbers of patients treated by HIV positive health workers have shown no evidence of transmission.

The risk to patients undergoing invasive surgical procedures from HIV positive health workers can be compared with that to health workers from infected patients. Even after a skin puncture with a needle contaminated with infected blood, the risk to a health worker of acquiring HIV is less than one in 200. This is much lower than for other infections such as hepatitis B (HBV), and illustrates that a significant transfer of blood or other infectious bodily fluid is needed for HIV to be transmitted. In most documented cases where health workers have become infected with HIV, this has resulted from skin puncture with a hollow needle containing blood. Incidents in which patients are exposed to comparable volumes of the blood of health care workers are likely to be very unusual.

This statement is intended to assist national organisations in formulating policies and guidance to protect the interests both of health workers and the public, in the light of the fact that workers are considerably more likely to acquire HIV infection from their patients than to transmit it.

Prevention of transmission of HIV infection between health workers and patients

Employers, doctors and other health care employees share a responsibility for health and safety in the workplace, including the prevention of parenteral exposures to blood and potentially infectious body fluids. The key to avoidance of transmission of HIV and other blood borne infections in health care settings is to maintain high standards of infection control at all times and in all circumstances, regardless of whether any individual

patient or worker is known or suspected to be infected with HIV.

The PWG recognises that doctors have a professional obligation to keep abreast of techniques to reduce the risks of cross infection and to apply all reasonable precautions to protect their patients, themselves, and their colleagues. They must comply with legal requirements for reporting of actual or suspected exposure incidents. Failure to adhere to appropriate standards of infection control practice may render a doctor liable to disciplinary action.

Employers should provide all necessary equipment, facilities and training to enable appropriate precautions to be followed, and must require incidents of parenteral exposure to blood or potentially infectious body fluids to be reported, through mechanisms to be agreed in consultation with staff representatives and in conformity with EC Council Directive 90/679/EEC of 26 November 1990.

All health care staff should have ready access to specialist occupational health services led by a consultant in occupational medicine, at no charge to the employee. Such services should be arranged in conformity with recognised principles of ethics in occupational medicine, whereby personal health information is not transmitted to the employer without the consent of the person to whom it relates. Health service occupational health services should be encouraged to develop appropriate services and policies for prevention of transmission of bloodborne infections and for the care of employees who have been exposed to potentially infectious body fluids (eg 24-hour "needlestick hot-lines") as well as those who are HIV positive.

Restrictions on the practice of HIV infected doctors

Despite the fact that no doctor is known to have infected a patient with HIV, the PWG accepts that some invasive surgical procedures may entail a remote but finite risk that a patient could be exposed to a sufficient quantity of the operator's blood for HIV infection to be transmitted. Such exposure could only occur if an HIV-infected operator suffered an injury during the procedure and this led to bleeding into a patient's exposed tissues or body cavity. This theoretical risk is confined to procedures which require insertion of (part of) the operator's hand(s) into the patient in the presence of sharp instruments, bone spicules, teeth or foreign objects such as broken glass. Such procedures are referred to as "exposure prone".

All other clinical procedures can be safely performed by staff who are infected with HIV, including invasive procedures such as venepuncture where there may be a risk of "needlestick" incidents in which the operator might be exposed to the patient's blood but not vice versa.

Some national authorities may take the view that the risk of transmission of infection is so remote, even during "exposure prone" procedures, that it does not justify restricting the practice of HIV positive doctors in any way. However, subject to national circumstances and policies, the PWG accepts that it may be necessary for doctors who know themselves to be HIV positive to refrain from performing some or all "exposure prone" procedures. Any such restrictions should be kept to the mini-

imum necessary, and if they are to be applied then the following criteria should be in place:

- The policy should be based upon voluntary self identification of infected doctors, in accordance with agreed ethical principles, including the highest standards of confidentiality.
- A competent national expert body should be established, in consultation with relevant professional organisations, to advise employers and infected health workers or their personal medical advisors about precisely which techniques and procedures may and may not be safely performed by infected workers.
- All possible measures should be taken to protect the training and career prospects of doctors who are obliged to modify their work pattern because of HIV infection (see below).
- Restrictions should be confined to individuals who are known to be HIV positive. If a doctor has been exposed to the blood of an HIV positive patient, he or she should not be required to cease performing "exposure prone" procedures during the period of follow-up while the doctor is undergoing testing but has not been confirmed as HIV infected.

The PWG recommends that doctors who believe they may have been at risk of HIV infection should seek advice in confidence from a suitably qualified specialist such as a consultant in occupational medicine, and should undergo voluntary HIV testing where this is recommended as a matter of professional ethics and/or national policy. Where necessary, such a specialist can seek guidance on behalf of the doctor without disclosing his or her identity and can act as his or her advocate.

In view of the very low risk of transmission of HIV in health care settings, it is unnecessary for doctors to seek routine HIV testing unless they have reason to believe they may have been at risk. The PWG would strongly oppose any move, whether on the part of employers or national authorities, to require doctors to undergo compulsory HIV testing as this would be an unjustifiable infringement of the human rights and privacy of those concerned.

Employment, training and professional advancement

Employers and relevant national authorities should take all necessary steps to preserve the employment and career prospects of doctors who need to alter their working practices because of HIV infection. Any change in duties should be the minimum necessary to avoid performing exposure prone procedures. Adequate resources, careers advice and retraining should be provided to enable the redeployment of those whose current speciality is so dominated by exposure prone procedures (eg some surgeons) that they cannot continue to practise it. Where re-deployment is needed, it should ordinarily be to an alternative clinical speciality unless the individual prefers to enter a non-clinical role. Dismissal cannot be justified on grounds of HIV infection alone. National policies and regulations may need to be developed to promote good employment practice in relation to doctors with HIV and similar infections, and coordinated action may be desirable to facilitate redeployment where

this involves a transfer between different employers.

Subject to national conditions, it may be necessary to allocate resources specifically for the purpose of retraining doctors who are seeking to change their speciality because of a physical or mental health condition. HIV infected individuals unable to pursue a surgical career would be among those eligible to benefit from such provision.

Provision for suitable retraining and redeployment is desirable even in countries where national policies do not require HIV positive doctors to restrict their practice in any way, because some individuals may wish to cease performing exposure prone procedures voluntarily out of concern for the welfare of their patients.

To the greatest extent possible, training programmes and requirements for specialist accreditation should provide flexibility to accommodate individuals who are unable to follow the standard training model for reasons of health. For example, where doctors are ordinarily expected to perform exposure prone procedures during early postqualification training, a requirement to observe such procedures might be substituted in the case of an individual with HIV or a similar infection to enable him/her to proceed to more specialised training towards a non-surgical career.

Asymptomatic HIV infection should have no bearing on the employment, training or professional advancement of doctors whose work does not involve performing exposure prone procedures. Flexible working arrangements, sickness benefits, and early retirement on health grounds may be required by doctors who develop symptomatic HIV disease, on an identical basis to those with other chronic progressive illnesses. National policies, including legislation if appropriate, should be developed to combat HIV-related discrimination in employment, including medical employment and training.

Medical confidentiality should be maintained in arranging altered working practices, retraining and redeployment for HIV positive doctors. The specialist in occupational medicine plays a crucial role in advocating on behalf of the affected individual while keeping medical details confidential.

Support for affected doctors

Diagnosis of HIV positivity inevitably causes significant stress, in view of its implications for personal health and future sexual and family relationships. For doctors, concerns about possible employment and career implications may create an additional burden of anxiety. Professional organisations should ensure that suitable services are available to advise and support doctors who find themselves to be HIV positive, and where necessary to assist them in negotiations with employers or training authorities. Procedures should be in place to ensure the confidentiality of doctors seeking the support of their professional organisations.

Occupationally acquired and non-occupationally acquired HIV infection

In accordance with national arrangements for compensation in respect of occupational diseases and injuries, doctors should be

entitled to seek redress for disability and loss of income where this is due to occupationally acquired HIV infection. In establishing the validity of claims for compensation, it is acceptable to examine the work practices of the doctor concerned to assess the probability of his or her having been in contact with the blood of patients with HIV infection. Where such a probability exists, the claim should be accepted without subjecting the doctor to intrusive questioning regarding his or her private behaviour. Parenteral exposures to blood may sometimes occur without being noticed, so compensation should be payable on balance of probability in cases where there has been no specific documented exposure but the doctor's work has involved performing invasive procedures on patients likely to be infected with HIV.

The route by which an HIV positive doctor acquired the infection is irrelevant to his/her future employment and training. It is inappropriate for anyone involved in selection processes for re-training and redeployment to enquire as to how the doctor might have become infected.

Patients who may have undergone exposure prone procedures performed by an infected worker

When a doctor is found to be HIV positive, concerns may arise regarding the welfare of patients on whom he or she has performed exposure prone procedures in the past, between the probable date of acquiring the infection and its being diagnosed. The question arises as to whether it is necessary to inform patients in these circumstances and to offer them counselling and HIV testing if they wish it, ie to perform a "look back" patient notification exercise. The PWG's view is that, given the very low risk of transmission involved, it is not necessary or appropriate routinely to notify patients who have undergone exposure prone procedures performed by a doctor who has been found to be HIV positive. There are a number of drawbacks associated with "look back" patient notification exercises, including:

- Substantial costs and diversion of staff resources for contacting and counselling patients and dealing with media enquiries;
- Risk of promoting public anxiety and fostering misconceptions about the level of risk involved;
- Significant risk that the infected doctor's privacy will be infringed if his or her identity can be deduced.

There may be individual cases where "look back" patient notification is judged necessary, for example if procedures have been performed which are thought to carry an unusual risk of patient exposure to the worker's blood, or if a potential lapse in infection control precautions is known to have occurred. Even in such cases, however, the infected doctor should be consulted where possible and every effort should be made to prevent deductive disclosure of his or her identity. Guidance regarding "look back" exercises should be developed at the national level in consultation with relevant professional bodies, to assist local public health authorities, employers and consultants in occupational medicine in the management of individual cases.

Summary of key conclusions

Health professionals are entitled to the same rights to confidentiality regarding their personal health status as any other patients.

The key to avoidance of transmission of HIV and other blood borne infections in health care settings is to maintain high standards of infection control at all times and in all circumstances.

Employers should provide all necessary equipment, facilities and training, and must require incidents of parenteral exposure to blood or potentially infectious body fluids to be reported.

All health care staff should have ready access to specialist occupational health services led by a consultant in occupational medicine.

Subject to national circumstances and policies, it may be necessary for doctors who are HIV positive to refrain from performing some or all "exposure prone" procedures (see definition). Any such restrictions should be kept to the minimum necessary, and applied in accordance with criteria set out above.

Doctors who believe they may have been at risk of HIV infection should seek advice in confidence from a suitably qualified specialist such as a consultant in occupational medicine, and should undergo voluntary HIV testing if appropriate.

It is unnecessary for doctors to seek routine HIV testing unless they have reason to believe they may have been at risk.

The PWG would strongly oppose any move, whether on the part of employers or national authorities, to require doctors to undergo compulsory HIV testing.

Employers and national authorities should take all necessary steps to preserve the training, employment and career prospects of doctors who need to alter their working practices because of HIV infection. Dismissal cannot be justified on grounds of HIV infection alone.

National policies, including legislation if appropriate, should be developed to combat HIV-related discrimination in employment, including medical employment and training.

Professional organisations should ensure suitable confidential services are available to advise and support doctors who are HIV positive, and where necessary to assist them in negotiations with employers or training authorities.

Doctors should be entitled to redress for disability and loss of income in respect of HIV infection where, on balance of probabilities, this is occupationally acquired.

It is not necessary routinely to notify patients who have undergone exposure prone procedures performed by a doctor who has subsequently been found to be HIV positive, and there are a number of drawbacks associated with doing so.

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PWG questionnaire on bloodborne pathogens in health professionals: summary of responses

This paper sets out the results of a survey carried out during 1993. It is attached as an annex to the PWG Policy Statement on HIV Infection and Hospital Doctors, as it provides useful background information.

As agreed at the May 1993 meeting of the PWG, the UK delegation circulated a questionnaire to appointed members of 15 national delegations on behalf of the working party on HIV/AIDS and bloodborne pathogens. Responses were requested by 1 August 1993; a number of delegations took longer to respond, because of the work involved in compiling the information, and a number did not respond at all. Some responses were very detailed, whereas it was clear from others that areas covered in the questionnaire are only beginning to be discussed.

The following information is based on the responses from the following national delegations:

Austria, Denmark, Finland, France, Germany, Iceland, Ireland, Italy, Latvia, Netherlands, Norway, Slovenia, Sweden, Switzerland, UK.

Extent of the problem

The extent of infection among doctors, either with HIV or HBV, is difficult to gauge, as in many countries there are no separate data. France is the exception, as HIV is a notifiable disease. By 31.03.92 there were 153 doctors or medical students reported HIV positive and 356 other health professionals (149 nurses, 107 care auxiliaries, 40 domestic staff, 28 dentists, 20 laboratory staff and 12 physiotherapists). Of these, 8 cases were proven to have been acquired at work (all nurses) and 28 presumed to have been so acquired (including 3 doctors, 1 house officer and 2 medical students). There were no exact figures for HBV infection among doctors, but the number of cases was reduced (divided by 15) between 1981 and 1991.

The UK has no system for reporting HIV infection among doctors or other health professionals, but a number of cases had been reported in the media. One doctor and 5 other health professionals were reported as having acquired HBV infection in 1992.

Among other countries giving figures, Denmark estimated HBV infection at 0–2 among doctors and 0–5 among other health professionals. Figures for HIV infection were unknown, but less than 10 and less than 100 respectively. In Finland, 5–10 doctors and 10–15 health professionals were known to be infected with HIV (none acquired occupationally). Slovenia had one doctor reported HIV positive, and 3 other health professionals. Iceland had one case of HIV infection in each category. Norway had one health professional reported HIV positive. Italy had "very few" (possibly 5–6) known cases of HIV infection among doctors and 15 among other health professionals.

There was no overall pattern as regards the disciplines in which doctors worked at the time of diagnosis. Ophthalmology,

obstetrics and gynaecology, general practice, general surgery, paediatrics, anaesthetics, radiology were all cited.

The level of debate within the medical profession was high in the UK, Ireland, Germany, Switzerland and Latvia. Elsewhere it seemed relatively low, although in Sweden there was discussion about how to minimise the risk of transmission of infection, and in Norway the issue had been discussed among surgeons in particular. In France, debate among both doctors and the public had been dominated by recent scandals over contaminated blood for transfusion. Media coverage of HIV infection among doctors had undoubtedly been greatest in the UK, although this did not necessarily mean that there was genuinely high public awareness or understanding of the problems. The Irish media were described as having dealt sensitively with the issue, which had certainly not been the case in the UK. Lama also reported public awareness, and there had been some discussion in Italy. The media in other countries (Austria, Finland, Norway) had reported on cases in the UK and USA.

The UK and Ireland seemed to be the only countries in which identifiable details of infected doctors had been made public, although the Irish response suggested that the details were those of British doctors. This had now happened in the cases of doctors suffering from HIV and HBV in the UK.

Ethical guidelines

Delegations were asked whether their regulatory bodies had published ethical guidelines on the responsibilities of doctors infected with HIV or HBV. Where there were guidelines, most delegations did not specify whether these applied to doctors infected with HIV or HBV or both, although the principles involved were similar. Some respondents interpreted the term "ethical" rather broadly.

Once again, the issues seemed to have been addressed in the greatest detail in the UK, where the government had produced guidance on the responsibilities of doctors with HIV and HBV infection (the latter published very recently) and the professional regulatory body for doctors with HIV infection. The Irish Medical Council had published guidelines for doctors with AIDS/HIV. Latvia and Switzerland also had guidelines, and guidance was currently being drawn up in Norway. Denmark and Austria had procedural, rather than ethical, guidelines. Some hospitals in Finland had their own guidance, and the situation in the Netherlands was described as being governed by "gentlemen's agreement", whereby infected doctors would appear before a committee of "wise men/women" to discuss their cases. Ethical guidance had been produced by other bodies in the following countries:

UK – medical association.

Germany – medical association; medical publisher; health ministry (general information).

Sweden – assumed to be medical association.

Italy – national AIDS advisory board.

Latvia – HIV medical association; department of health protection.

NB: In France, a working group under the authority of the health minister was examining the risks involved in exposure to blood.

Some delegations included copies of, or details from, their guidelines, but not all did so.

Where applicable, guidelines seemed to be generally accepted by the medical profession. The exception was the UK, where guidelines produced by professional bodies (the regulatory body and the medical association) were well-accepted, but those produced by the government had been controversial. The Swiss response pointed out that some senior doctors in the older generation objected to campaigns for safer sex etc. and wished to test all patients before treating them.

Where doctors were required, or advised, to disclose infection, this was as follows:

UK – Specialist advice to be sought, probably from consultant in occupational health, infectious diseases or public health. Governmental guidance requires those who have been involved in invasive procedures to inform their employers, probably through a senior occupational physician.

Ireland – Information given to professional colleagues.

France – HIV notifiable disease. Notification normally through occupational physicians or by hospital doctors if the infected person is hospitalised.

Finland – all HBV and HIV infections notified by doctors to – provincial and state officials" (i.e. no special requirement for doctors).

Austria – initials only given to the national health board.

Germany – hospitals may ask job applicants about their HIV status, and may ask them to undergo HIV tests if they are to work in certain areas where there is a high risk of transmitting infection.

Sweden – infected doctors advised to inform their heads of department (consultants).

Italy – heads of departments.

Latvia – Department of Health Protection and HIV Medical Association.

Netherlands – Committee of "wise men/women" described previously (no formal requirement).

Switzerland – infection at work dealt with by occupational physicians. Positive cases notified to national health board on anonymous basis.

Policy

There was no clear pattern as regards screening or vaccination. Notes on individual countries are as follows:

UK – No screening for HIV. All health care workers performing high-exposure procedures to be immunised against HBV. Until recent guidelines were published, there was a voluntary vaccination programme, but there were problems with funding, and its distribution was uneven.

Ireland – no governmental policy.

France – no screening, but compulsory vaccination against HBV, diphtheria, tetanus, TB and polio for all those exposed to risk of infection via their work (includes medical students).

Denmark – doctors training to become surgeons or pathologists, certain laboratory staff and other health professionals considered to be at risk of infection should be screened for HBV and vaccinated if necessary.

Finland – screening for TB and rubella immunity only.

Slovenia – no screening, but vaccination programme for all health professionals (and students) who may be exposed to HBV.

Austria – screening and vaccination only mentioned for TB

Iceland – no compulsory screening. HBV vaccination offered to health professionals at moderate to high risk and to medical students.

Norway – HBV vaccination programme for health professionals in casualty departments or dialysis units.

Latvia – Compulsory screening twice a year for medical students, doctors and other health workers for HIV, HBV and other diseases. No information about vaccination programmes.

Netherlands – HBV vaccination not compulsory, but strongly recommended and paid for by health authorities.

Switzerland – All doctors supposed to be vaccinated against HBV, if possible as medical students. Vaccination depends on the individual taking the initiative when vaccination sessions are organised by hospitals (usually once a year). Occupational exposure to HIV governed by recommendation, rather than by government policy. It should be followed by immediate testing, repeated after 3 and 6 months. Prophylaxis with zidovudine to be considered in serious cases.

Retraining of infected doctors had been discussed only in the UK, Denmark, Norway, Latvia, the Netherlands and Switzerland. Discussions seemed to be at an early stage, and almost no specific action had been taken. In the Netherlands, there had been

discussions about finding alternative placements for infected surgeons, but it was not known whether or not any action had been taken. In Switzerland, there was no recommendation to bar doctors with HIV infection from invasive work. It would be considered paradoxical to ask doctors to treat HIV-positive patients but to exclude them from their professional activities when they became infected themselves.

Financial compensation for infected doctors and their families was very limited. The UK offered compensation to doctors who suffered injury or infection in the course of their work (NHS Injury Benefit Scheme – 85% of normal salary); HBV was on a list of prescribed diseases which would normally be assumed to be due to exposure at work, but it would be extremely difficult to prove the origin of HIV infection. France would compensate salaried doctors for accidents at work if it could be proven according to strict scientific criteria that they had been infected at work; doctors in "liberal" practice had to take out their own insurance. Germany offered a compensation scheme for inability to work which covered both HBV and HIV.

Only the medical associations of the UK, Ireland, Germany and Sweden had policy on the areas covered in the questionnaire. British Medical Association policy and publications were extensive and either had been, or would be, made available to the PWG working party. The Irish Medical Organisation had called for HIV infection to be a notifiable disease and had urged health boards to assign protected resources to beat it. The Marburger Bund (Germany) supported guidelines drawn up by the Bundesärztekammer and German Hospital Association (available in German). It strictly opposed any screening policy, especially where doctors were concerned. The Swedish junior doctors' organisation did not support preemployment HIV screening. The only additional comments came from sources in the UK. They pointed out that, although media attention and debate – at least in the UK – had been directed primarily at risks associated with HIV infection, HBV was more infectious and posed a greater risk to health professionals. They also pointed out that consideration of the needs of infected doctors needed to go beyond retraining. Issues such as redeployment, employment protection, confidentiality and protection against discrimination should be considered.

Consequences for the Doctor and Patient Care in EU

Executive Summary

Brussels, 11 and 12 December 1995

Abstract

In order to help stimulate social dialogue between the "doctors in training" and their employers with the aim of negotiating a solution to extend working hours protection to "doctors in training," one of the groups excluded from coverage by Directive 93/104/EC on working time, the European organization representing Junior doctors (PWG) in cooperation with the European Trade Union Confederation (ETUC) and with the support of DG V, organized a European conference on this topic.

Attendance at the Conference, held in December 1995, included European representatives fully competent to negotiate from the employees' side whereas nobody Present was able to negotiate for the European employers. The conclusion drawn from the Conference makes it clear that social dialogue is not possible since there is no representative of the employers in Europe. The only remaining possibility for a solution is for the Commission to take legislative measures.

Introduction

In November 1993, the Council of Ministers adopted a directive on the regulation of certain aspects of the organization of working time (93/104/EC). Despite the majority recommendation of the European Parliament not to do so, the Directive excluded from its sphere of coverage a number of sectors, and 'doctors in training.' However, due to the Parliament's position, a clause making it possible to adopt separate measures for the excluded sectors was inserted in the Directive, and Commissioner Flynn indicated the intention of the Commission to consider some action to ensure the application of the principles for doctors in training.

The Commission's first initiative was to invite all relevant parties regarding 'doctors in training' to two meetings in Brussels. Representatives of all the 'doctors in training' in Europe and some of the national authorities we represent at both meetings, while no representatives from the employers' side on a European level were in attendance.

The Commission's second initiative was to contract with COSHAPE Ltd. to obtain comparative factual information to aid

the Commission in its considerations as to possible further initiatives. That Report, issued in December 1994, made it clear that further action to ensure coverage was appropriate. In its White Paper on Social Policy and in the Social Action Program for 1995/96, the Commission expressed its preference that a solution be found for the excluded sectors through the social dialogue.

As a third initiative, the Commission issued a grant to the PWG in spring 1995 to organize a major conference on the working conditions for doctors in training with special reference to working hours. Because the PWG is not a recognized social partner, it approached the European Trade Union Confederation, ETUC, which has such a status, to propose a cooperative approach with a view to effecting a social dialogue on the European level with the ETUC/PWG representing the doctors in training and the aim that the employers might be represented by a cooperation between the CEEP, UNICE, and HOPE.

The ETUC responded positively to the PWG approach and organized, with the support of the Commission, a preliminary meeting in Copenhagen in October 1995 to prepare for the main conference being organized by the PWG, to meet in Brussels in mid-December 1995.

The October 1995 ETUC Conference reconfirmed the need for action to obtain coverage for doctors in training and reconfirmed the cooperation between the ETUC and PWG in this respect, but included only a very disappointing representation by the representatives of the employers, all of whom had been invited.

The conference on working conditions for "doctors in training"

The PWG Conference convened on 11 & 12 December 1995 in Brussels with representatives from 19 countries attending for an in-depth study of the parameters of the situation. The doctors in training of all but one EU country were represented and ETUC again expressed its readiness to cooperate with the PWG in the social dialogue. However, once again, representation from the European employer organizations was absent.

