COUNCIL OF EUROPEAN DENTISTS

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Subject: Consultation paper by DG Internal Market and Services on the Professional Qualifications Directive

I – INTRODUCTION

The Council of European Dentists (CED) is the representative organisation of the dental profession in the European Union, representing over 327,000 practicing dentists from 32 national dental associations in 30 European countries. Established in 1961 to advise the European Commission on matters relating to the dental profession, the CED promotes high standards of oral healthcare and effective patient-safety centred professional practice across Europe and contributes to safeguarding the protection of public health.

The CED welcomes this opportunity to comment on the *"Consultation paper by DG Internal Market and Services on the Professional Qualifications Directive."* However, we would like to note that there has not yet been sufficient time to have national case-law or experience on the functioning of the Directive 2005/36/EC on the Recognition of Professional Qualifications (hereinafter PQD) due to the fact it has been transposed very late by several Member States.

The CED feels that the consultation paper does not address all the relevant issues. For that reason, in section III, the CED comments also on other aspects of the PQD which it considers of importance and which should be taken into account in the evaluation of the PQD.

II – CED RESPONSE

2. A CALL FOR SIMPLIFICATION

2.1 WHY SIMPLIFICATION

1) Do you have any suggestions for further improving citizens' access to information on the recognition processes for their professional qualification in another Member State?

The CED believes that the activities carried out by the points of single contact under the Services Directive, namely to provide and coordinate information as well as to assist in the recognition process, should be incorporated in the PQD and thus extended to the health professions, in particular to dental practitioners. The CED notes however that the current website (http://ec.europa.eu/internal_market/eu-go/index_en.htm)

does not provide sufficient information to the migrating professional as it only contains the links to all points of single contact.

The CED suggests that to improve citizens' access to information on the recognition process one could integrate the existing national information centres (e.g. Europe Direct centres) with the points of single contact under Article 6 of the Services Directive, the contact points under Article 57 of the PQD, and the future national contact points foreseen under the Directive on Patients' Rights in Cross-border Healthcare. We believe that the existence of such "one-stop shops" would be a rational measure and, if properly funded and publicized, would facilitate cross-border mobility and decrease the administrative burden on both citizens and competent authorities. The objective is that these information centres would help and lead the professional to the correct competent authority. Currently, and in the few cases of migrating dental practitioners, this information is being provided by the national dental associations or dental chambers of the host Member State. Nevertheless, Member States should be able to decide if this is feasible or not in the context of their national legislation.

2) Do you have any suggestions for the simplification of the current recognition procedures? If so, please provide suggestions with supporting evidence.

The CED is in favour of simplification of recognition procedures for dentists as long as it does not compromise patient safety. For that reason, the CED would only support the use of electronic means, for instance to complete procedures and formalities under the PQD, if the information exchanged could be reliably authenticated, for example through the IMI system (see also our comments on question 28). While using electronic communications would simplify the procedures, it should not increase the possibilities of forging qualifications and other documents, thus compromising patient safety. The CED fears that the use of general document formats such as PDF would not provide sufficient guarantees for authenticity and veracity of documents. A solution could be to implement a European electronic certification for documents transmitted through the IMI system.

2.2 MAKING BEST PRACTICE ENFORCEABLE

3) Should the Code of Conduct become enforceable? Is there a need to amend the contents of the Code of Conduct? Please specify and provide the reasons for your suggestions?

The CED is of the opinion that the Code of Conduct should continue to be used as guidelines. The content of the Code of Conduct is too detailed to be included in a Directive (where only general rules and objectives should be set out) and too administrative and bureaucratic to be included in a Regulation (contributing to the proliferation of legal acts in an already overregulated policy area).

The CED however suggests that the Commission dedicates its best efforts to publicising the content of the Code of Conduct to the public and to competent authorities. The Code of Conduct needs to be better known and easily accessible to citizens. The Points of Single Contact (or the information centres as suggested in our answer to question 1) could have an important role in this regard.

