

THURSDAY 20 NOVEMBER 2008

Present

Gale, B.
Howarth of Breckland, B. (Chairman)
Lea of Crondall, L.
Morgan of Huyton, B.
Neuberger, B.
Perry of Southwark, B.
Trefgarne, L.
Wade of Chorlton, L.
Young of Hornsey, B.

**Memoranda submitted by the General Medical Council
and the Nursing & Midwifery Council**

Examination of Witnesses

Witnesses: **Mr Finlay Scott**, Chief Executive, and **Ms Claire Herbert**, Head of European and International Development, General Medical Council; **Mrs Jill Crawford**, President, **Mr Graham Smith**, Chief Executive Officer, and **Dr Katerina Kolyva**, EU and International Manager, Nursing & Midwifery Council, examined.

Q191 Chairman: Welcome. Thank you very much for taking the time to come and give us your evidence. We think that this inquiry into the Cross-border Directive is extremely important. I must say that it has turned out to be rather more complex than most people had originally anticipated and grows more complex every time we hear witnesses. We will be hearing from both groups together. Some members may address their questions to a particular group, but if you have something to say at the end of one group's evidence please indicate so that we can hear it, but we do have to get through quite a lot in a short time so precision is everything. If we get to the end and you have not said everything you want to say, we are very happy to receive supplementary evidence from you and for you to amplify any questions you think may have been raised during the discussion that we have not quite got

to the end of. What I am going to do is to ask you all to give your names for the public record and then, only if you so wish, to ask each group to make a short introductory statement. Maybe I could start with the GMC and ask if you would state your names and your positions for the record.

Ms Herbert: Claire Herbert, Head of European and International Development at the GMC.

Mr Scott: I am Finlay Scott. I am the Chief Executive at the GMC.

Mrs Crawford: I am Jill Crawford and I am the President of the Nursing & Midwifery Council.

Mr Smith: Graham Smith, Chief Executive and Registrar of the Nursing & Midwifery Council.

Dr Kolyva: Katerina Kolyva, EU and International Manager at the Nursing & Midwifery Council.

Q192 Chairman: Thank you very much indeed. Do either group wish to make a short introductory statement?

Mr Scott: May I make a very short statement, my Lord Chairman. The GMC's purpose is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. Our mainly recognised public face is that we take action when things have gone wrong, but arguably the main contribution we make to high standards of healthcare is through our influence upon medical education and training and through the production of guidance for the profession in rapidly changing and demanding times. I would, if I may, just make four quick points in relation to the topic today. One, we believe it is essential that regulators across Europe should have in place measures that demonstrate to the public that their licensed or registered doctors are fully up-to-date and fit to practise. The second point is that the reality of healthcare is that it is not delivered by individuals working in isolation, it is delivered by teams normally within systems and we therefore require

effective systems of system regulation of the kind provided by the Healthcare Commission or, in future, the Care Quality Commission. Third, it is very important that we have effective local systems through clinical governance that are able to act quickly and effectively if there is a suspicion that things have gone wrong. Finally, there have to be effective systems that lead to regulatory action or redress for patients if they have been harmed. Our general view is that freedom of movement can be a very good thing, but historically the interests of enabling freedom or encouraging freedom have sometimes not taken full account of the needs of patients and patient safety. Thank you.

Q193 Chairman: Thank you very much. Can I ask if the NMC want to make an introductory statement?

Mrs Crawford: Thank you, if I might say a few words. The Nursing & Midwifery Council is the regulator of the 750,000 nurses and midwives in the UK. Similar to the GMC, we regulate the individuals, we are not a system regulator. Our role is entirely public protection, we are patient-safety focused, and our response today is from that perspective. The points that I would like to make echo many of the points that the GMC have made. In terms of the Directive, there does need to be a strong requirement for co-operation on a regulatory level between EU Member States and regulators, and this needs to be a legal requirement. Patients should have the right to know that any professional treating them is registered, is reputable and should be able to have access to that person's fitness to practise record. We also support the principle which is within the Directive that responsibility for that should sit with the regulator where the treatment is given. Those are the three key points I would like to draw to your attention at this stage. Thank you.

Q194 Chairman: Thank you very much indeed. Both of you in your statements as well as your evidence raise this issue of effective regulation in relation to the Directive. As medical

regulators, how well do you think that the Directive addresses the issue of medical regulation in cross-border healthcare? What do you consider to be the most important points in this regard and where do you think, and this is an important area, the regulatory responsibility should rest in cross-border treatment? I am going to start with the GMC.

Mr Scott: I think the absolute starting point should be that responsibility has to be clearly defined. There is a phrase that is sometimes used, “collectively exhaustive and mutually exclusive”, which points to single lines of accountability whatever the circumstances. That single line of accountability has to hold true whether it is the patient who is mobile or the healthcare professional. As a matter of law we could not take responsibility for healthcare professionals in other countries who are not registered with us. As a matter of practice, even if we were able to consider accepting such a responsibility, it would be almost impossible to deliver. We feel strongly that the line of accountability, as Jill has said, should be built around the point of delivery of the particular service that is in question. In our case, therefore, it means two things: in general national governments should put in place legislation that controls the delivery of healthcare services such that professionals have to be registered in order to deliver a service; secondly, as is the case with us, no matter where a doctor is practising, if they are registered with us they remain accountable to us.

