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Assessing the role of regulatory bodies in managing health professional issues and errors in Europe

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Abstract

Objective. This paper explores how medical regulatory bodies in nine European countries manage professional issues involving quality and patient safety, to build on limited existing information on procedures for regulating medical professionals in Europe.

Design. Twelve vignettes describing scenarios of concerns about standards of physicians were developed, covering clinical, criminal and administrative matters. Medical regulatory bodies in nine European countries were asked what action they would normally take in each situation. Their responses were related to their regulatory mandate.

Results. Responses varied greatly across participating countries. Regulators are always involved where patients are at risk or where a criminal offence is committed within the clinical setting. Non-criminal medical issues were generally handled by the employer, if any, at their discretion. Countries varied in the use of punitive measures, the extent to which they took an interest in issues arising outside professional activities, and whether they dealt with issues themselves or referred cases to another regulatory authority or took no action at all.

Conclusions. There is little consistency across Europe on the regulation of medical professionals. There is considerable diversity in the range of topics that regulatory bodies oversee, with almost all covering health care quality and safety and others encompassing issues related to reputation, respect and trust. These inconsistencies have significant implications for professional mobility, patient safety and quality of care.

Keywords: vignettes, medical regulators, legislation, Europe, professional mobility

Background

Health professionals can move freely within the European Union, under the provisions of the 2005 Directive on the recognition of Professional Qualifications [1], the most recent in an evolving series of directives dating back to 1973. However, some high-profile cases of medical malpractice have raised concerns about whether European regulatory bodies have responded adequately to the challenges posed by greater mobility and, specifically, whether there is any consistency in the regulation of physicians in Europe. This question is important, given evidence that doctors facing disciplinary action in one country have been allowed to practise in another, such as Dr Ubani, a German doctor who continued to practise in Germany after being struck off the UK register for an incident in which a patient died [2].

Remarkably, there is very little information about the systems or procedures in place to regulate the medical profession in European countries. A search of the peer-reviewed literature found a few papers discussing patient safety, quality of care and medical professionalism, but few examining the processes adopted by regulatory bodies. What exists focuses on individual countries, such as a discussion of Fitness to Practise in the UK [3] or Borow's exploration of the regulatory tasks of national medical authorities [4]. The literature is richest in the UK, with reflections on the UK Government's 2007 White Paper on the Regulation of Health Professionals [5–7], risk-based regulation, self-regulation initiatives [8] and the implications of a 'no blame culture' [9]. A RAND report, undertaken for the UK General Medical Council (GMC), is unusual in comparing medical regulatory structures in several countries [10]. Otherwise, we found no papers that examine the responses to disciplinary issues, leaving a gap in our understanding of the comparability of regulatory processes within Europe. Furthermore, there are few data on the number of doctors under investigation or disciplined for professional matters, although it is clear from media account that cases are handled differently in different countries.

We asked regulatory bodies in different European countries how they would manage a range of civil, criminal and administrative problems within and outside of medical practice to understand better the processes involved in addressing disciplinary matters. We examine the different scopes of responsibility of health regulators and describe typical processes and outcomes. Finally, we reflect on the balance between punitive and rehabilitative actions in different countries.

Methods

We analyse the responses to 12 hypothetical vignettes of potential professional transgressions presented to medical regulators in nine European countries to understand the scope and application of their disciplinary processes. Vignettes are particularly useful for comparing the approaches taken by people in different settings to similar situations [11] (Box 1).

Box 1 Details of the vignettes

(1) Pattern of poor performance with insight: Doctor Green—a senior surgeon—is discovered to be practising an out-of-date and inappropriate surgical technique, as well as not undertaking appropriate follow-up care with patients. On investigation by the regulators, significant deficiencies in performance are found and the regulator considers that the doctor needs to retrain. The doctor acknowledges the problem and agrees to retrain.

(2) Pattern of poor performance and lack of insight: Doctor Blue—an experienced surgeon—is audited following an incident in surgery, which revealed a series of clinical errors during major heart surgery. He is referred to the regulator. He insists he has not done anything wrong, although an investigation has found significant concerns about his performance. When the regulator invites the doctor to comment on the allegations, he repeats that he has done nothing wrong and does not need any training.