2.3 MITIGATING UNINTENDED CONSEQUENCES OF COMPENSATION MEASURES

6) Do you see a need to include the case-law on "partial access" into the Directive? Under what conditions could a professional who received "partial access" acquire full access?

The CED believes that the principle of partial access should not be applicable to the European sectoral professions that benefit from automatic recognition under the PQD since that situation can undermine patient and consumer safety. Safety concerns are in our opinion valid public reasons to prohibit partial access to professions, particularly in healthcare. We believe that partial access implies partial skills and competences and as such poses a real risk to the public.

The CED stresses that the economic crisis and the possible decreasing of public budgets for health and education should not justify the decision of allowing persons who have not completed the full course of study satisfying the minimum training requirement as currently set out in the PQD to have access to the dental profession.

2.4 FACILITATING MOVEMENT OF NEW GRADUATES

7) Do you consider it important to facilitate mobility for graduates who are not yet fully qualified professionals and who seek access to a remunerated traineeship or supervised practice in another Member State? Do you have any suggestions? Please be specific in your reasons.

The CED is of the opinion that the PQD legislates on the mobility of fully qualified professionals rather than students or trainees; consequently, we do not believe that provisions to facilitate the free movement of graduates should be included in the Directive.

At the same time, the CED considers that the PQD should not be used to allow ways of avoiding Member States' rules, particularly when the host Member State's rules on becoming a fully qualified professional are less stringent than those of the home Member State.

8) How should the home Member State proceed in case the professional wishes to return after a supervised practice in another Member State? Please be specific in your reasons.

See our comments on question 7.

3. INTEGRATING PROFESSIONAL INTO THE SINGLE MARKET

3.2 A EUROPEAN PROFESSIONAL CARD

11) What are your views about the objectives of a European Professional card? Should such a card speed up the recognition process? Should it increase transparency for consumers and employers? Should it enhance confidence and forge closer cooperation between a home and a host Member State?

The CED is of the opinion that the introduction of professional cards for dentists would not facilitate the free movement of professionals. The situations where professionals might use them would be very limited and without guarantees that the data was accurate, updated and trustworthy. In fact, competent authorities already have the IMI system to exchange information about the migrant professional, the use of which could be enhanced. Furthermore, if confronted with a professional card, a competent authority would most certainly need to verify the veracity of the data and the IMI system would probably be the safest and quickest way to do it. As for the patient, the CED would like to stress that the patients seeing a healthcare professional would not be able to independently verify the data contained on the card, meaning that the card would result in a false sense of security for the patients. In addition, because the card would be voluntary for the healthcare professionals, there is no guarantee that the individual provider would have the card, further increasing confusion for the patients.

For that reason, the CED believes that the professional card would not bring real added value to the mobility of professionals nor to patient confidence. Finally, a cost-benefit analysis should be made to determine whether the current numbers of migrants justify the costs of the new card.

However, if this idea progresses and a professional card is adopted, the CED would only support it if the information contained in the card were just a number which would provide access to the future IMI system database (see our comments to question 28). Thus, the card would only provide access to the IMI system database.

12) Do you agree with the proposed features of the card?

Without prejudice to what has been stated in our response to question 11, the professional card should be issued by national professional associations and/or competent authorities and only for migrating professionals who had requested it (on a voluntary basis).

13) What information would be essential on the card? How could a timely update of such information be organised?

Without prejudice to what has been stated in our response to question 11, the CED is of the opinion that the professional card should contain only a number which would give the competent authority in the Member State of establishment the possibility of accessing the information on a professional through the IMI system (or in a future IMI database, see our comments to question 28). In this situation, the card would always be valid and it would not need to be updated. The card should be returned if the professional lost his/her licence to practise.

14) Do you think that the title professional card is appropriate? Would the title professional passport, with its connotation of mobility, be more appropriate?

Without prejudice to what has been stated in our responses to questions 11 to 13, the CED is of the opinion that since citizens no longer use a passport to move across the EU – an ID card is sufficient – the word passport would only give a contrary message.