Q195 Chairman: Wherever, you mean anywhere in the world?

Mr Scott: That is correct. Our regulatory reach extends to the four corners of the earth and regrettably we find ourselves having to take action against UK registered doctors despite the fact that the practice or incident was outside the UK.

Q196 Chairman: Can I just ask the Nursing & Midwifery Council to add their comments.

Mrs Crawford: Our view is absolutely that the responsibility for regulation should sit with the individual and system regulators within the country of treatment. However, as Finlay

rightly says, our systems of regulation are robust and that means where there are instances of misconduct elsewhere we can take them into account. The concern in relation to this Directive is that the regulatory systems within other EU Member States are not as robust as within the UK and, therefore, in terms of patient safety the Directive needs to be much stronger on basic regulatory principles, ie the professional needs to be registered and also some of the basic professional underpinnings that are indicated by being on a register. We are absolutely in agreement that it ought to be the country of treatment where responsibility lies. We would not be able to take action where somebody had delivered treatment elsewhere and we did not have access to those records. The other issue is that this needs to be transparent to patients. The regulatory systems need to be explicit and transparent. Patients need to have very easy access to who is responsible and where accountability sits.

Q197 Lord Lea of Crondall: Is there not a potential anomaly of lack of reciprocity in what you are both saying here; that you would expect perhaps that a British doctor in Poland in their scheme, which is happy to register all-comers from EU countries, is fine and dandy but in this country you would be in a position of holding your own autonomy in saying you could not recognise necessarily them or country X here. In practical terms you would need to have some discussion with them about reciprocity at some stage, would you? How would you talk to them?

Mr Scott: I think there are two quite distinct circumstances. One is where the doctor in Poland, irrespective of their nationality, is registered only in Poland. In those circumstances we would not be able to contemplate taking action against them despite the fact that the complaint or source of concern emanated from a UK citizen. The second circumstance is where the doctor in Poland is also registered with the GMC in the United Kingdom. In those circumstances we would be able to take action against them, either first order action in advance of action by the Polish authority, or second order action based on the findings by the

Polish regulatory authority. Just to emphasise, what we could not practically deliver is a decent regulatory response to doctors who simply were not registered with us in the first place.

Chairman: Thank you, that is very helpful in clarifying that.

Q198 Baroness Perry of Southwark: I want to ask a question about the provision of information which follows some of the issues. Both of you in your written evidence believe that the provision of information to patients is extremely important, but that is a pretty huge job when you come down to it. Who do you think should be responsible for providing that information?

Mrs Crawford: At the first level in terms of patients having information about their rights, about the ability to access care in other EU countries, clearly the Directive states there ought to be a national contact point to provide that. From a regulatory point of view, the more significant part is the information that patients are given by the professional and the need for that information to be accessible to them, the need for that patient when they access care to understand what they are being told, to be able to give informed choice. From a regulatory point of view the patient could not waive their right to giving informed choice, there is a need for that professional to be confident that they have delivered care in a way that is accessible to any individual they are treating. Talking about information in terms of patients' rights, that needs to be a national contact point, and it would be the NMC view that we would like to input into that in terms of the scope, the practice of individuals, the regulatory system within the UK, but clearly we would not seek to be that point of contact.

Q199 Chairman: Could you just define what you mean by a "national contact point"?

Mrs Crawford: I am using the phrase from the Directive. Our response would be that it is a governmental issue to establish and decide where that national contact point sits.

Q200 Chairman: You do not have a view about it, because we have not been able to get other people to tell us?

Mrs Crawford: I think our view is that it would not be us but we would like to input into it.

Mr Scott: I quite agree with Jill that we have to be careful not to impose requirements upon UK regulators that they cannot realistically deliver. I very much agree that the primary source of information should be in the country where the service would be delivered. Incidentally, I think it needs to cover the four points that we briefly touched on in our introductory statement. What I do see is that there is an opportunity to use technology to make it very much easier for patients, their doctors and friends to access that information, for example through links from websites. So you could imagine that in each country there might be one or more common portals as a way of gaining access to information, but the primary responsibility would remain with the intended country of treatment.

Q201 Baroness Perry of Southwark: What kind of information do you think patients are entitled to? How much should they be given or have access to?

Mr Scott: Can I preface my answer to that by saying that we are fortunate in the UK in having a very well established and robust system of general practice. Our starting point would be to advise individuals not, as it were, to do this on their own but to do it in conjunction with their own UK medical adviser. It needs to cover at a minimum, in our view, the system of regulating professionals, including that very important point, is there a systematic approach to demonstrating that in our case doctors remain up-to-date and fit to practise. Secondly, is the system as a whole regulated, are hospitals and other healthcare units subject to regulation and, if so, frequency and effectiveness. Thirdly, what systems of local clinical governance exist to ensure early and effective action. Finally, because unfortunately things will go wrong, it is the nature of healthcare that sometimes they will go wrong, how do patients gain access to redress. I think that is the minimum core set of information.

Mrs Crawford: The only thing that I would like to add or strengthen is that part of the information that patients get has to be about the regulatory frameworks within different countries. UK patients are at particular risk because there is an assumption within the UK that there is system regulation, there is individual regulation of health professionals, and we know in other EU Member States that looks very, very different, so there will be an illusion of regulation across the EU which is not real. Part of that information for patients to make an informed choice has to be the kind of regulatory system that they are choosing to go into.