(3) Pattern of seriously poor performance and repeated failure to remediate: Doctor Red is referred to the regulator regarding concerns about his basic competency as a family doctor. An investigation concludes that he lacks even the most basic clinical knowledge. He is given several opportunities to retrain however he repeatedly fails to pass the exams. He eventually stops engaging with efforts to help him gain an appropriate level of knowledge.

(4) Pattern of serious misconduct (sexual): Doctor Orange is referred to the regulator by the police, following a conviction of sexually assaulting a patient. It is also proved that he made inappropriate sexual remarks to several other female patients and offered intimate examinations when they were not clinically indicated. The doctor accepts all the facts and says that he is sorry for any embarrassment caused to the profession.

(5) Single incident of misconduct (dishonesty): Doctor Brown is found cheating in an exam to qualify as a specialist in respiratory medicine and is referred to the regulator. He is a young doctor and when asked to comment by the regulator, he says he is very sorry. There are no other concerns about his conduct.

(6) Single incident of misconduct—driving conviction with health condition: Doctor Black is convicted of driving whilst under the influence of alcohol. An investigation finds that she has serious alcohol abuse issues and depression. The doctor is undergoing treatment for depression; however, she is not accessing medical help for her alcohol problem. There have been a number of incidents when she arrived at work whilst under the influence of alcohol and had to be sent home because she was not fit to perform surgery.

(7) Pattern of serious misconduct (dishonesty) with health condition: Doctor White is found to have stolen drugs from the hospital where she works on more than one occasion. An investigation finds that the doctor is suffering from chronic depression and an addiction to opiates. The doctor says she has been going through difficulties in her personal life.

(8) Pattern of serious misconduct (respect for colleagues) with no health condition: Doctor Grey is referred to the regulator after a colleague reported her for verbally abusive and racist comments in the workplace. An investigation finds that the doctor has a history of racial abuse and bullying colleagues, with a number of incidents over many years. The doctor insists that there is nothing wrong with this behaviour. The doctor attends a health assessment and is found not to have any mental health problem.

(9) Single incident of misconduct (physical violence in a domestic setting) with efforts to remediate: Doctor Silver is referred to us after receiving a police warning for common assault, following a domestic dispute at home with his wife. The doctor has since attended a course on controlling his temper.

(10) Misconduct—single incident (driving conviction) with no health impairment: Doctor Gold is convicted of driving whilst drunk/under the influence of alcohol and referred to the regulator. An investigation finds that he has no serious issues with alcohol abuse.

(11) Minor performance issue—single incident: Doctor Purple is referred to the regulator following an investigation into the death of a patient. An investigation into the circumstances regarding the patient's death find that on this occasion, the doctor's record keeping about patients was not of a good standard. There are no other concerns regarding the doctor.

(12) Minor misconduct—single incident (communication): Doctor Yellow—a family doctor—has a complaint submitted about him to the regulator from a member of the public who claims he was not very polite during the consultation and that they had to wait too long to see him.

The vignettes were developed in discussion with the UK's GMC, based on a conceptual framework that categorized potential professional regulatory matters and covered: the duration of the action in question (one off or persistent), its nature (based on competencies identified in the GMC's *Good Medical Practice* publication) and the response of the individual concerned (such as contrition or denial). These were then

operationalized to generate plausible vignettes that regulators may expect to encounter, some drawn from actual cases where a doctor's fitness to practise is assessed following an incident.

Scenarios were developed to capture a wide range and combination of themes [12], and were designed to appear plausible and realistic to respondents, avoiding extreme or bizarre events. They included sufficient context for respondents to be able to understand the situation being depicted. Finally, some topics addressed were those sitting on the periphery of regulatory bodies' remits, where variation was expected to be at its peak (Table 1).

Key informants working in regulatory bodies in nine European countries (Austria, Estonia, the UK, Germany, Belgium, Hungary, the Netherlands, Slovenia and Spain) were identified by researchers; informants had to be knowledgeable about the actors, institutions and processes involved in addressing disciplinary matters including civil, criminal and administrative problems. Each informant described how each vignette would be managed in their own country. Data were collected in writing or in an interview. Data from interviews were transcribed and translated into English. All responses were coded inductively using NVivo software, identifying key themes and subthemes that were then further cross-analysed for comparison between countries and vignettes. Informants were followed up for clarity over terminology where appropriate.