The Conference opened with a review by Mr H. Zonneveld (DG V) of the content of the Working Hour Directive. He noted that the Commission was now considering proposals to extend coverage of the protection in the Directive to the excluded sectors with a view to bringing formal possible proposals in 1996–97. To this end, the Commission viewed the outcome of the PWG Conference as being of major importance.

The COSHAPE Report

The Conference received a report by Mr S. Allman (COSHAPE Ltd.) which the Commission had contracted to carry out, a study on the working conditions of 'doctors in training' in the EU. In its Report to the Commission, COSHAPE stated *inter alia*:

1. "Doctors in training" are a totally integral part of the medical services.
2. In the majority of the countries studied, 'doctors in training' seem to bear the brunt of weekend cover and night duty.
3. Although the weekly hours worked by 'doctors in training' are highly variable, it is reasonable to conclude that these routinely exceed 55 hours a week in at least 10 out of the 15 countries that replied.
4. In terms of the tasks performed by 'doctors in training,' the Study found no logical arguments for excluding 'doctors in training' from the same protection as is provided by Directive 93/104/EC to the rest of the medical workforce.

The COSHAPE Report clearly demonstrated to the Commission the need for regulation in this area.

National Presentations by PWG and its Representatives

The PWG President, Jesper Poulsen, reported to the Conference that his organization had always favored a solution in this area based on negotiation, but the years had shown that this was not possible in all European countries. The PWG, therefore, now favored a European regulation. The PWG stated its willingness to enter a social dialogue procedure with an open mind. He elaborated on a number of problems that could be solved in such a process and presented the Conference with a number of points – especially concerning the definition of working time which in the PWG's opinion should greatly facilitate the social partners' possibilities of reaching a compromise.

Dr Joachim Grifka (D) supported the PWG request to bring doctors in training under the scope of the Directive, but stressed the necessity of the PWG's proposed amendments that would allow for national negotiation to tailor the regulations to national situations. The aim must be to obtain a directive that is locally applicable and leads to concrete changes.

Dr Doimínic Ó Brannáin (IR) noted that the COSHAPE Report named Ireland as one of the countries with the worst working hour conditions for doctors in training. The problem was getting worse.

Dr Keith Reid (UK) and Dr Andrew Carney (UK) described how excessive working hours for doctors in training in the United Kingdom lead to stress, sleep deprivation, social isolation, and

alcoholism among doctors in training and put the patients at risk as well.

Dr Sylvie Rouer Saporta (F) pointed out that excessive and very low paid working hours as well as an unofficial pressure to comply were making the situation even more intolerable for French doctors in training.

Mr Alex van Bolderen (NL) explained how the problem of excessive working hours for doctors in the Netherlands had been regulated successfully via national legislation.

The Economic Consequences of Covering "Doctors in Training"

A presentation was made by the MC' Treasurer, Mr Mogens Kring Rasmussen, on the economic implications. A major argument for excluding "doctors in training" from the Directive seems to have been the risk of serious economic consequences for the health care budgets in some countries if "doctors in training" were included.

At the Conference, it was demonstrated that due to the lack of relevant statistics and the fact that the economic consequences largely depend on the way in which the health care sector adjusts to the requirements resulting from an inclusion of "doctors in training," it is not possible to make any accurate calculations of the economic consequences.

On the other hand, possible economic consequences can be placed in perspective. In the EU member states, the total costs for "doctors in training" amount to 1–4 percent of the health care budgets and the member states with the most severe working conditions for "doctors in training" are in the absolute low end of this interval. Thus, there seems to be no justified reason to maintain that it would have serious consequences for the total health care budget to include 'doctors in training' under the coverage of the Directive.

National Employer Organizations

Mr Brendan Phelan of the Irish Department of health, while acknowledging some of the problems caused by doctors in training not being covered by Directive 93/104/EC, set forth the reasons why his Department did not support extending the Directive to cover doctors in training. In his opinion, this would cause problems for the management of the hospitals.

Mr Peter Roggendorff of the German Federal Labor and Social Department stated that his Department found no logical arguments for excluding doctors in training from the Directive. He stated further that if a procedure following the social dialogue did not solve the problem, Germany would not oppose a solution based on a legislative initiative from the Commission. In fact, he stated that the German position was that the simplest and probably best solution would be to simply extend the scope of the Directive to cover doctors in training as well.

A historic review by Mr Torben Rothenberg of the Association of County Councils in Denmark showed how the working hours of doctors in training had been regulated by collective agreements since 1937. He stated that if doctors in training had been covered by the Directive, it would have caused no problem for the management of the labor market of doctors in training in

084 Denmark. He further explained that the Danish model for organizing working time showed that it was possible to live with rules and regulations like the ones stipulated in the Directive.

European Employer Organizations

Prior to the Conference, the UNICE informed PWG, that they considered the organization of working time for doctors in training beyond the scope of their activities. Consequently, they declined to participate in the Conference.

The CEEP was also invited to participate – in the Brussels Conference as well as in the Conference held in Copenhagen in October 1995 on the same subject. On both occasions, a number of national CEEP members participated, but at both conferences they declined the invitation to officially represent the CEEP.

The HOPE – Standing Committee of the Hospitals of the European Union – was represented by its Secretary General, Professor Kris Schutyser, who explained that the HOPE Statutes do not allow it to represent its members in such a social dialogue.

Example of a Directive for 'Doctors in Training'

At the end of the Conference, the PWG tabled an example of how the Working Hour Directive could be amended to regulate the working time for "doctors in training." The essential part of the example is a new item 5 under Article 17 stating that derogations may be made from Article 2 (definition of working time) by means of collective agreements in each of the member states.

ETUC Presentation

The representative of the ETUC reiterated the ETUC pledge for cooperation to find a solution to the problem of working hours protection for "doctors in training."

Concluding remarks

At the Conference, the poor and unregulated working conditions of "doctors in training" in most of the European countries were demonstrated, both by the COSHAPE Report and by the presentations of the conditions in selected member states. Further, it was highlighted that "doctors in training" are a group of workers within a sector where all other workers are covered by Directive 93/104/EC. Nobody at the Conference disputed the need for regulation of the working conditions for "doctors in training."

At the same time, it became absolutely clear that it is not possible to solve the problem via the social dialogue as there is no one to represent the European employers within the health care sector.

The only possibility left for protection of "doctors in training" is that the Commission takes the relevant legislative measures.

PWG Policy Statement on Future Medical Work

Cologne, 1997

1. Introduction

The past half century has seen both enormous advances in medical science and rapid development in the health care systems of Europe with an attendant increase in the availability of medical care to all members of the population.

However, in most countries a situation exists where increased service and increased demand has not been met by a proportionate increase in resources. There is a risk of care and professionalism being replaced by economic objectives, with consequences for both patients and the health care staff.

Patients risk having to wait for medical services, being placed in overcrowded, hospital facilities where necessary equipment is outdated and poorly maintained and, in some countries, facing a lack of staff.

Physicians face the deterioration of working conditions which are vital for the optimal exercise of their medical responsibilities – vital for the care and health of their patients as well as for the health and efficiency of the doctors.

Factors entailed include: an excessively fast work tempo, frequent and stressful on-call work, the burden of great responsibility in relation to the individual patient with sometimes poor conditions for administering that responsibility, lack of respect and support, a lack of individual influence on the doctor's own working situation, inappropriate postgraduate training, in appropriate distribution of work amongst the doctors and between doctors and other health professionals, and fragmented treatment of and contact with patients.

A continually increasing activity level can only accelerate the work rate, increasing the risk of doctors making mistakes. This situation has developed concurrently with the increasing focus on the possibility of lodging medical malpractice charges.

This partly explains the poor working conditions of medical doctors, but is far from the whole explanation.

The medical profession as a whole has not succeeded in finding common ground from which to resist the pressure resulting from these conditions. Undoubtedly, this failure is due, in part, to the considerably individualistic training structure of doctors, but also to managerial miscalculation. Conflicts of interest can arise internally in the medical profession where doctors with

different ranks – for example chief physicians and doctors in training – do not consider themselves members of the same medical corps.

The situation is aggravated by the fact that doctors in training often have limited hospital employment contracts. The result of this is both restricted social protection and uncertainty about the professional future of those concerned, as well as incalculable pressure on longer ranking doctors to behave in a certain manner. A doctor with a fixed-term contract cannot afford to insist firmly on his own ideas and rights that may conflict with those of his superior or the clinic administration. This factual situation affects both medical decisions and matters related to employment law.

Consequently, the working conditions of a large number of hospital doctors are sometimes so poor as to risk dissatisfaction and demoralization. Thus, poor working conditions represent a potentially detrimental situation for patients, the doctors themselves, development within the medical profession, and for the health care system.

To improve the present situation, with its economic strains, misunderstanding between groups of doctors, and deteriorating working conditions, the profession needs to consider the content of work, the doctor-patient relationship, the internal "medical culture," and the distribution and organization of medical work.

2. Content of and Recommendations on Future Medical Work

2.1. Content of Future Medical Work

Medical work includes the following features:

- diagnosis and treatment of patients
- patient information/communication
- research
- quality assurance and development
- development of the profession
- training
- administration and management.

In more specific terms, medical work includes reception and assessment of patients, formulation of medical records, ward rounds, out-patient care with examination, diagnostic procedures and examinations, surgery, contact to patients and relatives, comments and referrals, intra- and inter-department conferences, postgraduate training, giving and receiving training and supervision, as well as research and quality development.

Orderly functions and clerical tasks should not be part of the work of doctors in training.

However, more important than a focus on the precise functions of medical work is the assurance that the services and responsibility for the patients are not unnecessarily fragmented. It is not possible to ensure meaningful and professionally developing medical work if the various functions related to the patient are divided and re-divided at the different hierarchical levels within the medical profession.

Ideally, the same doctor should receive the patient, take the medical history and, upon consultation with other doctors, make a diagnosis, initiate treatment and follow-up, and give information to the patient and other relevant parties. Nevertheless, this is not always feasible because:

- the individual doctor cannot be continuously present at the hospital
- not every doctor is equally experienced and qualified.

To a large extent, the first of the above two limitations can be compensated for by means of appropriate organization of the work via cooperation in smaller teams. The second limitation could be compensated for by supervision of the less experienced doctors in the team.

Another important aspect of this discussion is the round-the-clock distribution of tasks. In most countries, to be present at the hospital during evening and night is still considered less prestigious and desirable than during the regular day-hours. The major obstacle to change is probably found within the medical institution itself.

Some patient-related tasks are regarded as superior to others. In any event, due to the strong hierarchy in the medical structure, it is important to prevent the more prestigious tasks from being performed exclusively by doctors at the top. Tasks must be assigned according to both the qualifications and skills of the doctor and every doctor's professional need for continuing contacts with patients.

Thus, to achieve more coherent medical services in relation to the patient, efforts must be made to change the medical culture. However, this is not the only area in which the conception of the content and conditions of medical work should be changed.

2.2. Recommendations on Future Medical Work

To improve the working conditions of doctors and strengthen the doctor-patient relationship, the future medical work of the individual doctor should include:

- continuity of care in relation to the individual patient, with patient information as an integrated aspect

- applied postgraduate training, continuing medical education and supervision participation in research and advancement of quality of care based on audit
- participation and training in administration and management.

Medical work should be performed in a culture and environment characterized by the following features:

- the establishment of day work as the main part of the total working time of all medical doctors
- the delegation of responsibility and competence in accordance with the individual doctor's qualifications
- the equal distribution of on-call work with respect for qualifications and specific individual conditions
- the encouragement of an atmosphere amenable to discussion of uncertainty, weaknesses, and possible mistakes
- the nurturing of mutual support within the medical profession
- the inclusion of all doctors in a continuing discussion about the department's planned treatment protocols, research, quality assurance, teaching, and organizational structure
- the presence of an accessible medical management which actively takes part in the above and supports the medical team in relation to other health professionals.

3. Organization of Daytime Work

3.1. Quality Assessment of Daytime Tasks

When planning the distribution of tasks during day-time, thorough knowledge is needed concerning the nature and duration of the tasks involved. It would then be possible to make assessments of the time needed for daytime tasks so that the planning of the daytime work for all doctors fulfills set quality standards of treatment and patient care. Such knowledge can also facilitate planning of the duration of the day-time shift. A continuing debate as to whether the organization of medical work is in accordance with acceptable standards of patient care should be facilitated.

Daytime work should be organized in a way that assures the quality of treatment and care, based on set standards of the time needed for of each medical task.

3.2. Placement of Professional Development on the Weekly Work Schedule

For all doctors, adequate possibilities must be available to share professional knowledge, learn new techniques and acquire new skills. This has to be an integrated part of the daily work for all doctors.

This requires that:

- Teaching and supervision should be an integrated part of the daily work schedule for all doctors.

3.3. Clinical Teams Ensure Continuity of Daily Work

Establishment of clinical teams seems to be the best solution for a meaningful structure in organizing daytime work for doctors. Teams can provide continuity and support interdisciplinary work. Interdisciplinary teams also provide insight and under-

standing of the work of other health personnel. Within the medical specialty, working in teams furthers mutual respect of each other's work and knowledge of the status of each doctor's task. This also enables doctors to assist each other optimally, while individually carrying their responsibilities to completion. Consideration should be given to the size of the team, leaving the teams large enough to ensure supervision of less experienced doctors and care of patients. A sufficient team size ensures that continuity is possible with regard to the team's area of responsibility. It is not impossible to set up rotas suited to fit the clinical teams.

Clinical teams should be established to ensure quality and continuity in the daily work of all doctors.

3.4. Conferences and staff meetings

Conferences are an appropriate place for discussion and teaching. Well-organized conferences scheduled within normal working hours serve as a forum for tutoring and debate. Further, it is imperative to have a period of time for handing-over, which allows doctors from all shifts to meet and the doctor completing his shift to report on the condition of patients. It would be appropriate if educational, theoretical activities were placed so as to allow the doctors on duty to participate in them as a continuation or beginning of their duties, especially if the on-call work is organized in shifts. It is also important to have well-organized staff meetings, to increase interpersonal relations and mutual understanding, and to facilitate communication of professional information.

- conferences and staff meetings should be recognized as important parts of a day's work, and developed as fora for tutoring and debate.

4. On-Call Work

4.1. Definition of On-Call work

On one hand, it has previously been concluded that on-call work is organized in very different ways in the individual European countries and that the differences are of such a nature that it has not been possible on the European level to set up a meaningful and comprehensive definition of on-call work. On the other hand, on-call work is an integrated part of all medical work and, thus, a meaningful and often a well-established concept in the individual European countries. Accordingly, although the concrete forms of on-call work in the European countries vary considerably, the basic content and understanding of on-call work is so similar in Europe that despite the lack of definitions, it would seem reasonable to include the concept of "on-call work" in relation to Future Medical Work.

4.2. Organization of On-Call work

A hospital is a 24-hour enterprise. Accidents, critical illnesses, and emergencies do not always happen within normal working hours. Therefore, employees in hospitals dealing with patients must work while other employees are off duty. In addition, the medical profession must deal with special factors such as time

pressure and stress, highly concentrated work over long periods, the obligation to make many decisions very quickly and finally, steady contact to seriously ill or often terminal patients. Therefore, distribution of working hours plays an important role in hospitals.

Patients expect and demand medical treatment that meets the standard of a medical specialist. This principle has to be taken into consideration in the personnel planning of work. A medical specialist should be on duty or available as a supervisor if doctors in training are assigned to do on-call work with the aim of securing the right to medical treatment of a high standard.

To ensure that a doctor does not have to perform excessive amounts of on-call work, it is necessary to share the duties between the doctors in the department as far as possible with the exception of, for example, the administrative chief consultant and a few others with special functions requiring their presence during the day. The aim is to minimize the number of duties of the individual doctors and to minimize tasks during on-call work. In this way, on-call work would be made more attractive than it presently is.

The majority of patients can and should be treated during daytime hours to prevent a situation where on-call work comes to consist of uncompleted day tasks, not qualified as "emergency activities". Test results should be available during the day to be acted upon and ward round problems solved before the majority of doctors leave in the afternoon. For these reasons, it might be necessary to increase staff numbers in hospitals during the daytime.

- On-call work consists of urgent medical work that cannot be postponed until the next day and should be divided between as many doctors as possible to ensure good working conditions for all doctors.

4.3. Transformation of Night Work into Day Work

The aims of transforming night work into day work are several. First is the wish to gather as many activities as possible during daytime, where the prerequisites for making educational use of the tasks at hand are best. Viewed from a purely operational standpoint with regard to optimal use of all hospital facilities, including the technological ones, the order might be "full speed ahead day and night." But this is in opposition to the fully understandable wish of staff and probably patients to have as little activity during night shifts as possible. That human beings function best during the day is a fundamental physiological fact.

Some problems might be resolved by reviewing the length of planned day-time work, or establishing double coverage in the late afternoon, where a considerable number of tasks might need to be completed before the doctor on duty takes over.

Secondly, how acute tasks are to be handled during night shifts must be clearly defined. On-call work is urgent medical work.

Thorough change in the hospital schedule will, of course, also involve doctors outside of the hospitals as well as other health personnel within the hospitals. If the overall time schedule of the hospital is to be changed, consideration must be given to

why and how this can best be done together with a focus on urgent medical tasks.

4.4. Evaluation of tasks of On-Call work

To ensure that only urgent tasks are performed during on-call duties, it is essential that knowledge is obtained of the tasks to be performed.

This includes several aspects:

- the nature of the job to be performed
- who performs the job
- how the performance is evaluated/supervised
- how the job is organized.

Urgent tasks fall within the following categories:

- tasks resulting directly from personnel in charge of care performance of examinations for other departments
- acute consultation requested by other departments
- patient contacts in accident and emergency rooms
- acute admissions.

4.4.1. Tasks resulting from personnel in charge of care

- dialogue between doctors and nurses concerning division of labor and competence
- better para-clinical services in order that results required for clinical decisions are available during
- position on examinations which may be delayed to the following day.

4.4.2. Acute consultation requested by other departments

Basically, it is a question of the individual departments undertaking training in and maintenance of basic medical skills. Further, it is a matter of getting used to conferring on the telephone with colleagues and of the individual institutions providing common, basic instructional material on treatment and diagnosis in order that consultations may be performed when basic examinations and treatment are performed. Thus, this is a managerial task as well as a matter of attitude.

4.4.3. Acute admissions

If general practitioners and other medical colleagues in primary health care have easier access to hospital medical specialists during daytime, some hospital admissions might be avoided. A considerable number of acute admissions could be avoided with the possibility of sub-acute admissions or home visits the same or the following day. A central issue here is the establishment of a doctor-to-doctor referral system to ensure direct communication between the primary and secondary health care sectors.

- extended service in the form of acute beds in nursing homes and elsewhere could make it possible for certain marginalized groups to be placed outside of the hospitals, possibly after a visit in the emergency room or in a GP duty clinic.

Another issue relating to general health policies is the education of the population relating to how and where to contact the health services.

4.4.4. Staff demands

To improve the quality of medical care during on-call work might require resources from other health personnel without any reduction in medical salaries. The following is required during evening and night:

- employment of medical secretaries to cover the clerical tasks related to urgent medical functions
- employment of laboratory assistants to cover the laboratory functions
- employment of orderlies to cover orderly functions.

5. The Future of Staff structure

The PWG manpower studies have made clear that the medical profession in Europe as a whole faces a "graying of the ranks". The current age distribution of the medical profession in many countries calls for a reconsideration of the current hierarchical structure in which medical work is organized. In some countries, the few very young doctors will not be able to cover all hospital tasks as currently structured.

At the same time, a structure must be established which takes into consideration both working environment and training requirements.

To ensure a satisfactorily low number of duties per doctor, taking into account the achievement of a reasonable amount of daytime work, it will also be necessary to share the duties between as many doctors, medical specialists and doctors in training as possible. All doctors in a department with the exception of the chief administrative consultant and perhaps a few others with special functions requiring their presence during the day should take part in the on-call work.

It has been asserted that from an overall and socio-economic point-of-view, the "medical specialist in front" would seem the most advantageous solution. However, this does not take into consideration the training of junior doctors. More experienced doctors might more quickly perform the tasks and more efficiently deal with on-call work which might be less expensive for the health care sector in the short term; however, concentration on such a system would be seriously detrimental to the training of junior doctors in the long run and to the hospital system as a whole because new medical specialists, not having been exposed to on-call work earlier in their careers, will have no experience at making independent decisions in acute situations and thus be ill-equipped as independent specialists.

In departments with a heavy work load, a need for the presence of more than one doctor during shifts cannot be avoided. Because of the projected future number of permanent medical specialists as compared to doctors in training, the traditional organization of stratas with doctors with different competence cannot be maintained, as it will not be possible to avoid that two medical specialists are on duty in the same department at the same time.

The distribution of competence within the individual duty levels will, therefore, depend on the composition, and this together with the individual doctor's training needs must be considered when organizing on-call work. This can only be solved by as many doctors as possible participating in the on-call work - the anti-hierarchical staff structure -and on-call work being organized as described above in order that only urgent medical tasks are performed.

To change the attitudes of more senior doctors in this area, extensive work must be put into the explanations relating to the manpower based argumentation and the attitudes concerning the prestige and tradition of on-call work.

To ensure that most medical groups are involved in on-call work may require an economic inducement. If such inducements are not established, it may well be difficult to motivate permanent staff doctors presently without duty obligations to participate in duties.

At the same time, an upper age limit should be introduced according to which on-call work with night shifts is made voluntary, decreased, or eliminated.

The future medical staff structure should be based on the manpower situation of the individual countries and built on the foundation of equal working conditions of all doctors

6. Conclusion and summary of Recommendations

With the present policy paper, the PWG hopes to stimulate a debate on issues of importance to all doctors in Europe. Under the present situation, economic strains and lack of common understanding between various groups of doctors lead to deteriorating working conditions for doctors, to demoralization, and to some doctors wanting to abandon medical work. The profession needs to consider the content of the work, the doctor-patient relationship, the internal "medical culture-and the distribution and organization of medical work.

The PWG has previously adopted policy papers and recommendations in the areas of manpower and postgraduate medical training.

In the current policy paper, the PWG aims to set up recommendations on future medical work with the aim of ensuring change for the next millennium.

The recommendations are that the following aspects be assured in the system of Future Medical Work:

01. continuity of care in relation to the patient, with patient information as an integrated function,
02. applied postgraduate and continuing medical education and supervision,
03. participation of doctors in research and medical audit,
04. participation and training of doctors in administration and management,
05. the establishment of day work as the main part of the total working time of all medical doctors,
06. the delegation of responsibility and competence in accordance with the individual doctor's qualifications,
07. the equal distribution of on-call work with respect for qualifications and specific individual conditions,
08. the encouragement of an atmosphere amenable to discussion of uncertainty, weaknesses, and possible mistakes,
09. the nurturing of mutual support within the medical profession, for example with regard to new doctors beginning their duties and to management of situations with terminal patients, relatives, etc.,
10. the inclusion of all doctors in a continuing discussion of the development of the department's treatment methods, medical audit, teaching, and organizational structure,
11. the presence of an accessible medical management which actively takes part in the above and supports the medical team in relation to other health professionals,
12. the organization of daytime work in a way that assures the quality of treatment and care, based on set standards of the time need of each medical task,
13. the integration of teaching and supervision as a part of the daily work schedule for all doctors,
14. the establishment of clinical teams to ensure quality and continuity in the daily work of all doctors,
15. the recognition of conferences and staff meetings as important components of a day's work and their development as fora for tutoring and debate,
16. the recognition that on-call work consists of urgent medical work that cannot be postponed until the next day,
17. the foundation of the future medical staff structure on individual countries manpower situation and on the basis of equal working conditions all doctors.

Unanimously adopted
by the PWG Plenary Assembly
Tallinn, 3 May 1997

03

POLICY STATEMENTS OF THE PWG
Other Policy Resolutions & Studies





Other Policy Resolutions & Studies
Education and
Professional Development

Resolution on Specialist Training

April 1983, Glasgow

The evaluation of specialist training is necessary to maintain the standard of European medicine. PWG recognizes the importance of securing that each country ensures, as appropriate to its national situation, that specialist training positions provide sufficient educational content to produce specialists of uniformly high standard in Europe, and that the methods of evaluation used in various countries be studied with a view to possible coordination.

