COUNCIL OF EUROPEAN DENTISTS

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CED POSITION PAPER

The Council of European Dentists (CED) is the representative organisation of the dental profession in the European Union, representing over 330,000 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 the opportunity to comment on the Commission's *Proposal for a Directive of the European Parliament and the Council amending Directive 2005/36/EC on the recognition of professional qualifications and Regulation [...] on administrative cooperation through the Internal Market Information System, COM(2011)883* (hereinafter **"proposal"**).

Directive 2005/36/EC on the recognition of professional qualifications (hereinafter **"PQD"**) is currently one of the main concerns of the dental profession, since the evaluation process of the PQD has shown that the automatic recognition system does not work perfectly. In order to enhance confidence and to facilitate the principle of automatic recognition, the dental profession strongly recommends that the revision of the PQD takes into account the following:

a) Minimum duration of training for dental practitioners [Article 34(2)] – the minimum duration of training for dental practitioners should be expressed not only in years (5 years) but also (in a cumulative sense) in training hours (5000 hours), in order to safeguard against part-time training and the proliferation of "weekend diplomas" by private Universities, as well as to maintain an acceptable standard of dental education without jeopardizing patient safety and the delivery of healthcare.

Therefore, the CED would recommend that Article 34(2) be amended as follows: *"Basic dental training shall comprise a total of at least five years, which may also be expressed with the equivalent **of 300** ECTS credits, **and shall consist of at least 5000 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*."

b) European Credit Transfer and Accumulation System (ECTS) – the CED can only support the introduction of ECTS if the minimum duration of training is expressed both in years (5 years) and in training hours (5000 hours). Furthermore, Article 34(2) would have to mention 300 ECTS. The reasons for this are:

i. ECTS is not defined in the proposal providing a degree of uncertainty which is not desirable in a legislative document;

ii. The reference to 60 credits per one academic year (where 60x5years=300 ECTS) under recital 13 is non-binding; and,

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iii. The reference to 25-30 hours of "study" also under recital 13 does not specify which types of hours it includes – theoretical, practical or study at home. An interpreter which is not familiar with ECTS, would multiply (30hoursx60ECTS)x5years = 9000 hours. So the range would be between 7500-9000 hours, colliding with the desired 5000 hours under Article 34(2).

c) **Knowledge of languages (Article 53(2) second subparagraph) –** the wording proposed in the case of professions with patient safety implications needs to be simplified in order to avoid confusion. Indeed, the provision introduces new concepts, such as "affiliated" and "national health care system", involves new actors, particularly the "representative national patient organisations", and creates a request mechanism with different requirements. These elements do not bring a real added value to this process. For example, it is not clear what should be understood by "affiliated" – its meaning may vary across the EU. Moreover, in some Member States health professionals have a contract with social security systems rather than "health care systems", so this part would not be applicable in all Member States. Furthermore, patient organisations do not exist in all Member States. Some countries simply have organisations representing patients suffering from a specific disease. In these cases, the provision would increase the uncertainty as to which organisation would be the most representative. Finally, it is not clear how the language checking is triggered, if the request is on a case-by-case basis or by profession or a general request for all professions with patient safety implications.

Therefore, the CED would recommend that this provision be amended as follows: "*In case of professions with patient safety implications, Member States may confer to the competent authorities the right to carry out language checking covering all professionals concerned* ~~***if it is expressly requested by the national health care system, or in case of self-employed professionals not affiliated to the nationals health care system, by representative national patient organisations.***~~" This amendment simplifies the procedure and safeguards the correct result – the knowledge of the language.

The CED would further recommend that competent authorities use the Common European Framework of Reference for Languages (CEFR)[1] to control the knowledge of a language of a professional. This tool is widely used across the EU to self-assess language knowledge. The degree of knowledge could be decided by the competent authority of each Member State. The CED recommends that a high level of knowledge is required for professions with patient safety implications, such as C1.

d) **Dental practitioners' activities [Articles 34(3) second subparagraph and 36(3)]** - the dental practitioners' activities should be better described under this provision. The objective is to improve the wording so that the dentist skills/activities are in line with the currently acceptable scientific terminology and factually accurate (these are the activities already performed by dentists). This amendment serves the purpose of injecting more confidence into the system.

Hence, Article 34(3) second subparagraph should be amended as follows: *"This training shall provide him with the skills necessary for carrying out all activities involving* ***health promotion and specific*** *prevention* ***at individual and community level,*** *diagnosis and treatment* ***including anatomical and functional rehabilitation of all pathologies and*** *anomalies* ***of the hard and soft tissues of the*** *mouth,* ***its appendages and the stomatognathic system****"*.