Results

Responses to the scenarios varied considerably among countries. Some fell within the scope of the regulatory body in one country but outside it in others, where it might be a matter for the courts or the employer, or not seen as requiring any action by anyone (Table 2).

Scope of authority

Regulators in most countries responded that most of the scenarios would require action, although eliciting varying responses. Estonia, Hungary and the Netherlands would frequently refer the matter to another body (often the employer) or would decline from acting as the issue lay outside of their remit. Indeed, the Health Board of Estonia would not manage any scenario themselves, either referring it to another body or taking no action.

The greatest consistency in actions of regulatory bodies was where patients were at risk (Vignettes 1–4), issues considered serious (Vignettes 3, 4, 6, 7 and 8) and those involving criminal activity within a clinical setting (Vignettes 4, 6 and 7). This is consistent with core principles enshrined in the Hippocratic Oath. Vignettes 1, 2 and 3 address the issue of a doctor's poor performance and competency, where almost all regulatory bodies responded that they would usually suggest retraining or place constraints on the licence to practise. Potential criminal offences within a clinical setting would be referred to the prosecuting authorities, as well as being addressed by the regulatory body.

In many countries, the regulator considers the employer responsible for poor communication or performance (Vignettes 11 and 12). Furthermore, in some countries, the employer rather than the regulator would take disciplinary action in criminal cases involving alcohol or drug dependency (Vignettes 6 and 7) and poor attitudes by the doctor (Vignette 8), but often at their discretion. Interestingly the Estonia Health Board reported that they would refer most vignettes issues to the doctor's employer, as would Hungary in 4 out of 12 cases.

Some issues, particularly relating to criminal cases outside of the work setting, frequently resulted in no action by the medical regulator or the employer; with Vignettes 9 and 10, six of the nine participating countries reported that the matter lay outside of their scope of responsibility. With at least four vignettes, Estonia, the Netherlands and Spain responded that no action would be taken, suggesting that they have a narrower scope of responsibility than other countries.

Regulatory pathways

Table 3 compares how regulatory bodies in three countries would handle cases that fell within their responsibility (Vignettes 4 and 8, for sexual misconduct and theft of drugs, respectively). These countries were selected based on the diversity of responses.

In each case, the UK and Germany would consult their respective medical codes to identify whether they had been breached and what course of action would be permitted. In Spain, primary responsibility for investigating the case would lie with the prosecuting authorities and courts and, if convicted, the regional medical association would take further action such as rehabilitation or additional limitations on the doctor's licence. In the case of theft of drugs, the police and prosecuting authorities would decide whether an offence had taken place and not the regulatory bodies.

In all three countries, patient safety and trust in the profession are the main priorities. Interestingly, remorse shown by the doctor in Vignette 4 would have little or no impact upon the disciplinary action taken by any of the regulators, whilst the personal difficulties and addiction of the doctor in Vignette 7 would be considered in deciding the course of action.

Table 4 looks at the handling of non-criminal cases in three other countries, again chosen to illustrate diversity. In Vignette 1, the employer in Austria and Slovenia would request retraining, but the investigation and sanctions would be implemented by the regulators. In Belgium, however, the employer leads the investigation but has no legal basis to enforce any training. In Vignette 8, in all three countries the employer would lead the investigation. In Slovenia, the Medical Chamber would advise the employer on their management of the case. In Austria and Belgium, the employers would impose the disciplinary action, but only in relation to the doctor's employment contract, not their licence.

Outcomes and nature of action

The action in response to each vignette indicates how the regulators see their responsibility in regulating medical practice in their country.

