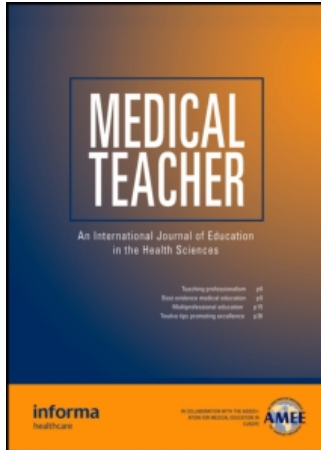


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Non-EEA doctors in EEA countries: doctors or cleaners?

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Abstract

Background: Migration of non-EEA doctors to EEA-countries has become a common phenomenon. As coordination within the EEA has not yet been established, every EEA-country is re-inventing the wheel of assessment of foreign medical degrees and developing additional programmes for non-EEA doctors. There is hardly any knowledge about assessment procedures in other EEA-countries.

Aim: To examine how 10 European Economic Area (EEA) countries deal with non-EEA doctors. Both national and university policies regarding non-EEA doctors were examined.

Methods: This was a qualitative study based on two structured questionnaires. One was used for staff members of national health departments and the other was used for staff members of university medical faculties. Staff members from the health departments of mid-European and north European countries, and staff members from universities in Austria, Belgium, Denmark, France, Germany, Norway, Sweden, UK, Spain, and The Netherlands participated in the study.

Results: There is no EEA directive concerning non-EEA doctors. Each EEA country, therefore, has devised its own policy towards non-EEA doctors. To enable non-EEA doctors to obtain a full license, thereby preventing them from ending up as unskilled labourers, the health departments in the Nordic countries and the UK have developed a 'fast-track' process for non-EEA doctors. In Austria, Belgium, and The Netherlands, however, non-EEA doctors are more dependent on programmes offered by university medical faculties. The situation in Germany is between these two extremes. As a rule, the programmes for non-EEA doctors in Belgium, Germany, and The Netherlands are two to three times longer than in the Nordic countries (18–36 months vs. 12–18 months, respectively). Financial aid is not available in most countries.

Conclusion: As the influx of non-EEA doctors is increasing, harmonisation within the EEA is strongly advisable. As long as there is no EEA directive about non-EEA doctors, the assessment procedures (diploma evaluation, medical-knowledge tests, language requirements, length of additional programmes, etc.) need to be coordinated.

Introduction

The process of integrating doctors not from the European Economic Area (EEA) into EEA countries requires standardisation, due to the increasing numbers of non-EEA doctors entering EEA countries (the EEA consists of 27 European Union countries, Iceland, Liechtenstein, and Norway). Is their education of an equal standard to that of EEA doctors? Is their working experience valid? Is their knowledge of the (new) language sufficient? The migrating doctors may enter EEA countries either as refugees, or to be with their spouses. Most non-EEA doctors have permanent residency in their host country because they have backgrounds like these. Unlike other EEA countries, the UK medical-healthcare system is dependent on migrating non-EEA doctors. In the 10 EEA countries involved in this study, there is an average of 327 medical doctors per 100,000 inhabitants, but in the UK there are only 166 medical doctors per 100,000 inhabitants (Table 1). It is clear that the UK does not train enough medical doctors to meet its needs. Therefore, non-EEA doctors' reasons for migrating to the UK may not be the same as those of non-EEA doctors migrating to other EEA countries.

Practice points

- There needs to be an EEA directive concerning doctors with non-EEA diplomas.
- Standardisation of procedures to deal with non-EEA doctors within EEA countries is strongly advisable. It is unclear if a non-EEA doctor who is authorised to work in one EEA country can migrate to another EEA country and work there under the same conditions as any EEA-doctor.
- Assessment procedures and additional programmes for non-EEA doctors who want to work as doctors in EEA countries differ greatly between countries.
- Mastering the language at the highest possible level is the non-EEA doctor's key to success in their new, EEA home countries.

Not every foreign doctor will eventually find a job in the medical profession in a new country. In every European country, examples are known of foreign doctors even working

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Table 1. Number of medical doctors per 100,000 inhabitants in 10 EEA countries (World Health Organisation 2001).