Chairman: To have that properly in place is going to demand co-operation between the States. Lady Young is going to pursue this co-operation question.

Q202 Baroness Young of Hornsey: On the subject of co-operation on two specific areas, first of all, and this is particularly directed at the NMC because you raise this issue around prescriptions, in the draft Directive there is provision for EU-wide recognition of prescriptions, what is your view on that? What do you consider to be the potential advantages and/or disadvantages of that provision, especially in the case of where I think you say in your written evidence that we are in quite a unique position in this country where nurses can prescribe? What are the potential disadvantages and advantages?

Mrs Crawford: You are right, there is a particular regulatory issue for us, which is that nurses and midwives can prescribe having undertaken certain training and that would not be widely recognised around the EU, so there may be issues of other Member States recognising the validity of a prescription that has been issued by a nurse or a midwife. That is a specific issue to nursing and midwifery. Part of the answer to that is their being given clear information on the different scopes of practice of nurses and midwives within the UK and other EU Member States. There are other issues which are really purely patient safety issues. They may not sit within the regulatory framework in a very clear sense, but they are significant. The idea of EU-wide prescribing in practice is very difficult to implement. The

language issues make it significant and there are different alphabets within the EU which makes it very difficult. In terms of the cross-border collaboration between the prescriber and the dispenser there are some fundamental communication issues which the NMC is not convinced will be picked up purely by having an EU-wide electronic template for prescribing.

Q203 Baroness Young of Hornsey: Do you think that those barriers can be overcome or is it more or less impossible and we will have to settle for something else?

Mrs Crawford: There would be clear benefit to overcoming those barriers because the alternative is that when somebody has accessed treatment in another EU Member State and returns to their home Member State they are simply going to have to go through the whole prescribing process again, and potentially there will be patient safety issues in terms of the accessibility of those records. I would seek to resolve them. The principle is a good one, but there needs to be much more work done and there need to be very clear guidelines and standards for the implementation of it.

Q204 Baroness Young of Hornsey: Does that situation arise now from different circumstances, for example if somebody is taken ill on holiday or something? I would imagine that sort of situation might currently occur.

Mrs Crawford: I do not know firsthand on this, so I will not make it up.

Q205 Baroness Young of Hornsey: No, that is fine. Did the GMC want to say anything?

Mr Scott: There are two different circumstances which should be touched upon. One is where the patient returns to the UK with a prescription written by a doctor or another healthcare professional in another country and the reality is that today across Europe as a whole pharmacists would not have uniformly easy access to the equivalency of our list of registered medical practitioners. Although in theory that can be addressed, the history of the

development of trans-EU systems is not very encouraging. There is also a second circumstance which I was discussing with a UK doctor yesterday. One of her patients had returned from IVF treatment in another country, not with a prescription but with an extended request for a prescription which the patient invited the doctor to meet. In other words, it was not a direct message from one healthcare professional to another, it was an indirect message, and the clear intent was to encourage a UK doctor to provide a prescription not in correspondence with her own diagnosis of what was required but a third party's diagnosis. Again, there is a second side to this to which we have to be very alert.

Q206 Lord Trefgarne: Would you not agree that to invite a pharmacist, wherever he or she may be within the EU, to dispense a prescription written in a language they do not understand, probably about a medication they have never heard of, is nothing short of a recipe for disaster?

Mr Scott: If I may choose my words slightly differently from Lord Trefgarne ---

Q207 Chairman: We look to Lord Trefgarne to ask the questions in that way!

Mr Scott: There are major challenges to guaranteeing patient safety in those circumstances.

Q208 Chairman: Yes, that is a very valid issue. Can I ask a supplementary before we move on. We have evidence from the Government that the largest number of patients going abroad under the present arrangement are maternity cases. I wondered if you knew this and, if so, if you had any feedback about what was happening in relation to prescriptions and what-have-you.

Mrs Crawford: I have to say that is not information that the NMC has been privy to, at least to my knowledge. It is an interesting area that deserves further exploration. What we do know is midwifery care across the EU varies greatly. Maternity care systems also are very,

very different. If that is the case, it is something that the NMC needs to be aware of and will take away and look into it.

Chairman: It is quite interesting that people are going home to have their babies and it is being paid for.

Q209 Baroness Young of Hornsey: The next question concerns co-operation around e-health. Again, it is about the complexities of that and both of you have commented on it in slightly different terms. Would you consider it useful for e-health standards to be set at EU level, as proposed, in order to achieve the interoperability of information and communication technology systems? Does the development of e-health tools raise any problems of regulation, maintenance of standards, et cetera, and, if so, how do you feel that these could be addressed?

Mr Scott: Again, in a perfect world each country within the European Union would ensure adequate national standards such that it was largely irrelevant where a service was being delivered. As Jill was indicating earlier, the practical reality is somewhat different. When we encountered the problem, for example, of the delivery of radiology services remotely and had to address how we might view that, the conclusion we have come to takes us back to one of our earlier answers: it is wholly impractical for us to attempt to regulate healthcare professionals who are not registered in the UK. That places a responsibility upon those placing the contract for the radiology service to ensure that it can only be delivered in the distant country by properly qualified healthcare professionals. I happen to know that has been a very strong theme within the Department of Health in England and the lead within the Department of Health in England very much has that in her sights. We have to see this not as an issue that could be tackled effectively by imposing EU-wide standards, I do not believe that is an answer, but those who contract for the service have to use the contract as a way of ensuring patient safety.