The strongest disciplinary sanction was the withdrawal or suspension of medical licence. Vignette 4, sexual misconduct with patients, was most likely to lead to withdrawal of licence or removal from the register (7/9 countries). In contrast, regulators in Estonia and Hungary both said the matter would be

Table 1 Components and nature of vignettes

	Key theme	V1 Out-of-date practice	V2 Surgical errors	V3 Poor competency	V4 Sexually inappropriate	V5 Cheating in exam	V6 Drink-driving	V7 Drug theft and abuse	V8 Abuse of colleagues	V9 Domestic violence	V10 Drink-driving	V11 Poor record keeping	V12 Impolite
Duration of issue	Single incident of poor performance											✓	
	Single incident of misconduct					✓	✓			✓	✓		✓
	Pattern of poor performance	✓	✓	✓									
	Pattern of misconduct				✓			✓	✓				
	Serious incident			✓	✓		✓	✓	✓			×	×
Nature of issue	Serious deficiency	✓	✓	✓									
	Risk to patients	✓	✓	✓	✓					×			
	Criminal conviction				✓		✓	✓		✓	✓		
	Dishonesty					✓		✓					
	Underlying health condition						✓	✓	×		×		
	Personal difficulties as contributing factor						✓	✓					
	Issue of confidence in the medical profession					✓	✓	✓	✓	✓	✓		
	Issues relating to administration of practice											✓	✓
Response by doctor	Doctor having insight into the problem	✓			✓	✓							
	Doctor lacking insight into the problem		✓						✓				
	Doctor makes efforts to remediate or apologise	✓	×		✓	✓				✓			
	Attempts to rehabilitate failed			✓									

✓, theme is explicitly present; ×, theme is explicitly absent.

Table 2 Responses from regulatory bodies by country and vignette

V1	V2	V3	V4	V5	V6	V7	V8	V9	V10	V11	V12
Austria											
Retraining by employer	Dismissal by employer	Removal from register	Removal from register; action by criminal court	Official reprimand	Removal from register; rehabilitation from employer	Removal from register; evaluation by employer	Suspend licence and disciplinary proceeding	Removal from register; evaluation by employer	Reprimand and investigation	Managed by employer	Warning
Belgium											
Internal investigation by law	Reprimand or suspension	N/A[a]	Suspend licence	Managed by university	Suspend licence, max 2 years	Suspend licence, max 2 years	Managed by employer	No action; criminal court action	N/A	Reprimand and retrained by employer	N/A
UK											
Work restrictions, retraining by employer	Disciplinary hearing and reprimand	Removal from register	Removal from register	Removal from register	Suspend licence, rehabilitation and supervision by employer	Removal from register; supervision by employer	Removal from register	Warning	Warning	Reprimand or warning	Managed by employer
Estonia											
Managed by and retrained by employer	Managed by employer	No action, possible legal action by patient	No action, possible legal action by patient	No action as outside of remit of regulator	Managed by employer	Managed by employer, maybe criminal court referral	Managed by employer	No action, managed legally or by employer	No action, criminal court action or managed by employer	Managed by employer	Managed by employer
Germany											
Reprimand, possible fine, restrictions on work	Possible revocation of licence	Removal from register	Removal from register; action by criminal court	Reprimand	Suspend licence; action by criminal court	Suspend licence; action by criminal court	Withdraw licence; reprimand	No action as outside of remit of regulator	No action as outside of remit of regulator; criminal court action	Official reprimand	No action as outside of remit of regulator
Hungary											
Internal investigation but unlikely due to strict CME protocol	Managed by employer	N/A	No action, action by criminal court	Managed by education authorities	Managed by employer; suspend licence and rehabilitation	Dismissal from position	N/A	Suspend licence and investigation	No action; maybe additional supervision by employer	Managed by employer	Audit of service
Netherlands											
Work restriction, reprimand	Reprimand	Warning or reprimand	Removal from register; action by criminal court	No action as outside of remit of regulator	Handled by College of Medical Supervision	Handled by College of Medical Supervision; criminal court action	No action as outside of remit of regulator	No action as outside of remit of regulator	No action as outside of remit of regulator; criminal court action	No action as outside of remit of regulator	No action as outside of remit of regulator

(*continued*)

Table 2 continued

V1	V2	V3	V4	V5	V6	V7	V8	V9	V10	V11	V12
Slovenia											
Withdraw licence, work restrictions, retraining by employer	Withdraw licence, work restrictions, retraining by employer	Withdraw licence	Withdraw licence, action by criminal court; investigation	Allowed to retake exams	Managed by employer; suspend licence and rehabilitation	Suspend licence and rehabilitation; criminal court only by employer	Withdraw licence; investigation by employer	No action as outside of remit of regulator	No action as outside of remit of regulator; criminal court action	Further investigation	No action as outside of remit of regulator
Spain											
Work restrictions, retraining by employer	Work restrictions, retraining by employer; legal action by patient	Suspend licence	Withdraw licence, action by criminal court	N/A	Suspend licence and rehabilitation	Suspend licence and rehabilitation; criminal court only by employer	Managed by employer, Suspend licence	No action as outside of remit of regulator	No action as outside of remit of regulator	No action as outside of remit of regulator	No action as outside of remit of regulator