Country	Total number of medical doctors	Number of medical doctors per 100,000 inhabitants
Austria	26,286	324
Belgium	42,978	418
Denmark	19,600	366
Germany	297,893	361
France	196,000	329
The Netherlands	52,602	329
Norway	15,978	355
Spain	130,300	319
UK	95,395	166
Sweden	26,979	304

as unskilled labourers such as cleaners, albeit in healthcare institutions! In this study, we are concentrated on doctors who obtained their diplomas outside the EEA. Doctors trained within EEA countries and holding EEA passports are allowed to work in other EEA countries; a special European Council directive has provided for this (European Parliament and the Council of the European Union 2005). There is no such EEA directive for doctors trained outside the EEA. As a consequence, every EEA country has its own procedure for foreign doctors who apply for permission to work there. For non-EEA doctors, it is very difficult to understand why admittance is easy in one country, while in another it takes a long process of renewed medical and language study. Moreover, even within a single country, policies can differ between universities. These differences could well influence the choice of the country and university that non-EEA doctors apply to. In 2005, in order to obtain more information about the admittance procedures, we performed a limited, comparative study of the policies and practices of 10 European countries regarding non-EEA doctors (Herfs 2007). A strong need was felt to disseminate the outcome of this study, as it could have a great social impact on EEA countries.

Methods

The national policies concerning holders of unrecognised medical degrees were investigated, together with the policies and practices of several (not randomly chosen) universities with medical schools in 10 EEA countries (see Table 2). For this research, we selected 10 (old) EEA countries that had plenty of experience with the immigration of non-Europeans. Our selection was based on data regarding global refugee trends (United Nations High Commissioner for Refugees 2004) and the Eurostat sources on migration in European Union countries.

Our starting point in each country was a university that operates within the Utrecht Network, an international framework for student exchange. All universities we approached were willing to cooperate. In some countries, it appeared that the university operating within the Utrecht Network had no experience with non-EEA doctors. In those situations, we were

referred to a university in the same country that had ample experience with non-EEA doctors.

Two questionnaires were used. The first questionnaire concerned the official national policy and contained questions about the following issues: central registration; availability of information on recognition procedures; responsibilities for a centralised or decentralised procedure; numbers of applicants; assessment on the basis of a medical-knowledge test or diploma evaluation; work experience and assessment; the qualifications of those assessing the non-EEA doctors; the policy in case of non-recognition; and the availability of special programmes at medical schools for non-EEA doctors. This questionnaire was given to staff members of the health departments of the countries involved in the study.

The second questionnaire concerned university policy and contained questions about recognition and admission, length of programmes or recognition procedures, cooperation of medical faculties, sufficient mastery of the language, support, and opportunities in the labour market after qualifying as doctors. This questionnaire was given to staff members from the medical faculties of the universities involved in the study.

Results

National policies and practices

Results are presented in Table 2. In all the countries involved in this research, a specific assessment procedure exists for holders of medical degrees. In most countries, assessment takes place on the basis of a medical-knowledge test; in some countries, this preceded by diploma evaluation. In the Nordic countries and the UK, the procedures are coordinated by their respective health departments. Systems are developed in which a non-EEA doctor can prove he has the required level of medical knowledge. Mastery of the language of the country is tested, either by means of a language test or by presenting all medical examinations in the language of that country. When a candidate fails to pass the tests (which, in the Nordic countries, are sometimes attached to a probationary period), the process is terminated. After a failure to complete the assessment procedure, admission to a medical school as a 'regular' medical student almost never occurs in Denmark, Norway, Sweden, and the UK. The majority of non-EEA doctors in these countries follow these health department procedures. As the initial route in the Nordic countries and the UK is highly efficient, there is no great demand for a second route through the universities.

In Austria, Belgium, and The Netherlands, the role of the health department is less clear. Universities in these countries offer a second route to non-EEA doctors, should the government refuse to recognise a foreign medical degree.

In order to be admitted to Austria, the non-EEA doctor is required to have studied medicine for at least 5 years. Rules are less rigid in Belgium and The Netherlands; every university has its own procedure. New procedures were introduced in France and The Netherlands in 2005. Under these new procedures, the health departments, not the universities, have the responsibility of assessing foreign medical degrees. Work experience as a medical doctor in the country of origin does

Table 2. National policies regarding non-EEA doctors.