Resolution on Equal Rights of Men and Woman Doctors

September 1983, Reykjavik

1. There should be no discrimination on the grounds of sex in postgraduate medical education.
2. More account than at present should be taken of the needs of doctors with domestic commitments; depending on circumstances, this may include better facilities for part-time training, more generous maternity or paternity leave, hospital creches, etc.

Resolution on the Evaluation of Specialist Training

September 1984, Porto

1. The evaluation of specialist training is necessary to maintain the high standard of European medicine.
2. In most countries, the trend towards evaluation of specialist training is increasing.
3. The PWC recognizes that the evaluation of specialist training facilities by professional bodies and universities throughout Europe needs to be coordinated.

Conclusions to the Survey on Compulsory Postgraduate Training

October 1987, Oslo

1. Compulsory post-graduate periods for junior doctors are recommended in western European countries.
2. The aims and the structure of the period need to be well planned and the posts evaluated.
3. The distribution mechanism for posts of this period should be made more efficient in some countries. The period should not become a bottleneck that prevents doctors from starting independent practice and/or further specialist training.
4. The social problems of the junior doctors and their family should be taken into consideration.

Comments on the “Edinburgh Declaration” on Medical Education

April 1989, Utrecht

The PWG, meeting in Utrecht in April 1989, welcomes the publication of the Edinburgh declaration and recognizes the importance of cooperation between ministries of health, ministries of Education, community health services and other relevant bodies in promoting medical education, but believes:

- that the central role of medical associations in this process should be emphasized;
- that reliable methods of selecting doctors on the basis of personal qualities remain to be developed and
- that joint learning involving medical trainees and other health professionals must not lower the educational standards for doctors.

Provisional Statement on Quality Assurance in Clinical Medicine

October 1990, Vienna

The Medical Profession has for many years been committed to the aim of securing the highest standards in clinical practice. It is also an integral part of that practice that doctors continuously seek to update their knowledge and skills and to assess (critically) their own performance against established standards of care. Postgraduate training, continuing medical education (CME), as well as much clinical research are also directly aimed at improving standards of care.

As medical technology and clinical practice become increasingly complex, and as the problem of maximizing the utility of available resources becomes more urgent, it is only natural that such efforts should be more firmly structured and organized, which will also serve to make this fundamental element of clinical practice more visible to the public.

The PWG considers that the following principles are fundamental in regard to Quality Assurance (QA):

- 1) QA should build on existing foundations in clinical practice.
- 2) As QA can be considered a professional responsibility of doctors, the medical profession must be independently responsible for the setting up and running of QA.
- 3) Successful QA programmes will require a substantial investment of resources.
- 4) The methodology of QA should be researched and developed so as to ensure reliable results.
- 5) QA should build on motivation, not sanctions.
- 6) Confidentiality vis-à-vis both patients and doctors concerned must be assured.
- 7) The participation in systematic QA programmes should as a rule be voluntary; however, this will in the longer run undoubtedly become a routine part of medical practice.
- 8) The core of QA must be seen as an educational process aimed at improving skills, knowledge and performance of those who participate.
- 9) The possibility of involving lay persons in the organizational framework concerned with QA should be viewed in a positive way.

April 1990, Birmingham

The PWG cannot and will not consider a prolongation of the time required for specialist training unless the recommendations of the PWG Policy Statement on Postgraduate Medical Education have been fully adopted and implemented.

Motion about Establishing European Specialty Boards by the European Union of Medical Specialists (UEMS)

April 1991, Reykjavik

The PWG has noted the proposal for the establishment of European specialty boards and believes:

- I that the first and principal task of such boards should be to promote uniformly high standards of training in all specialists throughout Europe, bearing in mind the statements on specialist training of the ACMT and PWG.
- II that ensuring the quality of training programmes is the most important means ensuring the quality of the end product.
- III that it is impossible to test the full range of skills and knowledge required in a specialty by any imaginable form of examination.
- IV that European specialist examinations should not be introduced.
- V that European specialty boards should only be established if they can adequately be financed without dependence upon income from individual (junior) doctors.
- VI that the PWG would welcome the opportunity to nominate a junior doctor from the relevant specialty to each specialty board.

Statement on Temporary Migration with an Educational Purpose

April 1978, Helsinki

The Permanent Working Group of European Junior Hospital Doctors is an international body created to improve the relationship between junior hospital doctors of the European countries, to exchange information, and to discuss a common approach to problems of mutual interest. Having a strong belief in mutual benefits of good international connections the Permanent Working Group of European junior Hospital Doctors (PWG) works to encourage junior doctors to temporary practice abroad.

Temporary practice abroad not only improves the skill and experience of the doctor involved, but also equalizes and improves the standards of European medicine as a whole.

The PWG suggests that governments, in cooperation with national medical organizations,

- direct the attention of their national professional individuals to the desirability of a stay in a foreign country to improve their quality of work
- support the efforts of creating a certain number of training posts especially reserved for foreign junior hospital doctors in the course of specialist education
- provide financial support, if necessary, for those junior hospital doctors.

Resolution on Transnational Training

April 1984, Vienna

Reaffirmation of the PWG's commitment to a transnational training program, calling upon the EEC authorities to support the proposed pilot project.

Definition of Quality Assurance

November 1991, Florence

Quality Assurance is the systematic and critical analysis of the quality of health care, including the procedures used for diagnosis and treatment and promotion of health, the use of resources, and the resulting outcome for the patient. This analysis leads to the implementation of any necessary changes, the outcome of which becomes the subject of further systematic, critical analysis.

Policy Statement on Postgraduate Medical Education in General Practice

Introduction

The Permanent Working Group of European junior Hospital Doctors adopted its policy statement on postgraduate medical education at a plenary meeting held in Munich on 15th October 1988. The statement was favorably received by the Standing Committee of Doctors of the European Communities, whose Education Sub-committee forwarded it to the EC Commission for further consideration. It has been endorsed by national medical associations and educational bodies and was published in the journal "Medical Education" (1).

The policy statement did not refer to any particular specialty nor did it attempt to define the content of the training leading to the status of specialist in any given field. Rather, it set out educational principles which the PWG believes should be applied in postgraduate medical education in general.

Trainee general practitioners receive between a half and two thirds of their training in hospital posts, sometimes the same posts which, at other times, are used by trainees intent on a hospital career to obtain their early experience.

The PWG believes that the educational principles set out in its policy statement on postgraduate medical education are applicable to trainee general practitioners during the hospital phase of their training as well as to those training for hospital specialties. Suitably interpreted, they are also relevant to those undergoing postgraduate training in all other fields of medical practice.

The PWG nonetheless recognises that trainee general practitioners do have particular requirements during their training. These have been identified by others, notably in a report from the Advisory Committee on Medical Training (EC) (2) and in several documents of the Union Européenne des Médecins Omnipraticiens (3–5). The training of general practitioners in the EC is also governed by a Directive (86/457/EEC), which sets out minimum standards for both the hospital and the practice-based components of the training (Annex 1).

The purpose of this paper is, therefore, to point out the way in which the principles enunciated in the PWG policy statement are applicable to the training of future general practitioners and to highlight the special requirements of these trainees. The

PWG does not feel qualified to make a comprehensive statement dealing with the practice based component of GP training but believes that many of the educational principles which it has identified are applicable to both phases of training for general practice.

The ACMT Recommendations, UEMO opinions and the Directive

The PWG policy statement began by endorsing the ACMT's recommendations on specialist training. The PWG also wishes to endorse the ACMT's recommendations on specific training for general practice contained in Doc III/D/697/3/77. This document sets out the role of the general practitioner and argues that specific training for this role is necessary. It reaches conclusions about the organisation and content of the training which are very similar to its conclusions in respect of specialist training, with the need for a competent authority to oversee the training and the importance of the trainee participating in the work of the training centre being emphasised particularly. A portion of the document is reproduced in Annex II.

In order to facilitate the free migration of doctors and to give all EC doctors access to the title of "general medical practitioner", which is legally protected in some member states, the Commission found it necessary to propose a further medical directive dealing with specific training in general practice. By way of formulating its opinion to the Commission on this matter, the UEMO produced its own document (UEMO 84/34) emphasising inter alia the need for appropriate supervision of the trainee by an experienced colleague, for both theoretical and practical instruction, for authorisation of hospitals and trainers and for a self-critical approach. The Directive (86/457/EEC) was published in September 1986 and sets out the transitional arrangements leading to the establishment of mandatory training in general practice throughout the EC by 1st January 1990. The important points of the ACMT and UEMO recommendations were incorporated in the Directive.

The UEMO has continued its consideration of the problems of training in general practice and held a symposium on the sub-

ject in December 1987, a summary of which was made public. At the symposium, many of the important principles of GP training were restated. In addition, a number of difficulties with the implementation of the Directive were identified, stemming mainly from lack of money and shortage of hospital posts for trainees intending to enter general practise. The UEMO called upon governments to provide the resources necessary for the provisions of the Directive to be fulfilled.

The PWG endorses the view that general practice is a specific discipline analogous to the medical specialties. It believes that specific training for general practice is essential. It wishes to see the highest possible standards of training in every field of medical practice and supports the principles enunciated by the ACMT and UEMO and contained in the Directive.

Relevance of the PWG Policy Statement

The PWG, while endorsing the recommendations of the ACMT, sought to extend an existing consensus to a wider range of issues. Its policy statement attempted to define the aims of training and discussed the needs of the trainees and the duties of trainers.

The aims of training include a high level of knowledge and skill, sufficient breadth of knowledge, social and communication skills, awareness of ethical problems, administrative skills and a willingness to teach and engage in research.

The aims are clearly the same in all disciplines and should not be confused with the contents, which vary. In particular, the knowledge and the breadth of knowledge required by a GP are different from those required by a hospital specialist and this must be recognised by the trainer.

Similarly, the trainee's need for a model of good practice, extensive experience, teaching and, most importantly, critical scrutiny and unambiguous feedback is universal. Though the model which is appropriate and the subject matter of the teaching vary. In all disciplines, these needs can only be met when there is a close relationship between trainee and a clearly identified trainer, and all trainers have a duty to recognise and fulfil the needs of their trainees. They themselves need time to fulfil their responsibilities, time for their own continuing education and training in educational methods.

Assessment of the training and of trainees is another universal requirement if standards are to be maintained. This in turn implies a competent authority or authorities to oversee the training. The fact that some trainees will fail to complete training in general practice to a satisfactory standard was recognised at the UEMO symposium of 1987. Sympathetic methods of dealing with such situations are necessary.

Special requirements of trainees in general practice

The PWG is, nonetheless, aware of several problems which are peculiar to GP training. These result partly from the different roles of GPs and hospital doctors and partly from the relative underdevelopment of primary care in some European countries. The role of the GP demands a training which is broadly based and ensures familiarity with those conditions which are commonly treated in a primary care setting. In addition, intending

GPs require training in practise management, collaboration with other health professionals, preventive medicine and the treatment of chronic and terminal illnesses. These are, however, curricular matters and can readily be compressed within the educational framework set out in the PWG policy statement.

The relative underdevelopment of primary care in some European states, the extent of medical unemployment in others have resulted in an acute shortage of hospital posts for intending GPs. A similar shortage of training posts in general practices exists, where governments have not provided the resources necessary to fund them. The PWG offers its endorsement to the efforts of general practitioners and others to ensure the availability of an appropriate number of posts for trainee general practitioners but believes that governments have a duty to ensure that the necessary resources are provided.

It is in the interests of patients that general practitioners should be properly trained and this cannot be the case unless suitable training posts are available in sufficient numbers. It is essential that governments and the medical profession itself should take whatever steps are necessary to ensure the availability of such posts.

The curriculum of general practice training is a matter for bodies representing general practitioners to determine in consultation with their trainees. The mechanism of inspection and approval of GP trainers, combined with the provision of training in educational methods for them, should ensure that trainees receive an appropriate education in all relevant matters during their period of training in the primary care setting. It is more difficult to ensure that their period of hospital training will be relevant to their needs, and complaints are sometimes heard that the training provided in hospital posts is orientated too much towards the specialist practice.

Given the shortage of such posts, this is a difficult problem to grapple with. Ideally, the competent authorities responsible for GP training should have the right to inspect and approve hospital posts which are used for training general practitioners. Where this is not feasible, they should at least provide guidance to hospital specialist, on the type of training which is appropriate for intending GPs and its content. Trainers in hospitals clearly have a duty to recognise the needs of all of their trainees, whatever their career intentions, and to meet them. It is to be hoped that continuing improvements in postgraduate training in all fields will make trainers more aware of their responsibilities and lead to greater recognition of the specific needs of each individual trainee.

References

1. The Permanent Working Group of European Junior Hospital Doctors. Policy statement on postgraduate Medical Education. *Medical Education* 1989; 23: 339–47.
2. Advisory Committee on Medical Training (EC). Report and opinion on specific training for general practice. doc. No III/D/697/3/77.
3. Union Européenne des Médecins Omnipraticiens. Contents of specific vocational training in general practice. UEMO document 84/34. 1984.
4. UEMO symposium on training for general practice in the EC,

Luxembourg, 1987.

5. Rowe A. Content of specific vocational training in general practice. UEMO doc 15 001 89. 1989.

ANNEX I

Extract from Directive 86/457/EEC

Article 2

1. The specific training in general medical practice referred to in Article 1 must meet the following minimum requirements:
 - a) entry shall be conditional upon the successful completion of at least six years' training within the framework of the training course referred to in article 1 of Directive 75/363/EEC;
 - b) it shall be a full time course lasting two years and shall be supervised by the competent authorities or bodies;
 - c) it shall be practically, rather than theoretically based; the practical instruction shall be given, on the one hand, for at least six months in an approved hospital or clinic with suitable equipment and services and on the other hand, for at least six months in an approved general medical practice or in an approved centre where doctors provide primary care; it shall be carried out in contact with other health establishments or structures concerned with general medical practice; however, without prejudice to the aforesaid minimum periods, the practical instruction may be given for a minimum of six months in other approved health establishments or structures concerned with general practice;
 - d) it shall entail the personal participation of the trainee in the professional activities and responsibilities of the person with whom he works.

ANNEX II

Extract from ACMT document III/D/697/3/77

OPINION OF THE COMMITTEE CONCERNING THE SPECIFIC TRAINING OF GENERAL PRACTITIONERS

5.1

In the interests of public health the Member States are urged to recognise general practice as a specific discipline which should be taught to all students during basic medical training in order to acquaint them with the main forms in which medicine is practiced and thereby enable them to make a reasoned choice of career.

5.2

The Member States are urged to promote specific training for general practice in order to prepare intending general practitioners as thoroughly as possible for their specialised role in

health care.

5.3

The Member States are urged to recognise general practice as a specific discipline, analogous to the recognised specialist disciplines, with a view to the application of Article 8 of Directive 75/362/EEC.

5.4

The Member States are urged to inform the Commission periodically concerning their requirements as regards specialised vocational training for general practice.

Supervision

In some European countries it is permissible to offer medical services to the public once the basic medical training has been obtained and any basic practice completed necessary to obtain registration as a medical practitioner. In recent years individual countries have sought to apply standards necessary to practice as specialists and included general practice more recently still as a speciality also. As the standard expected of a specialist has increased a minimum training, to reach that standard has become apparent. It is an obvious statement of fact therefore that practitioners working in a specialty who are not of specialist status are not competent enough in that specialty to practice unsupervised. This paper seeks to establish a basis for developing a policy on supervision which specialists could then apply to an individual trainee in order to establish good supervisory practice. Attention has previously been drawn to the necessity for good supervisory practice in the PWG paper on Post Graduate Training. Policy statement on Postgraduate Medical Education (Medical Education 1989, 23, 339–347). The following are the recommendations of the PWG on such a policy.

RECOMMENDATIONS

Supervision of junior doctors in their every day work should be maximised through passive and active supervision.

- a) Passive supervision entails constant availability with ease of access to a senior, more competent member of staff to deal with matters beyond the particular junior doctor's ability.
- b) Active supervision has many facets but at its most basic, entails the regular and consistent attendance of a fully qualified specialist to review or examine the work of the junior doctor in all aspects of his or her job, i.e.

- I Procedures and therapies;
- II Admissions and emergency assessment;
- III In-patient care;
- IV Discharges;
- V Correspondence and note keeping;
- VI Out-patient care;
- VII Consultation. Liason and community work.

It also includes: having written policies on (I) to (VII) above. These policies should, where possible, be standardised on a national or international basis.

- c) Each trainee should have at all times a nominated supervisor who is a qualified specialist available to him.
- d) Orientation courses should always be held for junior doctors commencing a new post. This should include an assessment by a nominated supervisor who is a qualified specialist, of the junior doctor's abilities, experience and deficits to estimate the starting level of responsibility which should be communicated to him. Information should also be given re hospital policies as outlined in (b) as well as any other hospital policies. The match of competence to responsibility taken can progress in a stepwise but flexible process thereafter.
- e) Supervision should be subject to regular medical audit.
- f) The standard of supervision should be a criterion of accreditation of a centre of training.

Comments of the Permanent Working Group of European Junior Hospital Doctors (PWG) concerning the UEMS draft charter on Training of Medical Specialists

The PWG obviously has a genuine and legitimate interest in medical education, especially postgraduate medical training, and as the representative body of doctors in training and young trainers it is entitled to express its views on this matter. The time is ripe for the preparation of a charter on postgraduate medical training at the European level, which for UEMS means specialist training, and the PWG of course welcomes the initiative taken by the UEMS.

The PWG defined its own policy on this matter quite a few years ago and is now working on more specific aspects of training. We are concerned that UEMS is "putting the cart before the horse"; there has been a rush of enthusiasm for the creation of European examinations and only now is attention turning to what the "final product should look like, how and where we should educate and train this product. There seems to be a lack of appropriate balance and coordination in current discussions. The profession at present has had a unique opportunity offered by the authorities to harmonize the medical education, which it cannot afford to jeopardize.

The introductory letter states that the new philosophy is not to aim at minimum requirements, but at the optimum. The PWG agrees in general with such a statement as long as there is no confusion between the optimum and the maximum. On the one hand it is unrealistic to believe that minimum standards are fulfilled throughout Europe; on the other hand, we believe in the necessity of guaranteeing a standard achievable not only by the top 10% but by a larger group. We fully agree that there is more than one line in medicine, and that therefore training contents and methods, education of trainers, requirements for training posts as well as methods of quality control of training may vary from one specialty to another. General guidelines should therefore be given in a neutral way.

One comment in the preamble will illustrate this point: The definition of a specialty in this charter is „an area of medicine for which a structured secondary training exists, possibly with examination". It is of paramount importance for a body like the UEMS to give a good definition of the term "specialty"; this being a natural part and traditional entity within medicine which requires structured specialized training; examinations, as

one possible form of assessment of training, have no place in a definition.

The view of the PWG on examinations is well known, and it can be read in our policy statement on postgraduate medical training. We consider examinations as one possible tool of assessment on the national level, but certainly not as the only and most important one since we believe that "it is impossible to test the full range of skills and knowledge required in a specialist by any imaginable form of examination". The PWG made its statements with national audiences in mind; the task at the European level are harmonization and supervision; examinations at this level are without value, dangerous for the profession and will not be considered by the PWG. The first draft for this charter is obsessed by the idea of European examinations; assessment, supervision and monitoring would be more general terms, examinations being only one method, not the best and surely not applicable in testing skills, even if they help to test a part of what we call knowledge:

Preamble C.3 "examinations or other means of qualification".

Chapter 1, point 1.4 "a system of qualification" is all that is needed at this stage. "Board examinations" do not need to be mentioned.

Point 2.5 is acceptable as drafted.

Manpower planning (1.5), (2.6)

The PWG is surprised at the certainty in some areas of the profession about the supply and demand of doctors in Europe: We agree, looking at the age profile of the population in Europe and at the financial resources available for health care, that in the future we may need more highly qualified general practitioners, whereas the need for more specialists will probably have to be handled in a more restrictive way; nevertheless it is dangerous to define numbers without being willing to discuss numerous clauses at European level.

The PWG will consider such a limitation only if based on clear studies – a possible methodology for which has been given by

102 the PWG itself – otherwise limitations risk being interpreted as pure lobbying for certain specialties; an approach repeatedly rejected by UEMS delegates.

The position of the PWG is quite clear on one point: Manpower is a national affair. Therefore regulation on this matter including numerus clausus must not be introduced at a European level.

Selection (2.1)

The PWG has studied in depth the problem of selection at several stages (admission to medical school, admission to postgraduate medical training) including studies of the literature; we could not find a clear solution. Examinations, especially when they occur at the very beginning of the curriculum, seem the most bizarre method of selecting people for specialist training; The PWG is convinced that we must trust teachers; they are able to judge, they are supposed to be able to advise young doctors during training and even, if necessary to offer guidance in changing a career pathway.

Duration of the training (2.2)

We suggest that the reference to a requirement for full time training be deleted from the charter, since in many countries it has become an established tradition to offer part-time posts at a time, where more and more doctors with domestic commitments are entering the medical labour market. Due to the special conditions in Greece, their delegation states that, for its own country, only full-time postgraduate training is acceptable.

Qualification of teachers (4.1)

We doubt, whether it will be possible to find enough teachers who have been qualified for at least 5 years. If this article is aimed at the doctor responsible for teaching i.e. the head of the department, this might be applicable. However, many other, younger specialists will function as teachers, if a reasonable teacher/trainee ratio, as stated in 4.3 is to be guaranteed. Furthermore we believe that "teacher" and "supervisor" are two different but very important functions in postgraduate training. They should both be defined in a clearly distinguishable way.

Specialty requirements (chapter 6)

The PWG believes that the statutes of the monospecialist sections should in all cases be subsidiary to the UEMS Charter. We consider all repetition in this chapter to be unnecessary. It is good style if the UEMS appears in all monospecialist statutes as the one organization responsible for the "ensemble" of specialist education and therefore the Charter of the UEMS is a part of all specialist statutes, the statutes for single specialties not being able to stand alone.

Foreign language (5.2. of chapter 6)

Although one foreign language may be desirable, it is not a prerequisite for good medical practice and therefore should not be mentioned as such in this charter.

Statement on the Quality Assurance of Postgraduate Medical Training

The Permanent Working Group of European junior Hospital Doctors (PWG) in its statement on Quality Assurance in Clinical Medicine identified postgraduate medical training as a specific area in which the aims and methodology of QA should apply.

The PWG has now completed a survey of the Quality Assurance of Postgraduate Training across Europe by Speciality, detailed results of which are available on request.

Our main findings were that the current systems in place in Europe for the Assurance of Quality of Postgraduate Medical Training are inadequate. Whilst most countries have begun to develop statements of their aims of training, assessment of the implementation of these remains very patchy and over reliant on assessment of individual trainees. Very few countries assure effectively the quality of the process training that the trainee receives.

In the light of this the PWG has formulated the following recommendations for future practice and would commend these not only to individual countries but also to the European Boards.

1. All training schemes should have detailed written statements outlining the content of their training programme and the standards they hope to achieve. These should include criteria for recognising Clinical Supervisors and Trainers.
2. There should be mechanisms to inspect training schemes to ensure that they fulfil these standards, which are not exclusively based on the performance of the trainee. Trainees should be encouraged to participate in this process, and enabled to do so in a non threatening way.
3. Mechanisms are required (which may include sanctions) to encourage those schemes which fall short of these standards to change their practices with the aim of achieving them. These changes themselves need to be monitored.
4. Reports on training schemes should be accessible both to trainers and trainees.
5. All training posts should have detailed educational job descriptions, and a process of review to ensure these educational aims are met.
6. Written reports on trainees should be discussed with the trainee in person to allow them to institute their own personal process of Quality Assurance.

PWG 93/066

MOTION

On Specific Training for General Practice

Malta, May 1993

PWG has considered the subject of specific training for general medical practice, and in particular the proposal of prolonging the minimum time for specific training for general practice.

PWG would like to reemphasize its views that the most important focus in this field is not on the duration of training, but on the structure, content, and quality of training for general practice.

Report on Survey on Training in General Surgery 1991

By Dr. Lise Kay (DK)

BACKGROUND

In 1991, the PWG decided to conduct a study on the training in general surgery in each of the PWG member countries. Dr Stephen Brearley (UK) was responsible for the study which was initiated in the autumn of 1991. Preliminary results were presented at the PWG meeting in Stockholm in spring 1992, but as the final results of the study were delayed, Danish Surgeons in Training offered to conclude the study in the autumn of 1993. These are the results of the study.