3.4 MAKING IT EASIER FOR PROFESSIONALS TO MOVE TEMPORARILY

18) How could the current declaration regime be simplified in order to reduce unnecessary burdens? Is it necessary to require a declaration where the essential part of the services is provided online without declaration? Is it necessary to clarify the terms "temporary or occasional" or should the conditions for professionals to seek recognition of qualifications on a permanent basis be simplified?

The CED is in favour of maintaining and strengthening the pro-forma registration procedure as it is necessary to enforce disciplinary sanctions in case of malpractice, in particular for healthcare professions such as dental practitioners. In most cases, professional organisations of the host Member State are unaware that dental practitioners are providing temporary services in their territory due to the fact that competent authorities are not notified by the migrating dental practitioners in the first place or competent authorities do not inform professional organisations about the migrant providing temporary services. This has a negative impact in the profession.

Hence, the CED believes that the current declaration regime should be simplified not by eliminating the pro-forma registration system but by simplifying the procedure for the migrant. This could be done by providing to the migrating professional the possibility of downloading the "declaration to be made in advance" from the internet (competent authority website and/or a role of the points of single contact), and sending it to the competent authority by email.

The CED also suggests that the exchange of information between competent authorities and professional organisations (e.g. national dental organisations and dental chambers) within the Member States should be improved and carefully monitored.

Furthermore, the CED would like to note that the service provider operating in a host Member State should continue to be subject to professional, ethical and administrative rules applicable in that Member State (the so-called destination principle) – Article 5 paragraph 3 of Directive 2005/36/EC.

The CED strongly recommends that where the insurance cover for professional liability is not compulsory in the home Member State, the professional should be denied the right to provide his/her services in the host Member State unless there was the possibility of immediately including the professional under an insurance

scheme in the host Member State or the professional was able to provide evidence of having an insurance cover in the home Member State which would also cover his/her activities in the host Member State.

Finally, the CED asks that a common definition of the temporary and occasional nature of provision of services be agreed among the Member States, to avoid the possibility of fraudulent establishment by migrating professionals.

19) Is there a need for retaining a pro-forma registration system?

Yes. See our comments to question 18.

20) Should Member States reduce the current scope for prior checks of qualifications and accordingly the scope for derogating from the declaration regime?

Member States should not reduce the current scope for prior checks of qualifications and accordingly the scope for derogating from the declaration regime.

4. INJECTING MORE CONFIDENCE INTO THE SYSTEM

4.1 RETAINING AUTOMATIC RECOGNITION IN THE 21ST CENTURY

22) Do you see a need to modernise the minimum training requirements? Should these requirements also include a limited set of competences? If so what kind of competences should be considered?

- **Training duration**

The CED would like to stress that the basic dental training should continue to comprise a total of five years of full-time theoretical and practical study, as currently established under the PQD.

The CED strongly recommends the addition of a minimum number of training hours - at least 5000 hours - under Article 34 paragraph 2 first part of the PQD to avoid the proliferation of weekend diplomas by private universities. Therefore, Article 34 paragraph 2 first part should be amended as follows: *"Basic dental training shall comprise a total of at least five years* ***and 5 000 hours*** *of full-time theoretical and practical study, comprising at least the programme described in Annex V, point 5.3.1 and given in a university, in a higher institute providing training recognised as being of an equivalent level or under the supervision of a university"*. This new criterion, already applied for medical practitioners, should be implemented in a flexible manner by the Member States and by the universities.

The CED requests that Article 22(a) which allows part-time education is revoked. The CED is also concerned that the abuse of use of new ways of learning, such as distance learning, part-time learning and individual study, might weaken the high standards in education of dental practitioners.

- **List of competences**

The CED strongly recommends the inclusion of a minimum list of competences which a dentist should have acquired by the end of his dental education, in line with the new trends of the profession, in a new Annex to the PQD (see attached CED's *Resolution on Competences Required for the Practice of Dentistry in the European Union* for further explanation):

Field of Competences I: Professionalism, Ethics and Communication

The dentist must have the competences necessary to provide ethical and evidence- based dental care for all patients.