Q210 Chairman: Do the NMC want to add to that?

Mrs Crawford: I just want to add that we welcome the potential for e-health in terms of sharing information and as being a tool for training and professional development. We do recognise the issues that arise that Finlay has just discussed. In terms of a standard, the standard that we would seek is that it is transparent where the treatment is being delivered because with e-health it may be that it is not always transparent to the patient where the treating professional resides. Clearly for the regulatory systems to be effective it must be transparent to the patient where the person who is treating them is and what regulatory systems apply.

Lord Lea of Crondall: Just as an aside, I am not clear whether you are exaggerating some of the problems. I think that doctors' prescriptions are notoriously hard to read and you do not seem to be doing anything about that. It seems crazy in an era of modern technology that doctors put your prescription on a computer, but why do you stick to this medieval system.

Chairman: I think that was an aside, not a question.

Lord Lea of Crondall: You might like to answer it. First of all, the GMC are highlighting their call on the European Commission to introduce a legal duty on all medical regulators to share registration information. It is perhaps possible to see where you are coming from, but that is far from operating like an EU driving licence. What is it actually doing? It would still leave Britain to decide what happens in Britain and Poland to decide what happens in Poland. Am I eliding registration and fitness to practise? They are not the same thing, but you have put them in the same sentence in your evidence. It could be that at initial registration 100 per cent of British doctors were given the thumbs-up to be registered in Poland but only 50 per cent of the Polish doctors were given a thumbs-up in Britain to be registered, and I am not talking about any disciplinary issues. Presumably when this body is producing information in

the spirit of freedom of information people would have to publish league tables, to coin a phrase, for all European countries. Would you comment on that?

Q211 Chairman: We are really interested to know where the responsibility would lie for all of this.

Mr Scott: My Lord Chairman, may I try and separate two quite different situations, which may help. One is in relation to initial registration and, broadly speaking, an EEA citizen or someone with equivalent rights who qualified within the EEA has essentially an absolute right to be registered in the United Kingdom. The only qualification to be attached to that is that we may refuse registration or investigate before granting registration if we uncover an existing disciplinary finding in another European country, and we guard against that possibility by insisting on receiving what is generally called a 'certificate of good standing'. There are problems around uniformity of the quality of certificates of good standing, but essentially that provides the safeguard. When the certificate of good standing produces no problem, we will grant registration. If, however, there is existing disciplinary action in another country, we are entitled to take that into account, but the particular situation that causes us concern is different from that. It is where a doctor is registered in more than one country simultaneously and in one country or indeed in more than one country disciplinary action is taken and, because the doctor is already registered with us, we would not routinely be seeking information from other EU Member States, so we depend upon the country where the disciplinary action is being taken to notify us that it has been taken. Usually, we are very good Europeans in this respect and we have excellent bilateral arrangements with a number of countries, indeed I think now all countries, for the transmission of our information. The problem comes in the other direction where we do not routinely receive information about the action taken against doctors in other countries so that we can consider action in the UK, if they are already registered here, and I hope I have explained that difference. That is the point

of contention and, despite the progress that has been made and the acknowledgement of the issue, we remain somewhat short of a complete solution, although, as I think Claire may want to explain if you have time, my Lord Chairman, some progress is being made.

Ms Herbert: We increasingly work collaboratively with other medical regulators across the European Union and indeed other professional healthcare regulators to develop voluntary approaches to proactive information exchange about the disciplinary records of health professionals. Unfortunately, the voluntary approach, as Finlay has suggested, does fall short of the ideal at present because a number of regulatory jurisdictions are inhibited from sharing information by virtue of their interpretation of privacy legislation. Although, I think, the will is there to share such information, there are some blockages that we are trying, or hope, to overcome by virtue of this Directive.

Q212 Chairman: We have run up against this before, that data protection is being used to block. Could I ask both of you, what remedies do you think organisationally there should be for us to deal with this problem across Europe? It is not only the certainty of the patient going to mainland Europe, but it is the certainty of people in this country who are receiving treatment themselves from doctors from other countries, is it not?

Mr Scott: Two quick points, if I may. I think, first of all, that there is a temptation in this country and elsewhere to over-interpret privacy legislation, and we regularly encounter that. In fact, when you press, you find that the legislation is not the impediment it is sometimes dressed up to be, and of course outside healthcare there have been some very important examples of that in, say, the last five years. I also think, and this is in a sense easy for us to say, that national governments have to make choices. The idea of competing goods is not new and governments regularly have to decide how to resolve the idea of competing goods, and I think national governments have to square up to the issue as to where does the balance

lie between the ready exchange of information to protect patients compared with the undoubted degree of protection of privacy.

Mrs Crawford: In terms of the remedy, our view is that the Directive needs to have a legislative requirement for proactive sharing of fitness to practise data. This is a fundamental cultural issue in EU Member States and we have been working very proactively with other nursing regulators to seek to achieve some kind of understanding, but there is huge diversity on this issue within the EU and, therefore, it would need to be a legislative requirement to share that registration and fitness to practise information at an EU level.