METHOD

The study was divided into three phases: a questionnaire concerning general aspects, a list of operations performed throughout a specified week, as well as a diary from the same week registering all activities at work (see enclosure).

In each country, a national coordinator was appointed as responsible for the study on the national level. The study was presented to the coordinator who had the possibility of commenting on the draft with regard to the training situation in the individual country. The task was then to recruit 20 doctors in training (trainees) on national level to participate and have the study conducted. The 20 trainees should include 10 individuals who had been in training for 2–4 years and 10 individuals who had been in training for 6–8 years.

RESULTS

Participation

Group I (2-4 years):

Austria 16; Belgium 8; Switzerland 6; Germany 10; Denmark 9; Spain 12; United Kingdom 10; Iceland 5; Norway 9; Netherlands 10; Sweden 6; Finland 10.

Group II (6-8 years):

Switzerland 5; Germany 3; Denmark 9; United Kingdom 7;

Norway 10; Netherlands 8; Sweden 9; Finland 6.

The following countries had no training in surgery corresponding to Group II: Austria, Spain, Belgium, and Iceland.

The following countries did not participate: France, Greece, Italy, Ireland, and Portugal.

Working and Training Conditions

Group I:

The working hours vary from 88 hours per week (Austria) to 52 hours per week (Denmark). In the Netherlands, an average of 18 hours per week was unpaid, while in Iceland, only half an hour per week was unpaid.

The majority of the trainees in Group I (83–100%) worked in duties at hospital with the exception of Iceland where duty in which the trainee has to remain within the hospital does not exist. Only in the United Kingdom, did all trainees have an experienced colleague present at the hospital when on duty, while in Iceland, the Netherlands, Sweden and Finland, a more experienced colleague was never present during duty work. Only in Denmark and Finland, did the doctors usually leave the hospital in the morning after a duty at night and only in Denmark and Norway, a 24-hour shift was divided into two shifts.

In Belgium, 42% of the working time was spent at the surgery ward as compared with only 18 % in Denmark, while 59% of the working time in Denmark was spent in the departments compared with 36% in Belgium and The Netherlands. The number of operations in which the trainees took part varied from 11.4 in Austria to 4.1 in Denmark, of which 46% were supervised in Switzerland while Austria had the lowest number of supervised operations (12%).

Within the previous 12 months, the average number of days dedicated to participation in courses/congresses varied from 12.4 days in The Netherlands to 3.8 days in Belgium. In The Netherlands, Iceland, Sweden, and United Kingdom, leave with pay was given to 100% of the trainees, while in Denmark, leave with pay was only offered to 22% of the trainees. In addition,

100% of the expenses were fully reimbursed in Iceland and United Kingdom, while in Belgium, expenses were not covered at all.

The satisfaction with the training was evaluated on a scale from 0 to 10 (maximum). Trainees from Iceland had the highest score with 7.8 points, while Denmark had the lowest score with 4.5 points.

Group II

The working hours varied from 87 hours per week (Switzerland) to 51 hours per week (Sweden). In the Netherlands, an average of 10 hours per week was unpaid, while in Finland, only 2 hours per week were unpaid.

Only "In Norway and Finland, all Group II trainees had to remain at the hospital while on duty while most other trainees in Group II had no obligation to remain at hospital (0–50%). No trainee had a more experienced colleague present at the hospital during cells. In Finland, all trainees left the hospital the morning after a duty at night which was always divided into two shifts.

In Sweden, 32% of the working time was spent at a surgery ward compared with only 18% in Switzerland, while 43% of the working time was spent at the departments in Norway and 24% in Switzerland. The number of operations per week in which the trainees took part varied from 11.1 in The Netherlands to 4.3 in Finland, of which 30% were supervised in United Kingdom, while Switzerland had the lowest number of supervised operations (13%).

Within the previous 12 months, the average number of days dedicated to participation in courses/congresses varied from 15.0 days in Switzerland to 5.3 days in Sweden. In The Netherlands and United Kingdom, leave with pay was offered to 100% of the trainees while in Finland, only 50% of the trainees were offered leave with pay. In addition, 86% of the expenses were reimbursed in Iceland and United Kingdom while no expenses were reimbursed in Finland.

The satisfaction with the training was evaluated on a scale from 0 to 10 (maximum). Trainees from The Netherlands had the highest score (7.9 points), while Denmark, Norway, and Switzerland had the lowest score (6.2 points).

CONCLUSION

The work and training conditions of trainees in surgery in Europe vary considerably and there are significant differences in the resources allocated to training.

EVALUATION OF THE METHOD

The idea of a national coordinator was good as it gave an unambiguous placement of the responsibility for the management of the survey on local level and also because it provided local contact to solve interpretation problems regarding the questionnaire and the answers received.

In addition, there is no doubt that the survey gave a good and detailed description of the participants' work and training conditions in the week in question. However, there might be problems with regard to representativity; whether the 10 participants in the two groups are truly representing the trainees of the country in question and whether it may be assumed that the week chosen for the survey is truly representative for the work conditions in general. A national coordinator has a vast possibility of selecting particularly good or bad training sites and, thus, influence the results from his/her country in a favourable or unfavourable direction. A higher number of participants and a longer registration period will obviously clarify this, but will also entail a considerable increase in expenses.

National differences in training programs weaken the comparability of the study. The Netherlands have e.g. a very short training period while the training period in Denmark is very long. Accordingly, a Dutch trainee will after 4 years be on another level than a similar trainee in Denmark.

Other national differences meant that some of the questions posed in the questionnaire could not be answered in a meaningful way. This is true for the questions about Patient Management (page 3) in which different organizational structures of the hospital system resulted in the answers being incomparable. Differences in the interpretation of words as "professor", "senior specialist", "more senior trainee," and "quality assurance" (page 4: General) made the answers incomparable in a meaningful way. Even the interpretation of the words "working hours" resulted in a few misunderstandings as the border between work and leisure could be difficult to determine (e.g. the processing of research results or the study of scientific literature which is done at home).

Nevertheless, most of the above problems could be solved in future studies by careful selection of questions and precise definitions of the terms used in the questionnaire. However, a major problem is the parameters applied to evaluate the objectives of good training. Within surgery, it seems obvious that the number of operations, and especially supervised operations, is an important and easily measurable parameter, but it is not the only relevant parameter. It is also essential that the surgeon learns to select the right operations to the right patients and is capable of following up postoperative treatment. Other specialties with less practical skills to be learned might find it even more difficult to find parameters which are relevant and measurable.

Finally, but not least: how is good training defined? Is training efficient in which everything is learned within a few years, but in which the work does not leave room for anything else? Or is it the less concentrated training which requires a longer training period, but also leaves room for other activities as e.g. family and home and, thus, also career possibilities for women? Is it the training in which most of the working time includes the relevant content of the training? Or is it the training in which the employer makes all resources available?

In conclusion, it should be emphasized that in addition to the results presented, the study in surgery has given experience which might improve similar future studies.

PWG 94/099 Final**MOTION****EU/EEA Citizens with 3rd Country Primary Medical Qualifications**

The PWG resolves that a doctor who is a citizen of an EU/EEA member state, has a primary medical qualification from a country outside the EU/EEA, and that this qualification has been registered as conferring competence to practice as a doctor by an EU/EEA member state, should be deemed equally competent to practice as a doctor within any other EU/EEA member state.

PWG 96/085 Final**MOTION****EU/EEA Citizens with 3rd Country Primary Medical Qualifications**

The PWG resolves that a doctor who is a citizen of an EU/EEA member state with a primary medical qualification from outside the EU/EEA, but who has done his or her specialist training in an EU/EEA member state and received specialist recognition in that member state should be deemed equally competent to practice in that specialty within any other EU/EEA member state within which it is recognized.

Adopted by PWG Plenary Assembly,
Copenhagen, October 1996

(Draft versions issued as PWG 95/019)

Policy Paper on Continuing Medical Education

SUMMARY

With reference to the CP Dublin Declaration on Continual Medical Education, the Permanent Working Group of European Junior Hospital Doctors finds that continuing medical education (CME) must be available, not only to medical specialists, but also to doctors in postgraduate training. PWG believes that CME available in all educational phases would improve the education of future doctors and especially secure doctors in postgraduate training access to educational activities other than those related to postgraduate medical training.

1. DEFINITION OF CME

The right to and need for CME at all educational levels.

At the Plenary Meeting of the PWG in Vienna in October 1994, the PWG, like UEMO and UEMS, adopted the revised CP Declaration of Dublin (CP 93/26 Final, see PWG 94/039) on Continuing Medical Education (CME).

The Declaration of Dublin states, that "the subject under consideration is the activity by which a doctor already fully trained and qualified to practice medicine renews, extends, and updates his professional skills."

The paper addresses the educational needs of the "fully qualified doctor" who "is legally entitled to offer medical services independently of any supervision by other doctors" and who has "undergone the basic, and where appropriate, specialist training necessary for the form of practice in which he engages."

Further, the Declaration states "that CME is an ethical obligation to every fully qualified doctor and that the doctor thereby has a double ethical duty to the patients, both to recognize his limitations and to find ways of continuous improving his capabilities. Only the individual doctor can know the true realities concerning his competence."

Finally, the Declaration states, that "it should, at the same time, equally be emphasized that every doctor has a right to participate in CME and (that) adequate provision for this be available to the doctor."

Therefore, the Permanent Working Group of European junior Hospital Doctors finds:

- it crucial to state that CME is a right for all doctors and that also doctors in training have a right and need for CME. It is of major importance that CME activities are made available to doctors in training as well as other doctors. This falls within the dynamic concept of CME which the Charter offers.
- that CME should be seen as dynamic educational activities, beginning on the first day in medical school with the aim of expanding and refining already accomplished knowledge. CME is not merely a static concept only directed towards fully trained specialists, but also a means of qualifying the whole medical profession. The concept of being taught how to learn should be fundamental in all medical education.
- that doctors in training have a right to CME activities directed towards basic clinical skills in the doctor's own specialty and in relation to other specialties. This can relate to basic, diagnostic procedures and early hospital treatment in general as well as subjects related to primary health care.
- that doctors in training should be given the opportunities of educational activities other than the postgraduate training related to the doctor's specialty.

II. PARTICIPATION IN & DOCUMENTATION OF CME

The PWG finds

1. that participation in CME as an ethical obligation is part of the individual doctor's responsibility in maintaining a high standard of practice and it is for the doctors to decide the extent of their participation;

- 108
2. that there are, however, reasons which may at times preclude a doctor from participating in CME such as research, family obligations, or other commitments;
 3. CME should be used in a supportive and dynamic manner and not as a means of establishing recertification or other assessment procedures in the medical profession.
The national medical organizations should take on the establishment of means of documentation of doctors' participation in CME.

III. Financial aspects

The PWG states that paid leave and participation in CME activities should be guaranteed in contracts for doctors in training.

SUMMARY NOTES

Presentation of PWG Policy on Postgraduate Medical Training to the Advisory Committee on Medical Training (ACMT)

Meeting of the Working Group on Specialist Training

Ischia, Italy, 30 June 1995

Working Group Representatives: see attached list (Annex II)

PWG Representatives:

Dr Edwin Borman & Mr Thomas E. Kennedy.

Invited by the Chairman of the meeting, Dr Hoppe (D), to put forth the PWG position, Edwin Borman presented the organizational background of the PWG as well as the PWG Policy Statement. He explained that both the original Policy Statement from 1988 as well as the new one had been circulated to the Group and that the latter was the up-to-date one. Further, he noted that the Proceedings of the PWG Symposium on Postgraduate Medical Training held in London on 11 May 1995 were currently being prepared and would be made available to the ACMT when they were published in the near future. He then presented the main conclusions of the Symposium and the recognition that the improvement of training was an essential link in the improvement of patient care. The directives from 1975 had not included content of training, but only a framework and many people now felt that the time had come to begin to include content. With regard to the CSOPH and the comitology procedure, he noted the PWG recognition of the fact that the European Commission was looking to the profession to help improve the general standard of training throughout Europe and the PWG was satisfied with the Commission's intention to continue to do so.

He recalled that the ACMT Working Group on General Practice had taken in the input from the UEMO and come forward with some recommendations that were now being presented as draft amendments to the directives. The PWG was prepared to make a similar proposal within its area.

He then proceeded to present the paper he had prepared for discussion in the Working Group, including nine recommendations and the proposals for where these might be inserted in the directives (Annex 1).

These were as follows:

1. That defined bodies responsible for the supervision, coordination, and regulation of postgraduate medical training

should be identified in all member states and their responsibilities in this area be clearly determined.

Edwin Borman proposed that this might be inserted in the Directive, Article 5.2. The main concern here was to see to it that this information was clear and that potential migrants knew where to obtain it from.

Ms Reilly, ACMT Secretary, noted that Article 42 of the Directive stated that the member states should designate the authority. She asked whether further information would be needed in that Article and Edwin Borman suggested a slight amendment to that effect, either in Article 5.2 or 42 to show where this information was to be published or available which would be extremely useful.

2. That for all specialties, there should be a defined training syllabus of agreed duration and structure, moving from the general to the more specific and determined by consultation between all relevant parties at a national level. For insertion in Article 7.2 or 24. The idea was to have an extension of the definition of the training syllabus with a little more explanation of the way the syllabus is constructed in terms of duration and content. The PWG would like to see this done at national level, but that stating it in the Directive might help elevate training standards.

The actual content/structure could be in a separate item in the Official journal of the EU and actually structured by the national authority itself. The views of trainees and other interested parties should be heard in this respect. This should also be in the directive, although perhaps the time was not yet right for this.

On a question from Dr Hoppe (D), Edwin Borman clarified that on a global scale, the PWG would like to see that whether or not there is a sub-specialty or what form they should follow, the same global pattern of more general first and specific afterwards should be followed. That should be put into the Directive.

Ms Reilly thought the appropriate place for this change would be Article 24, while Dr Twomey (IRL) suggested it actually involved 24, 25, 26, and 27. Dr Pera (E) urged that

care be used in the definition of "general" and "specific." Ms Reilly noted that this need for a definition of balance was in reference to Article 24. The names of the specialties mentioned in 7.2 do not necessarily refer to the same thing from country to country and that was why it was important to look at 24.

Professor George (UK) quoted, "there should be a period of general training in the discipline, normally to be followed by subspecialty training." Ms Reilly pointed out that it was necessary that the recommendations be accompanied by reasons and Professor George explained that by the nature of clinical practice, patients do not come to the doctor as falling within a very specific frame. Thus, it was not good for training to be too specific too soon.

3. That other than for short periods all trainees/junior doctors should be engaged in postgraduate medical training in accredited training programs based on these training syllabuses and utilizing a range of training methods.

It was suggested that this be incorporated in Article 24. Dr Karle (DK) while understanding the reasoning in including the phrase "other than for short periods," nonetheless, felt that it was inappropriate to include it in this definition. Edwin Borman was willing to drop the phrase.

Dr Twomey (IRL) noted that Article 28 of the PWG Policy Statement referred to training by service. He noted that there was a manpower issue which needed to be addressed. In the 1988 PWG Policy Statement, there was a reference saying that 70% of the time should be spent in clinical work. He asked what this indicated about the balance between training and service.

Edwin Borman noted that it was difficult to say when a trainee was involved in pure training, but the essence was for the trainee to be involved in service based education. The 70% figure had been removed from the updated document. The meaning was that a trainee is involved in supervised practice that involved an educational component.

4. That in order to ensure that high standards are achieved and maintained, a fundamental element of these training programs is the incorporation of defined scientific evaluation methods both of the trainee and also of the training posts and programs.

It was suggested to incorporate this in Article 24 as well. Edwin Borman noted that the issue of assessment and evaluation was left out of the original directive. The PWG felt that there was a need to have some evaluation of training programs and trainers and that it would be appropriate to include this in the directive.

Dr Pera (E) questioned what was meant by the term "scientific" evaluation, and Professor George (UK) suggested it be avoided in this context. He stressed the importance of a log-book and regular assessment with perhaps a final assessment. Edwin Borman explained that the PWG Policy found reliance on an examination at the end of a program as inappropriate. The recent PWG Symposium had included a survey of the many evaluation systems and it was felt that while

currently there was no single ideal method, evaluation did need to be regular, a combination of methods. The log-book was good – perhaps combined with other methods on a regular basis.

5. That a system of regular inspections of all programs and their individual posts is an essential aspect of this evaluation process and should be linked with their accreditation for training purposes.

A discussion was held as to the frequency of such inspections. Edwin Borman noted that in the United Kingdom, there were inspections every three or five years. In Sweden, the idea was for inspections every three years, although it was currently still at every five. It would be sufficient at this stage merely to say that the inspection should be regular and eventually every three years.

Dr Boevé (NL) noted that three year inspections were very expensive and that it was necessary to look at the costs involved as well.

In Spain, there were five year inspections as well as casual inspections when requested by a disappointed trainee. In Sweden, the inspection system was voluntary, but the findings were published in the Swedish Medical journal. Some departments requested an earlier evaluation when they have improved their shortcomings.

A question was raised about the feasibility of a European inspection team and Ms Reilly noted that the veterinarians already had such a system, although only at university level. In Sweden, the inspectors were Swedish, but not from the institution being inspected. They were all well known professors and consultants.

Professor Salvatore (I) queried whether the PWG was concerned only with hospital doctors and Edwin Borman replied that its remit did extend beyond hospital doctors. The PWG viewed the general practitioner as a specialist and the general practice system from country to country varied.

6. That the end-point of training programs should be directly linked with the recognition of specialist qualification by the body responsible for registration.

It was noted that this, in fact, already was contained in Articles 24 and 8.

7. That it is essential to the achievement of high quality training that all specialists involved in training junior doctors receive specific training to prepare them for this role and are themselves regularly assessed and monitored.

It was suggested that this be incorporated in Article 24. This was also highlighted in the PWG Policy Statement, Articles 40–42. Some of the questions which this item raised were the question of who was going to pay for this and who was going to train the trainers. To the latter question, Edwin Borman noted that within each member state, there were qualified individuals who are experts in the area of postgraduate medical training who should be involved in preparing programs for training trainers.

Dr Boevé (NL) noted the importance of using simulators, although Edwin Borman underscored the fact that simulated reality, while very useful, did not include the essential elements of human communication.

8. That in order to ensure the appropriate functioning of training programs, they must be linked with a manpower system capable of effecting changes in the number of trainee posts according to the need for specialists.

The PWG was uncertain whether this could, at this time, be placed into a directive, but still wished to underscore the importance of an increased awareness of this. Some countries still did not have numerous clausus despite the fact that there was a surplus of doctors.

Dr Twomey (IRL) noted that in Ireland, there was a current rating of approximately two trainees to one specialist. He wondered whether it might not be necessary to reverse this situation. However, despite years of discussion, no action had yet been taken on this.

9. That specific national budgets sufficient to meet the needs of postgraduate training and the implementation of the above recommendations be ensured.

This was connected with all of the recommendations and he suggested this might be included at the end of the Preamble. It seemed an appropriate time to try to get this into the Directive.

Ms Reilly noted that although it would not be her task to draft the changes for the Directive, she recognized that the meeting viewed this as an essential point and that it would be useful to include it in the Directive. If the structure was so clearly established, funding would have to follow.

Dr Hoppe (D) noted the importance of changing the philosophy of specialization.

The goal at present is first postgraduate training and secondly work; previously, the opposite attitude prevailed and still touched the system today. Dr Twomey (IRL) cautioned against arriving at an emphasis which would so clearly label training posts that a situation might be created where there was a split between the actual trainees and the workers. The Swedish participant noted that this stand might also have an effect on remuneration, turning specialist trainees into students again. However, Edwin Borman thought it unlikely that the service element would ever be so drastically reduced. Dr Karle (DK), however, also cautioned against going too far in promoting the educational essence of the training post, lest post be endangered in this way.

formal contact. Informal contact was always possible.

Dr Twomey (IRL) expressed thanks to the PWG for attending the current meeting and making the presentation. He considered healthy and important that the ACMT liaise with PWG, UEMS, and UEMO. The very useful information presented today would now have to be incorporated into a preliminary draft document and he felt it important that the ACMT continue to liaise formally and informally with the relevant groups in future. If further areas of clarification required such, the ACMT should invite the PWG to participate again as well as other organizations. The Group expressed their thanks to Edwin Borman for his presentation which was of great use in their work.

July 1995

PWG/ACMT COOPERATION

In conclusion, Edwin Borman noted that the PWG was keen to work with the ACMT to develop this process and the draft changes to the Directive. He asked how this cooperation might be continued. Ms Reilly posed the question to the members of the Group; first of all, whether they felt there was a need for

Paper from the PWG for Discussion by the ACMT Working Party on the Training of Medical Specialists at its Meeting in Ischia on 30 June 1995

Following the discussion surrounding the preparation of its policy paper on postgraduate medical training (PCT) and its one day symposium "Postgraduate Medical Training – A European Future", the Permanent Working Group of European junior Hospital Doctors (PWG) believes strongly that in order to encourage moves towards high standards of medical training it is necessary to revisit the area of recommendations on PGT and ensure their implementation.

In arriving at this decision the PWG acknowledges the work already performed by the ACMT and believes that this forms the basis for further progress based on recommendations that already command consensus agreement.

The PWG, believes that high quality outcomes in specialist medical training can best be ensured throughout Europe by achieving high standards in the structure and process of PGT; accordingly the PWG requests that the ACMT considers the following recommendations with a view to their potential adoption into a unifying document on PGT that should be applied in all member states.

RECOMMENDATIONS

- 1) That defined bodies responsible for the supervision, coordination, and regulation of PGT should be identified in all member states, and their responsibilities in this area be clearly determined.
- 2) That for all specialities there should be a defined training syllabus of agreed duration and structure, moving from the general to the more specific, and determined by consultation between all relevant parties at a national level.
- 3) That all trainees/junior doctors should be engaged in PGT in accredited training programmes based on these training syllabuses, and utilising a range of training methods.
- 4) That in order to ensure that high standards are achieved and maintained, a fundamental element of these training programmes is the incorporation of defined evaluation methods

both of the trainee, and also of the training posts and programmes.

- 5) That a system of regular inspections of all programmes and their individual posts is an essential aspect of this evaluation process, and should be linked with their accreditation for training purposes.
- 6) That the end-point of training programmes should be directly linked with the recognition of specialist qualification by the body responsible for registration.
- 7) That it is essential to the achievement of high quality training that all specialists involved in training junior doctors receive specific training to prepare them for this role, and are themselves regularly assessed and monitored.
- 8) That in order to ensure the appropriate functioning of training programmes they must be linked with a manpower system capable of effecting changes in the number of trainee posts according to the need for specialists.
- 9) That specific national budgets sufficient to meet the needs of postgraduate training and the implementation of the above recommendations be ensured.

The ACMT is further invited to consider these recommendations with a view to

- a) their inclusion in a possible EC directive on this issue;
- b) the preparation of a paper disseminating examples of good practice in which these essential prerequisites for successful PGT are already being achieved.

Working Party “Training for Medical Specialists”

List of members

M. J. DERCO	B	III	I. Experts from the practising profession.
M. H. KARLE	DK	III	II. Experts from pharmaceutical science teaching institutions.
M: J.-D. HOPPE	D	I	III. Experts from the competent authorities of the Member States.
M. T. DOSIOS	EL	I	
M. C. PERA	E	II	
M. P. EVEN	F	II	
M. C. TWOMEY	IRL	I	
M. G. SALVATORE	I	II	
M. H. METZ	L	II	
M. J. BOEVÉ	NL	I	
M. C. RIBEIRO	P	I	
M. C. GEORGE	UK	III	

Motion on the Future of the Advisory Committee on Medical Training

Response to the proposal for a Directive amending the sectoral Directives COM 97 638 Final

At the PWG meeting in Oslo on May 8th – 9th 1998, the proposal for a Directive by the European Parliament and the Council amending the sectoral directives (COM (97) 638 final), dated December 1997, was discussed:

Regarding the future of the Advisory Committee on Medical Training (ACMT) created by Council Decision 75/364/EEC, the PWG states the following:

ACMT enjoys the support and confidence of the organised representative medical profession in Europe.

PWG strongly urges that the existing representative structure (2 doctors and 1 representative from the competent authorities, with alternatives, for each Member State) be retained. This ensures healthy dialogue. The proposals on structure in COM (97) 638 final would seriously weaken ACMT.