[a]N/A is given when a participant either omitted a response or where no clear action is provided in the response for clarity, the matters not handled by the regulator have been shaded to illustrate patterns.

Table 3 Regulation management pathways for criminal cases

Regulatory body	UK	Germany	Spain
	General Medical Council	German Medical Association at Federal and Lander (state) level	General Council of Official Colleges of Doctors (CGCOM) and Regional College of Doctors
V4—sexual misconduct			
Initial point	Male doctor referred to regulator by the police, following a conviction for sexually assaulting a patient; investigation also finds he made inappropriate sexual remarks to other female patients and offered unnecessary intimate examinations. Doctor apologises.		
Process	Refer to 'Good Medical Practice' guidance on standards. This would be a breach of trust in the profession and risk to patient.	Refer to Federal Medical Code (*Bundesärzteordnung*—BÄO). Case stipulates unworthiness (lack of dignity) AND loss of reputation and trust.	Case examined in the courts—regulator must follow court ruling. Regulator also refers to CGCOM Code of Ethics by Regional Ethics Commission for guidance.[a]
Outcome	'Erasure' by GMC, meaning the removal of licence to practise and from the register of practising doctors, despite apology.	Further medical practice deemed impossible. Criminal proceeding likely, as well as professional legal proceeding. However, it is not possible to temporarily suspend their licence to practice prior to criminal proceeding.	If crime is proved in the court, the licence is automatically suspended. Recognition and regret have no effect on sanction.
V7—drug theft from hospital			
Initial point	Doctor found to have stolen drugs from the hospital where she works on more than one occasion. An investigation finds that the doctor is suffering from chronic depression and an addiction to opiates. The doctor admits difficulties in her personal life.		
Process	Refer to 'Good Medical Practice' guidance on doctor standards. Seen as a breach of patient and public trust, and risk to patients. Doctor's health and personal difficulties considered in disciplinary action.	Refer to Federal Medical Code (BÄO). Case stipulates unreliability and unworthiness to practise. Investigation at state level into degree of blame to examine whether to initiate Professional Law proceedings, taking personal difficulties into account.	Regional medical association would seek to enrol doctor in rehabilitation, such as through 'Ill Doctor Programme' by Barcelona Medical Association if the resources are available. Employers would also launch an investigation into the matter.
Outcome	Restrictions imposed on doctor's registration and therefore ability to practice. Doctor prohibited from prescribing certain drugs, and to undergo medical supervision. Doctor required to undergo psychiatric treatment and unannounced drug testing.	Revocation or suspension of licence and/or reprimand possible. Initiation of Professional Law proceedings dependent on outcome of investigation.	Suspension of licence and doctor to enrol in rehabilitation. Inquiry leading to possible disqualification (up to 5 years) launched by regulator. Employer might also prosecute doctor for theft (court proceedings would otherwise not be raised).

[a]Some information sourced from De Vries *et al.* [10].

handled by the legal authorities, reporting that they lacked a legislative basis to intervene.

Most countries also recommended a withdrawal of medical licence when the doctor is not considered suitable for further employment, such as the abusive attitude in Vignette 8 and deficient clinical competency in Vignette 3.

The UK, Slovenia and Austria responded with the more severe and punitive actions, recommending licence withdrawals for 5 of the 12 vignettes. They opted for stricter action when other countries would refer the matter to someone else, suggesting a broader mandate for regulators in these countries.

Some countries favoured rehabilitation in the less severe vignettes. With Vignette 1, where a senior surgeon used outdated techniques, Austria and Spain suggested further training to improve their practice, whilst other countries reported they would limit his scope of work. For drug and alcohol dependency in Vignettes 6 and 7, most countries would enforce rehabilitation, with possible suspension of licence until recovery.