National policy	Country									
	UK	Denmark	Norway	Sweden	Germany	Austria	Spain	France	Belgium	The Netherlands
Registering body concerning recognition of foreign degrees	Yes	Yes	Yes	n/a	No	Yes	Yes	Yes	Yes	Yes
Information about recognition by health department	Yes	Yes	Yes	Yes	Decentralised	Yes	Unknown	Yes	Yes	Yes
Recognition responsibility with health department	Yes	Yes	Yes	Yes	Decentralised	Yes	No	Yes	Yes	Yes
Assessment and recognition on the basis of test	Yes	Yes	Yes	Yes	No	No	Yes	Yes	No	Yes
Assessment and recognition procedure without test	No	No	No	No	Yes	Yes	No	No	Yes	No
Health department procedure successful	Yes	Yes	Yes	Yes	Yes (Decentralised)	Unknown	Unknown	Unknown	Unknown	No
University route possible after health department rejection	No	No	No	No	Yes	Yes	No	Yes	Yes	Yes
Length of programme for non-EEA doctors	0 months	12–18 months	12–18 months	18 months	12–24 months	12–18 months	n/a	24 months	24–36 months	18–36 months
Body responsible for non-EEA doctors programme	General medical council	Health department	Health department	Health department	University	University	n/a	University	University	University

n/a: not applicable. Notes: Since 2005, the Department of Health in France has introduced an assessment procedure for non-EEA doctors, as has The Netherlands. The Dutch results are based on the situation before its introduction on December 1 2005.

not play a significant part in the assessment procedures in the countries that participated in this research. In France, Sweden, and the UK, however, there are separate recognition routes for specialists. France even has a quota system for certain desired specialists. When, for instance, 15 internists are needed, then only 15 internists may apply, who must then pass an examination.

In the Nordic countries, the programmes are organised by their respective health departments. For the content of the programmes, they rely on professors of medical schools (University of Copenhagen, University of Oslo, and the Karolinska Institute in Stockholm). In the UK, a special programme has been set up for Refugee and Overseas Qualified Doctors at the Queen Mary University in London. This programme consists of a doctors' study club, structured linguistic courses, clinical experience, and career-advice services.

In Belgium, France, Germany, and The Netherlands, the non-EEA doctors will be enrolled in a higher year of the regular programmes at one of the medical schools. After graduation in one of these four countries, a non-EEA doctor will receive a 'new' medical degree from that medical school. In the other countries, the foreign medical degrees of the non-EEA doctors are eventually recognised. In Austria, each medical university has autonomy in determining the additional medical programme for a non-EEA doctor. Under the Austrian Universities Act, every university in that country has to offer a recognition procedure to holders of foreign credentials (National Council of the Republic of Austria 2002).

University policies and practices

Results are presented in Table 3. In Nordic countries and the UK, there is just one route stipulated for non-EEA doctors who have obtained permanent residency. Programmes for non-EEA doctors in the Nordic countries are only offered by a limited number of universities and medical schools, by the special request of their respective health departments.

In Denmark, Norway, Sweden, and Germany, relatively large groups of applicants end up having their foreign medical degrees recognised. In 2000–2003 in the Province of North Rhine-Westphalia, Germany, 1471 non-EEA doctors were recognised. Sweden recognized around 700 non-EEA doctors in the same period. Norway recognized 538 non-EEA doctors in 2003 and 2004. Exact figures for Denmark are not available. In the UK, 9336 non-EEA doctors were registered with the General Medical Council in 2003. This was the last year in which doctors from countries of the Commonwealth could obtain full registration without entrance examinations. Experience shows that relatively short additional programmes can result in foreign medical qualifications being recognised. This explains the fact that, in the Nordic countries and the UK, the second route to gain recognition—enrolment as a regular student in medical schools—has not really been developed. In building jargon, the medical faculties in the Nordic countries are subcontractors, while the health departments are the contractors. In Germany both routes are available to non-EEA doctors.

The health department of Germany and the General Medical Council of the UK have both developed procedures to assess the medical qualifications of non-EEA doctors. In Germany, if the outcome of direct assessment is negative, non-EEA doctors are allowed to request admission to a medical school. The Medical Faculty of the University of Leipzig admits approximately 30 non-EEA doctors per year, as they only 8% of their 340 medical students enrolled at the medical faculty per year may be foreign. In the UK, after a negative outcome in the assessment procedure, non-EEA doctors can apply to one of the medical schools, but hardly ever do so in view of the costs. A year at a medical school can cost an overseas student 25,000 British pounds (nearly 38,000 euros). Some years ago, the Queen Mary University of London started a so-called Refugee and Overseas Qualified Doctors' Programme, in which non-EEA doctors were prepared for linguistic exams.