With respect to the Fourth Report from the ACMT concerning specialist training PWG fully supports the Recommendations on Specialist Training published in June 1997, and the ten recommendations of the Commission report on specific training in General Medical Practice (COM 96/434 FINAL).

PWG urges the Commission to proceed, as a matter of urgency, to the insertion of the additional recommendations referring to the quality and content of specialist training. These are documented in Section 3.4 of the Fourth Report of ACMT.

PWG further believes that regular contacts must be established – both within individual Member States and the European level – between the representatives of ACMT and the Committee of Senior Officials on Public Health (CSOPH) if the role of ACMT is weakened in any way.

PWG 99/045

Statement on Recertification

The PWG recognises that it is important to ensure that doctors are competent to practise. However, it believes that recertification as currently understood is not an appropriate method of ensuring competency, and therefore opposes its introduction.

PWG 99/046

Statement, European Board Examination

The Permanent Working Group of European Junior Doctors (PWG) believes that no doctor should be required to hold a European Specialty Board Examination in addition to a national specialist qualification in order to obtain a post. The PWG will campaign at European level to prevent appointment committees discriminating in favour of candidates who possess a European Specialty Board Examination in addition to a national specialist qualification.

-Explanatory note-

In its Spring 1999 Plenary meeting in Reykjavik, Iceland, the PWG unanimously adopted a statement concerning European Board (EB) Examinations required in a certain number of specialities in order to obtain a post (PWG 99/046 REV).

We are aware that we are not protesting about the situation itself, i.e. the existence of EB Examinations, but about informal pressures being applied to doctors in training by the existence of appointment committees discriminating in favour of candidates who possess a EB examination in addition to a national specialist qualification.

The Importance of Research in Postgraduate Medical Training (PGT)

a discussion paper, by Fleur Sprangers

1. Why is research experience important for (junior) doctors, as part of PGT

Direct benefits:

- Research offers the opportunity to develop thorough knowledge and expertise in a chosen field of (bio) medicine. Within a medical department, this expertise will allow peer teaching and an advisory role in clinical practice.
- Research experience teaches one to critically review and resume literature.
- Writing a research protocol demands a thorough analysis of literature and the ability to transform the acquired knowledge into a precise hypothesis and to find the accurate method to test it. Writing after reading is the addition intellectual exercise of importance.
- Transforming raw data into a comprehensible text or article is an essential exercise in passing over one's findings and insights to others, colleagues and/or other experts.
- Working in research teams teaches one to collaborate with other professionals in the (bio) medical field, such as biologists, (bio) chemists, analysts, etc in their scientific fields. In addition, one gains insight in techniques and assays commonly used in (diagnostic) clinical practice.

Indirect benefits:

- It could be argued that experience in research teaches one a way of thinking (or approach), facilitating critical perceptivity and discernment in clinical practice, and stimulates one to approach clinical problems in an analytical way instead of a pragmatic way.
- Research experience not only offers a clinician tools to keep up to date with scientific developments, but also may enrich one with a persistent stimulus to keep up to date.

2. Aims and of "research activity" during PGT: (depending on time and effort)

1. critical appraisal of the literature (e.g. presenting a critical review of a published article in front of colleagues and medical staff), as part of readiness for permanent continuing medical education and professional development (CME/CPD);
2. studying and comparing practice with existing standards (medical audit); as an alternative to carrying out a research project;
3. carrying out a concise research program (preferably clinically applicable, e.g. epidemiological or disease-oriented), within an existing line of research under supervision of an acknowledged research team, writing a report on the results and presenting them at a research meeting and/or congress;
4. productive participation in a ongoing research program, analysing data and learning to transform raw data into a comprehensible text or article, presenting the data at research meetings and (a) congress (es), publishing one or more articles in (a) peer reviewed journal(s).
5. writing a research proposal/protocol in continuation of an initial project, submitting a research grant proposal approved by peer review and by a medical ethical committee;
6. writing a PhD-thesis

3. Practical integration of "research activity" in PGT

- Carrying out a complete research program demands personal dedication and time to concentrate on research.
- One should define clearly what one expects from "research activity" in relation to the given time, expectations, and the future profession.
- It may be necessary to separate the time dedicated to research from clinical obligations to prevent clinical tasks from prevailing over research tasks.
- The duration of the period dedicated to research during PGT could be defined as a percentage of the total duration of PGT.



Other Policy Resolutions & Studies Medical Workforce

Definitions of Various Employment States

October 1980, Lucerne, revised in Utrecht 1989

Over Qualification: A doctor is overqualified when, due to a lack of further posts, he or she is forced to remain in a post junior to what would be appropriate to his experience and qualification.

Misemployment: A doctor is misemployed when, on a specific date, he or she is eligible to practice, is unable to find work as a doctor, but obtains an income by working in a capacity not requiring a medical qualification.

Unemployed: A doctor is unemployed when, on a specified date, he is eligible to practice and is seeking a post but is without any form of remunerative work.

Long term unemployment: A doctor is long term unemployed when, while having been eligible to practice and seeking a post, he has been without any remunerative work for a continuous period exceeding six calendar months.

Underemployed: A doctor is underemployed if he is unable to find medical work during part of the normal working week or if he is unable to find sufficient medical work to yield a remuneration appropriate to his experience and qualifications.

Recommendations on Health Manpower Planning

April 1982, Maastricht

Recommendations of the PWG on Health Manpower Planning.

It seems clear that both short term and long term actions must be undertaken.

Short term because physician unemployment requires urgent attention and immediate action. The instrument for resolution of the immediate problem can be developed best at the national level with strong input from the subnational regions.

Long term planning, however, which would attempt to integrate health manpower planning with health services planning must begin at the national level but clearly needs transnational coordination. Implementation, again, requires powerful input from the infranational regions.

Recommendation number 1:

A message should be sent to each national government of the Community to urge each to establish a permanent working body having the following functions:

- A. Introduce measures to alleviate as quickly as possible the problems associated with physician unemployment;
- B. Establish continuing mechanisms for collecting and analyzing information relevant to an integrated planning program for health services and health manpower development in the country;
- C. Establish within each country a regional network of organization to make certain that each region of the country becomes intimately involved in the planning and implementation processes;
- D. The national and regional bodies will have as their long term function the development of national policy on health services and manpower which is consistent with and coordinated with that of other member nations of the European Economic Community.

Recommendation number 2:

A message should be sent to each national government of the Community and to the European Economic Community to urge the establishment of a permanent forum at the EEC level for intensive study and discussion of health manpower, health education, and health service planning and policy. Close liaison with the World Health Organization should be sought. The proposed EEC Body¹ should collect and analyze relevant information, publish its conclusions on a regular basis, and serve a basic function of heightening EEC awareness of the necessity of transnational planning for health.

One aim of this body, urgently needed, is to develop trans-European guidelines to coordinate health manpower legislation currently in the process of being formulated by member nations of the EEC.

Close working linkages between the regional-national bodies in each country and the trans-national bodies is required.

¹ The body or forum referred to could be the Advisory Committee on Medical Training and the Committee of Senior Officials on Public Health of the EEC with expanded functions and membership.

Resolution in Health Manpower Planning

April 1983, Glasgow

PWG urges all affiliated national organizations to establish both internal mechanisms and, in cooperation with concerned bodies in their countries, to take action in health manpower planning.

Motion about Unpaid Posts for Medical Doctors

April 1990, Birmingham

PWG condemns the practice of offering unpaid work in hospital departments to unemployed junior doctors, which undermines standards of training and represents an exploitation of junior doctors.

Main Findings of Manpower Symposium

October 1991, Florence, Italy

European Medical Manpower Symposium under the Presidency of the Coordinating Secretary, Hans-Ueli Würsten. Main findings of this symposium were:

- A) The Medical Profession faces unemployment and underemployment at the present time.
- B) The profession faces an imbalance in unemployment and underemployment between North and South; it might even be stated, that un- and underemployment takes place almost exclusively in the south, i.e. the Mediterranean countries.
- C) The Manpower situation does not seem to be related very closely to the health care system of a country. Nevertheless, In countries where almost all physicians are employed, statistics are traditionally easier to be collected. Therefore prognosis is easier in these countries (however, the figures are more difficult to collect does not mean they are less reliable). Could this be a reason why the manpower situation is more balanced in these countries?
- D) The profession in Europe might experience a manpower balance by the year 2000, and some of the countries may even run into a shortage of doctors.
- E) Surprisingly, even rather heavy unemployment does not promote greater migration; this leads to the question: Do people simply prefer to be unemployed at home than be employed in an unknown, strange environment abroad?

PWG 99/041

Statement, Medical Workforce Planning

The Permanent Working Group of European Junior Doctors (PWG), meeting in Iceland on 7/8 May 1999, unanimously adopted the following statements:

1. The PWG believes in effective medical workforce planning as integral to ensuring high quality medical training and service.
2. The PWG states that such planning must involve controls on numbers entering medical schools such that the supply of doctors should reflect the national requirement
3. The PWG will lobby through national member organisations, national governments, the CP and the European Commission to achieve these aims.
4. The PWG will bring forward a paper to a future plenary session detailing the current situation, together with a number of options and proposals.



Other Policy Resolutions & Studies **Working Conditions**

Resolution on Strike Action by Doctors

1984

"Doctors have the right to strike, which is generally recognised in all European countries. However, this does not exempt them from their ethical responsibilities as laid down in the relevant national and international ethical codes to which they have subscribed and by which they are bound."

This text, in French version, was accepted by the Standing Committee of Doctors of the EC (CP) in June 1985:

«Les médecins ont le droit de grève (ou de refuser collectivement leurs services), droit qui est généralement reconnu dans les pays européens. Toutefois ce droit ne les exonère pas de leurs responsabilités éthiques, telles qu'elles résultent en codomaine des règles ou Codes d'éthique nationaux ou internationaux, auxquels ils ont souscrit et qu'ils doivent respecter.»

Excessive Working Hours

April 1990, Birmingham

The PWG, meeting in plenary session in Birmingham on 6th/7th April 1990,

- having regard to the safety of patients and the effects of fatigue upon clinical judgement and skill;
- having regard to the fact that junior hospital doctors are trainees and require time for study; and that exhausted and sleep-deprived doctors are unlikely to be able to study effectively;
- having regard to the entitlement of all workers to adequate periods of rest and recuperation

resolves:

- that urgent action is required to reduce the excessively long hours of work of junior hospital doctors in some European countries and
- that where effective agreements to limit junior doctors' hours of work cannot be reached, their hours should be limited by legislation;
- that the Standing Committee of doctors of the EC (CP) be invited to endorse this motion and draw the attention of the EC Commission to the dangerously long hours of work of Junior hospital doctors in some European countries.

Definition: – In this motion, "work" shall be taken to mean the carrying out of medical work AND periods spent on duty and immediately available to do work.

PWG Response to EC Proposed Directive on Working Time

At its plenary assembly in Stockholm 1–2 May 1992, the PWG discussed the EC's proposed directive on working time.

PWG welcomes the EC's intention to secure safe humane working conditions for all European employees.

PWG is however concerned that the derogation provisions may exclude health sector workers and in particular junior doctors, one of the most vulnerable groups with regard to working conditions, from this important and praiseworthy initiative.

PWG urges the EC to ensure that junior doctors are given rights and protections with respect to working conditions which are equivalent to other European employees.

PWG 92/00174

Conclusions From the Questionnaire “Definition of Working Hours”

- 1) Time spent at the working-site, working or not, being considered as working time seems to be a very strong trend throughout Europe, although not yet implemented in all countries (A2); in some countries the time spent at the working site outside the normal working hours is "equipped" with an "activity index" depending on the specialty (B).
- 2) The time on the way to work during "on-call" duties (A4) is accepted as working time only in about half of the countries in one way or another, although this item seems to be an objective for future negotiations in several other countries.
- 3) Although work outside normal working hours and on public holidays etc. (A5) is generally accepted as a different "type" of work with either extra remuneration or compensation in time, implementation is obviously differing from one country to another.
- 4) In quite a few countries there is work being done and expected by the employer to be done (C) which is outside the normal, i.e. not contracted and not remunerated or compensated in time.

Corrected and adopted by PWG Plenary,
Stockholm, spring 1992

Permanent Working Group of European Junior Hospital Doctors

Synopsis:	A	B	DK	SF	F	D	ISL	IRL	I	NL	N	P	E	S	CH	UK	Slo	Lat	Isr	G	Est	Mal
A What is a working hour?																						
1. Time at w-site & working	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y	y
2. Time at working site	y	n	0.75 ¹	y	y	y	y	y	y	0.33 ⁵	y	y	y	n	y	y	y	n	y	y	n	n
3. Time off w-site, on call	n	n	0.33 ¹	y	n	y	y	y	y	n	0.25 ⁵	y	y	n	n	y	y	n	y ⁹	y	y	n ⁷
4. Time on the way to & from w-site, when called	n	n	1/2 ^(h)	y	n	y	y	y	y	y	y ⁵	y	n	y	n	y	y	n	n	n	n	y
5. Diff. definition for w-hours outside "normal"																						
5 a. night:	y	y	y	y	y	y	y	n	y	y	y ⁵	0.6 ⁵	y	y	n ⁸	y	y	n	y	y	y	y
5 b. Sundays and public holidays:	y	y	1.5	y	y	y	y	n	y	y	y ⁵	0.5 ⁵	y	y	y ⁸	y	y	n	y	y	y	y
5 c. no different def.:	n	n	n	n	n	n	n	y ⁴	n	n	n	n	n	n	n	n	n	y	n	n	n	n
B Activity indices for different specialities	n	n	n	y	n	y	n	n	n	n	n	n	n	n	n ⁸	n	n	n	y	n	n	n
C Hours normally "worked" but not "contracted" (categ. see Sect. A. 1-4)																						
A. 1.:													y ²	y ⁸	y ⁸					y		
A. 2.:														y ⁸	y ⁸							
A. 3.:					y								y	y ⁸	y ⁸							
A. 4.:														y ⁸	y ⁸						y	
Other:																						
D Do you include all working hours, or only contracted hours, when you inform about w-hours?	y	n	y	n	n	n	n	n	y	y	y	y	y	n	y	y	y	n	y	n	n	n
E What definition do you wish in the future?	Annexe 1																					
	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x

¹ While working = 1.5 each 37 working hours between 2 p.m. and 6 a.m. i compensated by 2 hours. ² There is some overtime done in several specialities in some hospitals, which is not remunerated. ³ Teaching and research activity. ⁴ Night and Sunday/holiday work exceeding 39 hours (average) paid at overtime rates. ⁵ Work during on call duty = 1.5-1.75/scheduled work Sunday/public holiday = small extra remuneration. ⁶ On special cases. ⁷ Only applicable on senior doctors, no junior doctors on call duty. ⁸ Large differences from canton to canton: some overtime paid, in some "hours or presence" paid, in some night/Sundays compensated/remunerated. ⁹ Only specialists. ¹⁰ Working hours at night and Sundays.

Questionnaire “Definition of Working Hours”

Synopsis of Question E:

In what direction does your national organisation wish to go in the future, what changes do you wish to be introduced concerning the definition?

Austria:

- Include the way to work in the working hours, when we are "on call".
- Reduction of total working hours down to 280 hours/month and 56 hours/week.
- Payment by the hour.

Belgium: —.

Denmark:

- The Representative Body of the Danish Association of junior Hospital Doctors has adopted a proposal to a new agreement, which, inter alia, includes that on call duty from the doctor's home is not included in the weekly average working hour, but is only remunerated. Furthermore, the proposal includes that on call duty at the working site is abolished and all presence at the working site is considered normal duty and, thus, is normally remunerated.

Finland:

- The objective of NLY has been to reduce the working hours of doctors on yearly and weekly basis on one hand and to reduce the number of hours in uninterrupted duty on the other.

France:

- Objective to have "on-call duty" hours remunerated.

Germany:

- Instead of financial compensation of the overtime and duties we ask for "compensation in Time", which would allow for employment of more doctors with the same money.

Iceland:

- Decrease of working hours.

Ireland:

- Full implementation of the presently agreed 65 hour average week.
- Limitation of the maximum average working hours.

Italy: — .

Netherlands:

- No further plans for the time being.

Norway:

- The YLF wishes that every hour at the disposal of the employer at the working site should be paid as 1 hour, whether or not it is an active hour.

Portugal:

- A normal working week for a Junior doctor is 44 hours. Extra time

is theoretically voluntary and paid 100% over the normal work 'rig hour. For the moment we do not intend to contest this situation.

Spain: —.

Sweden: —.

Switzerland:

- Implementation "nation-wide" presence = working time.
- Remuneration/compensation of "on call" duty.

UK.:

- We are moving towards "act with indices" by bonding into 3 bonds separated by the amount of rest the doctor will get when working outside normal working hours (outside 9 am–5 pm, Monday to Friday).

Slovenia:

- The working contracts are only to be signed at the beginning of 1992 so they are not yet fully definite. There is no major problem of excessive working hours for junior doctors.

Latvia:

- At present no negotiations between the state and the Latvian Physicians' Association on the subject of working hours are taking place. We intend to change that in the future.

Israel:

- Increase payment/working hour.
- Increase number of working posts.
- Decrease number of working hours.
- Sharing the workload.
- Quality control system.

Estonia:

- Legislation regulating relations between employers and employees is at present insufficient. The status of an employer is also not yet exactly defined. These are the major reasons why in reality no negotiations between Estonian Medical Association (younger doctors association included) and the representatives of employers concerning working conditions have so far taken place. Trends for the future:
 - increase in remuneration;
 - "activity indices" for on call duty work in different specialties should be introduced;
 - overtime should be remunerated 100% or compensated in time;
 - maintain 37.5 weekly hours.

Malta:

- The Medical Association of Malta is presently in arduous discussions with the government on better remuneration for hospital doctors. We have already managed to convince the Maltese Government to pay duties on the basis of a 1:1 ration instead of 1:0.8.

Resolution on proposed EC Directive on Working Time

Adopted at 35th Plenary Meeting of PWG,

7th and 8th May 1993, Malta

The PWG has noted that the UEMS has once again expressed its concern about the proposed EC-directive on working hours, most recently in the motion the UEMS tabled at the CP-meeting in Funchal, April 1993. This motion was adopted by the CP.

In this motion, the UEMS argues that the strict definitions and restrictions laid on the working hours of (junior) doctors, especially regarding work at night, will seriously hamper the planning of work in the hospitals, and create difficulties for the training of junior doctors.

The PWG agrees that derogations from the directive should be possible by negotiation with the labor organizations involved in order to secure a certain flexibility, for instance within the health-sector.

However, the PWG finds it only reasonable to secure the same overall protection and rights with respect to working conditions for Junior doctors as for other European employees.

Long and strenuous working hours are not only stressful to the employee but in the case of the health sector constitute a potential threat to the safe treatment of patients.

The PWG is therefore strongly opposed to the idea of excluding junior doctors or any other group of health sector workers from the realm of the proposed directive on working hours.

Regarding training of Junior doctors, the PWG believes that the quality of training should be assured by deliberate means, such as target descriptions, training programmes, inspection of training places etc. rather than by assuming that if the junior doctor only works long hours, the overall quality of the training will be guaranteed.

PWG 93/0065

Motion, Working Conditions

Whereas, working time for junior doctors is considered to include both the time actually carrying out a medical task and the time being immediately available to perform such tasks, and

Whereas, the working of long hours is detrimental to patient-care, the family life of a Junior doctor and his family especially since this is compounded by the long hours of study necessary throughout a medical professional life, initially to attain examinations and later to keep well up to date in the advances of Medicine for the benefit of the patient, and

Whereas, every country in Europe offers salaried doctors contractual study leave and payment of educational expenses for the ultimate benefit of the patient, and

Whereas, employed doctors in every European country benefit from malpractice indemnity cover provided by their employer

this General Assembly

strongly supports the stand of the Medical Association of Malta in defence of the rights of junior members of the profession particularly with regard to the above issues and hopes that Maltese junior doctors will come to enjoy equal benefits to those available to their colleagues in Europe.

The PWG feels that there is no reason to make a difference in working conditions for health care professionals in comparison to other employees; on the contrary we feel that training purposes and especially quality assurance are elements which can only increase in a well balanced working situation.

On Directive 93/104/EC

Working Time

The CP will be aware that, in June 1993, the Council of Ministers reached a common position on the proposed directive on the organisation of working time. The new text contains a clause exempting "doctors in training" from all provisions of the directive. The PWG deplores this discrimination against a vulnerable group of employees. It believes that doctors in training should be treated in the same way as other health care workers, for whom special provision is made in a derogation.

Concern for the quality of Junior doctors' training is sometimes put forward as an argument for long working hours. However, if doctors in training are to be asked to work 60–80 hours per week, there needs to be evidence that this assures the quality of their training. No such evidence has ever been provided. In fact, during the most vulnerable periods of extreme working hours, the junior doctor is most likely to be working in an unsupervised situation.

The work of a Junior doctor must also always be carried out with extreme caution with regard to the safety of patients. This safety could be compromised by exhaustion caused by excessively long working hours.

The arguments above demonstrate that junior doctors in Europe are one of the groups most in need of the protection afforded by this directive.

The CP has already adopted the PWG motion on working hours (CP 90/821 – Annex IV) and the PWG is grateful for this support. We now urge the CP to demonstrate its continuing support by adopting the following motion:

"The CP views with regret the decision by the Council of Ministers to exclude doctors in training from its common position on the proposed directive concerning the organisation of working time and supports the PWG in its efforts to have doctors in training treated in the same way as other health care employees".

Directorate General for Employment, Industrial Relations and Social Affairs

Final Report on the Working Hours of “Doctors in Training” in the Context of Directive 93/105/EC

Report submitted by Coshape Limited for contract no. SOC 94 100370

December 1994

1 INTRODUCTION

Scope

1.1 This document is the Final Report submitted by Coshape Limited to the European Commission under the terms of the Study Contract no. SOC 94 100370, dated 30 March 1994. The study was carried out in the period April-December 1994.

Background

1.2 "Doctors in training" are excluded from the provisions of European Council directive 93/104/EC on working hours.

1.3 During the second reading debate of the proposed directive in the European Parliament, the Commission stated its intention to take initiatives to ensure the application of the principles of the directive to doctors in training. The study by Coshape on behalf of the Commission constitutes such an initiative.

2 OUTLINE OF THE STUDY

Objective of the study

2.1 The general objective of this study was to provide comparative factual information for use by the Commission in its consideration of the possible forms that such initiatives might take.

2.2 To this end, the study covers the Member States of the European Union, the non-EU countries of the European Economic Area Agreement, and certain other countries that were either approached or that volunteered to participate in the study.

Methodology and procedure

2.3 The basis for the study was a questionnaire prepared by Coshape with the assistance of a small Steering Group of outside experts representing the interests of the employers and employees. The Steering Group's task was to help design a comprehensive and balanced questionnaire, not to discuss matters of substance relating to the working hours of doctors in training. Its members were:

- Dr. Rudolph Henke, Vice-President of the Marburger Bund, Germany.
- Mr. Michael Lowe, Deputy Secretary of the British Medical Association, United Kingdom.
- Prof. Jacques Massion, Directeur Administratif des Cliniques Universitaires Saint-Luc, Belgium, and President of the Hospital Committee of the European Union.
- Mr. Brendan Phelan, Principal Officer of the Department of Health, Ireland.
- Dr. Jesper Poulsen, President of the Permanent Working Group (PWG) of European junior Hospital Doctors, Denmark.

2.4 The Steering Group met twice, on 11 April and 7 December 1994. The latter meeting was to review broadly the outcome of the replies to the questionnaire, prior to the meeting on 8 December referred to below. Officials of DGV/D/2 participated in these meetings, and made a considerable input to the form and content of the questionnaire.

2.5 Coshape prepared English and French versions of the document. The Marburger Bund made an informal German translation, which it kindly agreed could be used by other organisations preferring a German version.

2.6 Coshape sent the questionnaire out in late June 1994 to a wide range of organisations representing the interests of employers and doctors in training in the European Union and EFTA countries. Copies of the questionnaire were delivered to the Permanent Representations or national delegations of the countries covered by the study, for forwarding to their appropriate national competent authorities. The list of recipients was drawn up with the help of the Steering Group. The Copenhagen office of the PWG and the Standing Committee of European Doctors also kindly drew the questionnaire to the attention of their members.