This amendment implies also an amendment to Article 36(3) as follows: *"Member States shall ensure that dental practitioners are generally able to gain access to and pursue the activities of* ***health promotion and specific*** *prevention* ***at individual and community level****, diagnosis and treatment* ***including anatomical and functional rehabilitation of all pathologies and*** *anomalies* ***of the hard and soft tissues of the*** *mouth,* ***its appendages and the stomatognathic system****,*

[1] The CEFR was put together by the Council of Europe: basic user - A1 and A2; independent user - B1 and B2; and proficient user - C1 and C2. For the grid see http://www.linguanet-europa.org/pdfs/self-assessment-grid-en.pdf.

having due regard to the regulatory provisions and rules of professional ethics on the reference dates referred to in Annex V, point 5.3.2.";

e) **Principle of partial access** – this principle should be generally excluded from Directive 2005/36/EC since it compromises the high standards of education and standardises the professions across the EU. It should particularly not be applied to health professions. According to Article 168 of the TFEU, it is up to Member States to regulate their healthcare services. The principle of partial access would require legislative changes in national healthcare services, forcing Member States to recognise new professions. This would mean that a health professional wishing to work in another Member State where his activities are performed by more qualified health professionals and where that health profession does not exist as such, but it is in fact part of the qualification of another profession, would be able to gain access to the profession in the host Member State (e.g. denturists). The logic of the internal market and the idea of standardising professions across the EU cannot be applied to the health sector where patient safety and public health considerations are at stake.

f) **Delegated acts (recital 24) -** Professional organisations should be consulted on a regular and official basis as they are the experts in their own field; a specific mechanism for the European Commission to consult with relevant stakeholders should be introduced in the PQD. Furthermore, the definition of "expert level" is required under the delegated acts regime.

g) **Remunerated traineeship (Article 55a)** – this provision obliges the recognition of a remunerated traineeship carried out in another Member State. For Article 55a to comply with Articles 165 and 166 of the TFEU[2] it must be amended in a way that the professional does not become a fully qualified professional after the recognition of the vocational training, particularly if the vocational training is different in terms of content and duration. The CED suggests the following amendment: *"With a view to grant access to a regulated profession, the home Member State shall* ***take proportionate account of*** ~~*recognise*~~ *the remunerated traineeship pursued in another Member State and certified by a competent authority of that Member State."*

h) **European Professional Card –** the CED welcomes the concept of the electronic certificate obtained via the IMI system but it is concerned about the newly created short deadlines established therein, especially taking into consideration that a professional will be allowed to practise if the competent authority fails to meet these deadlines. According to the proposal, the home Member State must take a decision within two-weeks and the host Member State within one-month after receiving a complete application, after which, in the absence of a reply, the card is automatically validated and the professional qualification recognised [Article 4d(5)]. These deadlines should be extended due to the substantial increase of the home Member State responsibilities under the recognition procedure and the full trust that it will require from the host Member States. Failure to do so would risk jeopardising patient safety.

i) **Procedures by electronic means [Article 57a (4)] –** this provision needs to be amended in a way that the time limits related to procedures and formalities only commence when the citizen has introduced a <u>complete</u> application [following the reasoning of Article 4c(1)]. Furthermore, it is necessary to demonstrate that the points of single contact are only intermediary actors that do not have direct access to the IMI system, which is reserved to the competent authorities. This provision should therefore be amended as follows: *"All procedures shall be carried out in accordance with the provisions of Directive 2006/123/EC relating to the points of single contact. Any time limits for Member States to be complied with procedures or formalities set out in this*

[2] Articles 165 and 166 of the TFEU, exclude any harmonisation of the laws and regulations of the Member States concerning the content of subjects taught and the organisation of education systems and their cultural and linguistic diversity, as well as the content and organisation of vocational training.

*Directive shall commence at the point when **a complete** application has been **received via** ~~submitted by a citizen to~~ a point of single contact **by the competent authority**.."*

In this sense, a similar provision of Article 6(2) of Directive 2006/123/EC should be introduced in the PQD: ***"The functioning of points of single contact shall be without prejudice to the allocation of functions and powers among the authorities within national systems.***

j) Alert mechanism [Article 56a(1) final subparagraph] – the CED is in favour of establishing an alert mechanism. However, the three-day deadline to notify the decision prohibiting the professional from exercising the profession does not take into account the possibility of appeals with suspensory effect and the negative impact that such an alert could have on the career of a professional if the decision is revoked. Thus, the decision should only be notified to other competent authorities when it becomes legally binding. The CED suggests therefore the following amendment: *"The information referred to in the first subparagraph shall be sent at the latest within three days from the date ~~of adoption of~~ **when** the decision prohibiting the professional concerned from **permanently** exercising a professional activity **is legally binding"*.**

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Adopted by the CED General Meeting on 11 May 2012