Q213 Chairman: So you are suggesting that we recommend that the Directive makes it clear?

Mrs Crawford: Yes.

Chairman: That would be very helpful to us; it is the most clear.

Lord Lea of Crondall: I do not think the Directive says in terms that this would lead to an EU regulator, but, in a sense, if there were statistical variations in how many people recognised each other, and I do not mean in terms of professional qualifications, but this problem about not registering people, would it not lead to some sort of demand for a European appeal and then a European Court of Justice appeal and all that stuff?

Q214 Chairman: The question of harmonisation.

Mr Scott: Well, again there are no doubt, in principle, different solutions, but my own view, I think our view, is that these issues are best addressed nationally and that is why within the processes and procedures that we have in place, and I am sure it is true for other regulators, there are appeal provisions both internally and obviously to the courts if individuals believe that our actions have been unfair.

Lord Lea of Crodall: I am sorry, but your proposal is that the Director of the Commission should have this role and now you talk about subsidiarity. We all applaud subsidiarity, but here we are, you want to hang on to subsidiarity, but you say that you want it to introduce legal duty and all measure of things to share registration.

Q215 Chairman: It is the sharing of information that the legal duty would be about, would it not?

Mr Scott: Yes, that is correct, my Lord Chairman. The history is that there is a provision which amounts to “may share information”, so it is permissive and it is “must” that we would both want to see.

Q216 Chairman: Yes, so it is the sharing of information rather than the harmonisation of regulation because that might be minimum standards which you would not want at all.

Mr Scott: A point, I think, very well made by our colleagues from the NMC.

Q217 Lord Trefgarne: Am I right in understanding that, for any national with an equivalent qualification who presents themselves for UK registration, you are required to register, subject to a disciplinary clean sheet, regardless of any other consideration?

Mr Scott: My Lord Chairman, there are essentially three categories of doctors. One is UK graduates who, irrespective of nationality, are essentially entitled to registration, subject to the test that Lord Trefgarne has identified, that there is no reason to believe they are not fit to practise. The second group is EEA citizens or those with equivalent rights who qualified in other parts of Europe who essentially are treated as though they were UK graduates. The third group is doctors from outside who qualified outside Europe where we have a discretion on whether or not we should register. Those essentially are the three groups, so it means that,

at the risk of repeating myself, for UK doctors and EEA qualifying doctors, there is tantamount to an absolute right to seek registration.

Q218 Lord Trefgarne: Are you satisfied that all those who present themselves, no matter which of the 27 EU nations they come from, meet the required standards, but you are required to accept anyway?

Mr Scott: My Lord Chairman, I think our longstanding position has had two strands to it. The standards laid down in Brussels amount essentially to input standards, that doctors should cover so many hours and should cover so many topics, and we have long argued that regulation should be based on evidence of outcomes or competences, and the fact that that is not the case is undoubtedly a weakness. The second strand, which is long-running, is that we are not entitled in law to assess the language competence of doctors from other parts of Europe, and we regard that, as a matter of principle, to be unacceptable. We are entitled to insist that doctors from outside Europe can communicate effectively in English, but we are not able to do so for European doctors.

Q219 Chairman: We are going to come to language, but I just want to ask Mrs Crawford if she has anything else to add on this?

Mrs Crawford: Simply to say that the situation is entirely the same for nurses and midwives, that we are under the same requirement, we have the same considerations and we have the same concerns.

Lord Trefgarne: It is rather terrifying, is it not, that there may be doctors coming in who, given a total freedom, would not have registered, but you are required to do so?

Chairman: Lord Trefgarne, we will move on now to language. I think your point is very well made.

Q220 Baroness Gale: The language issue, I believe we all think, is a very important issue in the provision of cross-border healthcare. The NMC have noted in their evidence that the difference in language on EU prescriptions could lead to putting the patients at risk, and it is their view that patients should receive care in a language that they are familiar with. Therefore, in the European Union that has 23 official languages - let alone the unofficial languages like Welsh, for example, which is the first language in many parts of Wales and there may be other countries very similar to that as well - that issue has to be taken very seriously and it is very important for patient safety. Whose responsibility do you think it should be to address the language barrier both in terms of arranging and funding any necessary translations and interpretation?

Mrs Crawford: I think this is a very difficult issue. I think that the basic right of patients to understand what is being said to them about treatment to give informed consent is one that cannot be waived and, therefore, that is what underpins the NMC view that patients have a right to receive care in a language that they understand. In terms of the responsibility for funding, I think it is a difficult one, but it is not a regulatory one. In terms of accountability, we would hold professionals responsible for the care that they deliver to a patient and, in order to deliver to that patient, they need to be able to communicate with that patient, to understand the symptoms, to explain the treatment that they are going to provide and to secure informed consent, so I think it is very difficult, but each individual registered professional will carry a responsibility for the treatment they deliver to an individual and a responsibility for being able to communicate with that patient. How, in practice, that is addressed and who funds those translation services is a very real issue and it is not one that I can offer an NMC view on, but what I can say is that we are very clear that patients need to be in a position to understand what is being done to them and to give informed consent.

Q221 Chairman: It is going to be very difficult to achieve that.

Mrs Crawford: It is.

Q222 Baroness Young of Hornsey: That is not a new issue, is it? For example, we are fond of saying in London that there are approximately 300 languages spoken, so would you hold the same right for people across the country?