2.7 Participants in the study were requested to complete the questionnaire by 9 September 1994. Coshape sent reminder letters on 18 September to those that had not done so. A director of Coshape informally attended a PWG meeting in Vienna on 7–8 October, and was able to clarify a number of points arising from its members' replies.

2.8 The Commission arranged on 8 December 1994 a meeting of a wide range of the interested parties that had either replied to the questionnaire or – as was the case with several national government agencies – that ought to be represented at the meeting because information provided from other sources about their countries would be discussed there. Coshape participated actively in the meeting. The purpose of the meeting was to:

- clarify as necessary the replies received for each country, and where possible add missing information.
- hold a general exchange of views on certain broad issues that had emerged from the replies as a whole.

2.9 This report takes account of the replies to the questionnaire, late and additional information received up to the meeting on 8 December, and points made at the meeting.

Response

2.10 The response to the study was Unbalanced.

2.11 The representatives of the medical profession responded fully, and mostly within the time limits laid down. As a result of some international medical associations informing their members of the study, Coshape received replies from medical groups in countries outside the intended geographical catchment of the study. Note has been taken of these unexpected replies, but they have not been included in the statistical analyses.

2.12. In contrast, the response from the national competent authorities responsible for doctors in training was more limited. By 8 December replies from this group had been received from Denmark, France, Ireland, Luxembourg, Netherlands, Portugal, Finland, Norway, Sweden and Switzerland. A reply from Austria reached Coshape after this date.

2.13 No replies at all to the questionnaire were received from any source in Italy.

2.14 The quality and thoroughness of replies were on the whole good, surprisingly so in view of the fact that many of the questions required details that would not be routinely held by some of the participants. There were marked variances in the replies to the same questions from different respondents in the same country. These were resolved either by correspondence or at the meeting on 8 December.

2.15 Coshape considers that the response to the questionnaire is full enough for the study to provide valid material for submission to the Commission. All interested parties were given adequate time to respond. None of those who failed to respond

contacted Coshape to explain any difficulties that they were having with the questionnaire, or to request additional information about the study. Coshape does not consider that their lack of participation is a reason for withholding from the Commission the material that has emerged from the study.

2.16 The recipients of the questionnaire and the respondents are listed in Appendix 1.

3 OUTCOME OF THE STUDY

3.1 The following sections summarise the replies to the questionnaire, together with additional information collected by correspondence or in discussions. The text largely follows the same sequence as the sections of the questionnaire.

3.2 As stated in section 2.3 above, the information obtained in the study to date cannot be considered as complete. In Coshape's view, the interested parties that did not reply to the questionnaire, notably the national competent authorities, should be given the opportunity to comment on sensitive materiel already collected in areas covered by the questionnaire before the Commission decides upon future initiatives that it might take in respect of doctors in training.

3.3 To collect such comments, individual contact will be required between the Commission and the authorities in question, which will take time. Coshape does not wish the Commission to be impeded by such a delay in any action that it may wish to take as regards making the bulk of this report public. Coshape therefore proposes to report on the outcome of the study at two levels:

- the present report, which the Commission may wish to use in public discussion at an early date.
- separate materiel on certain sensitive points, on which the Commission may wish to obtain the comments of the national authorities.

Definition of "doctors in training", and the duration of training

3.4 These topics were treated separately in the questionnaire. The replies show, however, that they are interdependent.

3.5 With one exception, all countries reviewed have a clear concept of the categories of their doctors covered by the term "doctors in training".

3.6 All national concepts of doctors in training are very close to each other in two important features:

1. The entry point. The doctors in training have successfully completed their basic (undergraduate) medical training. (This does not necessarily mean that they have already achieved full registration as medical practitioners.)

2. The purpose. They are preparing for a recognised higher medical qualification. This preparation often takes the form of an apprenticeship rather than formal training. In some cases, doctors in training are also completing obligatory practice prior to full registration. Most doctors in training are working towards specialist status, but some are undertaking the specific training in general medical practice that is now obligatory under EC legislation.

3.7 In some cases, the category is defined by national law. In others there is no official definition. In Germany, for instance, strictly speaking there are no "doctors in training". Doctors who would be considered as falling into this category are those who are engaged under contract to practice medicine and who, as a result of that activity, gain the necessary experience to complete their specialisation.

3.8 Two definitions are possible in France, respectively they would cover about 3400 or 16.000 doctors. The latter group conforms most closely to the concept of doctors in training in other countries. It includes all doctors in their third cycle of studies.

3.9 The exception is Iceland, which does not have doctors in training. Specialists are trained elsewhere, and while holding junior posts in Iceland awaiting such training, they are termed "assistant doctors". As such, they do not have the same conditions of service as their seniors.

3.10 The similarity between national concepts of doctors in training becomes weaker the longer the training proceeds.

3.11 The replies to the questions on the duration of training and the step that marks the end of training show a clear division between the countries studied, with two cases:

- countries where the duration of training is defined and is consistent with the periods of training set out in directive 93/16/EEC¹, and where the award of a specialist diploma and title (with or without examination) marks the end of training.
- countries where the duration of training is much longer, and is governed by the length of time that it takes to obtain a senior post (eg. as a consultant). The completion of training is effectively marked by the award of such a post, rather than by a decision that a certain level of competence has been reached.

¹ Council Directive 93/16/EEC of 5 April 1993 to facilitate the free movement of doctors and the mutual recognition of their diplomas, certificates and other evidence of formal qualifications. OJ L165 of 7 July 1993.

3.13 In the latter category, the length of time between starting as a doctor in training and obtaining a senior post ranges from 6–20 years in Denmark, Ireland, United Kingdom and Norway, with an average of 11–13 years. In these countries, training as such merges into queuing for promotion, and imbalance between the numbers of junior and senior posts can lead to bottlenecks in the promotion ladder and therefore to extended periods with junior status.

3.14 The purpose of this section of the study was to identify the groups of doctors who could be included in a definition of doctors in training, not those who would be so included. Coshape suggests that a conclusion to be drawn from the comments that were received is that it is difficult to find sound educational arguments for defending the notion that "in training" can extend for the protracted duration found in some countries.

The numerical strength of "doctors in training"

3.15 Coshape requested details on the number of doctors in training, where they work, and their proportional strength with respect to the overall numbers of doctors working in different sectors.

3.16 Due to the lack or inadequacy of replies from a number of countries on these points, the study cannot provide reliable comparative or total figures for all the countries examined. It is, however, possible to calculate the percentage of doctors in training within the total number of employed doctors for ten countries that did supply adequate information, which can be summarised as follows:

- for hospitals/clinics the range is 14–67%, with an average of around 38%.
- for general practice the range is 1–25%, with an average of around 10%.
- for all doctors the range is 12–41%, with an average of around 26.5%.

3.18 The ranges are wide in all categories. In the case of hospital services, the spread is indicative of the differences in the length of time that doctors remain "trainees" in some countries. The range in general practice possibly reflects the variable state of development of the training of general practitioners across Europe, coupled with the fact that in some countries there is no clear distinction between hospital and general practitioner trainees.

3.19 The figures show that doctors in training constitute a substantial proportion of all working doctors, in particular in hospitals/clinics. The proportion of doctors in training in this latter category is over 30% in Denmark, Germany, France, Ireland, Luxembourg, United Kingdom, Austria, Norway and Sweden. When all categories of doctors are considered, the proportion who are in training exceeds 30% in Germany, Ireland, Luxembourg and United Kingdom. Netherlands has uniformly low proportions of doctors in training in all the sectors mentioned above.

3.20 To place these percentages in a wider context, information from other sources suggests that the total number of doctors in the countries involved in the study is a little over one million.

3.21 The questionnaire deliberately did not ask about the tasks performed by doctors in training. The outcome would probably have been a mass of detail inappropriate to a preparatory study

of this nature. As expected, however, information collected in the course of written and oral responses to various parts of the questionnaire provide a broad picture of the role played by doctors in training within the medical services where they work.

3.22 The conclusion is that doctors in training are a totally integral part of the medical services. At the start of his or her traineeship, a young doctor will clearly be working under the delegated responsibility and supervision of a senior doctor, but the junior's relationship with patients is an active one from the outset. The doctor in training is not a medical supernumerary. In the majority of countries studied, doctors in training seem to bear the brunt of weekend cover and night duty, often without their seniors on site. From the figures given above, they make up a large part of the active medical workforce, especially in the hospital services.

3.23 In terms of the tasks they perform, the study has not produced any logical arguments for excluding doctors in training from the same protection as employees as is provided by directive 93/104/EC to the rest of the medical workforce.

Decision-taking on conditions of service

3.24 The study drew a distinction between:

- the level(s) at which decisions are taken on substantial matters affecting the conditions of service to be included in contracts of employment;
- the bodies with which doctors in training hold their actual contracts (ie. the employer).

3.26 On the first point, the outcome is clear. With the exception of three countries, the decisions directly affecting the contracts in question are taken at national level, either through national legislation alone, or national legislation plus administrative provisions. In most cases, such decisions form the basis for collective agreements, as mentioned in the following section on "national structures".

3.27 The three exceptions are Belgium, where conditions of service are decided primarily at hospital level, and Austria and Switzerland, where there is a mix of national and regional /hospital employment regulations.

3.28 The picture is therefore fairly uniform on this point as regards the level at which decisions are taken. The same cannot be said, however, of the extent to which specific aspects of the conditions of service covered by directive 93/104/EC are covered in the decision-taking process. National employment regulations are most comprehensive in Denmark, Germany, Luxembourg, Netherlands and Norway. Elsewhere, items like night work, daily and weekly rest, and rest breaks are left unclear, or without any provision.

3.29 On the second point, concerning the contracts of doctors in training, the picture is very mixed. To summarise, in Spain and Portugal all doctors in training have contracts with the

national authorities. In France, Greece, Luxembourg and Norway, all contracts are with the hospitals. In the remaining countries, there is a mix of arrangements, with contracts with generally being with either a regional/district authority or a hospital authority. Most Danish contracts are at regional level. Only Germany and Belgium seem to have significant numbers of individual contracts. All doctors in training in Netherlands are subject to the same employment regulations, regardless of their contractual employer.

3.30 For the most part, doctors in training occupy posts designated for training purposes. The main exceptions are Germany and Switzerland. As already noted in the discussion on the definition, specialist training in Germany is completed by a doctor employed in a normal service post. Doctors in training are contracted to a very wide range of organisations in Switzerland, where the concept of training posts is not used. In countries with designated training posts there can be some exceptions to the general rule, for instance, posts that have not been approved by the postgraduate colleges in Ireland and UK, general practitioner locums in UK, and temporarily regraded senior posts in Norway.

3.31 There is no evidence of significant numbers of doctors in training whose conditions of service are not subject to contracts. Only two instances of noncontractual activities were mentioned by respondents. In Belgium, overseas medical assistants form about 3% of the total number of doctors in training, they can find themselves engaged in activities not covered by contract. In Ireland, the small number of doctors in training holding privately-funded research posts are not included in national procedures, their contracts, if any, are negotiated personally.

Existing national structures and procedures for negotiations about contracts of service

3.32 In most countries the negotiation structures are a combination of employer and employee representatives working at national level, sometimes within national rules applying to all employees, e.g. the maximum working week, or minimum annual leave. In some cases, the agreements reached through such collective bargaining are not legally binding in the strictest sense, but virtually acquire de facto legality as a result of the high level of voluntary acceptance that they achieve. Generally speaking, either the negotiations have recourse to national arbitration and conciliation, or it is understood that the government will intervene in the event of an unresolved dispute reaching the stage of industrial action by the employees.

3.33 There is little in the replies to indicate that doctors in training are singled out for special treatment within the national structures described. They are dealt with within negotiations for the medical, as a whole.

3.34 There are a few countries where the negotiating structure is significantly different. Belgium has no national negotiating structure or procedures, reflecting the fact that 80% of con-

tracts are dealt with at hospital level, and that certain national laws on conditions of service are not applicable to doctors. In France there is no permanent structure for negotiations between doctors in training and their employer – in effect the State. Their conditions are settled by administrative provision; views differ on the extent to which these provisions are subject to adequate safeguards.

A structure for future consultations between the Commission and the Social Partners

3.35 At present there is no structure at European level whereby the Commission can consult recognised representatives of employers and employees as regards possible future initiatives concerning doctors in training. One task of the study was to try to identify such representatives, not only at a European level but also at national level.

3.36 The questionnaire asked for views on representative organisations. The outcome of the replies was presented for discussion at the meeting on 8 December. Appendix 2 of this report gives the outcome of that discussion for representation of employers and employees at national level. A mixed picture was presented.

3.37 In some countries, the choice of a national representative for the employers is straightforward, though in others there is a dual interest between state and private hospitals. There are gaps in the information obtained so far, but the competent authorities of the countries in question should be able to make suggestions. There are a range of different bodies providing healthcare in Austria and Switzerland, and discussion is needed to find single representatives for the employers in these cases.

3.38 On the employees' side, some countries have a number of representative organisations, and discussions during the study were unable to reduce the list beyond that given in Appendix 2. The existence of more than one organisation in a country does not necessarily imply rivalry or animosity between them. Each has its particular sphere of interest as regards the employment conditions of doctors in training.

3.39 The questionnaire also asked for views on international organisations that could act as social partners in consultations with the Commission. The replies were far more hunted than for national representatives. No strong candidate for an international organisation representing the interests of employers emerged from the replies. For employee representatives, the central Permanent Working Group of Junior Hospital Doctors is highly regarded. It has the support of its umbrella organisation, the Standing Committee of European Doctors, which was also mentioned in a number of replies.

The working time of doctors in training in practice

3.40 The hours that are actually worked by doctors in training in the countries studied are the central issue of this study and report. They are affected by or dependent upon many other factors, as discussed in this document, and in many respects seem

to reflect the requirements for medical manpower rather than any training need. The hours worked during on-call duty merit the most attention in this section, as it is primarily this type of duty that causes the weekly working hours to become excessive. The following comments relate mainly to doctors working in hospitals/clinics; very little information was provided concerning trainee general practitioners.

3.41 Article 2.1 of Council directive 93/104/EC defines working time as "any period during which the worker is working, at the employer's disposal and carrying out his activity or duties, in accordance with national laws and/or practice". In Article 6, it sets a maximum of 48 hours on average for each seven day period.

3.42 With these points in mind, the questionnaire distinguished between the component parts of the working week of doctors in training, namely basic hours, overtime and on-call duties, in order to clarify how these elements – individually and collectively – might relate to Articles 2.1 and 6.

3.43 In certain countries (Denmark, Ireland, UK, Iceland) the hours worked by doctors in training are not categorised as basic, overtime or on-call hours. Some of the replies from Norway also stated that it is not possible to distinguish between such hours, and this was also the case in some sectors of the Swiss health-care system. In Ireland and United Kingdom, a maximum overall total weekly number of hours is defined as a rolling average of 65 and 83 hours respectively, and any hours rostered are counted towards this total. In Denmark, a maximum weekly total of 37 hours is set, though hours worked over this figure may be paid separately. Iceland uses a system of 26-hour shifts for doctors in training.

3.44 All other countries distinguished between the basic, overtime and on-call hours worked by doctors in training, rather than considering them within an overall weekly total.

3.45 All respondent countries except France and Iceland indicated that there was a basic working week for doctors in training, which ranged from 35.5 to 48 hours. Doctors in training in France work 11 1/2-day shifts per week, where the duration of a 1/2-day is not specified, but can range from 4 to 7 hours. In most countries the basic working week seems primarily to serve to define pay and rostering structures, and additional hours, in particular overtime, may be obligatory.

3.46 Overtime is considered in a range of different ways within the conditions of employment of doctors in training. A doctor performing overtime would normally be actually working within the meaning of Article 2.1. It is stated that in Spain and Finland there is no provision for overtime in the contracts of doctors in training. In Germany, overtime should theoretically only be worked in exceptional circumstances, although in practice it would appear to be routine. In Ireland, UK and Iceland, paid overtime is indistinguishable from other hours worked towards the weekly total. Weekly overtime is limited in

Luxembourg (10 h.), Netherlands (10 h.), Norway (10 h.) and Sweden (50 h./month) In Portugal, doctors in training are required to work 12 hours overtime a week, but can elect to do more. There would appear to be no effective limit to the overtime that a doctor in training can be required to work in Belgium, Greece, Austria and Switzerland. Overtime worked by doctors in training in France cannot be distinguished from the basic working week.

3.47 In addition to the hours that they are required to work by the weekly roster, a certain amount of supplementary overtime would appear to be a feature of the working pattern of doctors in training in several countries. This is generally overtime that a doctor in training is not contractually obliged to perform, but feels a compunction to carry out, often without payment. One reason cited for such excess overtime is the workload relative to the number of posts. In units with a heavy workload, any absence, for example for vacation or study leave, may result in the workload on colleagues being increased, necessitating overtime that may be unpaid. Such a situation may also make it unrealistic for a doctor in training to take time off in lieu of hours worked previously, to which he or she may technically be entitled.

3.48 The "normal" situation of providing cover for unforeseen fluctuations in workload may well be exacerbated by the need to cater for unrealistic working patterns, such as those with no changeover periods or time for pre-operative tasks. If there is no mechanism for paying such unofficial overtime, there is no incentive for a doctor in training actually to record it, doing so may in fact produce administrative inconveniences if the prescribed limit on weekly hours has been exceeded.

3.49 A further cause of both official and unrecorded overtime is the dependency of doctors in training on their seniors with respect to their medical careers. Doctors in training are in a weak position to refuse to adopt workloads or working patterns that suit their seniors, even when the latter are in breach of rules laid down by the management. If in these circumstances there is no effective system for monitoring or regulating working hours in practice, to enable redress, rules on such hours are unlikely to be respected at local level.

3.50 As the total number of weekly hours worked by a doctor in training increases, the concept of overtime tends to lose its meaning. The capacity for working supplementary hours at the beginning or end of a shift is automatically reduced if the shifts are frequently preceded or followed by on-call work.

3.51 On-call hours are the most difficult of the conditions of employment of doctors in training to evaluate comprehensively, as the intensity and duration of such work is highly variable. There are also major differences in the interpretation of what constitutes "on-call".

3.52 The nature of hospital work means that medical care must be available around the clock, and on call is generally the means

whereby this is provided at night and over weekends. Almost every country that produced a comprehensive reply has an obligation for some form of on-call duty for doctors in training. In Portugal and Austria, where there is little or no oncall for doctors in training, such doctors have to work night shifts. It would appear that the difference between these night duties and on-call elsewhere is one of semantics rather than the reality of the hours worked and the professional duties performed.

3.53 Time spent on-call is integrated into the total weekly working hours required of doctors in training in Ireland, United Kingdom and Iceland, where all such hours are incorporated into the total. A similar situation prevails in Denmark, Norway and Sweden, but the calculation of the contribution of on-call hours is less straightforward, and also in Luxembourg. Upper and lower bounds were given for the weekly on-call hours for doctors in training in Belgium (26 h. min., 43 h. max.), Germany (16 h. min., 40 h. max.), Greece (16 h. min., 24 h. max.), Luxembourg (1–3 nights per week) and Spain (24 h. min., 48 h. max.). In the remaining countries from which a coherent reply was received on this subject (France, Netherlands, Finland and Switzerland), the number of hours that a doctor in training could theoretically be required to remain on-call is high, from 65 to 101 hours per week. In France, the lack of contractual clarity on the basic weekly working hours and overtime makes it hard to define the weekly limit for on-call, but a doctor in training could theoretically be permanently on duty or on-call.

3.54 Certain countries have restrictions on the number of hours that a doctor in training can actually work whilst on-call. In The Netherlands, the hours actually worked during on-call are counted towards the weekly total, which is limited to a maximum of 48 hours. In Denmark, Germany and Norway, on-call hours are weighted according to the amount of work performed during such duties.

3.55 From the replies and subsequent discussions, it is apparent that the duration and intensity of on-call work is very dependent on the hospital and specialisation in which the doctor is training. Though the former is difficult to quantify, it ought to be possible to identify certain specialisations such as obstetrics, that are noted for their workload within the medical profession.

3.56 On-call shifts are typically arranged to provide cover during the early evening and night, or over a weekend. The aim is to provide medical expertise in the required specialisation as and when it becomes necessary outside normal working hours. Such cover is often layered, with patients being seen in the first instance by junior doctors, and then by more senior staff if it is judged necessary.

3.57 In order to provide "front-line" cover, it is necessary for doctors with the appropriate expertise to remain to hand on hospital premises, a duty which is often delegated to doctors in training. Whilst they are theoretically only on-call, in practice this time may largely be spent providing continuous medical

care with only very sporadic breaks. Thus they could be considered as actually working within the meaning of Article 2. 1.

3.58 Doctors whose presence is required less frequently outside normal working hours are able to work on-call duties from home. These may be doctors in training in specialisations where urgent unforeseen treatment is infrequent, or more senior staff for whom the "front-line" can deal with most cases that arise. It is not unusual for such doctors to be permanently on-call, though they might rarely be called to the hospital. It is uncertain at this stage how such on-call duty might be interpreted under Article 2.1. The distinction between "front-line" on-call and that worked from home requires further consideration.

3.59 Evidently there are cases that lie between the two types of duty outlined above, such as on-call work in Germany and Netherlands, where the hours actually worked are monitored. It would seem, however, that unless there are effective preventative or regulatory mechanisms, there is a likelihood that on-call duty worked within a hospital may simply be used as a means of providing continuous cover.

3.60 It is evident that for doctors in training, the working practices that are most likely to be considered unsatisfactory arise as a result of on-call duty. A high number of weekly hours and excessively long periods of continuous duties are expected of doctors in training in several countries, and generally arise through the superimposition of night or weekend cover onto a typical weekly working pattern. As these practices stem from the same need, that of providing a certain level of cover with the available staff, they frequently occur in tandem.

3.61 Unless there are specific provisions for breaks, or other restrictions on the hours that may be worked, many rostering systems mean that a doctor in training is working without proper rest for 32 hours routinely, and in excess of 70 hours in the more extreme instances.

3.62 In summary, although the weekly hours worked by doctors in training are highly variable, it is reasonable to conclude that these routinely exceed 55 hours a week in at least 10 out of the 18 countries that replied. The highest weekly number of hours that was reported was 129. Conversely, it is likely that at most six countries out of those that responded have an average weekly total of 50 hours or less per week.

3.63 It is apparent that excessive working hours arise principally as a result of on-call duties, and that doctors in training are in some instances expected to provide medical services after protracted periods of continuous duty.

Additional professional commitments

3.64 The questionnaire enquired about extra commitments in order to assess the extent to which there was a risk of doctors in training themselves undermining working hours legislation, intended to protect them and their patients, by voluntarily tak-

ing on work additional to their main contract. The study shows that this is not a controversial or problematical issue.

3.65 Additional work by doctors in training is forbidden by national law in Greece and Spain. There are no rules, nor controls, in Denmark, Ireland, Portugal and Finland. Elsewhere there are rules governing additional professional commitments, often linked with the requirement that the principal employer should give agreement. Such rules are not, however, supported in all cases by controls.

3.66 Estimates provided in the study indicate that the number of doctors involved is low, approximately 0.5–5%, in most countries. Among the more experienced trainees in France, and in Norway, it can approach 20%. It should be pointed out that the workload of doctors in training effectively precludes any other activity in many countries.

3.67 The most common cited reason for taking on additional work is a combination of extra income and wider professional experience.

Training and study time

3.68 Allocating or leaving time for study in the working hours of doctors in training would appear to be very much secondary to meeting the demands for medical manpower, with the possible exception of Netherlands, where 10 hours a week is specifically intended for training. In France, up to 21/2-days per week may be set aside for training purposes in specialities where the workload is less intensive. Though time may theoretically be set aside for study, either on a weekly basis, such as in Norway, or as annual leave, such as in UK, it is rarely respected in practice, owing to manpower limitations.

3.69 Manpower needs also mean that some of the hours worked by doctors in training outside normal working hours have minimal educational value, as the doctor in training may be performing mundane tasks to fill in for support staff who work normal hours. Doctors on "front-line" on-call may effectively be viewed as extra pairs of hands in addition to providing skilled medical care when the need arises.

Payment of doctors in training

3.70 The questionnaire asked for an outline of how the different duties worked by doctors in training were remunerated. Aside from Belgium and Switzerland, which make single fixed payments, the salary of doctors in training is calculated using formulae involving basic, overtime and on-call hours. A wide range of different systems is used, and there is no apparent benefit to discussing these in detail in this report.