Competences:

- Professionalism (evidence-based therapy, Continuing Professional Development, self assessment, referral)
- Ethics and jurisprudence (knowledge and application of ethical principles and legal framework – EU and national regulation)
- Communication and interpersonal skills (application of these skills in contacts with patients, their relatives, colleagues, the dental team and other health professionals involved in the care of the patient)

Field of Competences II: Practice Organization and Management, Knowledge Management

The dentist must as an effective employer and leader of the dental team have the ability to apply organizational, managerial, financial, administrative and leadership skills to the functioning of the dental practice and to the treatment of patients.

Competences:

- Organization and management of structures and processes needed for functioning of the dental practice
- Organization and management of structures and processes needed for treatment of patients
- Patient safety
- Safety and health of the dental team, including ergonomics and working environment
- Environmental protection

Field of Competences III: Assessment of the Patient, Diagnosis, Treatment Planning

The dentist must be able to evaluate the patient's overall medical and oral condition, analyze the outcomes of patient care and previous treatment and plan treatment needs to improve oral health through application of best practices according to the relevant diagnostic tools and taking into account cultural and social background of the patient.

Competences:

- Obtaining and recording a comprehensive medical history of the patient's oral state through a comprehensive examination of the patient
- Diagnosis
- Treatment planning (informed consent)

Field of Competences IV: Establishment and Maintenance of Oral Health, Therapy

The dentist must be competent in the provision of preventive, therapeutic and continued oral health care. The dentist must be able to perform procedures that treat and manage oral diseases, and maintain and restore optimal oral health. This includes the competences required for oral health care of children, adolescents, the elderly and patients with special needs, in the following disciplines:

- Pain and anxiety management
- Caries therapy
- Endodontic therapy
- Periodontal therapy
- Musculoskeletal and occlusal therapy
- Surgical and pharmacological therapy
- Orthodontic therapy
- Paediatric dentistry
- Oral medicine and oral pathology
- Restorative/prosthodontic therapy

- Oral and medical emergencies
- Preventive dentistry
- Anaesthetics and sedation
- Dental radiology
- Dental materials

Field of Competences V: Prevention, Health Promotion, Public Health

The dentist must be able to provide comprehensive preventive care to patients of all ages according to their risk assessment status and treatment needs and educate patients and the public in oral health maintenance.

Competences:

- Adoption of a preventive approach throughout all dental procedures
- Oral disease prevention and oral health maintenance
- Individual patient oral health education
- Community involvement

Annex V.3/5.3.1 of Directive 2005/36/EC

The CED strongly recommends that Annex V.3/5.3.1 of the PQD is reviewed and proposes three types of changes which reflect the scientific and technical progress in dentistry. First, changes concerning the names of the subjects; second, deletion of certain subjects to the study program for dental practitioners; and third, addition of other subjects (see attached CED's *Resolution on Annex V.3/5.3.1 of Directive 2005/36/EC* for further explanation):

SUMMARY TABLE

Current Annex 5.3.1	**CED Proposal**
A. Basic subjects	A. Basic subjects
– Chemistry	– Medical Chemistry
– Physics	– Biophysics or Medical Physics
– Biology	– Molecular Biology and Genetics
	– Biostatistics
B. Medico-biological subjects and general medical subjects	B. Medico-biological subjects and general medical subjects
– Anatomy	– Anatomy
– Embryology	– Embryology
– Histology, including cytology	– Histology, including cytology
– Physiology	– Physiology
– Biochemistry (or physiological chemistry)	– Biochemistry (or physiological chemistry)
– Pathological anatomy	– Pathological anatomy
– General pathology	– General pathology
– Pharmacology	– Pharmacology
–Microbiology	– Microbiology
– Hygiene	– Hygiene
– Preventive medicine and epidemiology	– Preventive medicine and epidemiology
– Radiology	– Radiology

