Specialist medical training and the European Community

*Is Britain out of line?*

The European Commission has challenged the legality of the United Kingdom’s system of accreditation and the General Medical Council’s recently introduced indicative register of those who have completed specialist training. The British government has responded by setting up a working party to advise on how to bring the United Kingdom into line with European law on specialist medical training.1 Earlier this month, the group held its first meeting.2

Health ministers need answers to two related questions. Firstly, does “a certificate of specialist training” (provided for in the European Community’s medical directives) mean exactly what it says? Secondly, does requiring higher standards of training for consultant appointments (accreditation) and for inclusion on the General Medical Council’s indicative register breach the directives?

Although certificates of specialist training are awarded by the General Medical Council (which the directives designate as the competent authority in the United Kingdom), the council has invariably sought advice from the joint higher training committees on the eligibility of each candidate for certification. The various training committees have used different, often unpublished, criteria to assess applications but generally have used standards comparable to the modest ones set out in the directives. None has demanded a standard equivalent to accreditation. The question now is whether the United Kingdom can continue to demand a higher standard of training for consultant appointment and the award of the suffix “T” (denoting completed specialist training) in the medical register than that which leads to specialist status in other countries or whether accreditation and specialist certification must become identical and legally equivalent to other specialist qualifications within the European Community.

The medical directives’ original purpose was to guarantee the free movement of doctors, whose right to practise depends on possession of legally recognised qualifications. In some countries, mainly those providing health care through a social security system, the title “medical specialist” and the right to charge fees at the higher, specialist, level are legally restricted to those holding recognised specialist qualifications. To enable specialists to migrate to a country with such a system the medical directives had to deal with specialist qualifications as well as basic qualifications. The training requirements for the award of a recognised certificate are minimal, the directives being concerned with free migration—which is a European Community competence—rather than with educational standards—which are not.

The directives did not seek to define the completion of specialist training. The word “completion” appears uniquely in the title of the United Kingdom qualification as printed in the English version and represents an error in translation of the original text. The directives intended simply that those enjoying the legal privileges of specialist status in one country should be entitled to equivalent privileges in other countries.

The directives require each member state to recognise the diplomas awarded by the other member states and listed in the directives by giving them the same effect as they give to their own qualifications. All basic qualifications awarded in the United Kingdom are included, but the listed specialist qualification is the certificate of specialist training. Memberships and fellowships of the royal colleges and certificates of accreditation are not listed and so have no standing in European Community law. Furthermore, each state is required to give other countries’ listed qualifications the same effect as the national qualification has in that state. Specialist titles are not legally protected in Britain and there are no privileges which are legally reserved only for specialists. Consequently, there is no effect to be given in the United Kingdom either to the certificate of specialist training or to the equivalent European Community qualifications.

The difficulty which the United Kingdom faces results from trying to apply directives designed to deal with specialist practice in social security systems to a different type of health service. Unfortunately, the differences between British and continental specialist training and practice are not well understood either here or in Brussels, and this has led to several misconceptions.

Firstly, the idea exists that specialist certificates indicate suitability for appointment to a given post or grade. They do not. Most specialists within the European Community are not in salaried posts but conduct a largely or exclusively outpatient practice from their own premises and therefore do not offer the more complex and demanding treatments provided by hospital based specialists. Their certificates do not indicate fitness to provide such treatments but simply their entitlement to charge fees on the specialists’ scale.

A few continental specialists are hospital based. Because of differences in staffing structures, identifying those who are the equivalents of NHS consultants is not always easy, but invariably doctors acquiring their specialist certificates take up posts of intermediate responsibility and achieve promotion to the most senior level only after acquiring further experience. In Britain such experience is defined as training and is
regulated; in most other countries it is not. The fact remains that nowhere are specialist certificates regarded as indicating suitability for appointment to a post carrying responsibilities equivalent to those of a consultant.

The second misconception is that there is such a thing as completion of full specialist training. Medical education is a lifelong process—defining a point at which training is complete is impossible. The best that can be achieved is to define training sufficient for a particular purpose. The directives have done this in setting down minimum standards for those seeking the legally defined privileges of specialists within social security systems. In another setting the joint higher training committees have also done it by laying down standards required for consultant appointment.

