Department of Health

From Dr Dan Poulter MP
Parliamentary under Secretary of State for Health

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Dr F Wilcox
HM Senior Coroner
Westminster Coroner's Court
65 Horseferry Road
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24th February 2015

Dear Dr Wilcox,

Thank you for your letter following the inquest into the death of Pauline Edwards. I was very sorry to learn of Ms Edwards's death and wish to extend my sincere condolences to her family.

The inquest concluded that Ms Edwards died as a result of an operation under general anaesthetic for benign ovarian cyst, hypoxic ischaemic encephalopathy and cardiorespiratory arrest.

You outline the events surrounding the operation and explain several serious failings on the part of the responsible anaesthetist that led to a prolonged period of hypoxia resulting in cardiac arrest and death.

You report that the responsible anaesthetist had trained in Italy and, from evidence at the inquest, clearly had insufficient experience to deal with the most common anaesthetic emergency even though she was supposed to be qualified to the equivalent level of consultant. You point out that EU Regulations require the UK to recognise EU qualifications of doctors even though the actual training may be well below that of an equivalently qualified doctor in the UK.

You had particular concerns:

- That UK hospitals are forced by law to accept the qualifications of EU trained doctors even though these doctors may not have the same training and experience as doctors in the UK.
- That UK hospitals are unaware of this and so allow such doctors to practise unsupervised and so put patients' lives at risk.

You also commend a training and supervision programme that St George's hospital has put in place following this death and ask that the Department considers sharing this example of good practice within the wider NHS.
To address your concern about the equivalency of non-UK medical training and standards, I would like to first draw your attention to the Mutual Recognition of Professional Qualifications Directive (MRPQ).

This Directive, agreed in 2005 and transposed into UK law in 2007, allows professionals to have their qualifications, obtained in one Member State, recognised in another and thus allows them to be employed anywhere within the Single Market irrespective of where they have trained. The Directive applies to the European Economic Area (EEA), which includes EU Member States along with Norway, Iceland and Liechtenstein.

The system of automatic recognition under this Directive applies to seven professions; doctors, dentists, general care nurses, midwives, pharmacists, veterinary surgeons and architects. For these professions there are harmonised minimum training requirements and Member States are obliged automatically to recognise qualifications which meet these criteria.

In addition, Article 25 of the MRPQ Directive requires that any admission to medical specialty training is contingent upon completion of the harmonised basic medical training requirements under the Directive. In order for an individual to benefit from automatic recognition of a specialty qualification the specialty courses must be listed in Annex 5 of the Directive under both the home and host Member State. In order to be listed under Annex 5 the specialty training must comply with the minimum period of training, which is set out in Annex 5 point 5.1.3 of the Directive, for each listed specialty.

However, the Department is aware that the General Medical Council (GMC) has some concerns around the comparability of curriculum between some of the UK specialties and specialties in other Member States listed under Annex 5. Subsequently officials at the Department of Health are working with the GMC to strengthen the processes around confirming that medical specialties have equivalent curriculum content to ensure that EU doctors working in the UK are of a suitable standard to maintain patient safety.

The Department is also working with the GMC to make sure there is a robust process for considering new additions to the medical specialties listed in Annex 5 of the Directive before the UK agrees to list its own comparable specialty.

Regarding the training and supervision programme at St George's hospital, as part of the application process for registration, clinical staff from within the EU have their qualifications verified by the General Medical Council. These clinical staff are then encouraged to carry out an "observership" placement, prior to applying for jobs, to familiarise themselves with the NHS.

When the St George's Healthcare NHS Trust receives a job application, the applicant's written communication skills are assessed from their application form and their verbal communication skills are assessed at interview. An applicant's level of training, experience and knowledge is assessed at interview through clinical scenario assessments. References and letters detailing employment are sought from relevant overseas employers to confirm an applicant's experience.

Staff appointed then attend a course run by the simulation team at St George's Hospital which aids their transition to the UK and to the NHS.

Health Education England (HEE) is the appropriate body to comment on the training and supervision programme run by St. George's hospital. They consider this induction programme, which features increased initial supervision and mandatory sign-off for non-UK trained staff before they can go onto any rota appears thorough and could be disseminated as an example of good practice. However, whilst HEE provides national, strategic leadership on education and training that is responsive to patient's changing needs, primary responsibility for induction arrangements for clinical staff rests with individual employers.

I hope that this response is helpful and I am grateful to you for bringing the circumstances of Ms Edwards's death to my attention.

Best wishes,

DR DAN POULTER