Employers commonly handle personnel and training matters that are generally less severe or risky by nature, and regulators address more serious offences with commensurate disciplinary action.

Table 4 Regulation management pathways for non-criminal cases

Regulatory body	Austria	Belgium	Slovenia
	Austrian Medical Chamber and Regional Association of Hospitals of Vienna	Belgian Order of Physicians	Medical Chamber of Slovenia
V1—pattern of poor performance			
Initial point	A senior surgeon is discovered to be practising an out-of-date and inappropriate surgical technique, as well as not undertaking appropriate follow-up care with patients. On investigation by the regulators, significant deficiencies in performance are found and the regulator considers that the doctor needs to retrain. The doctor acknowledges the problem and agrees to retrain.		
Process	Appropriate medical institution would investigate and examine competence. Investigation into possible damages to patients.	Medical Council and Medical Director of the hospital would launch an internal investigation	Refer to General Practitioner Services Act (Official Gazette RS, 72/2006); conduct an audit of the doctor's work.
Outcome	Disciplinary complaint would be followed through. Possible criminal complaint or extra-juridical arbitration according to civil law. Employer has legal duty to retrain doctor.	Doctor may face a warning, based on outcome of investigation. Possible suspension from the order's registry. There is no legal obligation in Belgium to retrain, although there are financial incentives.	Temporary licence withdrawal and retraining by employer.
V8—verbal abuse of colleagues			
Initial point	Doctor is referred to the regulator after a colleague reported her for verbally abusive and racist comments in the workplace. An investigation finds that the doctor has a history of racial abuse and bullying colleagues. The doctor insists that there is nothing wrong with this behaviour.		
Process	Investigation and evaluation by the employer.	Medical Council and Medical Director of the hospital would assess the situation.	Refer to labour legislation. Employer would launch investigation. If harm against patient, Medical Chamber would undertake an audit. Chamber may also make recommendations through its committee on ethical issues.
Outcome	Possible outcomes are dismissal from post, suspension or resulting in a criminal complaint against the doctor.	Disciplinary action by Medical Director of hospital. Possible criminal complaint by victim against doctor.	Temporary licence withdrawal or warning would be considered.

It should be noted that some respondents commented that some professional issues featured in the vignettes were unlikely to come to their attention. For example, the vignettes covering doctor's poor performance (vignette 1) and requiring retraining (vignette 2) were reported as unlikely to be escalated to the regulators in Estonia and Hungary but instead be dealt with within medical teams. Respondents from Belgium and the UK also suggested that monitoring systems and continuous medical education had reduced the risk of such issues arising.

Discussion

The breadth of the vignettes studied allows us to assess the scope and practice of regulatory bodies through their responses to hypothetical scenarios. Overall, regulators take responsibility for matters where patients are at risk or where a criminal offence is suspected within a clinical setting, for which severe, and often punitive, actions are enforced (suspension of licence or erasure from the medical register). These events are relatively rare, as there are many self- and peer-regulatory mechanisms in place to prevent such events from occurring. Meanwhile, the more numerous but less severe issues are managed with a broader range of softer 'disciplinary actions'. These are often decided at the employer's discretion and usually pertain to non-criminal medical issues, such as those related to competency/training or attitude. This shows how some countries differentiate a doctor's accountability for professional standards, overseen by the regulatory bodies, from their accountability as an employee in medical practice, where their competency and ability to practise in a respectful way is regulated by the employer. Furthermore, the emphasis

is on incident reporting and transparency to prevent clinical errors occurring rather than regulators reacting after the event.

Interestingly, countries that made reference to specific legislation in their responses—Austria, the UK, Germany and Slovenia—also opted for more punitive actions more frequently than other countries. These regulators—except in Slovenia—tended to have a broader remit that encompasses medical errors as well as doctors' professional standards, and therefore might penalise doctors who commit criminal offences (such as domestic violence or drink-driving) outside their working practice. They take a more holistic view of the performance of a doctor, both clinically and within their role in society, whilst other regulatory bodies focus more on patient safety. Meanwhile, countries which offered more reflexive and contemplative responses, such as Belgium and Spain, recommended less punitive action and more frequently encouraged correctional support or rehabilitation. The introduction of varying forms of revalidation processes in some EU countries might also encourage countries to further define the scope of their regulatory bodies, to perhaps extend beyond clinical work, although the UK stands out from all others in the broad scope and complex nature of its revalidation process [13].

