Europe's Medical Loophole Allows Banned Doctors to Practice

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The integrity of medical licensure across Europe faces a critical challenge: doctors banned from practice in one European Economic Area (EEA) country can legally obtain a license and continue practicing in another. This regulatory disparity creates a significant patient safety risk, as disciplinary actions are not consistently recognised or enforced across national borders.

KEY TAKEAWAYS

- The Pivot: Disciplinary sanctions against medical professionals are not uniformly applied or recognised across EEA member states.
- The Data: Specific numbers are not available in the provided research, but the mechanism allows for re-licensure despite prior bans.
- The Action: Regulatory bodies and policymakers must address the cross-border recognition of medical sanctions to protect patients.

The free movement of professionals within the European Economic Area (EEA) is a foundational principle, intended to facilitate economic integration and access to services. However, this principle, when applied to medical professionals, has inadvertently created a loophole that undermines patient safety. A doctor who has been struck off the medical register in one EEA country for serious misconduct, such as malpractice, negligence, or ethical violations, can potentially apply for and receive a license to practice in another EEA country without their previous disciplinary history being fully considered or acting as an automatic bar to registration.1

National medical regulatory bodies are primarily responsible for licensing and disciplining doctors within their own jurisdictions. While there are mechanisms for information exchange, these are often reactive and dependent on specific requests rather than proactive, automatic sharing of disciplinary sanctions. The process for a doctor to register in a new EEA country typically involves submitting qualifications and a certificate of good standing from their previous regulatory body. However, a certificate of good standing may only reflect the doctor's status at the time of issue and may not always fully disclose ongoing or past disciplinary proceedings if the doctor has already been removed from the register.2

The clinical context for this issue is broad, encompassing all medical specialties and patient populations. A doctor banned for surgical negligence in one country could potentially perform surgery in another, exposing patients to the same risks that led to their initial de-registration. Similarly, a general practitioner removed for prescribing irregularities or a psychiatrist for boundary violations could continue to practice, potentially endangering vulnerable individuals seeking primary care or mental health support. The lack of a unified system means that patients, often unaware of a practitioner's history, place their trust in individuals who have failed to meet professional standards elsewhere. This mechanism of

re-licensing effectively allows a practitioner to circumvent accountability by simply crossing a national border within the EEA.

The Regulatory Disparity

The core issue lies in the varying legal frameworks and interpretations of professional conduct across EEA member states. What constitutes a sanction sufficient to bar a doctor from practice in one country may not automatically trigger the same response in another. For instance, a doctor found guilty of gross negligence in Country A and subsequently removed from its medical register might apply to practice in Country B. If Country B's regulatory body does not have an immediate, robust, and legally binding mechanism to recognise and enforce Country A's disciplinary decision, the doctor may be re-licensed. This situation is exacerbated by the fact that national regulators often lack direct jurisdiction over actions taken in other countries.3

The European Union's Professional Qualifications Directive (2005/36/EC), which facilitates the mutual recognition of professional qualifications, includes provisions for administrative cooperation and information exchange between competent authorities. However, these provisions have not proven sufficient to close this specific loophole. The directive aims to prevent barriers to free movement, but its application has not fully reconciled the need for professional mobility with the imperative of patient protection from practitioners with a history of serious misconduct. The system relies heavily on the diligence of individual regulatory bodies and the completeness of information provided by applicants, rather than a centralised, mandatory, and immediately accessible database of disciplinary actions.4

The limitations of the current system extend beyond mere information exchange. Even when disciplinary information is shared, the legal weight given to a foreign disciplinary decision can vary significantly. Some national laws may require a full re-investigation of the original misconduct, which is resource-intensive and often impractical, rather than simply recognizing the judgment of the originating country's regulator. This disparity in legal recognition creates a significant barrier to effective enforcement. The epidemiology of such cases is difficult to quantify precisely due to the lack of a centralized tracking system, but anecdotal evidence and reports from national medical councils suggest that this is not an isolated phenomenon, posing a persistent risk to public health across the EEA.

The consequences of this regulatory gap are significant. Patients in countries that inadvertently license banned doctors are exposed to practitioners whose competence or ethical standards have been deemed unacceptable elsewhere. This erodes public trust in the medical profession and the regulatory systems designed to safeguard health. Furthermore, it creates an uneven playing field for medical professionals, as those who adhere to high standards may find themselves working alongside individuals who have circumvented disciplinary actions. Addressing this issue requires a concerted effort to harmonise the recognition of serious disciplinary sanctions across all EEA member states, ensuring that a doctor banned in one country cannot simply relocate and resume practice elsewhere.5

> **CLINICAL IMPLICATIONS**
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> The current regulatory framework within the European Economic Area presents a stark dilemma for patient safety. When a doctor is struck off a medical register for serious misconduct, the expectation is that their ability to practice medicine is curtailed. The reality, however, is that this sanction can be circumvented by simply moving to another EEA country. This is not merely an administrative oversight; it is a systemic vulnerability that directly impacts patient care and public confidence in the medical profession. National medical councils,

> such as the General Medical Council in the UK or the various Ärztekammern in Germany, invest significant resources in disciplinary processes. To have these decisions effectively nullified by cross-border re-licensure undermines the very purpose of professional regulation.
> For clinicians, this situation creates an uncomfortable ethical landscape. While the vast majority of medical professionals uphold the highest standards, the presence of individuals who have evaded serious sanctions can tarnish the reputation of the profession as a whole. It also places an undue burden on healthcare systems in receiving countries, which may unknowingly employ practitioners with a history of serious professional failings. The onus should not be on individual hospitals or clinics to conduct exhaustive international background checks that national regulatory bodies are better equipped to perform. A more robust, perhaps even automated, system for sharing and recognising disciplinary actions is imperative. This would ensure that a doctor deemed unfit to practice in Dublin is also deemed unfit to practice in Lisbon, without requiring a new disciplinary process.
> The pharmaceutical and medical device industries, while not directly involved in medical licensure, operate within this regulatory environment. Any erosion of trust in the medical profession due to such loopholes can indirectly affect the perception of medical advancements and treatments. Ultimately, the current situation calls for a re-evaluation of the Professional Qualifications Directive's implementation regarding disciplinary actions. A unified, legally binding mechanism for the mutual recognition of serious medical sanctions is not just desirable; it is essential for maintaining the integrity of medical practice across Europe and, crucially, for protecting patients from harm.

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REFERENCES

1. 1. European Commission. Professional Qualifications Directive 2005/36/EC. Official Journal of the European Union. 2005;L255:22-142.
2. 2. General Medical Council. Good medical practice. London: General Medical Council; 2013.
3. 3. World Health Organization. Global code of practice on the international recruitment of health personnel. Geneva: World Health Organization; 2010.
4. 4. European Parliament and Council. Directive 2005/36/EC on the recognition of professional qualifications. Official Journal of the European Union. 2005;L255:22-142.
5. 5. Council of European Professional Informatics Societies. The European professional card: a tool for mobility. Brussels: CEPIS; 2016.

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