Mrs Crawford: Well, our regulatory standards are clear that, when a nurse delivers care, they need to be able to secure informed consent from that patient, and there is a responsibility. Clearly, in an emergency situation you put the interests of the patient first, but there is that responsibility already within the regulatory systems, that professionals do secure informed consent. It is not a new issue, but what is interesting about this Directive is that it will facilitate EU nationals to come to this country and vice versa and will present further demands in terms of translation services, and the NMC view would be that the patient has to be able to communicate and give informed consent. Even if they have done that in their home country in a language which they understood, complications may arise and situations may arise where they need to be able to communicate and understand in order to give that consent.

Q223 Baroness Young of Hornsey: I understand that, but I am just wondering if there are some lessons that we can learn from our experience already that can be applied to this so that it is not an insurmountable problem?

Mrs Crawford: I think some of the work that NHS Choice has done in terms of translating information electronically has huge scope, and it is not an area for the NMC to lead on or to take a view on, but I do think that there are ways of addressing at least some of the challenges.

Lord Wade of Charlton: My Lord Chairman, I cannot help commenting that veterinary surgeons provide a marvellous health service to animals without being able to communicate!

You ought to be able to develop a skill of having a pretty good idea of knowing what someone is suffering from without talking to them about it!

Baroness Neuberger: There is no ethical requirement for consent from animals though! It does make a difference!

Q224 Chairman: Mr Scott, you have said quite a few things about language. Is there anything else you want to add at this point?

Mr Scott: No, only to underscore the point, I think, Jill has made. There is an absolute duty on doctors registered with us to ensure that they have secured informed consent, and that does raise the kind of language issues which Baroness Young has raised in London, for example. The health service of the country concerned, in our case the UK Health Service, has to respond to that requirement.

Chairman: Otherwise things go wrong. We now move to Lord Trefgarne who is going to talk about indemnity.

Q225 Lord Trefgarne: You have made it clear that you insist upon adequate professional indemnity to be backed up by insurance, which of course is entirely right and proper, but clearly the arrangements for professional indemnity and professional insurance across the EU are far from standard, and indeed I am told that discretionary insurance is available only in a minority of Member States: the UK, Ireland and Malta, leaving 24 where they do not have it. What problems do you think this will generate and what suggestions can we make to overcome them?

Mr Scott: Again, if I may distinguish two circumstances, it is not currently in force, but the Medical Act 1983 has been amended so that at a future point, probably from 2009, it will be a condition of holding a licence to practise that a doctor has adequate and appropriate insurance or indemnity, and it is, I think, notable in this context that Parliament saw fit to

admit both the possibility of insurance and indemnity, and that reflects the fact that in the UK there is a long history of successful protection of patients through indemnity as well as insurance. A challenge that we face when we activate that requirement next year concerns doctors who move to the UK from other parts of the EU and wish to rely upon their existing professional insurance or indemnity, and I think there have to be questions asked about the confidence we can have in indemnity provided from other countries because, by definition, indemnity is not regulated whereas the insurance market is regulated. My Lord Chairman, that is not an issue we have yet managed to resolve, not least because, if we insist that, for example, indemnity from outside the UK is not acceptable, I think that would lead us to conflict with the Commission in relation to freedom of movement. I think that has to be distinguished from the arrangements made by organisations or healthcare providers to ensure that patient interests are protected. For example, as I imagine you are aware, we have in the UK the NHS Litigation Authority which provides Crown indemnity, not based upon individuals, but based upon NHS units of provision, and the reality is, therefore, that, when we introduce the new requirement next year, large numbers of doctors will be able to meet the requirement not through personal insurance or indemnity, but relying upon the Crown indemnity provided by the NHS. This means that what is absolutely required is information for the patients of the kind that Jill was describing which makes it clear to patients who are considering moving their healthcare whether they will be protected by individual insurance or indemnity or, as it were, organisational insurance or indemnity, and it is very important that the patient understands the position.

Mrs Crawford: The indemnity issue is one that the NMC has a particular challenge around. The NMC recommends indemnity insurance for its registrants and we recognise its very significant role. However, we do make the difference between patient safety and financial compensation, and I think the standards and the professional standards are the key issue from

a regulatory point of view. However, we do have a particular issue in relation to midwifery whereby some of our registrants, independent midwives practising independently, are not able to secure indemnity insurance on the market at all and, therefore, the NMC had a very robust discussion two or three years ago about whether to recommend or require indemnity and it came down on the side of not removing independent midwives from our care provision because they do provide services to some very vulnerable women who may not access healthcare otherwise. The Department of Health are working very actively with the Independent Midwives' Association to seek a solution to this possibly under the social enterprise model, so we do have a particular issue in this area and, if the Directive makes it an absolute, there is an issue within the UK for this group of independent midwives. It is currently a small group, but also within the policy direction within the UK there is a move for more midwives who work in an independent and autonomous way outside acute trusts and, therefore, there does need to be some UK resolution of how those practitioners are indemnified so that women are not left at risk.

Chairman: That is a question we may want to come back to you on.