By demanding greater than the minimum experience from those seeking consultant posts, the United Kingdom cannot reasonably be seen to be breaching the directives, not least because all countries have, in practice, similar requirements. These arrangements do not discriminate against specialists from other countries of the European Community, who are entitled to be appointed to NHS posts commensurate with their training and experience. They would be discriminatory if eligibility for appointment depended on training having taken place in posts supervised by one of the higher training committees, but this is not the case. At least one specialist trained elsewhere in Europe has already been appointed a consultant in Britain.

The challenge to training arrangements in Britain has resulted directly from the appearance of the General Medical Council’s indicative register of those who have completed specialist training. Although the medical acts do not empower the council to keep a specialist register (and any doctor may, in Britain, legally describe himself or herself as a specialist), the indicative register has for the first time conferred on those holding certificates of accreditation or appointed to NHS consultant posts a privilege not available to others—namely, the inclusion of the suffix T in the medical register. This privilege is unlikely to have any discriminatory effect in terms of the likelihood of appointment to a post in the NHS as appointments committees base their judgments on candidates’ training and experience. It may, however, be held to be discriminatory in respect of a consultant from another country of the European Community wanting to enter private practice in the United Kingdom. One of the principal purposes of the indicative register was to enable the public to distinguish those trained to consultant standard from those with lesser experience in the unregulated field of private practice.

Legal opinion on this matter is divided, and a definitive answer can come only from the European Court of Justice. The General Medical Council has several options. The first is to allow certified specialists from other countries within the European Community to use the T indicator. This would be irrational as their specialist certificates and United Kingdom accreditation are different in kind. It would also be unfair to British trained doctors wishing to work as specialists in other European countries, who would have to complete a much longer training to acquire a certificate than is demanded elsewhere. Alternatively, the council might maintain an indicative register of those trained to the standards laid down in the directives, but the relevance of this to medical practice in Britain and to the aims of the present indicative register is questionable. To publish two indicators would perpetuate any discrimination implicit in the present system. The council’s last option is to abandon the indicative register altogether.

Regarding doctors who have completed training up to the minimum standards set out in the directives as fully trained and employing them in career posts would be incompatible with the exclusively hospital based pattern of specialist practice in Britain and would remove at a stroke any obligation on the NHS to provide training for them beyond this level. The well organised and regulated system of specialist training that exists in Britain is an asset worth retaining.

The future of the General Medical Council’s indicative register is less sure. The legal arguments in support of it are sufficiently strong for them to be tested in the European court. The potential benefits from the indicative register are, however, marginal, and sacrificing it would be preferable to losing the essential elements of British specialist training.

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1 Beecham L. Trying to satisfy EC directives on specialisation. BMJ 1992;305:332.

Diagnosing maxillary sinusitis

Often difficult

People frequently attribute episodes of facial pain to sinusitis, and many of them are right: maxillary sinusitis usually accompanies the common cold. Other causes include tension headache, migraine, or dental disease; in some cases no cause is found. Many patients treat themselves with decongestants. Others consult their general practitioners, possibly having their sinuses examined radiologically, and are prescribed antibiotics. These may not affect the outcome as infection is not the only factor. In short, while the diagnosis is obvious in many patients, in many it is not. Once these patients become convinced that they have sinusitis ear, nose, and throat surgeons often find this belief difficult to dispel.

Even specialists have difficulties in deciding what constitutes significant maxillary sinus disease. Plain radiographs, even with multiple projections, are notoriously unreliable. Only complete opacity or a fluid level is significant; polyps or mucosal thickening do not necessarily equate with active disease. Rates of false positive and negative results of 35% and 10% respectively have been quoted. To complicate matters further, more sophisticated imaging techniques often show incidental abnormalities of the paranasal sinuses. In a retrospective study of 483 magnetic resonance scans undertaken for investigation of posterior fossa signs or symptoms, a quarter of maxillary sinuses appeared abnormal. In a prospective study of 133 patients the same workers failed to find any statistical relation between nasal symptoms, other than a cold, and the appearance on magnetic resonance imaging. Some simple tests are appropriate for acute symptoms—