In Austria, Belgium, France, and The Netherlands, medical schools offer additional medical programmes to non-EEA doctors after initial negative assessments. Apparently, the routes through the health departments in those countries are not as effective as in the Nordic countries and the UK. In fact, the route through the medical schools is the most significant one there. To use building jargon again, the universities in Austria, Belgium, France, and The Netherlands act as contractors and there are no subcontractors. As new central assessment procedures were introduced in 2005, no results can be reported. Before the introduction of the new assessment procedure, however, the Medical Faculty of the University of Lille 2 received 50 applications a year, of which 10 were accepted following a selection process. The Medical University of Vienna also receives nearly 50 requests a year. In the last 2 years, the Flemish Interuniversity Council has admitted 70 non-EEA doctors to their procedure. Up until 2005, the eight Dutch medical faculties admitted approximately 110 non-EEA doctors every year.

Admission options

In the Nordic countries and the UK, universities hardly ever admit non-EEA doctors, with the exception of the University of London. In Austria, the Medical University in Vienna starts recognition procedures for all non-EEA doctors who have permanent residency in Austria and request recognition. If the outcome of the assessment, based on transcript comparison, shows deficiencies or a level equalling less than 5 years of medical study, the candidate will not be admitted in Austria.

In Belgium, the Flemish universities with medical schools will start an admissions procedure for those non-EEA doctors whose recognition requests to the Belgian health department ended in rejections. Most of the applicants have permanent residency in Belgium. Once an applicant has successfully completed a standard assessment procedure (a medical-knowledge test and interview) organised by the Flemish Interuniversity Council, he or she is free to start at any medical school in Flanders. The board of the medical school decides the duration and content of the programme to be completed.

In Spain, if their medical degree is refused recognition, a non-EEA doctor may apply for partial recognition at a

Table 3. University policies regarding non-EEA doctors.

University policy	Country									
	UK	Denmark	Norway	Sweden	Germany	Austria	Spain	France	Belgium	The Netherlands
Responsible for third country doctors programme	No	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes
Length of programme for third country doctors	0 months	12–18 months	12–18 months	18 months	12–24 months	12–18 months	No standards	24 months	24–36 months	18–36 months
Graduation with 'new' medical degree	No	No	No	No	Yes	No	No	Yes	Yes	Yes
Necessity of second route to work as a doctor	No	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes
Mastery of the language required	Explicit	Explicit	Explicit	Explicit	Explicit	Implicit	Implicit	Implicit	Explicit	Explicit
Courses in medical language available	No	No	Yes	Yes	No	No	No	No	No	Yes
Cooperation medical schools conc. third country doctors	No	No	No	No	No	No	No	No	Yes	Yes
Chances of third country doctors on the labour market	Not equal	Not equal	Unknown	Unknown	Unknown	Not equal	Equal	Equal	Equal	Equal

medical school. After sitting an examination, the non-EEA doctor can proceed with a programme that is based on the outcome of that examination.

In Germany, if the health department refuses to recognise a degree, the Medical School of the University of Leipzig allows non-EEA doctors to apply for admission, although only excellent students are admitted. In The Netherlands, medical schools cooperate in the admission and dispersal of non-EEA doctors throughout the eight universities with medical schools. The programmes the non-EEA doctors have to follow, however, may vary from university to university.

Sufficient mastery of the language

In every country, sufficient mastery of the country's main language is a major requirement. In Denmark, France, and Spain, mastery of the language is an implicit demand (no specific language test involved). For instance, medical-knowledge tests in Denmark cannot be passed successfully without sufficient mastery of the Danish language. This holds true for the procedures in France and Spain. In all other countries, proof of mastery of the language is an explicit demand; failing the language exam results in the refusal of admittance to the medical course of study. Medical language programmes for non-EEA doctors have only been developed in The Netherlands, Norway, and Sweden.

Length of programmes or recognition procedures

The Danish procedure for recognition consists of two different probationary periods in a Danish hospital, each lasting for at least 3 months, a verbal test of general medical knowledge and three medical examinations in social medicine, legislation on the practice of medicine, and legislation on the prescription of pharmaceuticals (Danish National Board of Health 2001). The examinations are all conducted in Danish. In Denmark and Norway, the whole procedure can be completed within a year. In Sweden, it takes 18 months. In the UK, the average time needed is also about 18 months (Butler & Eversley 2005).