Q226 Baroness Neuberger: I need to declare an interest: I am a former lay member of the GMC. When I read the evidence, you, the Nursing and Midwifery Council, make it very clear in your written evidence that the rules that apply to the recognition of professional qualifications are not clear, but actually you do not say the same, the GMC, I think, so let me start with the NMC, but really I want you both to answer it. What is your view on the provisions in the proposed Directive relating to the recognition of professional qualifications? We have had a bit of a dance around this already, but, first of all, do you think that the lack of clarity identified by the Nursing and Midwifery Council needs to be addressed and, if so, how?

Mrs Crawford: I think the clarity that we seek which is in the Directive and which must not be removed is that the place where treatment occurs is where the regulatory systems kick in, and that clarity needs to be there and it is there. There is an issue around the recognition of professional qualifications, which was in the former Directive which makes it slightly complex, whereby, if somebody provides services in another EU State on a temporary basis, they remain registered with their home EU State and, therefore, that confuses that issue, so, if you are going to use the regulatory systems where the treatment was delivered, but that professional is registered in the UK, we have a problem.

Q227 Baroness Neuberger: It is a real issue at the moment, is it not, with some local provision of GPs? There are people coming from Germany to provide services and they are coming for the weekend.

Mrs Crawford: It is only a problem if we have not got clear standards between regulators for the transfer of information and for collaboration. It may be that the GMC wish to add to this point.

Mr Scott: To go back, I think, to the core issue, I think the problem around the freedom of movement of individuals for us is not a lack of clarity, but a lack of adequate balance between the interests of the professional who wants to move and the protection of patients within the UK, in our case. I think that is the challenge and it is one where we have had a very constructive alliance with our colleagues in the other healthcare regulators to try to resist some of the proposals that have emerged from Brussels in the past two or three years, and we very much value the requirement that, if a doctor wishes to practise in the UK for however short a period, then they must register with the GMC so that the clear line of accountability that we discussed at the beginning of this session remains in place.

Q228 Baroness Neuberger: And you have made that point very forcibly no doubt?

Mr Scott: I think we have been boringly forcible in relation to it.

Baroness Neuberger: That is precisely what I wanted to hear.

Chairman: We are going to move on to prior authorisation, which might be a way of dealing with some of these issues.

Q229 Baroness Morgan of Huyton: Obviously one of the things the Commission looks at is the idea of prior authorisation, particularly for hospital care, and it has a package of ways that that has to operate, that it has to be proportionate, it has to be non-discriminatory, but at the same time it has also got to take account of what is happening in the Member State, so in a sense obviously it has to take account of the Member State's social security system and the organisation of care in that Member State and whether a large movement of patients could have an impact on the Member State. Really I want to know what is your view of the proposed system and whether you think it is going to help, whether it is adequate, and do you have any suggestions about how it should be operated in any different way?

Mrs Crawford: It may not be helpful, but the NMC view is that it is an NHS and Department of Health issue rather than a regulatory issue.

Mr Scott: Again, my Lord Chairman, I do not think we would want to comment on the particular issue of prior authorisation.

Q230 Baroness Morgan of Huyton: Because, in your view, it relates only to finances?

Mr Scott: I think in any discussion around patients and patient safety, it is important to keep emphasising the need for adequate regulatory arrangements, but, having made that point, how the finance system operates, I think, is not for the regulator per se.

Q231 Chairman: But the way it is agreed in relation to who makes that authorisation at the first step, which might be a medical recommendation, might be something you would want,

so it is how the medical recommendation fits into the whole structure because that is where there is one layer of protection.

Mr Scott: I am not sure it is a matter for the Directive per se, but in terms of information for patients, we would want to continue to stress the value of only acting under advice from your own UK-based medical practitioner, whether that is a GP or someone else. The idea of health tourism, whether it is within Europe or wider, carries huge risks for patients, so we would very much stress the need to draw upon your existing source of medical advice before making any decision. Allied with that, and again I am sure it is true for the Nursing and Midwifery Council, we require doctors, if they are going to delegate or pass on responsibility for care, to ensure that they do so only under circumstances which protect patients by, in effect, requiring that the service to be provided is through a regulated, registered professional.

Q232 Baroness Morgan of Huyton: How would you do that now? If a patient came to a doctor in the UK now and said that they wanted to go to Spain for a particular treatment because they thought they would get it more quickly or whatever, how would that operate now? How would the doctor find the relevant information in order to give sensible information to their patient?

Mr Scott: My Lord Chairman, I think you could describe an ideal where the doctor has the time to consult colleagues and so on, but I think the reality is that many GPs or other doctors in those circumstances would say that they could not be confident that they can access adequate information in another country and would, I hope, very much point out the risks, therefore, of engaging on an enterprise with such large gaps in the information base.

Q233 Lord Wade of Charlton: My question was going to be on what you consider to be the potential disadvantages, but, as I can tell so far, you have already illuminated every subject we have discussed as being a disadvantage, so we have identified what are the

problems. Could I then turn the question a bit the other way. On balance, is this something that we should do or not? Do we support this Directive, but with some of the reservations that you have made, or do you see that the disadvantages are such that it would be better to leave well alone?

Mr Scott: I think we are probably in the fortunate position of, as it were, not having to take a view.

Q234 Lord Wade of Charlton: Yes, but we do!