The regulatory bodies in the Netherlands, Spain and Estonia seemed to have the narrowest scope of authority, evident by the frequency at which they referred the issue to another regulatory authority or took no action at all. This was particularly the case for the non-clinical criminal cases and personnel matters (Vignettes 5, 8 and 12).

Regulatory bodies hold different mandates and prioritize different issues, often based on precedent cases or influenced by health systems structures and whether they separate the agency function from the promotion of private professional interests institutionally [14]. These differences can give rise to very different disciplinary actions against doctors for the same professional issues in European countries. For example, a doctor could be punished professionally for a non-clinical crime in one country and left untouched by the regulator in another. With the variety in scope of regulatory bodies, doctors can continue with behaviours or practices in one country that may be seen as a disciplinary matter in another. The complexity of this issue can be seen in the variety of different pathways and actors involved in regulating medical professionals.

These findings have implications for the EU Directive on the recognition of professional qualifications, given increased migration of physicians. In the modernization of the Directive, the European Commission plans to introduce a proactive Europe-wide alert mechanism, in which 'Member States are to declare cases of health professionals who have been stripped of their right to pursue their professional activity', including temporary suspensions [15, 16]. Such a mechanism should increase patient safety and transparency, but also creates concerns about data protection, witch-hunting and what White describes as the 'blame culture'. However, a regulatory framework is necessary to offer protection from and for the management of 'bad apples' and retain the public's trust in the profession, since self-regulation was deemed to have failed to protect patients in the past [8]. Implementing such an alert system will have resourcing implications for Member states—both exporters and importers of professionals—as efforts are made to align and operationalize regulatory processes. There is also the risk of rising political tensions in countries between which professional mobility is high and regulatory processes remain unsynchronized, which can leave countries vulnerable to scandals.

The vignette analysis has highlighted variation in the regulation of doctors in Europe. We cannot say which approaches are best and anyway the diversity is likely to reflect cultural norms. However, with increasing numbers of doctors crossing borders to work, these inconsistencies risk giving rise to concerns about patient safety, quality of care and the public's trust in the medical profession. Regulatory bodies often contest the degree of regulation necessary as quality of care may be compromised at each end of the regulation spectrum. Applied on an EU scale, this could have implications for public trust of foreign doctors within the EU.

Strengths and limitations

Previous studies have, although only to a limited degree, looked at the structure and processes involved in regulation of health care professionals; in contrast, this innovative use of vignettes has examined how they would actually respond to a range of issues raising both clinical and criminal issues. A combination of both policy analysis and vignettes would give a more complete and in-depth assessment of the situation.

The use of vignettes has been criticized as failing to capture what people would actually do, as opposed to what they say they would do, yet the practical experience of the respondents with such issues offers reassurance. However, some of the vignettes covered issues outside the scope of the regulator and therefore there may have been a degree of speculation in their responses.

There was some variation in the style of responses given by each country, with some responses being more ambiguous and others more concise and citing specific legislation, which could be interpreted as one country having a less clear scope and another being more structured. There was also some confusion over specific terminology used, resolved by following up with country respondents to provide clarification.

It would have been helpful to have been able to complement our findings with data on actual performance of professionals, such as rates of substance abuse or medical errors, but no such data exist in a comparable form across countries.

Conclusion

The diversity of issues raised by the responses to vignettes allowed for the showcasing of regulatory processes in response to hypothetical, yet realistic, scenarios. There is little consistency across Europe in how events questioning competency and qualities of medical professionals are handled. There is considerable diversity in the range of topics that regulatory bodies address, with almost all covering health care quality and safety, and others exploring themes around reputation and maintaining the public's trust in the profession. With increased

professional and patient mobility, the lack of standardization in the regulatory management of doctors in the region may have significant implications regarding patient safety and quality of care. However, given the variation in practices demonstrated in this paper, any harmonization initiatives should be carefully planned and take existing structures and pathways into account.

Ethical approval

None required. In the UK, data were accessed from standard responses from the GMC. In other countries, ethical approval was not required for data collection.

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