In Austria, the length of the programme at the Medical University of Vienna is at least a year (four exams, each taking about 3 months to pass). In Belgium, the minimum programme length is 2 years. In The Netherlands, the length of the programme (under the old procedure) depended on the medical school the non-EEA doctor was sent to. The shortest programme took 18 months, the longest more than 3 years. In France (under the old procedure), the programme at the Medical Faculty at Lille University took 2 years.

Only in Belgium and The Netherlands do medical schools cooperate on the subject of policies regarding non-EEA doctors. In the Nordic countries and the UK, there is hardly any university involvement in the procedures.

Support for non-EEA doctors

Most of our participants were not aware of any organisations in their country that could help non-EEA doctors financially while negotiating the recognition procedures of the health

departments or medical schools. Most countries do have a welfare system that provides refugees with a social security benefit.

In the UK, the Refugee Doctor Programme at Queen Mary University of London helps non-EEA doctors find financial assistance for their exams. In Germany, the Otto Benecke Stiftung helps non-EEA doctors seeking to become medical doctors in Germany. In The Netherlands, a nongovernmental organisation called the University Asylum Fund supports refugees and asylum seekers wishing to enter university or the labour market, giving study and career advice, financial support, and the like. In the other countries, these organisations seem to be absent, or are at least hard to find.

Finding work as a medical doctor

Most participants reported that non-EEA doctors will have the same chances as indigenous doctors of finding work practising medicine after successfully graduating in their new countries.

In the UK, however, studies have showed that equal opportunities for ethnic minority health workers were jeopardised simply by having the wrong name and skin colour (Esmail & Everington 1997; Cooke et al. 2003). In Denmark, it was shown that non-EEA doctors and dentists who had been through the Danish system for recognition experienced severe problems in finding work (Sjouwerman 2002). By contrast, non-EEA doctors who obtained a Dutch medical degree succeeded quite easily in finding work as doctors in The Netherlands. A study showed that 4 months after completing medical training, more than 90% had a medical appointment (Herfs et al. 2001). The specialisation options of non-EEA doctors are quite diverse and are often associated with their profession in their home country.

Discussion

At the start of this investigation, it proved difficult to identify those people who were best informed about national and university policies concerning non-EEA doctors. The sources at health departments and universities and medical faculties were all very eager to learn about the policies towards non-EEA doctors in other EEA-countries. It became obvious that there was no cooperation whatsoever between countries on this subject. Only in Flanders, Belgium and The Netherlands is there cooperation between medical schools regarding non-EEA doctors. It seems that all countries and universities are re-inventing the wheel of assessment and recognition of foreign medical degrees, admission of non-EEA doctors, and the development of additional programmes for non-EEA doctors. The attitude of every person involved in this study, however, was remarkably similar: they all felt a major responsibility for the quality of the non-EEA doctors recognised by their society. In view of the large influx of non-EEA doctors into Europe, the procedures for acceptance and training for generally accepted degrees need to be coordinated. Until now, there has been no pan-European approach. This means that there are significant differences between countries. In January 2007, the EEA expanded again. It would be useful to extend this enquiry to all EEA-countries.

This study could be the first step towards a better understanding of all the EEA systems that are already in place to assess and train non-EEA doctors in order to include them in our society as doctors, not as cleaners. EEA countries should not waste medical talent, whatever its origin.

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Notes on contributors

PAUL HERFS was a student counsellor and admissions officer at Utrecht University. He was one of the founders of the Dutch committee that has been responsible for the admittance of non-EEA doctors in the eight medical schools in The Netherlands since the mid-1990s. He has written a dissertation on non-EEA doctors in The Netherlands. He currently works as an ombudsman at Utrecht University.

LOUIS KATER is a professor (emeritus) of internal medicine. He is the coordinator of the Matriculation Committee for foreign Medical Graduates at Utrecht Medical Centre Utrecht.

JEEN HAALBOOM is a specialist in internal medicine and especially in the prevention and treatment of cardiovascular diseases. Since the early 1990s, he has been involved with the integration of non-EEA physicians into the Dutch health care system. Together with Paul Herfs, he initiated a special medical Dutch language book that at present is an essential part of the programme non-EEA doctors have to complete before being admitted to a Dutch medical course.

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