– Physiotherapy	
– General surgery	– General surgery
– General medicine, including paediatrics	– General medicine, including paediatrics
– Oto-rhino-laryngology	– Oto-rhino-laryngology
– Dermato-venereology	– Dermato-venereology
– General psychology – psychopathology – neuropathology	– General psychology – psychopathology – neuropathology
– Anaesthetics	– Anaesthesiology
	– Internal Medicine
C. Subjects directly related to dentistry	C. Subjects directly related to dentistry
– Prosthodontics	– Prosthetic Dentistry
– Dental materials and equipment	– Dental materials and equipment
– Conservative dentistry	– Conservative dentistry
– Preventive dentistry	– Preventive and Community dentistry
– Anaesthetics and sedation	– Anaesthesia and sedation (Local, Nitrous oxide)
– Special surgery	– Oral surgery
– Special pathology	– Oral Medicine and pathology
– Clinical practice	
– Paedodontics	– Paediatric Dentistry
– Orthodontics	– Orthodontics
– Periodontics	– Periodontology
– Dental radiology	– Oral diagnosis and Radiology
– Dental occlusion and function of the jaw	– Stomatognathic Physiology
– Professional organisation, ethics and legislation	– Dental Practice Management, Ergonomics
	– Ethics and legislation, patient safety
– Social aspects of dental practice	– Behavioral sciences in Communication and interpersonal skills
	– Endodontology
	– Forensic Dentistry
	– Emergency Medical care (CPR)
	– New technologies and informatics
	– Biomaterials
	– Dental Implantology
	– Gerodontology

4.2 CONTINUING PROFESSIONAL DEVELOPMENT

27) Do you see a need for taking more account of continuing professional development at EU level? If yes, how could this need be reflected in the Directive?

No, the CED does not support harmonisation of continuing professional development (CPD) at EU level. Once a dental student graduates and is qualified to practice dentistry, additional training outside the

academic environment is essential in the form of CPD. CPD is executed very differently in each Member State, for several reasons. It is defined according to each population's oral needs and it can be obtained in different settings. Each dental practitioner chooses his specific lifelong continuing education programme on the basis of his individual, personal and professional interests, as well as his needs. The diversity of continuing education activities on offer and the principle of free choice by the practitioners themselves should be maintained in line with the policy in each Member State.

In conclusion, each Member State should continue to have their own specific rules for CPD which already meet dental practitioners' expectations and are adapted to national oral health needs (principles of proportionality and subsidiarity should apply).

4.3 MORE EFFICIENT COOPERATION BETWEEN COMPETENT AUTHORITIES

28) Would the extension of IMI to the professions outside the scope of the Services Directive create more confidence between Member States?

As a first step, and before extending it to other professions outside the scope of the Services Directive, it would be important to ensure that the IMI system functions as it was initially intended. In this sense, consolidation of the network by monitoring the competent authorities' work practices and ensuring adequate training for the competent authorities' officials should be envisioned.

As a second step, and once the IMI starts to operate efficiently, the CED would support further functionalities, in particular an alert function to exchange important information on fitness to practice, a dialogue interface, and the possibility to attach a file when putting a question to the competent authority. The CED would also support making the use of the IMI compulsory for purposes of administrative cooperation in PQD (as in the Services Directive), establishing mandatory deadlines for replying.

As a third step, the CED would suggest transforming the IMI into a database to be used not only by competent authorities but also by dental practitioners and patients, these groups having different user rights. The IMI system database could either be an interface of the databases of the 27 Member States (or more to include regional and local authorities), or a single database which the 27 Member States would access as users. Competent authorities, healthcare professionals) and patients would all be able to access the database at different levels of access (consult, upload or update information). Restrictions should be envisaged so that data protection rules were fully respected. For example, patients could see if a professional was lawfully established in a Member State and had certain professional qualifications or experience; professionals could easily retrieve certificates regarding their current qualifications or experiences if they wanted to migrate; and competent authorities could easily confirm and trust the information in that system since only competent authorities would be able to upload and update the data.

Should the extension of the mandatory use of IMI include a proactive alert mechanism for cases where such a mechanism currently does not apply, notably health professions?

Yes. See our comments to question 29.

29) In which cases should an alert obligation be triggered?