3.71 In the majority of countries that provided useful data, basic salary makes up 70–90% of pay. In Greece and Austria, this proportion is roughly 50%, with payment for overtime composing the bulk of the remainder.

3.72 Although payment is a secondary issue, as it ought not to

have a direct bearing on the weekly hours required of a doctor in training, it cannot be ignored as a contributory factor. Often no payment is made for hours worked outside those rostered, for example during handover or preparation periods, and there is therefore little incentive to record such hours. Systems of payment may also not recognise differences in the intensity of work whilst on-call. In such cases, some doctors or specialisations may benefit disproportionately from on-call duty.

3.73 As discussed previously, doctors in training do not in general seem to be expressly forbidden from taking on paid commitments with other employers. However, it is generally stated that other paid professional work must not conflict with the principal employment of a doctor in training, which evidently limits the scope for this kind of practice.

Monitoring

3.74 Only Belgium and Switzerland lack monitoring at both local and regional/national levels. In other countries, there seem to be no formalised and enforced systems of monitoring, but at local level the employer generally has an obligation to ensure that contracts are respected, often in association with local employee representatives. Such obligations are often linked with a regional/national monitoring procedure.

3.75 To be of real value, monitoring needs to be accurate and to have an impact. This does not currently seem to be the case, and participants in the study have expressed little confidence in present systems. At local level, monitoring may not accurately reflect the true situation, as the hours worked by doctors in training are frequently under-recorded. The two main reasons put forward for this during the study are management's need for figures that conform to theory rather than reality, and the lack of financial incentive to record excess hours when no payment will be made for such work. If the basis for registering the hours actually worked is subjective, other control mechanisms in a monitoring system will be unable to function as they should.

3.76 Effective monitoring could be a safeguard for employers and employees. At present it seems to be regarded as a tool for financial control rather than for the control of the hours worked. If the monitoring of the working time of doctors in training was made effective, both technically and in terms of sanctions against defaulters, it could contribute to reducing some of the excesses identified in this study.

Matters other than the hours worked

3.77 The questionnaire asked about breaks, daily and weekly rest, and transitions to and from night work and shift work.

3.78 Detailed replies were received from most countries. No common pattern emerged that could be summarised in this report. As already reported above, breaks and rest periods are a neglected area in contractual agreements in some countries, and therefore the on-site outcome for doctors in training on these matters can be haphazard. Within this section, most

respondents did not record any problems of transition with night and shift work, but replies elsewhere in the questionnaire indicate that poor local organisation of such transitions can be one of the causes of protracted periods of continuous duty.

3.79 General discussion of these matters left the impression that when staffing levels were too low for service needs, or rosters too tightly organised, break and rest time for doctors in training is easily eroded.

4 OTHER ISSUES

4.1 The following points were not anticipated in the questionnaire. They arose from reviewing the replies, or during discussions with the interested parties.

Protracted hours of continuous duty

4.2 The length of continuous duty that doctors in training are routinely required to work has been mentioned earlier in this report. Even in countries that nominally limit working hours, weekly rostering may be organised in such a way as to lead to doctors in training moving directly from one type of duty to another. In a number of replies attention has been drawn to doctors in training "theoretically" being on duty for periods of over 100 hours. Unless adequate safeguards are provided, the duration of continuous duty can also be excessive in practice.

Informal pressures on doctors in training

4.3 There is a very real problem with respect to the informal pressures that are put on doctors in training. Rules and recommended practices break down in the face of informal pressures exerted at the place of work. The apprenticeship nature of post-graduate medical education is often to blame, as it places the junior in a position of dependency upon his or her senior. Future career prospects could be jeopardised by a junior's refusal to accept extra duties demanded by the senior despite the fact that they may exceed contractual agreements. Unrealistic rostering that routinely leaves services under-staffed to meet known needs also places doctors in training under moral and professional pressure to undertake extra duties or hours.

The cost of change

4.4 The study shows that doctors in training form a substantial part of the medical workforce. Where doctors in training work hours well beyond the maximum foreseen in directive 93/104/EC, as is the case in several countries, the simplistic solution is to increase the numbers of either junior doctors, or senior doctors, or both. Replies and comments in the study point also to other factors that should be studied in any assessment of the cost of change, including the availability and deployment of support staff, and more efficient working methods at local levels.

4.5 It is also suggested that there should be assessment of the cost of not changing the working hours of doctors in training

in countries where excessive hours are worked. The risk to patients arising from over-tiredness of doctors was mentioned in this context, and in particular the possibility that adverse conditions of service could become a factor in claims for compensation for professional negligence.

5. SUMMARY AND CONCLUSIONS

5.1 The study has attempted to throw light on a number of aspects of the working time and conditions of service of doctors in training. Coshape offers the following comments to the Commission from the material obtained in the study.

5.2 The Commission wishes to consider future initiatives that it might take to extend the principles of directive 93/104/EC to doctors in training. In doing so, the Commission may wish to distinguish between issues that ought not to give rise to much dispute or difficulty, and those that are likely to be more complicated to resolve.

5.3 The study indicates that the following issues are relatively straightforward:

1. Identifying the doctors covered by the concept of "doctors in training".
2. Establishing the importance of doctors in training within the medical workforce in terms of:
 - their proportionate strength.
 - the professional duties they undertake.
3. Establishing the attribution of contractual responsibility for doctors in training, including the structures by which decisions are reached on their conditions of service.
4. Assessing professional commitments additional to the principal contract of employment.

5.4 The following issues are less straightforward, but do not seem likely to present insurmountable problems:

1. Defining criteria with respect to the duration of "training" in some countries.
2. Establishing effective systems of monitoring.

5.5 The most complicated issues to deal with are likely to be:

1. Excessive hours of work in several countries.
2. On-call duty.
3. Unrecorded (and often unpaid) hours.
4. Unrealistic rostering.
5. Protracted periods of continuous duty.
6. The vulnerability of breaks and time off in the face of pressures of service needs.
7. The attribution of duties between junior and senior doctors.
8. Informal pressures on doctors in training.
9. The cost of change.

5.6 A structure for future consultation between the Commission and the Social Partners also needs to be arrived at, taking into consideration the existing representative bodies.

6 ACKNOWLEDGEMENTS

6.1 This study could not have been undertaken without the active interest and support of the officials of Directorate General V/D/2 of the European Commission. The idea for such a study was theirs in the first place, and their continued guidance and help was invaluable. The contribution made by members of the Steering Group was also greatly appreciated. They had a very specific brief – to assist Coshape in designing a comprehensive and balanced questionnaire without entering into issues of substance, they kept to their brief admirably. The Steering Group also helped to identify the interested parties to be invited to complete the questionnaire. The Standing Committee of European Doctors and the Permanent Working Group of junior Hospital Doctors kindly used their networks to stimulate replies to the questionnaire. The Fédération Européenne des Médecins Salariés also obtained replies from its members. Finally, thanks are due to the individuals and organisations that participated in the study. For many of them this task was not easy, as they had to deal with a complicated questionnaire in a language that was not their own. The high standard of replies is indicative of their interest in the subject.

APPENDIX 1

Recipients of Questionnaire on the Working Hours of Doctors in Training

The Belgian Permanent Representation to the European Union
Fédération Belge des Chambres Syndicales des Médecins
Association Belge des Syndicats Médicaux

Confédération des Etablissements Publics de Soins (Bruxelles)
Ordre des Médecins (Bruxelles)

The Danish Permanent Representation to the European Union
The Danish Medical Association

The German Permanent Representation to the European Union
Marburger Bund (Germany)

Bundesärztekammer (Germany)

NAV (Germany)

BPA (Germany)

Hartmannbund (Germany)

Deutsche Krankenhausgesellschaft (Germany)

Deutsche Angestellten Gewerkschaft (Germany)

The Greek Permanent Representation to the European Union
Panhellenic Medical Association (Greece)

Association of Hospital Doctors of Athens and Piraeus (Greece)

The Spanish Permanent Representation to the European Union
Consejo General de Colegios Oficiales de Médicos de España
(Spain)

The French Permanent Representation to the European Union
ISNIH/ISNCCA (France)

Conseil National de l'Ordre des Médecins de France
 The Irish Permanent Representation to the European Union
 The Irish Medical Organisation
 Irish Business and Employers Confederation
 The Medical Council (Ireland)
 The Italian Permanent Representation to the European Union
 Federazione Nazionale degli Ordini dei Medici (Italy)
 Associazione Nazionale Aiuti e Assistenti Ospedalieri (Italy)
 The Luxembourg Permanent Representation to the European Union
 Association des Médecins et des Médecins-Dentistes (Luxembourg)
 The Netherlands Permanent Representation to the European Union
 The Royal Dutch Medical Association
 Landelijke Vereniging van Artsen in Dienstverband (Netherlands)
 De Geneeskundige Hoofinspecteur van der Volksgesondheid (Netherlands)
 The Portuguese Permanent Representation to the European Union
 Ordem dos Médicos (Portugal)
 The UK Permanent Representation to the European Union
 The British Medical Association
 The Austrian Mission to the European Union
 Österreichische Ärztekammer (Austria)
 The Finnish Mission to the European Union
 The Finnish Medical Association
 Finnish junior Doctors Association
 Association of Finnish Local Authorities
 The Icelandic Mission to the European Union
 The Icelandic Medical Association
 The Norwegian Mission to the European Union
 The Norwegian Medical Association
 Norwegian Junior Doctors Association
 Association of Counties (Norway)
 The Swedish Mission to the European Union
 The Swedish Medical Association
 Swedish Junior Doctors Association
 Federation of Swedish County Councils
 The Swiss Mission to the European Union
 The Swiss Medical Association

PWG of Junior Hospital Doctors

EFTA Secretariat (Bruxelles)
 Hospital Committee of the European Community (Belgium)
 International Hospital Federation (London)
 European Public Services Committee (Bruxelles)
 European Association of General Practitioners (Copenhagen)
 Standing Committee of Doctors of the EC (Bruxelles)
 Union Européenne des Médecins Spécialistes (Bruxelles)
 World Federation for Medical Education (Edinburgh)
 Confédération Européenne des Syndicats Indépendants (Bruxelles)
 Fédération Européenne des Médecins Salariés (Brescia, Italy)

Respondants to Questionnaire on the Working

Hours of Doctors in Training

Chambre Syndicales des Médecins des Provinces du Hainaut et de Namur et du Brabant Wallon
 Chambre Syndicale des Médecins de l'Agglomération Bruxelloise
 Arbejdsministeriet (Denmark)

The Danish Medical Association
 Marburger Bund (Germany)
 Bundesärztekammer (Germany)
 Deutsche Krankenhausgesellschaft (Germany)
 Panhellenic Medical Association (Greece)
 EINAP (junior Doctors Association, Greece)
 Consejo General de Colegios Oficiales de Médicos de España (Spain)
 Ministère des Affaires Sociales de la Santé et de la Ville (France)
 ISNIH/ISNCCA (France)
 Irish Business and Employers Confederation
 The Irish Medical Organisation Department of Health, (Ireland)
 Local Government Staff Negotiations Board (Ireland)
 Ministère du Travail (Luxembourg)
 The Royal Dutch Medical Association
 Ministerie van Sociale Zaken (Netherlands)
 The Portuguese Permanent Representation to the European Union
 Ordem dos Médicos (Portugal)
 The British Medical Association
 Ärztekammer für Oberösterreich (Austria)
 The Finnish Medical Association
 Finnish junior Doctors Association
 Association of Finnish Local Authorities
 The Icelandic Medical Association
 The Norwegian Mission to the European Union
 The Norwegian Medical Association
 Norwegian junior Doctors Association
 Norwegian Association of Local Authorities
 Norwegian Board of Health
 The Swedish Medical Association
 Swedish junior Doctors Association
 Federation of Swedish County Councils
 National Board of Health and Welfare (Sweden)
 The Swiss Mission to the European Union
 The Swiss Medical Association
 The Medical Association of Malta
 The Rumanian Order of Doctors

PWG of Junior Hospital Doctors

Confédération Européenne des Syndicats Indépendants (Bruxelles)
 Fédération Européenne des Médecins Salariés (Brescia, Italy).

Organisations proposed as representative of employers and employees

Country	Employers	Employees
BELGIUM	Le Rectorat des Universités Hospital Committee of the European Community	Chambre Syndicale des Médecins Les Groupements d' Assistants
DENMARK	Association of Country Councils National Association of Local Authorities	Danish Medical Association
GERMANY	Federal Ministry of the Interior Collective Bargaining Group of the German Länder Assoc. of Municipal Employer Federation	Marburger Bund OTV – Public Sector & Transport Workers Union DAG – German Employers Union GGVOD – Fed. of Unions and Associations in the Public Service Sector Vereinigung der Kommunalen Arbeitgeberverbände
GREECE	Ministry of Health	Panhellenic Medical Association Regional Association Association of Hospital Doctors EINAM
SPAIN	Ministry of Health	Consejo Medicos CESM – Confederacion Estatal de Sindicatos Medicos
FRANCE	Ministère des Affaires Sociales et de la Santé	ISNIH – Inter Syndicat National des Internes des Hospitaux
IRELAND	Local Government Staff Negotiations Board Irish Business and Employers Confederation	Irish Medical Organisation
ITALY		
LUXEMBOURG		
NETHERLANDS	Eight suggestions	LAD – Dutch Organisation of Salaried Doctors KNMG – Royal Dutch Medical Association
PORTUGAL	Ministério da Saúde	Ordem dos Médicos Sindicato Independente dos Médicos
UK	National Health Service Executive	British Medical Association
AUSTRIA	1	Österreichische Ärztekammer
FINLAND	Kunallinen Työmarkkinalaitos (Commission for Local Authority Employers)	Finnish Medical Association
ICELAND		Icelandic Medical Association Icelandic Junior Doctors Association
NORWAY	Staten v/Socialdepartement A4 Kommunenes Sentralforbund Oslo Kommune APO (Privately owned hospitals association)	Norwegian Medical Association
SWEDEN	Federation of Country Councils	Swedish Medical Association
SWITZERLAND	1	ASMAC – Assoc. Suisse des Médecins Assistants et Chefs de Clinique
MALTA	Ministry of Health	Medical Association of Malta
RUMANIA	Ministère de la Santé	Ordre des Médecins de Roumanie

¹ No single representative organisation exists.

Working Hours of Junior Doctors in Europe

By Jesper Poulsen, President, PWG

WORKING HOURS & JUNIOR DOCTORS

The subject of working hours has been a major item on the political agenda of junior doctors in Europe for many years. For the last century, doctors in general – and junior doctors in particular – have been exposed to much longer working hours than the rest of the labor market. Historically, this is a result of doctors being a scarce commodity in nearly all countries until the 1950s and 1960s. Junior doctors have been seen to be a kind of apprentices in the hospital system and have been called upon to perform most of the work in hospitals outside the normal working hours i.e. during night and weekend shifts.

In the 1960s, the production of doctors in Europe increased considerably. This development continued throughout the 1970s, resulting in a relative overproduction of doctors which in turn led to medical unemployment in many countries. Firstly, because of the unemployment situation and secondly because Junior doctors were generally dissatisfied with working hours that routinely exceeded 80 hours per week, increasing pressure from junior doctor organizations placed the subject of working hours on the negotiation tables all over Europe.

In some countries, this led to a general reduction of junior doctors' working hours – especially in the Nordic countries, whereas other countries, despite efforts, have not been able to solve this problem. The magnitude of the problem is clearly described in the report presented by Coshape (PWG 95/004).

FORMULATION OF THE 1993 DIRECTIVE

The PWG was founded in 1976 as a body organizing junior doctors associations in Europe. When the European Union first suggested regulating the working hours of the European work force by means of a directive in order to secure the health and safety of workers, this was warmly welcomed by the PWG. The PWG recognizes that the character of work performed in hospitals is different from many other working situations, but we were pleased to see that Article VII of the proposed directive provided vast opportunities to derogate from some of the

stricter regulations governing the rest of the labor market by allowing "alternative protection measures" to substitute some of the stricter measures for work performed in hospitals. Junior doctors hoped that the adoption of the Directive on Working Hours would assist Junior doctors in solving a problem which national negotiations had been unable to solve in many European countries.

Obviously, junior doctors were very upset when in June 1993 at the meeting which adopted the Common Position on the Working Hours Directive, the Council of Ministers chose to exclude work performed by doctors in training together with a number of other sectors (i.e. transport, the fishing industry, etc.).

It is still not quite clear to us what happened at the meeting of the Council of Ministers in June 1993, but apparently the Governments of the United Kingdom and Ireland insisted upon the exclusion of doctors in training. Rumors were heard that a bargaining was held in which ministers from some countries insisted on having the off-shore sector excluded and others accepted this on the condition that doctors in training were excluded as well.

Ireland and the United Kingdom are two of the countries in Europe where long working hours for junior doctors prevail. No doubt, some governments kept their heads down at that meeting, allowing Ireland and the United Kingdom to take blame for the exclusion of doctors in training, even though it also suited their national interests perfectly well.

The PWG reacted to the Common Position with an intense lobbying campaign mainly directed at the European Parliament, but also at the national ministers for health and/or employment. We stated that given the number of unemployed doctors in Europe, we saw no objective reason to exclude junior doctors and, in fact, that Junior doctors were one of the groups in Europe in direct need of the protection given in this Directive. We further stated that not only was it damaging to the health and safety of junior doctors to work sometimes in excess of 70 hours per week, but it could also very well have a negative

effect on patient care to have overworked doctors in the hospitals. We noted that with the possibilities of derogations indicated in Article 17 of the Directive, we could see no reason that the Directive should cause problems for the functioning of the hospitals if junior doctors were included under the protection given by the Directive.

QUALITY OF TRAINING

The question of quality of training for junior doctors has been mentioned several times in connection with the question of working hours – although, to the best of my knowledge, not by the European Union. Traditionally, the quality of training has been guaranteed by the very long working hours and the many years doctors spend as a junior doctor. Very little effort has been spent on securing that the hours worked by junior doctors have any real training value. It is our opinion that before junior doctors are asked to work considerably longer hours than the rest of the work force, it should be proven beyond any doubt that maximum effort has gone into securing that junior doctors receive the optimum training in the hours they actually work. Following PWG's lobbying campaign, the European Parliament's Committee on Social Affairs recommended to Parliament that the clause excluding doctors in training from the scope of the Directive be deleted. In October 1993, the European Parliament voted with an overwhelming majority to urge the Commission to delete the exclusion clause, which, thus, would have extended coverage to Junior doctors.

In December 1993, the Council of Ministers adopted the Directive on Certain Aspects of the Organization of Working Time with the exclusion clause intact. Due to the position of the European Parliament, a sentence was included in the Preamble of the Directive stating that "whereas, given the specific nature of the work concerned, it may be necessary to adopt separate measures with regard to the organization of working time in certain sectors or activities which are excluded from the scope of this Directive."

A SOCIAL DIALOGUE ON THE EUROPEAN LEVEL

Commissioner Flynn has declared to the PWG and in several other contexts that it is the Commission's intention to secure coverage for the excluded sectors. In the Commission's White Paper on Social Policy, it is stated on pages 22–23 that the Commission would like to see the problem of Junior doctors solved through the social dialogue by agreement between partners and this is repeated in the Social Action Program. It should be noted that it is the Commission's intention to resort to legislative measures if the social dialogue fails to produce a solution. The PWG has always been in favor of junior doctors' working hours being reduced to an appropriate level by negotiation and we are, thus, willing to commit ourselves fully and completely to a negotiated solution through the social dialogue. The PWG represents all the organizations in Europe negotiating

on behalf of the junior doctors, but we are not a registered social partner. Nevertheless, in collaboration with the ETUC, we see the employees' side as being well structured and well organized to enter these negotiations and reach an agreement. The problem seems to be finding an employer with sufficient representativity to do the same.

THE COSHAPE REPORT

The Commission's DG V has devoted many efforts to analyzing the situation. The Commission employed a consultant company, COSHAPE, to produce a study of the question of Junior doctors' working hours, known as the COSHAPE Report. It is here clarified that a problem of junior doctors' working hours is very real. The nature of the problem is discussed in detail and the organizational background is analyzed. A number of junior doctor organizations contributed to this study as well as a few from the employers' side. The failure of the employers to enter the process on this investigatory level to a sufficient degree is underlined. It is the position of the PWG that the COSHAPE Report gives a clear and well-documented report of the situation. The COSHAPE Report stresses a number of ambiguities and unclear points in Directive 93/104/EEC. First of all, it is not very clear who is included in the term "doctors in training". All doctors have an ethical obligation to undergo continuing medical education throughout their entire career and in this sense, all doctors could be said to be in training. On the other hand, after a doctor has worked one to two years as a doctor, several countries issue a license allowing the doctor to work independently. If that is the criterion, "doctors in training" would be a very small group.

DEFINITION OF "DOCTORS IN TRAINING"

The most widely accepted definition of "doctors in training – and the most logical one in the eyes of the PWG is to consider "doctors in training" those who are training to become specialists or general practitioners. Thus, the PWG has suggested that the following definition of "doctors in training" in relation to Directive 93/104/EEC be applied:

A "doctor in training" should be defined as a doctor in postgraduate, specialized, or specific (vocational) training who simultaneously as part of the training is working in a department in which employment in accordance with national regulations is needed to achieve recognition or authorization as a specialist or some other postgraduate vocational category.

DEFINITION OF "WORKING TIME"

Another unclear point in the Directive is the concept of working time. According to the Directive, working time shall mean

the period during which the worker is working, at the employer's disposal and carrying out his activities or duties, in accordance with national laws and/or practice. A number of the hours worked by junior doctors are so called "on-call" hours. This means that the doctor is either at home or in a designated space of the hospital, mainly at night or during weekends, available for immediate work. The amount of work actually performed during these on-call hours varies considerably from specialty to specialty. Some doctors are only occasionally called upon to perform their activities during on-call duty and at the other end of the spectrum, doctors in e.g. surgery, gynecology, or anaesthesia normally work actively during nearly all their on-call time. They are often remunerated accordingly.

The PWG finds that it would be very difficult to regulate all these different situations via a European negotiated agreement or by a directive, which would have to be very detailed, even to an extreme degree.

The PWG, therefore, suggests that the definition of "working time" should read as follows:

Working time should mean any period during which the doctor is working at the employer's disposal and carrying out his activities or duties, in accordance with national law and/or practice. By national negotiation between relevant parties, other restrictions concerning working time may be agreed upon.

This would allow for a certain amount of subsidiarity by national negotiation and agreement as to which part of a doctor's activities should be considered working time.

In general, it is the opinion of the PWG that a directive or an agreement negotiated through the social dialogue should take the form of a frame. The idea should be to provide junior doctor organizations nationally with a strong European backing when they negotiate to achieve a reasonable working week for their members.

We understand that this is very much in line with how the ETUC prefers to settle this kind of situation.

PROPOSED ITEMS TO BE DISCUSSED AT THE ETUC CONFERENCE IN OCTOBER

1. What can be done to ensure that in future, employees or professions which are particularly vulnerable are not excluded from coverage by EU directives on protection of employees?
2. What can be done to ensure that the interests of smaller groups working under specific conditions be considered in the social dialogue?
3. Would it be possible to organize the negotiation of the conditions of particular groups in the social dialogue in such a way that representatives from the group in question - on behalf of ETUC under the chairmanship of an ETUC representative negotiate with representatives of the employers?
4. How should the ETUC react in situations in which no relevant and interested employer counterpart can be identified with a view to negotiation?

Basis for PWG Policy on EU Regulation concerning Working Hours for Doctors in Training

At the PWG Plenary Assembly meeting in Basel (Switzerland) on 6 & 7 October 1995, it was agreed that the following should form the basis of PWG policy on the above topic:

A doctor in training should be defined as a doctor in postgraduate specialized or specific (vocational) training who simultaneously as part of the training is working in a department in which employment in accordance with national regulations is needed to achieve recognition or authorization as a specialist or some other postgraduate vocational category.

The definition of working time should read: working time should mean any period during which the doctor is working at the employer's disposal and carrying out his activities or duties in accordance with national laws and/or practice.

An amendment to Article 17, subitem 3 in EU Directive 93/104/EEC should read as follows: Derogations may be made from Article 2 by means of collective agreements or agreements concluded between the two sides of industry at national (or regional) level or, in conformity with the rules laid down by them, by means of collective agreements or agreements concluded between the two sides of industry at a lower level.