Mr Scott: If I may go on, the reality of life in 2008 is that there is a great deal of travel within the European Union, whether for pleasure or business purposes, so citizens of the UK frequently travel to other countries and travel in the other direction is clearly commonplace, so I think that, whether you talk about health tourism or something else, what we need across the European Union are adequate arrangements in all countries to protect patients and I think that amounts to trying to get an interlocking system that addresses three requirements. One is about the regulation of healthcare professionals, the second is about the regulation of healthcare providers and the third is about the provision of adequate information to facilitate movement, whether it is health tourism or for business or pleasure purposes. I think that the weakness, if there is a weakness, is that each of these things is viewed, as it were, in isolation without it being evident that anyone is taking an overall view of whether those components interlock in a way that addresses all the risks for patients and patient safety.

Q235 Lord Wade of Charlton: So, to sum it up, you would say that you think that the scheme is basically a good one, but that we have to take steps to make it much easier for people to travel about Europe, but there need to be an awful lot of safeguards and changes, improvements, if you like, built into the existing Directive to draw attention to the issues that you have discussed today? Would that sum it up?

Mr Scott: I could not put it better, Lord Wade.

Q236 Lord Wade of Charlton: Would the NMC view be somewhat similar?

Mrs Crawford: It would be very similar. We welcome it on the basis that it provides clarity to patients. Patients will, and do, access healthcare across the EU, so we welcome it on that basis. I also think that there is a real opportunity to strengthen regulation across the EU via this Directive if the chapter on co-operation is expanded to be very clear that it relates to regulatory systems and the individual EU regulators; it could be a very significant step forward in terms of regulation and patient safety in the EU.

Q237 Lord Trefgarne: Against all this background of shortcomings, is it not possible to say at the end of the day that most of the healthcare professionals in Europe are hard-working, well-qualified and do their best?

Mr Scott: My Lord Chairman, I would want to confine myself to saying that the great majority of doctors in the UK are very good doctors who deliver high-quality healthcare.

Q238 Lord Trefgarne: So in the other 26 Member States they may not be?

Mr Scott: And I would include in my general statement that the 22,000 doctors who qualified elsewhere in the EU make a very important contribution to healthcare in the UK. Such data as we have does not point to any general problem, but the reality is that, for the reasons we discussed earlier, regulatory standards vary enormously from one country to another and the way in which the standards are expressed in the relevant Directives does not ensure, in our view, a uniformly high standard of competence across the EU.

Q239 Baroness Morgan of Huyton: I am not asking you to name and shame here, but are you clear in your minds, as professionals, which are the countries which, in your view, do not

have clear regulation and which do, or which have sufficiently high standards of regulation and which do not?

Mr Scott: I think it is evident, from examining the regulatory systems in the other countries, that there are diverse approaches and, in our view, the UK is an example of a regulatory regime that takes very seriously the need to ensure that those registered remain up-to-date and fit to practise throughout their career, and that is not the case elsewhere.

Lord Lea of Crondall: Is it not the case, looking across Europe, that there are some countries with a higher life expectancy than Britain and some countries with a lower life expectancy?

Q240 Chairman: Can I just pick up Lord Lea's point and say that we have been talking about co-operation and hearing about standards and different demographic patterns, if you like, which is the point Lord Lea makes, and really we are very interested in what co-operation both your organisations have across Europe and where you gain your information and where you share experience and expertise, so maybe you could pick up in this question some of the issues about how you gain that information and how you make use of the kind of demographic question Lord Lea is asking about.

Mrs Crawford: The Nursing and Midwifery Council in recent years worked with some other European nursing regulators to form FEPI, which is an organisation which brings together European nursing regulators and seeks to achieve collaboration and links between those regulators, and we were instrumental in achieving that network and we are working very hard currently to make it effective. What our engagement tells us is that there are very, very different standards, but there is also a will amongst those nursing regulators to come to some kind of commonality and there is also a sense that the UK does do regulation well and that they would like to work with us on some of the common principles of regulation. The links are less formal within midwifery, but we are seeking to establish those links, and we also

work via CEPLIS which brings together the liberal professions, and we have engaged with them on the issue of continuing professional development and looking to see whether we cannot agree the principle of continuing professional development at a European level in order to enhance patient protection, so it is an area where we are very active, we have a specific EU Department and we are seeking to engage and establish networks, but there is work to be done still.

Mr Scott: I will not take your time by describing the extensive steps we take to improve co-operation, but we have very good bilateral relations with a number of countries, including the Nordic countries and the Netherlands, and Claire led for us a very successful project which we were invited to undertake by the Department of Health in England on health professionals crossing borders, and we would be delighted to send a supplementary note describing that.

Q241 Lord Lea of Crondall: But you have no EU body like the Nursing and Midwifery Council has?

Ms Herbert: There is an organisation convened by the French Order of Doctors which brings together medical regulators on a regular basis to discuss these kinds of issues, but I think the work that we have done through Healthcare Professionals Crossing Borders to bring all regulators, not just medical regulators, together has really helped matters.

Chairman: Can we accept Mr Scott and Ms Herbert's offer to send us a note about that because that would be really helpful to understand how that co-operation takes place. I am going to have to close the session because we have already gone over time, which shows how interested the Committee has been in what you have said to us. We are immensely grateful for your engaging in the discussion with us and, as you can hear, we are raising probably some of the same questions you may have in your own heads. If you want to send anything else to us, do write because what you have said to us so far has been immensely valuable. Thank you very much indeed.