The CED would support an alert mechanism to be triggered in case a professional presents a fake diploma to a competent authority or gives false declarations/evidence, and when a professional is subject to sanctions which forbid him/her to practise in a Member State.

In addition, the CED would also support considering measures that would prevent a healthcare professional from using the principle of free movement to escape disciplinary action in a Member State. A provision could be added to the PQD in this sense.

4.4 LANGUAGES SKILLS

30) Have you encountered any major problems with the current language regime as foreseen in the Directive?

The CED believes that, for reasons of patient safety, the rules of the language regime under the PQD should be clarified. Healthcare professionals particularly should be able to communicate with their patients in a proper way (to inform them about the procedure and the risks, to explain treatment options and to obtain informed consent) and understand fully the information given by the patient. Misinterpretation in healthcare can lead to fatal errors.

In practice, problems have been encountered as a result of clear guidelines about the language skills test. In case of dentists, each national dental association or chamber carries out a different test. Some ask questions about the ethical code, others about the scientific practice, others also include national legislation applied to the profession. This leads to incoherence in the application of the language regime, uncertainty for the migrating dentists and compromised safety for the patients.

The CED points out that the knowledge of the host Member State's language(s) is necessary and justified especially in the case of liberal professions. Indeed, the vast majority of dental practitioners are self-employed, and therefore the control by employers of linguistic knowledge does not exist.

III – OTHER ISSUES

- **Third country diplomas**

The CED would like to stress the need for better enforcement of Article 2/2, second sentence, of the PQD which establishes that *"In case of professions covered by Title III, Chapter III, this initial recognition shall respect the minimum training conditions laid down in that Chapter"* and a clarification in the Code of Conduct in this regard. Reality shows that in the case of third country diplomas the "first application for recognition" (that is to say when the professional has obtained his/her qualification in a third country, Member State A recognises the diploma under a bilateral agreement and the applicant wants to work in Member State B) does not necessarily comply with the minimum conditions of training established in the PQD, in particular Annex V.3.1.

Furthermore, the CED believes that similar criteria for the recognition of third country diplomas should be established. A European code of conduct in this regard could be envisaged.

- **Unity of the dental training cycle**

The CED welcomes the principle of mutual recognition of professional qualifications for dentists as laid down in Directive 2005/36/EC. However, the CED calls for the unity of the dental training cycle to be maintained. The principles and the guarantees set by Directive 2005/36/EC, ensuring a high quality of training and free movement of dentists, should not in any way be jeopardized nor weakened.

The CED strongly opposes the implementation of the two-cycle structure (Bachelor/Master) for the dental profession and calls on academics and politicians responsible for education and health, for the protection of the public and the dental profession, to exclude dentistry from the two cycles completely, refusing to transform their curricula into the two-tier degree system.

The CED is against any autonomous, independent treatment of patients by non-dentists in the absence of supervision by a qualified dentist and opposes any kind of undergraduate and postgraduate education which gives non-dentists the status of a partial provider of dental services, with the right to practise certain areas of dentistry on an independent basis. In fact, one of the downsides is precisely the possible risk of having non-dentists working on an independent basis, where there is no control on the extent of tasks executed by these non-dentists and where a patient cannot identify, due to the lack of scientific knowledge, what tasks are non-dentists authorised to perform. In that sense, harmonisation should be envisaged since we cannot have the same category of professionals qualified to execute different medical acts in different Member States,

although they went through the same study programmes (e.g., in some Member States, dental hygienists are only allowed to clean teeth whereas in others they are authorised to perform fillings, a medical act which should only belong to dentists). This problem should be addressed, in order to facilitate professional mobility.

Recital 20 of the PQD – word "dental"

The CED strongly requests the introduction of the word *"dental"* in recital 20, second sentence, of the PQD for better clarification and to avoid different interpretations regarding the automatic recognition of dental specialties after the date of entry into force of the directive. In fact, the CED believes that the introduction of this word would facilitate the mobility of dental practitioners between Member States (as specialities would be recognized more easily) and patients would be better informed about the legitimate qualifications of dental practitioners.

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