PWG 96/116 Final

MOTION

Working Hours for Doctors in Training & the Implementation of the Working Hour Directive

The Permanent Working Group of European Junior Doctors (PWG), meeting in Plenary Session in Copenhagen on 5 October 1996, expressed grave concern over the fact that the European Commission has not yet issued its white paper on the problem of the sectors excluded from Directive 93/104/EC on working time.

The PWG is particularly alarmed about this in view of the fact that the Directive, adopted three years ago, comes into effect in November 1996 and no solution has yet been found for the excluded sub-sectoral group of doctors in training.

The Commission has on several occasions recognized the fact that working conditions for doctors in training are already unfavourable. The coming into effect of Directive 93/104/EC, in fact, threatens to worsen those already poor conditions since other groups of doctors and health professionals who are not excluded from the Directive's coverage will now be protected from excess working hours with the result that those hours will now be liable to be placed upon the only unprotected part of the medical sector, the doctors in training. The consequences of this will effect not only the doctors in training, but also will worsen the situation of patient care in Europe.

For these reasons, it is urgent and imperative that the Commission act now to secure protection for this group of workers from the impending worsening of an already poor working situation and from the endangerment of high quality patient care.

The PWG urges the Commission to act now to avoid the possible situation that the implementation of the Directive meant to protect the workers in Europe will actually lead to a worsening of working conditions for a small and already overworked group of European workers, the doctors in training.

Unanimously adopted by
PWG Plenary Assembly
Copenhagen, 5 October 1996

Opinion of the Permanent Working Group of European junior Doctors (PWG) and the Standing Committee of European Doctors (CP) on the Council Common Position on the excluded sectors from the working time directive (05/07/99)

1. Doctors in training were excluded from the protection of Council Directive 93/104 concerning certain aspects of the organisation of working time adopted in November 1993.
2. The European Commission opposed this exclusion, finding it ill-reasoned on objective grounds and discriminatory, as expressed in the Commission White Paper on excluded sectors, 1998.
3. The European Parliament has repeatedly since 1993 urged the Commission to propose amendments to 93/104, especially in the light of the documentation gathered by the Commission indicating the abuse of doctors in training taking place in several member states ("European Commission, DGV: Final Report on the working hours of doctors in training in the context of directive 93/104/EC, report submitted by COSHAPE").
4. The proposed Council Directive to amend 93/104 put forward in November 1998 was welcomed by the medical profession, as it proposed to reduce the maximum working week to 48 hours. The suggested possibility of derogation from this by agreement between the two sides at a national level for a 7 year transition period was deemed fair and necessary.
5. Therefore, it was with disappointment and anger that the profession received the Common Position from the Council in July 1999. The Council Position would allow member states, without agreement between the two sides, to let discrimination against doctors in training to continue for 9 years after the entry into force of the amending directive – thus for a total of 13 years.
6. Meanwhile, the situation remains acute: in the United Kingdom, Ireland, France, Italy, Spain, Austria and the EEA member Iceland, doctors in training routinely and by far exceed 48 working hours on a weekly basis, thus endangering their own health and that of their patients.
7. The Standing Committee of European Doctors (CP) and the Permanent Working Group of European Junior Doctors (PWG) welcomed the position taken by the European Parliament after its first reading of the proposed amending directive aimed at maintaining the possibility of derogations from the 48 hours limit in the transition period only by national agreement between the two sides.
8. The Standing Committee of European Doctors (CP) and the Permanent Working Group of European Junior Doctors (PWG) now urge the European Parliament to work for
 - a) an amendment to the Council's Common Position to reintroduce the clause by which national derogation from the 48 hour limit can take place only by agreement between the two sides;
 - b) a significant reduction of the transition period. This is especially important – should it not be possible to reintroduce the derogation by agreement only clause.
9. The Standing Committee of European Doctors (CP) and the Permanent Working Group of European Junior Doctors (PWG) underline the importance of achieving a result within a narrow time frame – a result that will start the clock ticking away the transition period: the situation of the working hours of doctors in training remains, in large parts of the Union, disastrous!

Resolution on The European working Time directive

Noting the agreement between the European Parliament and the Council of Ministers to extend the Working Time Directive to cover doctors in training, the PWG:

1. Regards this as a positive step forward in Protecting the health and safety of doctors and their patients.
2. Deplores the unnecessarily delays insisted upon by the Council of Ministers, and believes that full implementation is possible in much less than the proposed standard transition time of 9 years.
3. Is astonished that Member States would be able to extend unilaterally the period of transition.
4. Considers that the mechanisms for triggering extensions to the transition period are insufficiently robust, and will do little to persuade member states to make all efforts to achieve the hours-reduction targets in less than the standard period.
5. Calls upon the European Parliament, when considering the Amending Directive to make clear to member states.
 - a. that they should make clear plans for implementation as soon as possible and within the standard transition period;
 - b. that use of the extension periods should only be sought in exceptional circumstances and where every effort has been to deliver the directive within the standard time.
6. Calls upon member states to make clear their intent to achieve full implementation of the directive as soon as possible and within the standard transition time, and to publish their plans for doing this.
7. Will continue to press for real reductions in junior doctors' working hours and for implementation in the shortest possible time.



Other Policy Resolutions & Studies Ethics

Comment on the Revision of the Declaration of Helsinki on medical Ethics and Research by WMA in Tokyo

October 1979, Utrecht

The Permanent Working Group of European Junior Hospital Doctors noting the revision of the Declaration of Helsinki II adopted by the World Medical Association in Tokyo, 1975, emphasizing that ethical principles for the guidance of medical doctors within biomedical research are already in effect in the European countries, stressing the obligation of the medical profession to develop and maintain the highest ethical standards for biomedical research, suggests that an extensive survey be carried out with the purpose of studying present ethical principles in action in the European countries with the view of developing a practical, written guide for the use of medical doctors engaged in biomedical research.

Motion on AIDS

April 1990, Birmingham

The PWG has considered and wishes to support document CP 88/165 of the Standing Committee of Doctors of the EC (CP) on AIDS. We are aware, that members of the medical professions carry a certain professional risk which, in some cases like that of AIDS, cannot be fully excluded even by the best possible protection. Therefore this risk has to be considered inherent to the profession and has to be accepted by those choosing the medical field. Nevertheless, PWG thinks that this fact is the logical basis on which AIDS should be recognized as an occupational disease or occupational accident for persons working or having worked in the medical profession without any restrictions whatsoever.*

The PWG cannot accept compulsory pre-employment or regular HIV testing for medical personnel.

* The text was accepted by the Standing Committee of Doctors of the W in May 1991 with deletion of the words "without any restrictions whatsoever".

Recommendation re publication of HIV Document

The PWG Working Party on AIDS met at 09.00 hours on 12 May. The main item on the agenda was the PWG policy statement on HIV infection and hospital doctors (PWG94/089 final).

The group agreed that this was an important document and that the PWG should ensure that it was disseminated widely to individual doctors and, particularly, to influential policy-makers. The group agreed that the document should be produced in a glossy form suitable for distribution to influential bodies, but that a simple manuscript version would be adequate for more personal distribution. This would have the added advantage of reducing costs.

The Norwegian delegation had previously expressed some interest in publishing the document, and the British delegation also felt some obligation in view of the input by the BMA Foundation for AIDS.

The group recommended the following action to ensure appropriate dissemination of the document.

1. National delegations (probably through their secretariats) should identify influential organizations and individuals within their own country who should be sent the glossy version of the document. They should give the PWG secretariat an estimate of the print run needed to meet these local needs by 16 June. They should also, if possible, identify potential sponsors in their own countries who might be willing to make a contribution towards the total cost of production. (In due course, they should send to the PWG secretariat

confirmation of the amount agreed and details so that the sponsor's name could appear on the document).

2. Based on the above information collected from each country the PWG secretariat, working with the UK and the Norwegian delegations, would estimate the total cost of publishing the glossy version of the document. The UK and the Norwegian delegations would consider their ability to contribute to this and the best way of doing so. Ideally, the production cost would be shared between them. Each would obtain estimates for local production (as would the PWG secretariat) and the cheapest option would be selected.
3. Unless major unforeseen difficulties arose, the PWG President and secretariat would then authorise production of the document in advance of the next PWG meeting.
4. Each national delegation would eventually receive an appropriate number of glossy versions of the document for distribution and a disk version (plus a small number of hard copies) of the text of the manuscript to allow local distribution to individual doctors as required.

The Working Group particularly emphasised the importance of distributing this document to medical schools and medical students to ensure that they are well informed about the implications of this issue at an appropriate stage in their careers.



Other Policy Resolutions & Studies
Organisational

Decision to Seek Formal Affiliation with the Standing Committee of Doctors of the EC (CP), April 1983, Glasgow.

- granted by the CP in November 1993.

Decision to Seek Formal Consultative Status with the Council of Europe, October 1986, Copenhagen.

- granted by the Council of Europe in August 1987.

Affiliating with Association on Medical Education in Europe, AMEE, 1989.

Reopening Formal Links (liaison officer) with European Union of Medical Specialists (UEMS), 1989.

Establishing Links with the European Union of General Practitioners (UEMO), 1991.

Establishing Links with International Federation of Medical Student Association, IFMSA, 1994.

Establishing Links with the European Medical Students' Association (EMSA), 2001

Statement on Smoking

adopted April 1990, Birmingham

Recognizing that tobacco smoking is one of our time's major problems and that it is the individual's right to refuse to be exposed to cigarette smoke, and in accordance with the World Health Organization, the British Medical Association and most national medical associations, the PWG will not accept smoking during plenary sessions.

Criteria for membership, observer or guest status within the PWG

adopted April 1991, Reykjavik

In order to become members of the PWG, applicants must fulfil] the criteria laid down in the charter and must be eligible for membership of the Council of Europe.

In order to become observers, applicants must fulfill the criteria for membership. All observers must apply for full membership within two years of being granted observer status.

In order to become guests, delegations must be invited officially by the Coordinating Secretary. Delegations wishing to bring guests must issue their invitations via the Coordinating Secretary.

PWG 95/049

MOTION

On the European Parliament and Council Directive amending Directive 93/16/EEC

Article 44A of the above proposal provides that the Commission shall be assisted by the Committee of Senior Officials on Public Health in a procedure of comitology on further modifications of the directive. The amendment procedure for medical training, however, raises vital questions for the medical profession that must be discussed by experts.

The PWG is, therefore, of the opinion that the ACMT, the CP, the PWG and other European medical bodies should continue to be consulted by the Commission in order to secure that the necessary medical and professional input is provided.

PWG 96/115

Additional responsibilities of PWG delegates to UEMS Boards

- Provide the PWG Secretariat with their name, address, specialty, phone number (fax, E-mail).
- Provide dates of future Board meetings if they are known or indicate to the PWG Secretariat that these dates are not known.
- Provide a report of the activity of their Board for each PWG meeting and this is to be provided even if there has been no meeting.

If a Board delegate does not fulfil these responsibilities their position could be reviewed by the PWG Postgraduate Medical Training Subcommittee or between meetings by the chairman of the Subcommittee.

PWG 98/108

PWG Support Fund Guidelines

The PWG resolves to set up the PWG Support Fund.

The purpose of the support fund is: to support financially representatives of junior doctors' organisations with financial difficulties to participate in PWG activities.

Money from the support fund will be allocated according to the following principles:

- The contribution to any country applying for the funds, must not be more than 50% of the total expenses needed for travelling and accommodation, it should only cover the expenses of one delegate (however exceptional circumstances will be considered).
- The countries applying for funds must send in a written application, specifying the exact junior doctors' associations' situation explaining their financial difficulties (this application need not be circulated as a PWG document).
- The application will then be discussed and approved or not by the decision group of the Support Fund Subcommittee.

The Relationship between CP and the Associated Organisations and the Management of Documents submitted by the Associated Organisations to the Board / General Assembly of CP

PRINCIPLES

1. The CP, as the umbrella organisation representing the medical profession as a whole in Europe, should, whenever appropriate, be the principal spokesman of the profession in order to strengthen that advocacy.
2. The associated organisations of the CP perform expert work in their individual branch of the profession, expanding the scope of medical activities beyond the possibilities of the CP.
3. The autonomy and expertise of both the Associated Organisations (AEMH, FEMS, CIO, EMSA/IFMSA, PWG, UEMO, UEMS, WMA) and the CP must be respected.
4. The Associated Organisations, as independent bodies, representing their individual/separate constituencies, are free to communicate and promote their documents to external institutions, including those of the European Community. However, all efforts should be made to co-ordinate individual views to ensure unity of the profession and maximum impact in representation. The CP secretariat should be informed when such institutions are approached and vice versa.
5. It is to be hoped that the documents of an Associated Organisation, whilst expressing the expert views of that group, in order to maximise impact and maintain unity, should also be acceptable to the medical profession as a whole. As these documents are the results of extensive deliberations between the members of the originating organisation and represent the agreed European position of that organisation, such documents are not alterable by the CP.
6. The officers of the CP will actively promote and commend the endorsed documents of the Associated Organisations to the appropriate European Institutions (Council of Ministers, European Commission, European Parliament, Council of Europe). Whenever a document is being presented in person, then a member of the originating organisation will, if possible, accompany the CP representative.
7. The CP should find ways to speed up the handling of these documents.
8. The Board may decide that the content of a document raises an important principle for the whole profession. Such issues may form the basis of a new CP statement, which should include a reference to the Associated Organisation document.

METHODS

1. All documents must be accompanied by:
 - A short explanation of the generation of the document
 - Its background
 - Its aim
 - A formal proposal
2. The individual organisation will indicate whether the document is commended to the CP
 - For information
 - For recognition of its view on a particular matter
 - For endorsement
 - For active promotion to the European institutions
3. Prior to submission to the CP, the document will initially be circulated to the other Associated Organisations, who will be invited to comment back to the initiating organisation.
4. The overall aim is to facilitate the endorsement of position papers from any organisation by the others.
5. Ownership of any document must be retained by the original authorising body with its distinctive logo. Other bodies may add their logo together with the words "endorsed by..." as appropriate.
6. The document will then be discussed at the next meeting of the Associated Organisations (at which the President and the Secretary General of the CP participate) to ensure the quality of the document and that no damage will be incurred to the interests of other Associated Organisations.
7. If supported unanimously at the meeting of the Associated Organisations, then the document will be presented to the next (not current) CP Board meeting by the President for formal endorsement according to the Statutes and Rules of Procedure on voting.
8. Where there is a difference of opinion within the meeting of the Associated Organisations, that decision is communicated by the CP President to the Board.
9. Where the Board cannot endorse a document, it will be received by the CP as the position of that Associated Organisation.

Approved
CP General Assembly
11th November 2000
Brussels



Other Policy Resolutions & Studies
Other Documents

Resolution on the Involvement of Doctors in Health Service Management

April 1986, Helsinki

The Permanent Working Group of European junior Hospital Doctors, having considered the role of medical practitioners in the management of health services, believes that:

1. Good medical practice should include awareness and use of management techniques, including self-audit and the efficient and economic use of personnel and resources, and that involvement in the management of health services at an appropriate level should be regarded as a criterion of professionalism;
2. Doctors with management responsibility may be faced with ethical dilemmas in the allocation and use of medical resources, but these potential dilemmas are not a reason for doctors to shun involvement in health service management;
3. Doctors should receive training in management techniques appropriate to the level of management responsibility which they will be expected to carry out.

RESOLUTION

Diagnosis Related Groups (DRGs) and other Systems for Cutting Hospital Coasts

adopted, PWG Plenary Assembly Vienna, Autumn 1994

In nearly every European country, there have been strong political moves towards rationing the financial resources of the health sector. The costs of hospital care in particular have been seen as a "cost increasing factor." New management instruments have been introduced such as DRGs and other financing schemes that operate on the basis of lump sums per case and diagnosis. The PWG is concerned about the many negative side effects, already known from cost cutting programs in the USA that can endanger the quality of patient care in the following ways:

1. Purely Economic Attitudes

I The patient is treated more as a cost unit than as human being in need of care.

II The hospital concentrates more on "less expensive" patients

III Patients in need of expensive care (in case of multiple pathology, high age, risks of complication, intensive person to person care) are discriminated against.

2. Setting Limits to Treatment

I When the capped budget of a treatment procedure has run out, the treating doctor may be pressed to inform the patient that the budget has reached its limit. This interferes with a patient/ doctor relationship based on trust, introducing a sense that a diagnostic and therapeutic procedure is contaminated by economic restrictions that interfere with the necessary quality.

II A trend toward excessive shortening of the inpatient period shifts the necessary after care to doctors and services outside the hospital sector. However, when out-patient structures are not adequately provided for, responsibility for care is placed upon the family instead of upon qualified health personnel. This tendency, combined with cutbacks in social budgets, could cause a dramatic loss in the quality of medical support.

3. Data Protection of All Patients

I The requirement to submit detailed reports to bodies whose function is primarily economically motivated entails a danger of undermining medical confidentiality.

4. Questioning the Cost-Effectiveness

I Claims are made that various management instruments result in saving, but:

II The standardized basic costs of treatment calculated in the DRG do not correspond to varying capacities of hospitals (variety in services, staff structure, age and state of the building);

III DRG and similar financing systems induce more bureaucratic expenditure and, thus, more costs and cause even more administrative work for the doctors concerned;

IV In the US, where such programs were started, the increase in administrative personnel between 1983 and 1993 was over 300%, while in the same period, the number of doctors increased by only 18%.

5. Quality of Training

I Training is part of the work in hospitals that costs time and the human resources of the "most expensive" group of doctors, the seniors and specialists, and this cost is not "calculated" in DRG financing systems. How will these costs be covered? Will there be a reimbursement to the hospital for the training work?

II The pressure to shift some medical service procedures to cheaper groups of health personnel could have the following effects:

- junior doctors are not protected against long working hours and are highly dependent on the work in the hospital in connection with their training to become specialists or general practitioners. Thus, they are vulnerable to pressure to work excessive hours with minimal compensation.

- while some of the doctors' work may be shifted to paramedics, the responsibility may in some cases remain with the doctors;

- as senior doctors' and specialists' presence in the hospitals will be reduced as short as possible, the supervision will be weakened and teaching time minimized;

- some special skills which are now taught during the daily work may have to be gained via paid training seminars at the cost of the junior doctors themselves.

III As the organization representing the coming generation

of doctors, the Permanent Working Group of European junior Hospital Doctors (PWG) expresses deep concern about the danger of these effects on the professional field of the junior doctors.

IV The PWG advises caution with regard to the employment of rationing programs and expresses opposition to the

employment of hospital doctors as a tool for cost cutting programs. The PWG calls for the support of the Standing Committee of European Doctors (CP) in transmitting these concerns to decision-makers in the national health authorities and other relevant sectors in the countries of Europe.

PWG 94/116 Final

MOTION on

Good Pharmacy Practice in Europe

The CP, and the associated organisations, meeting in Lisbon on 25 November 1994, considered the text published by the Pharmaceutical Group of the European Union entitled "Good Pharmacy Practice in Europe" (CP 94/43).

The meeting noted the numerous objections which have been expressed to the document by all the CP national delegations and all the Associated Organisations.

The meeting further expressed its agreement in the name of all participating bodies that the underlying philosophy of the document is unacceptable as it attributes to the pharmacists in Europe professional responsibility for matters beyond their sphere of competence, including matters which can only be under the responsibility of the patient's physician.

While noting the positive benefit of a good co-operation between physician and pharmacist in the interests of the patient and in agreement with accepted national practice, the CP finds the PGEU document to be in conflict with these interests.

The CP and the Associated Organisations, therefore, hereby express disagreement with the document in question and resolve to bring it to the attention of the Pharmaceutical Group of the European Union and all other relevant sectors to which the PGEU document may have been transmitted.

PWG 96/046 Final

STATEMENT

WHO Draft Charter on General Practice in Europe

The PWG believes that the principles expressed in the WHO Charter on General Practice/Family Medicine in Europe are very important. Many countries in Europe have undergone great changes in recent years, and their health services have been part of this process. Many are now seeking to develop and improve their primary health care infrastructure.

The PWG supports the development of high quality, well resourced primary care services and recognizes the pivotal role of the general practitioner. It is essential, however, to acknowledge the different approaches to primary care which have evolved across Europe. No single model should be imposed, and each country should be free to develop the services most suited to its own needs. All professional groups involved in the delivery of primary medical care should participate in the dialogue about its development to ensure that all points of view are represented and the debate is not undermined by cultural misunderstandings.

Unanimously adopted by
PWG Plenary Assembly
Helsinki, 18 May 1996

MOTION

Medical Training Schemes for Doctors Affected by Civil Strife and Conflict

Recognising that the infrastructure necessary to provide medical training has been severely affected in some countries which have recently experienced civil strife and conflict, the PWG endorses initiatives taken by individual countries to provide structured specialist training for junior doctors so affected.

Unanimously adopted by
PWG Plenary Assembly
Helsinki, 18 May 1996

PWG 99/105

Statement on Priority Setting in Health Care

The Permanent Working Group of European Junior Doctors has discussed priority setting in health care and considers it to be an issue of great concern, which must not be ignored by the medical profession.

The PWG invites the Standing Committee of European Doctors, representing the medical profession on the European level, to examine the current position in priority setting in health care in EU member states and to stimulate debate within the profession.

PWG Plenary Meeting

04

APPENDIX





Appendix

PWG Member Organisations

2001

Austria
Österreichische Ärztekammer

Belgium
Fédération Belge de Chambres Syndicales des Médecins

Denmark
Den Almindelige Danske Lægeforening

Estonia
Estonian Junior Doctors' Association

Finland
Nuorten Lääkärien Yhdistys

France
I.S.N.I.H/I.S.N.C.C.A

Germany
Marburger Bund

Hungary
Hungarian Medical Association

Iceland
Félag Ungra Lækna

Ireland
Irish Medical Organisation

Italy
AMSCE

Lithuania
Lithuanian Junior Physicians' Association

Luxembourg
Association des Médecins et Médecins-Dentistes

Malta
Medical Association of Malta

The Netherlands
Landelijke Vereniging van Artsen I Dienstverband

Norway
Yngre Legers Forening

Poland
Polish Medical Association, Junior Doctors' Section

Portugal
Ordem dos Médicos

Slovenia
Seckcija Mladih Zdravnikov

Spain
Consejo General de Colegios Oficiales de Médicos

Sweden
Sveriges Yngre Läkares Förening

Switzerland
Verband Schweizerischer Assistenz und Überarztze

United Kingdom
British Medical Association

List of PWG Publications

PWG 10 Year Report, 1976–1986 (Copenhagen, 1987: out of print).

PWG 15 Year Report, 1976–1991 (Bern, 1992: out of print).

Health Manpower Planning (ed. Frans C.A. Jaspers, Alvin R. Tarlov, Eric J. Vrijland, Martins Nijhoff Publishers, 1983, ISBN 0–89838–557–1).

Medical Manpower in Europe by the Year 2000: from surplus to deficit? [PWG Medical Manpower Study] (ed. Svend M. Christensen and Jesper Poulsen, Copenhagen 1992).

Medical Manpower in Europe: the conditions for equilibrium between supply and demand by the year 2000 (ed. Peter Saugmann-Jensen, Copenhagen 1991).

European Migrant Doctors Series (Copenhagen 1979, 1986: out of print)
Where Do I Ask?
How Do You Do?

Doctors' Own International Medical Abbreviations, edited by Otto Grove, 1977 and 1979.

PWG Policy Statement on Postgraduate Medical Training – a European Future (ed. Edwin Borman).

PWG Policy Statement on HIV Infection & Hospital Doctors (ed. Guttorm Brattebo).

Proceedings of Conference on Working Conditions of Junior Doctors (December 1995).

PWG Manpower Study 1994/95 (1996)

PWG Handbook of Resolutions, 1976–1997.

PWG Policy Statement on Future Medical Work, adopted in Tallinn, May 1997 (1997)

Proceedings, PWG Conference on Future Medical Work, Promoting Health for Patients and Doctors, Cologne, October 1997 (1999)

PWG Policy Statement on Continuing Medical Education/Continuous Professional Development, Killarney, October 1999

Proceedings, Conference on Continuing Medical Education/Continuous Professional Development, Lisbon, May 2000 (2000)

Proceedings, PWG Seminar on the implementation of the European Working Time Directive, Paris, October 2001

PWG Handbook of Policy Statements, 1976/2001

